Social Policy in a Cold Climate

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Labour's Record on Health (1997-2010)

Polly Vizard and Polina Obolenskaya

Preface

This is one of a series of papers arising from a programme of research called Social Policy in a Cold Climate, designed to examine the effects of the major economic and political changes in the UK since 2007, particularly their impact on the distribution of wealth, poverty, inequality and spatial difference. The analysis includes policies and spending decisions from the last period of the Labour government (2007-2010), including the beginning of the financial crisis, as well as those made by the Coalition government since May 2010. The programme is funded by the Joseph Rowntree Foundation and the Nuffield Foundation, with London-specific analysis funded by the Trust for London. The views expressed are those of the authors and not necessarily those of the funders.

The research is taking place from October 2011 to May 2015. More detail and other papers in the series will be found at:
http://sticerd.lse.ac.uk/case/_new/research/Social_Policy_in_a_Cold_Climate.asp

In our first set of papers, we look back at the policies of the Labour government from 1997 to 2010, charting their approach and assessing their impact on the distribution of outcomes and on poverty and inequality particularly. This provides a basis for analysing and understanding the changes that have subsequently taken place under the Coalition.

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We welcome comments on this paper, to p.a.vizard@lse.ac.uk.

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Research aims

The aim of this research report is to provide an overall evaluation of Labour's record on health 1997-2010 as an input into the Social Policy in a Cold Climate research programme. The report summarises, brings together and assesses the available evidence on goals, policy aims and policies; trends in public and private expenditure; trends in healthcare provision and delivery; and outcomes including in relation the healthcare system itself, overall population health, heath inequalities and the UK's international position. A follow on paper will evaluate the Coalition's record on health after 2010 using a similar conceptual framework.

Goals, policy aims and policies

- **Two high level goals** can be identified from Labour Party Manifestos and other key policy statements. These are (1) 'saving the NHS' through a programme of healthcare investment, modernisation and reform; (2) improving overall population health outcomes and reducing health inequalities. In England, Labour's programme of healthcare modernisation and reform included targets and strengthened performance management; promotion of a plurality of providers to expand capacity and to drive up quality, with increasing emphasis on patient choice and provider competition; decentralized organizational structure (retention of the purchaser/provider split, commissioning by Primary Care Trusts and practice based commissioning); "bottom-up" pressure to drive up standards; and strengthened regulation, inspection and complaints handling.
- **Labour's first term (1997-2001).** The state of the NHS was a key fault line of the 1997 General Election Campaign, with Blair famously declaring on the eve of the election that voters had "24 hours to save the NHS". However, immediate plans for large cash injections into the NHS were delayed until after 2000, with early commitments to uphold Conservative expenditure plans and not raise tax upheld and plans for alternative financing models (e.g. a hypothecated health tax) were considered but rejected. The healthcare modernisation and reform programme took hold, with the creation of regulators, NICE, national Frameworks, NHS Direct, targets including for reduction in waiting lists, performing ratings, primary legislation, White Papers, the NHS Plan, organizational reform / retention of the purchaser-provider split, PFIs. Public health measures included the Acheson Inquiry into Health Inequalities and the Food Standards Agency, with multidimensional strategies such as Health Action Zones and Sure Start Centres.
- **Labour's second term (2001-2005).** Developments included the "world class public services" agenda, intended to raise standards, and the introduction of Public Service Agreements (PSAs). These set outcome-orientated targets for improving healthcare and overall health outcomes and reducing inequalities. The Wanless Review into the resources needed for an improved public health service was followed by unprecedented funding increases to implement a "catching up and keeping up" agenda. Further emphasis was put on competition and choice. This was linked to the creation of commissioning bodies such as Primary Care Trusts and Foundation Trusts, while a Quality Outcomes Framework was introduced. Public health measures included the launch of a cross-departmental health inequalities strategy and a White Paper signalling the Government's intention to introduce a smoking ban.
- **Labour's third term (2005-2010).** The rate of increase in public expenditure on healthcare eased following years of sustained increases. Nevertheless, public spending on healthcare

continued to grow in real terms between 2008/9 and 2009/10 (by almost 6 per cent in 2009-10). The pace of organisational change and reform also slowed, although waiting time targets were tightened. Inquiries into NHS reform (the Darzi Review) and health inequalities (the Marmot Review) produced further recommendations for reform. A ban on smoking in public places was introduced, as well as a new cancer strategy, a health inequalities intervention tool, and a constitution for the NHS. Measures were taken to improve accountability for public health, including through local authority Local Area Agreements.

- **Healthcare policy in the devolved countries.** Following devolution, there were key divergences between policies ('means') in constituent countries of the UK, with Scotland, Wales and Northern Ireland putting less emphasis on competition, choice and the purchaser/provider split. Prescription charges maintained in England but abolished in Wales with plans for abolition in Scotland. Ban on smoking in public places implemented in Scotland and Wales ahead of England.

Resources

- **Health expenditure as a national priority.** Health was a key national priority under Labour with significant real growth in public expenditure on health across all three terms above historical trend, well above the growth rates under Thatcher and Major, and with a substantial increase in the share of national resources devoted to healthcare.
- **Catching up and keeping up.** The growth of real public expenditure on healthcare outstripped whole range of other aggregates such as GDP, TME GHDI in absolute and per capita terms; and annual rates of real growth in public expenditure on health broadly in line with recommendations set out in the Wanless Report (2001).
- **The UK's international position.** The gap with the European average measured by the ratio of total real (public and private) expenditure to GDP was virtually eliminated. Whilst public expenditure on healthcare as a percentage of GDP increased, private expenditure as a percentage of GDP flat-lined in real terms and remained low by international standards.
- **The distribution and allocation of funding across the constituent countries of the UK.** Expenditure in England per capita remained below that of the other three countries of the UK but the variance in finding between the four countries of the UK fell. The principle of needs-based resource allocation was deepened and extended, with the introduction of a new health-inequalities component to the funding formula (England).
- **Labour's financing model.** General taxation remained the primary source of NHS financing throughout the period with national insurance based funding also playing a role. Alternative financing models including social insurance and a ring-fenced hypothecated tax model were actively considered during Labour's but ultimately rejected.

Inputs and outputs

- **How big was the supply side expansion?** There was a substantial expansion of healthcare supply over the period 1997-2010. Whilst debate continues about the extent to which cash increases were absorbed by increasing wages and salaries, indirect (expenditure based) estimates of volume growth suggest that the supply side expansion was substantial even when NHS specific wage costs and inflation are taken into account. According to official ONS (direct) estimates, the volume of publicly financed healthcare output grew by 97 percentage points between 1997 and 2010. Further, this estimate should be regarded as a lower-bound estimate of the volume of healthcare output growth over the period
- **The debate about healthcare productivity.** On-going political debates about whether the cash increases under Labour were well spent have been fuelled by suggestions that growth in healthcare inputs outpaced growth in outputs, with a consequent fall in productivity. Official ONS estimates which suggested a fall in productivity over the period have recently been revised. The most recent figures suggest that publicly financed healthcare productivity increased by 6.2 percentage points between 1997 and 2010. This estimate should be regarded as a lower-bound estimate of healthcare productivity growth over the period.
- **The changing balance of public/private provision.** According to official ONS estimates, the volume of healthcare goods and services that were publicly financed but that were provided *outside* the NHS increased by a factor of five during Labour's period in office. This finding is in line with broader shifts in the balance of provision of welfare towards publicly funded but privately delivered public services. Nevertheless, according to ONS analysis, the main contribution to the growth in the volume of healthcare goods and services during Labour's period in office was from growth in goods and services procured from *within* the NHS.
- **Supply, demand and need**. The growth in real healthcare output per capita significantly outpaced the growth in the population over 65, the population over 85, and the growth in real expenditure implied by demographic pressure alone.

Healthcare outcomes

There were substantial overall improvements in healthcare access and quality over period measured by a range of indicators.

- **Access to healthcare.** Waiting lists and waiting times improved dramatically and the number of GPs per head increased. However, according to NAO research, inequities in access to GPs between more and less deprived areas were not fully eliminated by 2010.
- **Healthcare quality.** According to ONS analysis, there were improvements in healthcare quality including post-operative survival rates and reductions in avoidable mortality.
- **Patient experience and individual satisfaction.** Overall patient experience scores were high in a range of service areas. Overall satisfaction with National Health Services rose from lows of 36% in 1997 to highs of 71% in 2010.
- **Variations in hospital performance and sub-standard care** remained a key concern at the end of Labour's period in power. Variations in standardised hospital mortality rates, sub-standard care and managerial, supervisory and regulatory failure were subsequently highlighted by the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013).

Overall health outcomes

There were important improvements in overall population outcomes over the period 1997-2010, with a remarkable reductions in circulatory disease mortality and further reductions in mortality from lung cancer and suicide.

- **Life expectancy.** Overall life expectancy continued its long run tendency to improve over the period 1997-2010 and Labour's target to improve overall life expectancy was virtually achieved based on a data window 1995-1997 / 2008-2010 (England only, with one year's data outstanding).
- **Infant mortality.** Overall infant mortality reaching historic lows in all four constituent countries of the UK.
- **Circulatory mortality.** A reduction in circulatory disease mortality was a major achievement of the period with a 52% reduction in three-year average circulatory disease mortality per 100,000 men under 75 between 1995-1997 / 2008-2010 (England only). Targets to reduce overall circulatory mortality were met.
- **Cancer mortality.** The overall cancer mortality rate also fell during the period (with a 22% fall over the period 1995-1997 / 2008-2010) and with important reductions for some specific cancers (e.g. a decline in the lung cancer mortality rate for men). Targets to reduce mortality from cancer were met (based on data for the period 1995-1997 / 2008-2010, England only).
- **Suicide.** Labour's target for reducing overall mortality through suicide (or undetermined intent) was missed despite a 13% reduction in the age standardized rate whilst Labour was in power (based on figures for 1995-1997 / 2008-2010). The age-standardized suicide rate per 100,000 males over 15 increased in 2008 and 2009, in line with increases in other European countries in the wake of the financial crisis and economic downturn.

Inequalities in population health outcomes

Reducing inequalities in population health outcomes proved challenging, although the closure of the infant mortality gap by social class is an important "good news" story of the Labour years.

- **Life expectancy.** A target to reduce life expectancy inequalities was specified in terms of reducing the relative gap between areas with the worst health and deprivation ('spearhead' areas) and the England average. For both men and women: absolute and relative gaps increased and the target was not met (based on a data window 1995-1998-2008/2010, England only).
- **Infant mortality.** A target to reduce infant mortality inequalities was specified in terms of reducing the relative gap between the routine / manual occupational groups and the all England average. Progress was initially slow and both the absolute and relative gaps initially increased. However, there was a fall in inequality towards the end of Labour's period in power and the absolute and relative gaps fell by 42% and 25% respectively over the period 1997-99 / 2008-2010 as a whole (England only, with one year of data outstanding).
- **Circulatory mortality.** Labour's target for circulatory mortality was specified in terms of reducing the absolute gap between areas with the worst health and deprivation ('spearhead' areas) and the England average. The absolute gap improved during Labour's period in power and the target was met based on a data window 1995-1997 / 2008-2010 (England only). However, the relative gap increased by 15.2 per cent over this period.
- **Cancer mortality.** Labour's cancer mortality target was specified in terms of reducing the absolute gap between 'spearhead' areas and the England average. The absolute gaps improved and the target was met based on a data window over the period 1995-1997 /

2008-2010 (England only). However, relative gaps increased by 13.4 per cent of this period.

Behavioural, lifestyle and risk factors

Tackling underlying behavioural, lifestyle and risk factors also proved challenging between 1997 and 2010 although smoking prevalence, a major priority for Labour, did fall.

- **Obesity** continued its medium term tendency to increase between 1997 and 2010. An early target to halt the increase in child obesity in children by 2004 was not met. However, there was some evidence of a halt in the increase in child obesity towards the end of Labour's period in power (between 2006-08 and 2008-2010).
- **Teenage pregnancy.** The under 18 conception rate fell from 46.6 per 1000 females aged 15-17 in 1998 to 35.4 in 2010. However, Labour's target to reduce teenage pregnancy, which aimed at a 50% reduction in teenage pregnancies, was not met.
- **Smoking.** Labour's target to reduce the overall smoking prevalence rate was met and a further target to reduce the disparity between the overall population smoking prevalence rate, and the rate for individuals from the manual occupational groups, was achieved in 2007. However, the smoking prevalence rate amongst individuals from the manual occupational groups subsequently increased and the figure was above target in 2010.

The UK's international position

Disappointingly, whilst a number of outcome indicators improved during Labour's period in power, the advances did not amount to a "race to the top" of international league tables. By 2010, the UK can be characterised as having a "mid" table position on international tables and remained below the best performers, comparator countries and the OECD average for a range of outcomes.

- **Healthcare access.** Access to healthcare was equitable in the UK in 2010 by international standards.
- **Healthcare quality.** The UK had a disappointing "mid" table positioning in 2010 in relation to a number of healthcare outcomes compared with OECD countries. Case fatality for acute myocardial infarction and for ischemic and haemorrhagic stroke remained below that in the best performing OECD countries. Cancer survival in the UK remained below the OECD average for some specific cancers including breast cancer, cervical cancer, colorectal cancer.
- Overall health outcomes. There was a negligible improvement in the UK's international ranking for life expectancy for men (with the UK moving from 14th to 13th position amongst 34 OECD countries) between 1997 and 2010. There was a slight worsening for women, with the UK dropping from 20th to 24th position. The UK's infant mortality rate ranking dropped from 19th to 25th position amongst 34 OECD countries 1997 to 2010.
- Heart disease and stroke mortality. The UK had a mid-table position in relation to the age-standardized mortality rate for ischaemic heart disease for men. It was ranked 19th out of 33 OECD countries (based on data for 2010 or nearest available period). This was a higher rate than the France and the Netherlands. At the same time, it was a similar rate to Germany and Sweden, below the rate in US and below the OECD (33) average.
- Cancer mortality. The improvement in the UK's international standing in relation to age-standardized all-cancer mortality for women whilst Labour was in power was negligible (with the UK moving from 29th to 28th position in the table between 1997 and 2010 amongst OECD 33 countries). For men, the UK's position remained unchanged at 17th position. International rankings for specific-cause cancer mortality in 2010 were variable by cancer type and sex. Age-standardized mortality rates for colorectal cancer for men and women, and for cervical

cancer for women, were below the OECD average. Age standardized mortality rates for lung cancer for women, for breast cancer (for women) and prostate cancer (for men) were above the OECD average and stand out as particular concerns.

- **Lifestyle, behaviour and risk factors.** The UK was ranked within worst performing cluster of OECD countries for obesity prevalence in 2010.

Conclusions

- Substantial returns on Labour's large-scale investment in the National Health Service were achieved and were reflected in measures of healthcare quantity, quality and satisfaction. Given the "big picture" of massive supply expansion, the elimination of capacity constraints; improvements in a range of quality indicators and a remarkable increase in overall satisfaction with the NHS, the gains in terms of what was extracted from an extra 3% of GDP were considerable. In 1997, the public were highly dissatisfied with the NHS, with long waiting lists, pressure for more expenditure on healthcare and demand for private medical insurance going up. By the end of period, waiting lists and waiting time were down, demand for private medical insurance was down, and satisfaction with the NHS was running at more than 70%.
- However, variations in healthcare quality and performance remained a key concern in 2010 as they were in 1997. Greater regulation itself helped to generate a growing body of empirical evidence on sub-standard care coupled in some instances by regulatory failure, as highlighted in the Mid-Staffordshire NHS Trust Public Inquiry. There are on-going debates about productivity growth over the period 1997-2010 and whether the money was well spent. Whilst overall population health outcomes mainly improved, the task Labour set itself of reducing health inequalities proved challenging and yielded mixed results. Health inequalities remained pervasive in 2010, as highlighted in the Marmot Review. Progress in addressing lifestyle, behavioural and risk factors was also limited and the UK's position on international health league tables relative to other comparator countries remained disappointing.
- Looking forward, a number of key issues emergence from our analysis as requiring evaluation and scrutiny. The 2010 General Election represented a seismic break-point for health services both in terms of the UK's economic and fiscal climate; and an acceleration of adverse trends in terms of demographic pressure. Whilst public expenditure on health is in principle being protectively ring-fenced, what will be the impact on resource allocation and supply?
- Labour sought to encourage a greater diversity of providers through greater competition and choice in the NHS against backdrop of sustained spending increases and supply side expansion. The Health and Social Care Act 2012 seeks a radical acceleration of this process against a backdrop of austerity and fiscal consolidation. Organisational reforms and new approaches to commissioning and decentralization are being taken further and faster by the Coalition. The balance in the public / private provision of healthcare also looks set to undergo a much more substantial transformation. The effects on quality and equity will require scrutiny.
- The Coalition has criticised 'command and control' and the use of central targets. The targeting regime of PSAs has been dropped, but will this mean more or less accountability for health inequalities? Further decentralization and the localization agenda are now viewed as key to accountability and improvement - but will this strategy work?
- The Public Inquiry into Mid-Staffordshire NHS Foundation Trust has raised important questions about the enforcement of minimum standards and effective supervision and regulation. How will the Coalition respond?

A later paper in the series will evaluate health policy under the Coalition Government and the impact of fiscal retrenchment. Other papers will examine other major social policy areas including education, children's services, neighbourhood renewal and tax / benefit. A final paper will draw together the findings and examine the broader implications for social policy up to 2015.

1. Introduction

One of the first moves of the Coalition Government that came to power in May 2010 was to launch a major programme of healthcare reform. The Health and Social Care Act 2012 was passed amidst a protracted political debate and is resulting in a major transformation of the way in which the NHS operates. Organizational decentralization of the NHS and the introduction of commissioning groups are being accompanied by other key changes, including the devolution of responsibilities for public health. The reform programme is being undertaken in the context of a seismic change in the fiscal landscape following the financial crisis and economic downturn that began in the autumn of 2007, with far-reaching consequences for the trajectory of future NHS funding. The period of significant and sustained year-on-year, real terms increases in spending has come to a rapid halt.

A later paper in the series will evaluate health policy under the Coalition Government and the impact of fiscal retrenchment. The current paper provides the context for on-going developments by looking back at the record of the recent Labour Government on health over the period 1997-2010[i]. The paper examines Labour's programme of healthcare investment, modernisation and reform together with its public health programme. It examines achievements and challenges in terms of the expansion of good health (that is, the capability to be healthy, free from premature mortality, illness, disease, disability and injury), health equity (that is, the extent to which good health is distributed equally across individuals and groups) and efficiency (defined, broadly, as the success of Government policy in achieving the goal of good health for all, but including the efficient use of resources and productivity).

Like the other papers in this series, the paper examines a conceptual chain beginning with high level aims and objectives, and then moving on to look at policies, resources, inputs / outputs, and outcomes. By working through this conceptual chain in a number of discrete social policy areas (healthcare, education, children's services etc.) we aim to build-up a systematic framework for evaluating social policy achievements under Labour (1997-2010) and for making comparisons with progress made under the Coalition (2010-2015).

The paper is set out in ten main parts. Following this introductory section, **section 1** provides an overview of goals, policy aims and policies. Labour's period in power 1997-2010 was characterised by two high-level overarching goals. The first was to secure high quality healthcare for all by investing in, modernising and reforming the NHS. The second was to promote overall population health and wellbeing and reduce health inequalities by making public health a national priority. In England, policy strategies developed to promote these aims included a programme of healthcare modernisation and reform including unprecedented targets and strengthened performance management; promotion of a plurality of providers to expand capacity and to drive up quality, with increasing emphasis on patient choice and provider competition; decentralized organizational structure (retention of the purchaser/provider split, commissioning by Primary Care Trusts and practice based commissioning; "bottom-up" pressure to drive up standards; and strengthened regulation, inspection and complaints handling.

During Labour's first term (1997-2001), immediate plans for large cash injections into the NHS were delayed until after 2000, with early commitments to uphold Conservative expenditure plans and not raise tax upheld and plans for alternative financing models (e.g. a hypothecated health tax) considered but rejected. The healthcare modernisation and reform programme took hold, with the

creation of regulators, NICE, national Frameworks, NHS Direct, targets including for reducing waiting lists, performing ratings, primary legislation, White Papers, the NHS Plan, organizational reform / retention of the purchaser-provider split and, in relation to capital projects, PFIs. Public health measures included the Acheson Inquiry into Health Inequalities, recognition of non-health determinants (e.g. Sure Start Centres), the creation of Health Action Zones and the Food Standards Agency.

Labour's second term (2001-2005) gave rise to the *World Class Public Services* agenda; with ground breaking Public Service Agreements establishing outcome-orientated national targets covering healthcare outcomes, population health outcomes and health inequalities. The Wanless review was followed by unprecedented sustained cash injections to implement the "catching up and keeping up" agenda; whilst new plans for moving "beyond a monolithic top down centralized NHS" came to the fore. There was more emphasis on competition, choice and commissioning (with an expansion of Independent Treatment Sector provision, organisational reform, creation of Primary Care Trusts, Foundation Trusts, payment by results, patient choice initiatives and Quality Outcomes Framework). On public health, measures included a tobacco advertising ban, the launch of a cross-departmental health inequalities strategy; and a White Paper signalling the Government's intention to introduce a smoking ban. The second term also saw the emergence of a health "responsibilities" agenda.

Labour's third term (2005-2010) ushered in a new wave of waiting times targets. There was an easing off in the growth in the rate of public expenditure on healthcare following the years of sustained increase, in line with the Wanless trajectory. Whilst there was a general tightening of purse strings against a backdrop of contracting GDP following economic crisis and downturn that began Autumn 2007, public expenditure on healthcare continued to grow 2008/9-2009/10 in real terms. Under Brown, there was a slowdown of the pace of organizational change and reform. Measures in this period included the Darzi Review and the NHS Constitution, the introduction of the smoking ban, the launch of a new cancer strategy, a new health inequalities intervention tool and family-nurse partnerships. There were a number of measures to align health targets and indicators and to strengthen accountability for achieving population health improvements and reducing health inequalities, including Local Area Agreements. The third term ended with the recognition of the persistence of health inequalities in the Marmot Review (2010).

Finally on goals, policy aims and policies, we highlight that devolution was an early measure under Labour that resulted in important divergences between policies ('means') in constituent countries of the UK, with Scotland, Wales and Northern Ireland putting less emphasis on competition, choice and the purchaser/provider split. Prescription charges were maintained in England but abolished in Wales (with plans for abolition in Scotland that were later implemented). The ban on smoking in public places was implemented in Scotland and Wales ahead of England.

In **section 2,** we examine the increase in real resources that were allocated to healthcare during the Labour years. In the UK as a whole, there was significant real growth in public expenditure on health across all three Labour terms with annual average growth rates well above historical trend and the rates under the previous Thatcher and Major administrations. The growth of real public expenditure on healthcare outstripped whole range of other aggregates such as GDP, TME GHDI in both absolute and per capita terms. There was substantial increase in the share of national resources devoted to healthcare, broadly in line with the "catching up and keeping up" recommendations set out in the Wanless Review. The gap with the European average measured by the ratio of total real (public and private) expenditure to GDP was virtually eliminated. Whilst expenditure in England per capita

remained below that of the other three countries of the UK, the variance in funding between the four countries of the UK fell. Finally on resources, we find that general taxation remained the primary source of NHS financing throughout the period that Labour was in power. National insurance based funding also played a growing role, but alternative financing models including social insurance and a ring-fenced hypothecated tax model that were actively considered during Labour's period in office were ultimately rejected.

In section 3, we examine trends in healthcare inputs and outputs over the period 1997-2010. We first consider the magnitude of the supply side expansion and the way in which increased public expenditure was translated into an expansion of the volume of healthcare provision. Whilst debate continues about the extent to which Labour's cash injections into the NHS were absorbed by high wage costs, we find that the expansion of the supply side was extremely substantial even when NHS specific wage and non-wage inflation is taken into account and that, according to official ONS (direct) estimates, the volume of publicly financed healthcare output grew by 97 percentage points between 1997 and 2010. We then turn to the question of healthcare productivity, which has moved up the public policy agenda since 2010. Official ONS figures suggesting that whilst economy-wide productivity increased during Labour's period in power, publicly financed healthcare productivity declined have recently been revised. The most recent figures suggest that publicly financed healthcare productivity increased by 6.2 percentage points between 1997 and 2010. We highlight a number of reasons why the ONS estimates should be regarded as a lower-bound estimate of healthcare output growth. On the changing balance of public and private welfare, we note that, in line with the broader shifts in the balance of provision of welfare towards publicly funded but privately delivered public services discussed in (Hills 2011), the volume of healthcare goods and services that were publicly financed but that were provided *outside* the NHS increased by a factor of five during Labour's period in office. Nevertheless, according to ONS analysis, the main contribution to the growth in the volume of healthcare goods and services during Labour's period in office was from growth in goods and services procured from *within* the NHS. Finally on inputs and outputs, we make some broad comments on trends in supply relative to demand and need, finding that the growth in real healthcare output per capita significantly outpaced the growth in the population over 65, the population over 85, and the growth in real expenditure implied by demographic pressure alone.

In **Sections 5-9,** we turn to an analysis of outcomes. In **section 5,** we begin by highlighting a broad picture of improving healthcare access and quality over the period 1997-2010 based on a range of indicators. Waiting lists and waiting times improved dramatically and the number of GPs per head increased (although inequities in access to GPs between more and less deprived areas were not fully eliminated by 2010). There were significant improvements in healthcare quality including post-operative survival rates and reductions in avoidable mortality. Overall patient experience scores were high in a range of service areas, and overall satisfaction with National Health Services rose from lows of 36% in 1997 to highs of 71% in 2010. Nevertheless, variations in hospital performance and poor quality healthcare remained a key concern at the end of Labour's period in power (for example, variations in standardized hospital mortality rates) with a growing body of evidence of poor treatment of vulnerable groups (e.g. older people, people with learning difficulties). Poor quality care was coupled with evidence of regulatory failure in some instances (e.g. Mid-Staffordshire Foundation Trust).

In **section 6**, we find that progress in improving overall population health outcomes over the period was also broadly positive. There were important improvements in a number of overall population outcome indicators over the period 1997-2010, with overall life expectancy continued its long run

tendency to improve over the period 1997-2010 and Labour's target to improve overall life expectancy was virtually achieved based on a data window 1995-1997 / 2008-2010 (England only, with one year's data outstanding). Overall infant mortality reached historic lows in all four constituent countries of the UK. A reduction in circulatory disease mortality was a major achievement of the period with a 52% reduction in three-year average circulatory disease mortality per 100,000 men under 75 between 1995-1997 / 2008-2010 (England only and targets to reduce overall circulatory mortality were met). The overall cancer mortality rate also fell during the period (with a 22% fall over the period 1995-1997 / 2008-2010) with important reductions for some specific cancers (e.g. a decline in the lung cancer mortality rate for men) and targets to reduce mortality from cancer were met (based on data for the period 1995-1997 / 2008-2010, England only). Labour's target for reducing overall mortality through suicide (or undetermined intent) was missed despite a 13% reduction in the age standardized rate whilst Labour was in power (based on figures for 1995-1997 / 2008-2010).

In **section 7** we find that reducing *inequalities* in population health outcomes over the period 1997-2010 proved challenging. The health targets set by Labour were demanding, particularly those specified in terms of the reduction of relative as well as absolute health gaps. For example, target to reduce life expectancy inequalities specified in terms of reducing the relative gap between areas with the worst health and deprivation ('spearhead' areas) and the England average. For both men and women, both absolute and relative gaps increased and the targets were not met (based on a data window 1995-1998-2008/2010, England only). In contrast, progress in reducing inequalities in infant mortality between the routine / manual occupational groups and the all England average was a "good news story" of the later Labour years. Again, Labour's target to reduce infant mortality inequalities was specified in terms of reducing the relative gap. Progress was initially slow and both the absolute and relative gaps initially increased. However, there was a rapid fall in the relative gap toward the end of Labour's period in power, and the most recent data suggests that the absolute and relative gaps fell by 42% and 25% respectively over the period 1997-99 / 2008-2010 as a whole (England only). Hence, whereas the relative gap Labour's target was not looking on course to be met at the time of the 2010 General Election, this target was in fact achieved (with one year of data outstanding).

Labour's targets for circulatory and cancer mortality were perhaps less demanding, being specified in terms of reducing absolute rather than relative health gaps. The absolute gap for circulatory mortality improved during Labour's period in power and the target was met based on a data window 1995-1997 / 2008-2010 (England only). However, the relative gap increased by 15.2 per cent over this period. Similarly, Labour's cancer mortality target was specified in terms of reducing the absolute gap between 'spearhead' areas and the England average. The absolute gaps improved and the target was met based on a data window over the period 1995-1997 / 2008-2010 (England only). However, relative gaps increased by 13.4 per cent over the period.

In **section 8,** we find that tackling underlying behavioural, lifestyle and risk factors also proved a major challenge with outcome indicators proving difficult to "nudge". Adult obesity continued its medium term tendency to increase between 1997 and 2010 and an early target to halt the increase in child obesity in children by 2004 was not met. However, there was some evidence of a halt in the increase in child obesity towards the end of Labour's period in power (between 2006-08 and 2008-2010). On teenage pregnancy, the under 18 conception rate fell from 46.6 per 1000 females aged 15-17 in 1998 to 35.4 in 2010. However, Labour's target to reduce teenage pregnancy, which aimed at a 50% reduction in teenage pregnancies, was not met. Smoking prevalence, a major priority for Labour, was a partial success story. Labour's target to reduce the overall smoking prevalence rate was met and a further target to reduce the disparity between the overall population smoking prevalence rate,

and the rate for individuals from the manual occupational groups, was achieved in 2007. However, the smoking prevalence rate amongst individuals from the manual occupational groups subsequently increased and the figure was above target in 2010.

In section 9, we find that the UK's international position also still lagged behind the best performers and comparator countries in 2010. Disappointingly, whilst a number of outcome indicators improved during Labour's period in power, the advances did not amount to a "race to the top" of international league tables. By 2010, whilst access to healthcare was highly equitable in the UK by international standards. The UK can be characterised as having a "mid" table position on international tables and remained below the best performers, comparator countries and the OECD average for a range of outcomes. The UK had a disappointing "mid" table positioning in 2010 in relation to a number of healthcare and population health outcomes compared with OECD countries, whilst for some lifestyle, behaviour and risk factors, the UK was ranked within worst performing cluster of OECD countries.

Finally, in **section 10** we consider overall evaluations of Labour's record on health 1997-2010, draw conclusions and highlight legacy issues.

2. Goals, Policy Aims and Policies

In this section we review health goals, policy aims and policies under Labour 1997-2010. We begin by identifying two high level goals and then provide a policy overview for each of Labour's three administrations (1997-2001, 2001-2005 and 2005-2010). We finish the section with a discussion of policy divergence in four countries of the UK following devolution.

Key findings

Goals, policy aims and policies

- **Two high level goals** can be identified from Labour Party Manifestos and other key policy statements. These are (1) 'saving the NHS' through a programme of healthcare investment, modernisation and reform; (2) improving overall population health outcomes and reducing health inequalities. In England, Labour's programme of healthcare modernisation and reform included targets and strengthened performance management; promotion of a plurality of providers to expand capacity and to drive up quality, with increasing emphasis on patient choice and provider competition; decentralized organizational structure (retention of the purchaser/provider split, commissioning by Primary Care Trusts and practice based commissioning; "bottom-up" pressure to drive up standards; and strengthened regulation, inspection and complaints handling.

- **Labour's first term (1997-2001).** The state of the NHS was a key fault line of the 1997 General Election Campaign, with Blair famously declaring on the eve of the election that voters had "24 hours to save the NHS". However, immediate plans for large cash injections into the NHS were delayed until after 2000, with early commitments to uphold Conservative expenditure plans and not raise tax upheld and plans for alternative financing models (e.g. a hypothecated health tax) were considered but rejected. The healthcare modernisation and reform programme took hold, with the creation of regulators, NICE, national Frameworks, NHS Direct, targets including for reduction in waiting lists, performing ratings, primary legislation, White Papers, the NHS Plan, organizational reform / retention of the purchaser-provider split, PFIs and public health measures including the Acheson Inquiry into Health Inequalities, Health Action Zones and the Food Standards Agency with some multi-dimensional strategies (e.g. Sure Start Centres).

- **Labour's second term (2001-2005).** Developments included the "world class public services" agenda, intended to raise standards, and the introduction of Public Service Agreements (PSAs). These set outcome-orientated targets for improving healthcare and overall health outcomes and reducing inequalities. The Wanless Review into the resources needed for an improved public health service was followed by unprecedented funding increases to implement a "catching up and keeping up" agenda. Further emphasis was put on competition and choice. This was linked to the creation of commissioning bodies such as Primary Care Trusts and Foundation Trusts, while a Quality Outcomes Framework was introduced. Public health measures included the launch of a cross-departmental health inequalities strategy and a White Paper signalling the Government's intention to introduce a smoking ban.

- **Labour's third term (2005-2010).** The rate of increase in public expenditure on healthcare eased following years of sustained increases. Nevertheless, public spending on healthcare continued to grow in real terms between 2008/9 and 2009/10 (by almost 6 per cent in 2009-10). The pace of organisational change and reform also slowed, although waiting time targets were tightened. Inquiries into NHS reform (the Darzi Review) and health inequalities (the Marmot Review) produced further recommendations for reform. A ban on smoking in public places was introduced, as well as a new cancer strategy, a health inequalities intervention tool, and a constitution for the NHS. Measures were taken to improve accountability for public health, including through local authority Local Area Agreements.

- **Healthcare policy in the devolved countries.** Following devolution, there were key divergences between policies ('means') in constituent countries of the UK, with Scotland, Wales and Northern Ireland putting less emphasis on competition, choice and the purchaser/provider split. Prescription charges maintained in England but abolished in Wales with plans for abolition in Scotland. Ban on smoking in public places implemented in Scotland and Wales ahead of England.

Labour's period in power 1997-2010 was characterized by two high-level overarching goals. The first was to secure high quality healthcare for all by investing in, modernising and reforming the NHS. The second was to promote overall population health and wellbeing and reduce health inequalities by making public health a national priority.

The first of these goals, creating a world class publicly funded health service with universal access by addressing underinvestment, expanding the supply side and promoting a programme of modernisation and reform emerged as a central leitmotiv of the Labour years. It was acknowledged from the start that achieving this goal would require significant investment to eliminate systemic capacity constraints (manifest most obviously in 1997 in long waiting lists and waiting times). A programme of policies would also be required to eliminate poor quality practice and reduce variations in access, quality and outcomes both within the UK (for example, unequal access to GPs in deprived areas and variations in hospital outcomes) and between the UK and comparator countries (reflected in the relatively low position of the UK on international league tables such as cancer care). Other key aims included improving quality and outcomes by establishing an efficient, responsive and individualized (that is, differentiated or personalised) public health service, tailored around the different needs of individuals and groups.

The policies that emerged to achieve these aims and objectives did so incrementally, with discontinuities and changes of direction on the way. For example, there was more emphasis on central direction earlier on in the period, for example, with emphasis on competition and choice accelerating before easing off under Brown. Broadly speaking, however, the healthcare delivery model that emerged in England had the following key elements:

- **Maintenance of publicly funded system of universal healthcare:** retention of universal (or near universal) access to healthcare based on need, free at the point of delivery and funded through general taxation; resource allocation to local populations on the basis of medical need.

- **Extra funding and supply side expansion:** a major expansion in the quantity and quality of healthcare achieved by a significant increase in the share of national resources committed to healthcare;
- **Strengthened performance management:** extensive use of targets, National Service Frameworks, Public Service Agreements, Departmental Strategic Objectives, Payment by Results, the Quality and Outcomes Framework, performance ratings and new forms of information on quality (e.g. star-ratings, health check, patient experience survey data);
- **Promotion of a plurality of providers:** mainly public provision but with Foundation Trusts and an increased role for the private and third sector service providers and capital projects, both to **expand capacity** and to drive up quality, with increasing emphasis on **patient choice and provider competition**);
- **Decentralized organizational structure**: retention of the purchaser/provider split begun by the previous Government and the evolution of a decentralized organizational structure e.g. Primary Care Trusts and practice based commissioning;
- **"Bottom-up" pressure to drive up standards and increase responsiveness**: patient choice with "money following the patient" together with mechanisms to improvement patient voice (e.g. "bottom-up" empowerment and accountability mechanisms such as patient involvement strategies, governance arrangements, and a NHS constitution);
- **Strengthened regulation, inspection and complaints handling:** national architecture for regulation and inspection, with decentralization, patient choice and provider competition underpinned by a framework of national standards and enforcement mechanisms;
- **Information:** publicly available ***/*** transparent information on quality and standards.

Labour's second high-level goal was to deliver a new public health strategy aimed at improving overall population health and wellbeing and reducing health inequalities. The root causes of health inequality including a range of factors outside of the healthcare system including poverty, unemployment, poor housing and the environment, and the need for public action beyond the establishment of a modernised healthcare system and for explicit measures to tackle health inequalities, were explicitly acknowledged in Labour's early statements of its aims and objectives. The new public health agenda was viewed as signalling a pivotal strategic break from the Conservative years, including the perceived failure to provide an adequate political response to the Black Report published at the beginning of the Thatcher administration. The latter had examined the persistence of health inequality despite the establishment of the National Health Service and the welfare state with a particular focus on the persistence of health inequalities by social class and on income inequality as an underlying determinant. It concluded that broad public policies beyond the healthcare system itself would be required to tackle health inequalities (DHSS 1980).

Labour's first term (1997-2001)

The state of the NHS was a key fault line in the 1997 General Election campaign, with waiting lists high, satisfaction ratings falling, extensive media reports of the failure to access treatment and care, and a widespread perception of underfunding and crisis. Prime Minister- to-be Tony Blair famously declared on the eve of the election that voters had "24 hours to save the NHS".

The aims and objectives of the new Government on coming to power were set out in the 1997 Labour Party Manifesto, which stated: "Labour created the NHS 50 years ago. It is under threat from the Conservatives. We want to save and modernise the NHS. ..[If] the Conservatives are elected again there may well not be an NHS in five years' time – neither national nor comprehensive'. The

Manifesto committed Labour to a series of measures including reducing waiting lists by 100,000 people, reducing waiting times for cancer, new national standards and quality targets, real terms year-on-year expenditure rises, ending the internal market, and reducing administrative costs. On public health, pledges included a minister for public health, goal-setting for improving the overall health of the nation and a tobacco advertising ban (Labour Party, 1997).

Two early overarching measures were important in setting the broad parameters for developments in health in Labour's first term and beyond. First, the Comprehensive Spending Review 1998 (Modern Public Services for Britain: Investing in Reform) set out plans for the period 1999-2002 and introduced the Public Service Agreement system, the new framework for accountability for public services that became a defining feature of Labour's period in office. The Review set the stage for subsequent settlements, establishing the principle that increases in resources would be conditional on public services performance and reform, with achievements evaluated in terms of 'outcome-orientated' performance indicators.

Second, once in power, and following a series of referendums, the Labour Government introduced the Scottish Parliament and new assemblies in Wales and Northern Ireland with devolved responsibilities including for health. The policy divergence after 1997 that resulted in this measure has subsequently been characterised as providing a "natural experiment", with the different policy trajectories in the four countries of the UK providing the focus for an examination of the extent to which different policies (for example, performance management, decentralization, provider competition and patient choice) are successful in achieving common objectives (or "ends") such as improving performance and quality (see Connolly *et al*:2011).

The dual strategy of modernising and reforming healthcare on the one hand, and improving population health including tackling health inequalities on the other, was embedded in the goals and strategic objectives of the Department of Health in the 1998 Comprehensive Spending Review. The Review specified the Department of Health's overall aim as being "to improve the health and wellbeing of the people of England, through the resources available" including both by securing the provision of comprehensive, high quality health care for all those who need it, regardless of their ability to pay or where they live; and by supporting activity at national level to improve the nation's health and reduce health inequalities (HM Treasury, 1998).

On finances, the Manifesto commitment on real term increases on public expenditure on healthcare were honoured during Labour's first term. However, plans to inject very large sums into the NHS were initially put on hold given broader commitments to uphold Conservative expenditure plans for the first two years in Government and not to raise the basic or top rates of income tax. The Chancellor Gordon Brown's first Budget after the Labour Party's victory in the 1997 general election included the abolition of tax relief for private medical insurance. The relief could be claimed by individuals paying premiums for those aged 60 or over and had been introduced in 1990 partly to reduce pressure on the National Health Service (Seely 2011: 1). With waiting lists still long and waiting times still high and satisfaction with the NHS still running at less than 50% (on which, see section 5), pressure for increased healthcare funding mounted during the first term. In January 2000, on the David Frost programme, and perhaps in a foreshadow of future rifts with the Treasury to come, Tony Blair controversially announced that healthcare spending would increase substantially in real terms with a view to eliminating the gap with the EU average spend as a percentage of GDP. Unprecedented sustained real increases in NHS UK funding of 6.1 per cent on average in real terms over the four years to 2003-04 were announced in the 2000 Budget by the Chancellor Gordon Brown.

Consideration of the options for a new NHS funding model were also by now being actively considered, with the Brown-commissioned Wanless Review producing an early report emphasising both the equity and efficiency effects of public provision, and the advantages of general taxation as a financing model (Wanless 2001). Media reports suggested that other senior Labour figures including Mandelson, Milburn, Powell and Adonis favoured an alternative approach. In a Blair initiated move, Adair Turner was asked to review the financing options, including social insurance and ring-fenced / hypothecated health tax-based models. Patient charges were left unchanged in the 1998 Comprehensive Spending Review, but in another symbolic act, charges for over 60s were abolished in 1999. In the end, alternative funding models including private insurance, social insurance, patient user charges and a rationed "core" healthcare service were considered but explicitly rejected in the NHS Plan (2000).

The healthcare modernisation and reform programme took hold during Labour's first term in office. In England, early emphasis was put on tackling poor quality care and variations in service provision by putting into place a national framework of quality standards. Regulation and inspection during the Conservative years had been weak, and the new approach included establishing a 'national minimum floor' for service provision through the creation of the Commission for Health Improvement (later the Healthcare Commission, and more recently, together with the Social Care Inspectorate, the Care Quality Commission). The Cancer Plan (2000) was the first of a series evidence-based national frameworks designed to drive up quality and embed best practice nation-wide. Similar frameworks were subsequently introduced for coronary heart disease, mental illness, older people, diabetes, renal disease, long-term conditions, chronic obstructive pulmonary disease and children's services. Measures to strengthen clinical governance included a new duty on service providers to monitor and improve the quality of care (the Health Act 1999), whilst treatment cost-ineffectiveness were addressed through the creation of the National Institute for Health and Clinical Excellence (NICE). This provided an innovative new model of demand management and rationing, with recommendations on cost-effective interventions based on 'Quality of Life Adjusted Life Years'. The first performance ratings for NHS Trusts providing acute services were published in 2001, providing a step towards information on provider quality and performance (DH 2002), and new forms of 24-hour and digital access were also established, with the creation of NHS Direct.

Initial plans were set out in White Papers including '*The New NHS: Modern, Dependable*' (DH 1997) and *A first class service: Quality within the NHS* (DH 1998) and, following Frank Dobson's replacement as Secretary of State for Health by Alan Milburn in 1999, the NHS Plan (2000). The latter set out a 10 year strategy to ease capacity constraints and reduce waiting lists by expanding supply and envisaged extra resources, extra staffing, extra beds, extra buildings, extra activities (procedures and treatments and consultations) as well as tackling new concerns (such as MRSA). The stated aim was to radically transform the NHS through a sustained programme of investment, modernisation and reform, replacing "an outdated system" given that 'the 1948 model is inadequate for today's needs'. The new strategy would tackle unacceptable variations in quality through national standards, inspection and regulation, with performance evaluated against a series of clearly specified and benchmarked targets including specified maximum waiting times. Mental health was recognized as a priority, and a scheme for improving access to GPs in deprived areas was introduced (DH 2000).

In opposition, Labour had opposed the internal market, and GP fundholding was abolished soon after Labour assumed power. However, the 1997 Labour Party Manifesto included a commitment to organizational decentralization and the purchaser-provider split was retained under Labour. In this

respect there was an essential continuity rather than a break with previous policy. A process of organisational reform involving a redistribution of power away from the centre and to decentralized commissioning units also took hold during Labour's first term, with the commissioning function being put in the hands of new primary care groups. This arrangement was intended to overcome the limitations of the previous system by providing larger units and more universal coverage (on which, see evaluations by Glennerster et al 1998 and Le Grand et al 1998). With commitments to reduce administrative costs also high on the agenda, other early organisation reforms included the abolition of health authorities and their replacement with strategic health authorities.

On the use of the private sector, whilst Labour's opposition to the privatisation of health services had been explicit in its 1997 Manifesto, the introduction of new Independent Sector Treatment Centres - run by the private and independent sectors and contracted to provide key services such as surgical treatments and diagnostic tests services - was a key policy development of Labour's first term. Initial justifications of private and independent sector delivery mechanisms focussed on the need for a strategy of co-operation between the public, independent and private sectors, with a particular emphasis on easing capacity constraints and expanding supply - a critical element of the overall strategy of reducing waiting lists. After 2002, the instrumental role of choice and competition in promoting quality was to become a key policy justification for public and independent sector involvement. However, whilst the NHS Plan (2000) made a commitment to extending patient choice, and signalled the use of the new private and independent sectors, it nevertheless suggested that the competition and the internal markets of the markets of the 1990s had resulted in fragmentation and failed to bring about improvements. Other key levers for raising quality – such as national quality standards backed by inspection and regulation - were viewed as having been neglected during the Conservative years and co-operation rather than competition was put forward as a primary driver of improvement and change.

The 1997 Manifesto had signalled commitment to improving rather than ending the use of the Private Finance Imitative, which was viewed by the Chancellor as critical to expanding capacity in public services after years of under investment. A new NHS buildings programme was put into place during Labour's first term, with the public sector specifying the outputs to be delivered and being charged annually for the services provided, whilst the private sector covering initial capital projects and assuming responsibility for cost-overruns. Political debate about the long-run consequence for public finances and the possibility of links between PFI funding and hospital deficits continued throughout Labour's terms in office and beyond.

Performance management during Labour's period in office has been widely characterised in terms of the old system of 'command and control' and old-style, top-down bureaucratic processes. However, the NHS Plan flagged up the need to move away from over central "command and control" (DH 2000: 30). Wanless et al (2007) also suggest a more complex picture even during Labour's first term, with an initial emphasis on active central management soon giving way to recognition of the need for decentralization and freedom from central control. For example, whilst the waiting list target included in the 1997 General Election Manifesto was enforced by the centre by active management, and the NHS Implementation Plan (2001) emphasised central active management together with clear targets and milestones, the publication of *Shifting the Balance of Power* in 2001 signalled a move away from central direction and recognized that a vast range of targets might be counterproductive (Wanless *et al*; 2007 41-43).

On public health, the importance of a two-pronged health strategy combining measures to modernise and improve the healthcare system with broader measures to improve overall population health was reflected in Labour's early statements of its high-level aims and objectives (e.g. Labour Party 1997, HM Treasury 1998). The *Independent Inquiry into Health Inequalities* (Acheson Report 1998) found that improvements in population mortality were advancing amongst the upper social classes at a faster rate than for routine and manual occupational groups and set out a series of recommendations for broad-based policy measures to improve overall population health and reduce health inequalities. The Acheson Inquiry was followed-up by a ground-breaking public health green paper (DH 1998). Health Action Zones designed to tackle health inequalities were introduced in 1999. The importance of social determinants of health, as well as the impact of early years on health inequalities, both received recognition in the Sure Start programme launched in 1999 which aimed, inter alia, to improve health and emotional development for young children living in deprived areas. The 2000 Spending Review included national targets to reduce mortality from heart disease, cancer, suicide and undetermined injury and announced new targets to reduce health inequalities between socio-economic groups and between the most deprived areas (HM Treasury 2000). The need to promote consumer interests over producer food interests was recognized in 2000 following the BSE crisis and deaths from food borne illnesses, with the creation of the independent Food Standards Agency.

Equality and human rights initiatives created a new framework of binding minimum standards through Labour's period in power. During the first term, the Human Rights Act (1998) imposed duties on public authorities of compliance with the European Convention on Human Rights (with implications for health service providers and commissioners). Other initiatives include the National Framework for Older People, designed to eradicate age discrimination in health and social care.

Labour's second term (2001-2005)

Labour's 2001 Manifesto committed the Government to creating "world class public services" through a major programme of investment and reform. Pledges included real-term increases in health spending averaging six per cent over a three year period, with a commitment that "over time we will bring UK health spending up to the EU average". UK health spending up to the EU average over time. Measures for healthcare included 20,000 extra nurses and 10,000 extra doctors; cutting maximum waiting times by the end of 2005 for outpatients appointments from six months to three months and for inpatients, from 18 month to six months; prioritizing cancer, heart disease and stroke; use of the private and independent sectors; and more patient choice. Measures for public health included targets to close the health gap in poorer communities, more screening and smoking prevention, together free fruit every day for children aged four to six in nursery and primary schools.

On finances, the Wanless Review was commissioned by Gordon Brown to examine health care funding needs in the period up to 2020. Reporting in 2002, the Review set out a medium term plan for UK health services to "catch up" and "keep up" with those in other developed countries. Wanless foresaw a first decade of real expenditure growth designed to enable the UK to "catch up' with best practice in other countries, followed by a "keeping up" decade in which the growth rate of spending would fall back. Overall, total real UK NHS spending would need to increase from around £68 billion in 2002/3 to £154 - £184 billion in 2022/23 (a real terms growth of around 126 per cent). However, the Review highlighted that resources alone would not be sufficient to implement the "catching up and keeping up" agenda and the transformation of healthcare would also require radical reform to tackle problems such as excessive waiting times, poor access to services, poor quality care and poor outcomes. The health outcomes trajectory would also critically depend on productivity gains (with

Wanless anticipating that that ICT innovation would play a key role) and to broader factors such as life-styles and smoking behaviour (Wanless, 2002, 2007).

In the 2002 budget, the Chancellor Gordon Brown announced that over the five years to 2007/8 the NHS would receive a 7.4 per cent average annual real-term growth in funding across the UK. The proposed funding in trajectory was in line with the Wanless recommendations, heralding "a five year period of sustained and high growth" to correct for decades of underinvestment, moving to lower projected rates of growth in the period 2007/8-2020 once the period of "catch-up" had been achieved (Brown 2002, Wanless 2007: 12). The increase in funding was to be financed in part through an increase in national insurance payments, including the removal of the national insurance ceiling for higher earners, characterised in the media as Brown's "NHS tax". However, the increase in funding for healthcare during Labour's second term was not unconditional. The 2004 Comprehensive Spending Review launched a major programme of public services reform. In health, a new series of PSA targets reflected the Governments two-pronged approach, with agreements and a raft of indicators relating to both the performance of the healthcare system itself and to broader population health outcomes and inequalities (on which, see section 5).

On modernisation and reform, the Government's plans were set out in *Delivering the NHS Plan: Next Steps in NHS Investment and Reform*, which suggested that, with extra "catch up funding" for the NHS on the table, the reform process would now accelerate. The publication set a series of supply side reforms that were characterised as "a journey, begun with the NHS Plan" involving "nothing less than the replacement of an outdated system". The aim was to move "beyond the 1940s monolithic top down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values" (DH 2002). The Independent Treatment Sector provision envisaged by the NHS Plan continued to expand and patient choice was introduced. Organisational reform, spearheaded by Number 10 Downing Street, now accelerated, with Primary Care Trusts introduced as a replacement for the former Primary Care Groups.

With proposals for Foundation Trusts now on the table, media reports of a major rift between Tony Blair and Alan Milburn on the one hand, and Gordon Brown on the other, intensified in 2002. Whereas the model for fully autonomous foundation trusts entailed revenue raising and borrowing powers, the objection from the Exchequer was articulated in terms of the consequences for public finances with foundation trusts still officially on the public sector books. John Reed replaced Alan Milburn as Secretary of State for Health in 2003 and Foundation Trusts were introduced in 2004 with circumscribed revenue raising and borrowing powers (including caps on private patient revenue).

Nevertheless, Foundation Trusts represented a radical break with the past and a milestone in the healthcare decentralization agenda. The bodies were established as independent legal entities (public benefit corporations) with duties to provide services to NHS patients and to consult and involve a board of governors (comprising patients, staff, members of the public and partner organisations) in the strategic planning of the organisation. The explicit objective was to decentralize power from central government and to make healthcare providers more responsive to the needs of local communities by establishing self-governing organizations free from operational control / management by health authorities and run by local managers, staff and members of the public. New financial powers included the ability to raise capital from both the public and private sectors (within borrowing limits determined by projected cash flows and based on affordability) and powers to retain financial surpluses to invest in the delivery of new NHS services (subject to caps). The new bodies were to be

regulated by a new independent body, Monitor, and fell within the scope of NHS inspection and standards (DH 2005).

In other key moves, a new system of *Payment by Results* was introduced in 2003-2004, with periodic extensions thereafter. The system was characterised by the Audit Office as a key modernisation measure that would ensure better use of resources by paying hospitals for their activities based on a system of average cost pricing, with built in incentives for throughput, efficiency and quality (Audit Commission 2004). The *Quality Outcomes Framework* was introduced in 2004 as part of the GP contractual arrangements, providing an incentive system that rewarded good performance and preventative work measured by a range of outcome indicators such as coronary heart disease management and blood pressure control. Having abolished GP commissioning when it came to power in 1997, a new form of GP commissioning, *practice-based commissioning*, was announced in the NHS Improvement Plan in 2004 and on a voluntary basis thereafter. Patient choice schemes were piloted in areas such as coronary heart disease and with the *London Patient Choice Project*. A timetable for extending patient choice was announced in 2004, with plans for patients needing elective surgery to be offered a choice of four or five hospitals and with hospitals able to compete for extra patients (and associated payments) beyond their traditional geographic boundaries. Critically though, price competition was ruled out, with prices set via the Payments by Results scheme.

Patient choice and provider competition were characterised as a key Blair legacy by Julian Le Grand (2006), who was appointed as health advisor in 2004. For Le Grand, competition and choice were not only instrumental to achieving responsiveness and efficiency in public services, but also represented a key equity measure. The key problem of monopoly state supply had resulted in equity traps whereby some users faced single poor quality providers with no possibility of "exit". In Le Grand's analysis, monopoly state provision was the key problem to be addressed in healthcare provision and could be overcome through quasi-markets and the extension of choice and competition with "money following the patient", rather than through resource increases, performance management or targets (Le Grand 2006). Years later, commenting on the Coalition healthcare reforms that followed on from Labour's term in office, Le Grand suggested an essential continuity with the Blair era, with the essential elements of competition and choice already in place in Blair's second term (Le Grand 2012).

Labour's public service reform agenda launched an important debate about the relative merits of patient choice and provider competition on the one hand, and voice-based mechanisms involving extensions of democratic practice and accountability (e.g. through individual rights, empowerment, participation and involvement, complaints and redress mechanisms, charters and constitutions etc.) as drivers of public services quality. Le Grand has argued that voice-based mechanisms are likely to disproportionately benefit the middle classes (e.g. Le Grand 2007). Others have put more emphasis on the role of voice-based mechanisms where price information is absent or plays a limited role (for example, see Dunleavy et al. 2005; c.f. World Bank 2005, 2006, Dowding and John 2008, Stiglitz 2002). In practice, a combination of choice-based and voice-based public service reform strategies were promoted under Labour 1997-2010, alongside targets and performance management, and strategies to ensure the availability of information on quality (the importance of which is highlighted by both camps).

On public health, following a protracted period of political negotiation, the tobacco advertising and promotion ban came into effect in 2003. A cross-departmental national health inequalities strategy (*Programme for Action DH* 2003) was launched. Building on the Acheson Inquiry the strategy highlighted the relevance of broader public action to reduce social inequality, including the

Government's child poverty strategy, the Sure Start programme, to the health agenda. The strategy aimed to reduce health inequalities and to deliver the 2010 health inequalities target with developments monitored against 12 cross-departmental headline indicators tracking wider determinants of health and 82 departmental commitments (DH 2009a).

A follow up report by Wanless on public health was also published in 2004. This suggested that in order to achieve the "fully engaged" trajectory set out in the main Wanless Report would require a step change in public health effort and achievement and that public health – the promotion of good health and the prevention of disease – should be central to the work of a tax funded NHS, with fundamental challenges relating to implementation including incentives, levers in delivery. This included the need to realignment of incentives within the system towards the reduction of the burden of disease and tackling key lifestyle and environmental risks, with clear priorities for action and accountabilities defined for those both within and outside of the NHS for delivering them, and reflected in the performance and inspection regimes for the NHS and local government. The importance of the 2004 Public Service Agreements were highlighted in this context (Wanless, 2004). The Wanless report was followed by a public health White Paper C*hoosing Health,* which announced the Government's intention to introduce a smoking ban in enclosed public places in England and Wales (DH 2004).

Designated 'spearhead areas', which provided the basis for the specification of revised PSA health inequalities targets for life expectancy and mortality, were introduced in late 2004. 'Spearhead areas' were a fixed list of 70 local authorities in the bottom fifth nationally in 1995-97 for health (life expectancy, cancer and cardiovascular disease mortality) and deprivation (Index of Multiple Deprivation 2004 average score), mapping onto 62 PCTs. The spearhead areas were located in six regions (North East), north West, London, West Midlands, Yorkshire and Humber, and East Midlands and included 44 per cent of the black and ethnic minority population of England (NAO 2010: 6). The revised targets aimed to reduce health inequalities in 'spearhead areas' versus the all England average on a range of indicators.

The health responsibilities agenda also took off during this period. Alongside the growing influence of ideas such as self-care and co-production, the view that access to certain treatment should be conditional on certain behaviours (for example, in relation to smoking and weight management) began to take hold.

Labour's third term (2005-2010)

Labour's 2005 Manifesto repeated the world class public services commitment. Further goals were set to reduce waiting times, with a pledge that by the end of 2008, no NHS patient would wait longer than a maximum of 18 weeks from the time they were referred for a hospital operation by their GP until the time they have that operation, meaning an average wait of nine to ten weeks; for faster tests for cervical smears and improvements in cancer waiting times; reducing bureaucracy; by the end of 2008, a choice of any hospital that can provide an operation to NHS medical and financial standards; choice in maternity and cancer care; commitments to reduce deaths from coronary heart disease and strokes by 40 per cent from 1997, and cancer by 20 per cent; to extend the provision of free fruit to 4 to 6 year old children at school; increased investment in the schools meals service, including legislation to tighten standards.

On finances, a shift from the "catch up" to "keep up" trajectory - with an easing off of the rate of increase in public expenditure of healthcare following the years of sustained increase following the 2002 budget - had been foreseen in both the Wanless Review and in the Treasury's medium term budget plans. Further, with the economic downturn that began with the financial crash of autumn 2007, the new Chancellor Alistair Darling also warned of the gravity and depth of the crisis and that purse strings would need to tighten further by late 2007. Yet the 2007 Comprehensive Spending Review assumed that GDP would continue its steady growth and expenditure plans were set on this basis Hills (2011: 599). Total managed expenditure on public services and total public sector expenditure on healthcare continued to grow in real terms in 2008/9-2009/10 against a backdrop of contracting GDP. At the same time, there were signs of a slowdown in public expenditure allocations to healthcare by the end of Labour's period in power (on which, see Sections 2.1 and 2.4).

Patricia Hewitt replaced John Reid as Secretary for State for Health after the General Election in 2005. Discontent amongst NHS staff was, however, running at high levels by this point in time, with junior doctors objecting to new appointment systems, staff campaigning against bed and job cuts resulting from the reform programme, disquiet around the role of the private sector, IT projects stalling, and growing concerns around hospital deficits. Following Blair's replacement by Brown, Hewitt was replaced by Alan Johnson in 2007, and Johnson by Andy Burnham in 2009. Both appointments signalled a slowdown in the pace of organizational change and reform.

Brown's ascendency as Prime Minister was followed by the launch of a new constitutional reform agenda put emphasis on commitment to the NHS as a "British value". The Government's Green Paper on a *Bill of Rights* (MoJ 2009) considered but appeared to reject the possibility of a codified right to health.

The need to develop "outcome orientated" frameworks for measuring progress and performance in public services moved up the political agenda during Labour's third term (e.g. Cabinet Office 2008: 37). Reporting in 2008, the Darzi Review made key recommendations on the development of an information base for monitoring health services that captures a broad range of outcomes covering clinical results both also elements of treatment (such as dignity and respect) and autonomy (such as patient involvement) as an alternative to a top-down, target-driven approach to performance management. The recommendations were an important precursor to the Health and Social Care Outcomes Frameworks, to be introduced after the 2010 General Election under Coalition.

A new NHS Constitution first published with the Darzi Review represented a key new accountability measure, reaffirming the right to NHS services free of charge (with equal access for all) and to NICE-approved drugs, and imposed a legal duty on all NHS organizations to take account of the Constitution in their work. A free choice of any provider that can conform to NHS quality and price standards (including Independent Sector Treatment Centres) was introduced in April 2008 and the right to choice was incorporated into the New Constitution.

A Cancer Reform Strategy aiming to improve cancer services was published in 2007 (DH 2007b). On public health, a ban on smoking in public places which was included in the Health Act 2006, and came into effect the following year, was perhaps Labour's most significant public health measure during its three terms in office. In a bid to speed up progress on reducing health inequalities, a National Support Team and a Health Inequalities Intervention Tool were introduced. The latter identified three key interventions (increasing the prescribing of drugs to control blood pressure and to reduce cholesterol, together with an increase in smoking prevention activities) as the most cost

effective ways of reducing the gap in life expectancy (NAO 2010). The legal age for tobacco sales was increased from 16 to 18 in October 2007, and further provisions to protect children and young people from the harm caused by tobacco were introduced in the Health Act (2009). Emphasis on early intervention continued, with a new children and young people's health strategy (*Healthy Lives, Brighter Futures*) setting out plans for the expansion of the Family Nurse Partnership Scheme (DH 2009a).

Following the 2007 Comprehensive Spending Review, a series of new measures were introduced to strengthen the implementation of public health goals by strengthening and coordinating incentivisation and delivery. Indicator systems were better aligned, with all-cause mortality included as a "Vital Sign" for the NHS as part of the 2008 Operating Framework and as a priority for planning at the national and local levels. Local and national performance management systems were better aligned through the inclusion of the all-cause mortality indicator in the National Indicator Set, which identified national priority outcomes that were delivered by local authorities either alone or in partnership. Joint Strategic Needs Assessments and Local Area Agreements became statutory requirements in 2008. As well as strengthening local accountability and providing a mechanism for the identification of local priorities for action, it was envisaged that the new arrangements would help to strengthen partnerships between local authorities and health bodies and provide a framework for the delivery of common objectives. The new measures reflected concerns that health inequalities targets had been insufficiently aligned with other targets, and that levers and delivery systems for implementation had been insufficiently coordinated and too weak (NAO 2010: 10; DH 2008 9-12, 2009a 20).

The health inequalities agenda was moved forward by the Marmot Review 2010, *Fair Society, Healthy Lives.* The Review built on the earlier WHO Commission on the Social Determinants of Health as well as the earlier Black and Acheson reports, advised on the development of a health inequalities strategy in England and set out a new indicator-based framework for monitoring health inequalities using a social determinants approach. Existing health inequalities targets based on the Government's spearhead approach were criticised for being too insensitive to within area inequalities and new indicators capturing inequalities within as well as between areas were proposed. A new Equality Act was also passed just before the 2010 General Election. The new legislation put increased emphasis on the importance of inequalities by characteristics such as sex, ethnicity, disability and sexual orientation, as well as social class. Earlier equalities legislation had created positive duties on public authorities to give due regard to promoting equality by sex, race and disability. The new legislation reaffirmed and extended this approach with implications for both public health service commissioners and providers. The Food Standards Agency continued to promote the idea of a European-wide nutritional traffic-light system.

Health policy in the devolved administrations

Scotland, Wales and Northern Ireland received similar increase in resources to those that occurred in England, with the overall increases in public sector expenditure on health also applying to the devolved administrations. However, there were important divergences in health policy, particularly in relation to performance management, with the devolved administrations explicitly rejecting a range of the tools and levers of change being promoted in England. The biggest differences were in the stress on organisational reforms driven by quasi market ideas which were taken forward in England particularly after 2000, but which were explicitly rejected in Scotland and Wales. Other important differences related to public health, prescription charges and social care financing (although the latter is beyond the scope of the current paper) (Glennerster 2012).

Policy divergence in the devolved administrations is reviewed in CIPFA (2008), Nuffield Trust (Connolly et al 2011: 17-19), Propper et al (2008) and Bevan and Fasolo (2011). Whilst waiting list targets were introduced in Scotland and Wales, key elements of the modernisation and reform programme – particularly around patient choice and competition – that were undertaken in England were not implemented or were subsequently reversed in the other countries of the UK. For example, in England, the purchaser-provider split was maintained after 1997. However in Scotland, the NHS Reform (Scotland) Act (2004) dissolved NHS trusts and transferred their responsibilities to Local Health Boards. Similar reforms were subsequently undertaken in Wales in 2009. In England, patient choice and provider diversity was promoted with the introduction of foundation trusts and publicly financed/privately delivered health services. In contrast, the use of Independent Sector Treatment Centres was gradually withdrawn in both Wales and Scotland and the use of PFIs was ruled out in Wales towards the end of the period.

Critical differences emerged in relation to performance management. In England, the Treasury driven system of PSA targets was intended to ensure accountability for outcomes, with increases in resources linked to improved performance. Other targets (such as the annual performance checks, and subsequently the star ratings and the annual health checks) further embedded the links between increased resources on the one hand, and improved performance on the other. However, conditionality of this type was not emphasised in Scotland and Wales. The health PSAs only covered England and the system of annual performance evaluation in England ("star ratings" and subsequently annual health checks) - with public reporting of performance against targets – was not introduced in the other three countries of the UK (Connolly et al 2011), Propper et al (2008), Bevan and Fasolo (2011).

Both Scotland and Wales adopted distinctive health policy stances. In Scotland, there was an emphasis on partnerships rather than competition, with a view to addressing service fragmentation by promoting co-ordination and developing improved integrated care pathways. A new Bill of Rights provided for participation in decisions about health, privacy, confidentiality, accessible care and a waiting time guarantee (CIPFA 2008, Connolly et al 2011).

Prescription charges were maintained in England but abolished in Wales in 2007 and reduced with plans for abolition in Scotland, where eye tests and dental check-ups were also free (along with personal care). In Scotland, the Scottish Assembly took a more aggressive line on legislating about smoking than in England and both Scotland and Wales implemented the ban on smoking in public places ahead of England. Scotland also put more focussed emphasis on public health. This emphasis was also apparent in Wales, though perhaps less intensively than in the Scottish context (Glennerster 2012).

Devolution itself was a key policy initiative under Labour. A number of studies including Conolly *et al* (2011: 16), Propper et al (2008) and Bevan and Fasolo (2011) highlight how the introduction of devolution in health services provides a "natural experiment" for evaluating the impact of different policy instruments (particularly around competition, choice, the use of the private sector) on the achievement of Government "ends" or policy goals such as reducing waiting times and improving quality across the countries of the UK. The findings from these studies are discussed in Part 5.

3. Resources

In this Chapter we report on real resources allocated to health care 1997-2010. We comment on trends in real public expenditure on health, real total expenditure on health, international comparisons and the distribution of resources across the UK. In the run up to the 1997 General Election, there was a widespread perception that the NHS was underfunded. An explicit aim of Labour was to increase resources allocated to healthcare across the UK by initiating a sustained period of "catch up". In contrast, health expenditure was a major national priority under Labour, with unprecedented sustained increases in real healthcare expenditure (a period of "catching up and keeping") and a closing of international gaps with the virtual elimination of international gaps. Further, real expenditure on healthcare continued to grow following the financial crisis and economic downturn that began in the Autumn of 2007.

Key findings

- **Health expenditure as a national priority.** Health was a key national priority under Labour with significant real growth in public expenditure on health across all three terms above historical trend, well above the growth rates under Thatcher and Major, and with a substantial increase in the share of national resources devoted to healthcare.
- **Catching up and keeping up.** The growth of real public expenditure on healthcare outstripped whole range of other aggregates such as GDP, TME GHDI in absolute and per capita terms; and annual rates of real growth in public expenditure on health broadly in line with recommendations set out in the Wanless Report (2001).
- **The UK's international position.** The gap with the European average measured by the ratio of total real (public and private) healthcare expenditure to GDP was virtually eliminated. Whilst public expenditure on healthcare as a percentage of GDP increased, private expenditure as a percentage of GDP flat-lined in real terms and remained low by international standards at the end of Labour's period in office.
- **The distribution and allocation of funding across the constituent countries of the UK.** Expenditure in England per capita remained below that of the other three countries of the UK but the variance in finding between the four countries of the UK fell. The principle of needs-based resource allocation was deepened and extended, with the introduction of a new health-inequalities component to the funding formula (England).
- **Labour's financing model.** General taxation remained the primary source of NHS financing throughout the period with national insurance based funding also playing a role. Alternative financing models including social insurance and a ring-fenced hypothecated tax model were actively considered during Labour's but ultimately rejected.

Real expenditure on healthcare

Table 1 reports trends in real public sector expenditure on health in the UK using the Public Expenditure Statistical Analysis (PESA) system of accounting. The PESA system broadly captures total current and capital spending of the public sector, including spending by departments, the devolved administrations, local government and the capital spending of public corporations. The allocation of public spending by functions (health, education and so forth) is consistent with the United Nations' *Classification of the Functions of Government* (UN COFOG) system. Note that the real public expenditure data presented in Table 1 are deflated by a general GDP deflator (rather than taking account of health specific costs).

Table 1 shows that real public sector expenditure on health in the UK increased between 1997/8 and 2009/10 from £57.3 billion to £118.3 billion in 2009/10 prices, a real terms increase of 106.5 per cent over Labour's period in Government as a whole. The average annual growth rate of real public expenditure on health in the UK over this period was 5.8%. This figure breaks down into an average annual growth rate of 4.4% under Blair's first term (1997/98-2000/01), 8.6% under Blair's second term (2001/02-2004/05) and 4.8% under Labour's third term (2005/06-2009/10).

The 4.4% growth rate during the first Labour administration reflected the high priority given to health given the tight settlements in the years after New Labour were elected, as the Blair Government stuck to its electoral commitment to match the Conservative Government's spending plans for two years. However, the allocation of funding for healthcare increased in the run up to the 2001 General Election and further sustained increased followed the publication of the NHS plan in 2000, the recommendations of the Wanless Review (2002) and the 2002 Budget. As Table 1 shows, the annual growth rate of real public sector expenditure on health accelerated from 1.2% in 1997-1998, remaining relatively low during the two subsequent years, before increasing sharply to 9.3 per cent in 2000-01 in the run up to the 2001 General Election. The rate remained at high historical rates throughout Labour's second term (peaking at 10.8 per cent in 2003-4) before falling back during Labour's third time as the period of "catch up" came to an end with an average annual growth rate of 4.1 per cent under Blair (2005/06-2006/07) and 5.2 per cent under Brown (2007/08-2009/10).

Historically, trends in real public sector expenditure on health in the UK are generally evaluated using 1950/51 as a base year (with the annual growth rate in 1948/9 viewed as non-comparable). The annual average rate of real public sector expenditure on health over the period 1950/51-1996/7 was 3.6 per cent. The average annual growth rate of real public sector expenditure on health under the Conservative period in office between 1979/80 and 1996/7 was below this historical trend, at 3.3 per cent, including a low of 2.3 per cent under the second Thatcher administration (1983/4 to 1986/87). The annual rates of growth of public sector expenditure on health under Labour were therefore significantly above both historical trends and the rates achieved under the previous Conservative administration. Even during the first administration (when resources were tight) and the third term (once the period of "catch up" was over and the period of slow-down had begun), the average real annual growth rate of public services expenditure on health remained higher than both during the Conservative period in power and relative to the historical trend.

The average annual growth rate over the "catching up" period ushered in by the 2002 budget announcement unleashed a period of unprecedented, sustained increases in funding, with real terms annual growth in public sector health expenditure between 2003/4 and 2007/8 of 6.4 per cent.

Table 1: Public sector expenditure on health, United Kingdom, 1991/2-2009/10 (a)

Prime Minister (c)	Years (d)	Nominal expenditure (£ billion)	Real expenditure (£ billion)	Real expenditure (per capita) (£) (e)	Real GDP (£ billion)	Real expenditure as % of GDP	Annual growth rate (%) (f)	Real expenditure on health as % real TME (g)	Real expenditure on health as % of real expenditure on public services (h)	Volume expenditure (£ billion) (i)	Volume annual growth (%)
Thatcher/Major	1991/92	30.9	46.9	817.3	922.7	5.1		12.2	13.0	59.9	
	1992/93	34.2	50.4	875.3	924.4	5.5	7.4	12.5	13.1	61.1	3.5
	1993/94	36.6	52.5	909.7	953.9	5.5	4.2	12.8	13.5	63.2	3.5
Major	1994/95	39.4	55.6	961.7	993.9	5.6	6.0	13.2	13.9	66.3	4.9
	1995/96	41.4	56.8	979.5	1021.5	5.6	2.1	13.3	14.0	67.0	1.0
	1996/97	42.8	56.7	974.3	1056.5	5.4	-0.3	13.5	14.1	67.4	0.6
	1997/98	44.5	57.3	983.4	1085.0	5.3	1.2	13.8	14.4	68.9	2.2
Blair (1)	1998/99	46.9	59.6	1019.1	1129.3	5.3	3.9	14.2	14.7	69.8	1.3
	1999/00	49.4	61.5	1048.1	1175.8	5.2	3.2	14.4	14.9	70.4	0.8
	2000/01	54.2	67.2	1141.6	1224.2	5.5	9.3	14.9	15.3	74.1	5.3
	2001/02	59.8	72.8	1232.0	1259.4	5.8	8.3	15.4	15.9	77.8	5.0
Blair (2)	2002/03	66.2	78.6	1324.4	1269.9	6.1	7.9	15.7	16.4	83.2	7.0
	2003/04	74.9	87.1	1426.1	1341.1	6.5	10.8	16.5	17.0	89.5	7.5
	2004/05	82.9	93.7	1565.5	1373.2	6.8	7.6	16.8	17.6	95.9	7.1
Blair (3)	2005/06	89.8	99.5	1651.0	1413.1	7.0	6.2	17.1	17.9	100.2	4.5
	2006/07	94.7	101.5	1675.6	1431.8	7.1	2.1	17.2	18.1	101.9	1.7
	2007/08	102.3	107.2	1757.7	1497.6	7.2	5.6	17.6	18.4	106.9	5.0
Brown	2008/09	110.0	111.9	1822.5	1454.4	7.7	4.4	17.5	18.2	110.7	3.5
	2009/10	118.3	118.3	1914.5	1401.1	8.4	5.7	17.7	18.4	118.3	6.9

Source: Authors calculations. Expenditure figures: nominal figures and GDP deflators from HM Treasury (2011a) with reference year changed to 2009/10. NHS specific deflator: HCHS Pay and Prices Series 2009/10 (Department of Health (n.d.)). Population estimates: ONS (2011b).

Notes:

a. Total expenditure on health excludes spending on Personal Social Services
b. The real public expenditure on health series has been constructed using the GDP deflator published in HM Treasury with a base year changed from 2010/11 to 2009/10
c. Time in office: Margaret Thatcher 4 May 1979 – 28 November 1990 (1st term 4 May 1979-June 1983, 2nd term June 1983-June 1987, 3rd term June 1987-November 1990); John Major: 28 November 1990 (election in April 1992) - 2 May 1997; Tony Blair: 2 May 1997 - 27 June 2007 (1st term 1997-2001, 2nd term 2001-2005 and 3rd term 2005-2007); Gordon Brown 27 June 2007 - 11 May 2010.
d. All years are reported as financial years
e. The estimated resident population of an area includes all people of all ages who usually live there, whatever their nationality. People arriving into an area from outside the UK are only included in the population estimates if their total stay in the UK is 12 months or more. Visitors and short term migrants (those who enter the UK for 3 to 12 months for certain purposes) are not included. Similarly, people who leave the UK are only excluded from the population estimates if they remain outside the UK for 12 months or more. This is consistent with the United Nations recommended definition of an international long-term migrant. Members of UK and non-UK armed forces stationed in the UK are included in the population and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address. Population figures for the United Kingdom do not include the population of the Channel Islands or the Isle of Man.
f. Year on year percentage growth rate in real terms health expenditure
g. TME=Total Managed Expenditure, includes total expenditure on public services, EU transactions and Accounting Adjustments
h. Real expenditure on Total Public Services includes EU transactions but excludes Accounting Adjustments
i. Department of Health (n.d.) HCHS Pay and Prices Series 2009/10 used to deflate nominal figures

Wanless et al (2007:12) concluded that the real increase in resources over these years was broadly in line with the recommended increases in the Wanless Review for the first five years of its spending trajectories. In further evaluation undertaken in 2009 by the IFS and Kings Fund also concluded that Labour broadly delivered the Wanless recommendations on closing the funding gap during its period in power (IFS 2009).

Table 2: Average real annual growth rate of public sector expenditure on health by political administration, the United Kingdom, 1959/51 – 2009/10

	Average annual growth rate (a)
1. Historical trends	
Historical trend (1950/1-1996-7)	3.6
Historical trend (1950/1-2009/10)	4.0
2. Conservative (1979/80-1996/7)	3.3
Thatcher (1979/80-1982/3)	3.2
Thatcher (1983/4-1986/7)	2.4
Thatcher / Major (1987/88-1991/2)	3.3
Major (1992/3-1996/7)	3.8
3. Labour (1997/8-2009/2010)	5.8
1st term (Blair: 1997/8-2000/1)	4.4
2nd term (Blair: 2001/2-2004/5)	8.6
3rd term (Blair/ Brown: 2005/6-2009/10)	4.8
- Blair (2005/6-2006/7)	4.1
- Brown (2007/8-2009/10)	5.2
4. "Catching up" period 2003/4-2007/8	6.4

Source: Authors calculations using HM Treasury (2011a) and (Harker, 2011). "Historical Trends" and "Conservative" are based on the real growth rate time series in (Harker, 2011, Table 1). " Labour" and "Catching up period" are calculated using real expenditure figures and GDP deflator in HM Treasury (2011a, Table 8a).

Notes: (a) Average annual growth rates are calculated using a geometric mean of the real annual growth rates within each time period. The annual growth rates calculated as following: annual growth rate=(present year spent-previous year spent)/previous year spent*100.

(b) Figures in "1. Historical Trends" and in "2. Conservative" are in 2010/11 prices

(c)Figures in "3. Labour" and "4. Catching up period" are in 2009/10 prices.

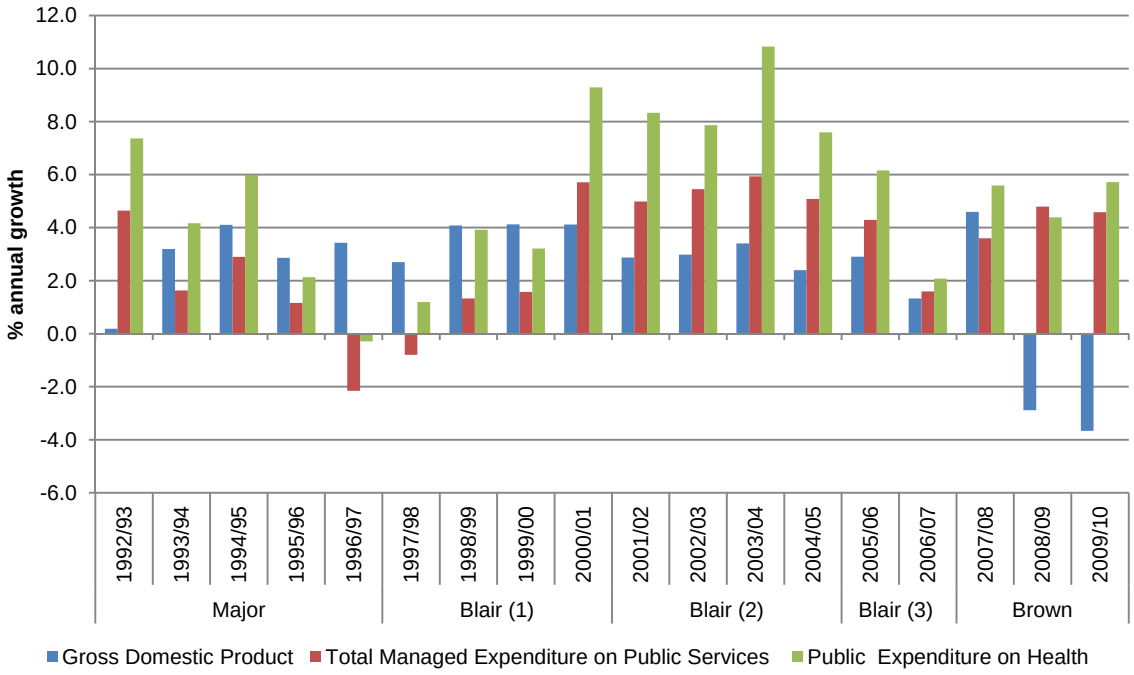
The priority given to health over the period 1997/8-2009/10 is reflected in the rapid rise in public sector expenditure on health compared with the growth of gross domestic product and other key indicators such as real total managed expenditure and real public services expenditure. Table 1 shows that the share of health in overall public sector expenditure allocations rose from 14.4 per cent in 1997/8 to 18.4 per cent in 2009/10) and as a share of total managed expenditure from 13.8 per cent in 1997/8 to 17.7 in 2009/10).

The growth in public sector expenditure on health also outstripped the growth in GDP between 1997/8 and 2009/10 by a very significant margin. Again referring to Table 1, GDP increased in real terms by 29.1% over this period compared to the 106.5% figure for real public expenditure on health. The result was a significant increase in public sector expenditure on health as a percentage of GDP over the Labour years. Based on PESA definitions, this figure rose from 5.3% in the first year of the Blair

administration to 8.4 per cent in the final year of Brown - that is, a rise of more than three percentage points over Labour's period in office.

As Figure 1 shows, real public sector expenditure on health continued to grow even after the onset of the financial crisis and economic downturn that began in October 2007 and the negative GDP growth that followed.

Figure 1: **Average real annual growth rate of public sector expenditure on health in the UK by political administration/Prime Minister, United Kingdom, 1992/93 – 2009/10 (2009/10 prices)**



Source: see Table 1

Real total (public and private) expenditure on healthcare

Public expenditure on health is only one element of total expenditure on health. In order to provide a broader picture, Table 3 provides a time series of total expenditure on healthcare in the UK using the OECD system of classification, which provides a broad measure covering *any* spending on healthcare regardless of who is paying for or providing it. The definition covers *any* current final consumption expenditure on health by residents and capital expenditure on healthcare by any health agency such as the government, non-profit institutions serving households (NPISH) and the private for-profit sector. It includes spending on people treated in private hospitals, clinics and care homes, charities, armed forces and prisons, as well as the cost of occupational healthcare and the value of government benefits paid to those providing home healthcare for their relatives.

The public and private elements of total expenditure on healthcare are also identified within the OECD system. The OECD definition of *public* expenditure on healthcare includes government current and capital expenditure on healthcare, expenditure on healthcare in prisons and the armed forces. This definition is somewhat different to that in the PESA system, resulting in slightly different figures and

trends from those reported in section 2.1. The OECD definition of *private* expenditure on healthcare includes final consumption expenditure on health by households, NPISH and capital expenditure by private healthcare service providers (OECD 2000, Jurd 2012: 3).

Figures based on these definitions are produced by ONS and are submitted both to OECD (which produces a range of international comparisons on a consistent basis) and Eurostat (in order to meet the requirements of the Maastricht Treaty). It should be noted that various adjustments are required in order to bring greater international comparability to the UK estimates (including the addition of non-NHS expenditure on nursing care in nursing homes, expenditure on government benefits that relate to household production of home healthcare for relatives (OECD 2000, Jurd 2012: 3-8)).

Table 3 presents data for total, public and private expenditure on healthcare using the OECD definitions and are consistent with National Accounts (Blue Book) estimates. We have deflated the nominal figures provided by ONS in order to produce a real total, public and private expenditure series and we also present the figures as a share of GDP.

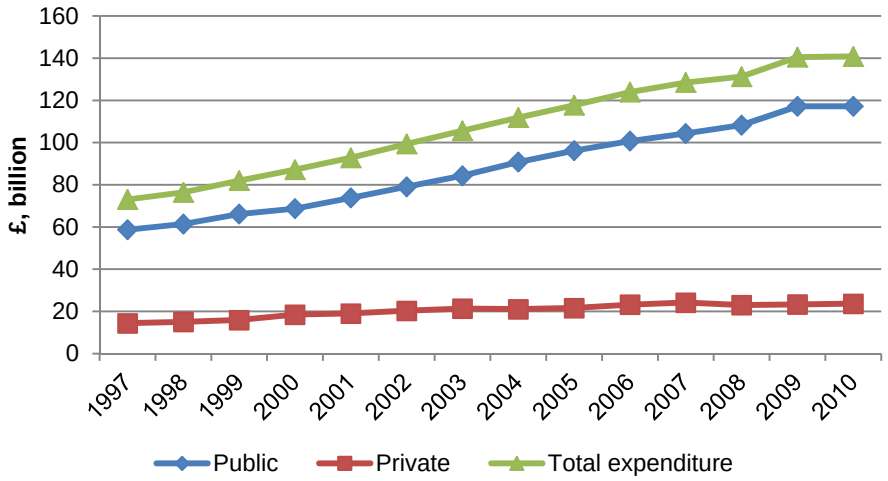
Based on the OECD definition, total (public and private) real expenditure on healthcare increased in real terms by £67.7 billion between 1997 and 2009, representing a real increase of 92.6% over this period. Total expenditure on healthcare as a percentage of GDP increased continually year on year from 6.6% in 1997 to a peak of 9.8 % in 2009 and falling back to 9.7% in 2010 – an increase of more than three percentage points during Labour's period in office (1997-2010). Trends for public expenditure on healthcare are broadly in line with the trends reported in section 2.1 above (although slight differences arise due to definitional differences and the calendar year basis of the OECD-based figures).

The figures show that the share of real private expenditure in overall real total expenditure between 1997 and 2010 remained relatively low. At the beginning of Labour's period in office, this share was 19.6 per cent. By the end of Blair's Premiership, the share had decreased to 18.8 per cent, and under Brown it fell further to 16.8 per cent by the end of Labour's period in office. Private as a percentage of GDP also remained low: at the start of Labour's period it comprised 1.3 per cent of GDP, reaching 1.6 per cent by the end of Brown's Premiership. Nevertheless, private expenditure on health increased in real terms from £14.3 billion to £23.6 billion during Labour's period in office (in 2010 prices), a real terms increase of 65%.

Table 3: Total real (public and private) health expenditure, United Kingdom, 1997 to 2010 (2010 prices)

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Public															
	£ billion (a)	58.7	61.4	66.1	68.7	73.8	79.1	84.3	90.8	96.2	100.7	104.3	108.3	117.2	117.2
	% GDP	5.3	5.4	5.6	5.5	5.8	6.0	6.2	6.5	6.7	6.9	6.9	7.2	8.2	8.0
	% Total expenditure	80.4	80.4	80.6	78.8	79.5	79.6	79.8	81.2	81.7	81.3	81.2	82.5	83.4	83.2
Private															
	£ billion (a)	14.3	15.0	15.9	18.5	19.0	20.3	21.3	21.1	21.6	23.2	24.2	23.0	23.3	23.6
	% GDP	1.3	1.3	1.3	1.5	1.5	1.5	1.6	1.5	1.5	1.6	1.6	1.5	1.6	1.6
	% Total expenditure	19.6	19.6	19.4	21.2	20.5	20.4	20.2	18.8	18.3	18.7	18.8	17.5	16.6	16.8
Total expenditure															
	£ billion (a)	73.1	76.4	82.0	87.2	92.8	99.4	105.6	111.9	117.7	124.0	128.5	131.3	140.5	140.8
	% GDP	6.6	6.7	6.9	7.0	7.3	7.6	7.8	8.0	8.2	8.5	8.5	8.8	9.8	9.7

Figure 2: Total real public and private expenditure on healthcare, United Kingdom, 1997-2010 (2010 prices)



Source:

Authors' calculations using current prices figures from Office for National Statistics (Jurd 2012) and using GDP deflator derived from Blue Book (ONS 2011d) online resource figures for current and real GDP

Notes:

a. Calendar years, 2010 prices.

The figures for private expenditure include private expenditure incurred within the NHS, for example, NHS patient charges and private patient revenue. Labour remained committed to the principle of access based on need, not on ability to pay, and free at the point of delivery, and out-of-pocket costs for NHS healthcare remained low. However, whilst the NHS was launched with free prescriptions, dentistry, sight tests and glasses, charges were introduced in the years following 1948 and the issue of patient charges has subsequently been an important faultline in the politics of healthcare. Prescription charges had controversially increased rapidly in real terms during the Conservative years (Table 5).

Labour ended charges for eye tests for over 60s during its first term. However, other new charges such as chargeable hospital bedside televisions and telephones were introduced in 2006, alongside a new system of dental charges, whilst charges for parking became particularly controversial during Labour's period in power (Health Select Committee 2006). Under Labour, the rate of the annual increases slowed down. A prescription exemption for cancer patients was introduced in 2009.

Figures for overall receipts from patient charges are no longer published by the Department of Health, but estimates from the Office for Health Economics suggest that the increase in NHS patient charges from hospital, pharmaceutical and dental services was muted during Labour's three terms in power, rising in nominal terms from £919 million in 1997/8 to £1486 million in 2009-10 (Table 4).

Table 4: NHS patient charges, United Kingdom, 1990/91 – 2009/10

	Hospital services		Pharmaceutical services		Dental services		Total
	£ million	% of total payments	£ million	% of total payments	£ million	% of total payments	£ million
1990-91	510	42.6	247	20.6	441	36.8	1,198
1996-97	42	4.9	376	43.5	447	51.7	865
1997-98	48	5.2	396	43.1	475	51.7	919
1998-99	84	8.9	391	41.4	470	49.7	945
1999-00	138	13.5	405	39.5	483	47.1	1,026
2000-01	138	12.9	425	39.8	506	47.4	1,068
2001-02	155	12.9	478	39.9	568	47.4	1,199
2002-03	172	13.0	528	39.8	628	47.4	1,326
2003-04	194	13.0	596	39.8	709	47.3	1,498
2009-10	326	21.9	473	31.8	687	46.2	1,486

Sources: 1990-91 to 2003-04 figures are from Annual Abstract of Statistics (2002 and 2007 issues), 2009-10 figures are from OHE 2011 (Hawe et 2011, 48, Figure 2.4) and 2010-11 figures are from OHE (2012).
Note:

a. The following notes were included in a source document OHE 2011 (Hawe et al 2011, 48, figure 2.4): Prescription charges were introduced in 1952 and temporarily abolished in 1966 - 1968. Ophthalmic Services were part-privatised in 1985. From 1994 hospital charges no longer include pay-bed and similar income collected locally by NHS Trusts.

The rising cost of prescription charges was a particularly politically charged issue during Labour's years in opposition before 1997. Prescription charges increased in real terms by a factor of 10 under the Thatcher/Major administrations (April 1979-April 1997). Whilst annual increases in prescription

charges generally continued under Labour (May 1997-May 2010), the rate of increase slowed considerably, with the real cost of prescriptions falling by 3.76% in real terms (Table 5).

Table 5: Prescription charges, England, 1949 - 2010

Year (a)	Cash cost of a prescription		Real cost of a prescription (2009/10 prices)
Historical			
1949	0		
1952	One shilling per form (one shilling per item 1954)		
1971	20p per item		£2.05
Conservative (Thatcher/Major)			
1979 baseline (April 1979)	20p		70p
1979	Increased to 45p in July 1979		£1.57
1980	Increased to 70p in April 1980, followed by annual increases	£2.07	
1997	Increased to £5.65 in April 1997, just before Labour came to power	£7.28	
Labour (Blair/Brown)			
1997 baseline (April 1997)	£5.65		£7.28
2010	£7.20 in April 2010		£7.01

Source: Authors' calculations (using GDP deflators from HM Treasury (2011a) with reference year changed to 2009/10_ and data published in Hitiris (2000: Table 1) and Hansard Written Statements (2010).
Notes:

a. Treating the years as financial years, e.g. April 1979 as a financial year 1979/80

b. Annual growth rate is calculated by dividing the real percentage increase over the period by the number of years in that period

With a cap in place on the income-revenue powers of Foundation Trust hospitals, the real annual growth in NHS income from private patients decelerated compared with the Conservative years and was negative on a number of occasions. Although the low rate of growth was particularly marked after the economic crisis and downturn that began in autumn 2007, there was virtually no growth after 2002. A loophole whereby trusts established operating companies through joint ventures and associated arrangements to bypass the cap was closed in 2008 following changes in rules by the Charity Commission and Monitor. However, with hospital deficits looming and the Foundation Trust Network campaigning for a more flexible and less restrictive private patient income cap, Labour announced a review of the cap prior to the General Election (2010) (Laing and Bouisson, 2012, 55).

Private expenditure on *private* healthcare includes household spending on healthcare that is both publicly provided but paid for privately (e.g. NHS private nursing care services) and privately provided (e.g. private health insurance payments and out-of-pocket payments). Private out-of-pocket payments remained very low by international standards in the UK (for example, see OECD 2012: 137) by the end of Labour's period in power. With unprecedented injections of funding, levels of satisfaction with

the NHS running at an all-time high and waiting lists and waiting times falling, the growth in real annual growth in private medical cover spending over the period was muted, particularly in the period after 2002. This trend is particularly notable given the rapid increases in real household disposable income during much of Labour's period in power (Table 6).

Laing and Buisson's analysis suggest that demand for private medical cover (representing subscribers to private medical insurance and self-insured medical expenses schemes fell by 3.8 % in 2010 to reach a total of 3,962,000 subscribers, dipping under 4 million subscribers for the first time since 1999. The contractions in 2009 and 2010 are put down to recessionary pressures and prior to the financial crisis and economic downturn that began in Autumn 2007 spending on private medical insurance was increasing in real terms (Laing and Buisson, 169; see Table (6). It was worth noting however that in the context of expanding capacity, falling waiting list and increasing satisfaction with the NHS, there was no great growth in primate medical insurance, notwithstanding the rapid growth in real disposable household income during much of this period.

Table 6: NHS private patient revenue and demand for private medical insurance, United Kingdom, 1972/73 - 2010/11

	NHS income from private treatment[a]		Private medical cover spending[b]	
	NHS private patient income £ million	Real Annual Growth, %	£ million	Real Annual growth, %
1972/73	14	-		
1980/74	48	-		
1990/91	113	4.2		
1991/92	147	24.9		
1992/93	164	7.9		
1993/94	185	10.6		
199495	209	10.1		
1995/96	229	6.2	1,772	3.5
1996/97	249	6.1	1,936	6.7
1997/98	288	12.0	2,069	3.6
1998/99	309	4.2	2,149	0.4
1999/00	321	2.2	2,353	7.8
2000/01	334	1.0	2,608	7.6
2001/02	359	6.0	2,859	7.7
2002/03	388	5.8	3,121	7.4
2003/04	398	-0.1	3,260	1.5
2004/05	401	-2.5	3,361	0.1
2005/06	417	1.4	3,511	1.6
2006/07	429	-0.8	3,644	0.6
2007/08	426	-4.4	3,877	2.0
2008/09	439	-0.1	4,173	3.5
2009/10	430	-2.6	4,084	-1.6
2010/11	445	-1.6	4,146	-3.0

Source: Laing and Buisson (2011/12, 176-177, Tables 3.6-3.7; 55, Table 2.6)

Notes: a. Based on fiscal years i.e. the year beginning 1st April of each year b. Covers company paid and individual paid spending

International comparisons

The OECD data can be used to evaluate the profile and trends in expenditure on healthcare in the UK compared with other European and OECD countries. According to OECD analysis, the UK is included within a cluster of OECD countries including Northern European countries such as France and Germany, but also certain other countries including Japan, New Zealand, where public expenditure accounts for more than 80% of the total expenditure on health. The model of healthcare expenditure in this cluster of countries contrasts sharply with the picture in the US and Mexico (where the share of public expenditure in total health expenditure is under 50% (OECD 2011b).

Figure 3 provides a breakdown of total, public and private expenditure on healthcare as a percentage of GDP for OECD countries in 2010. The highest healthcare to GDP ratio was in the US, with its large private health sector, where the share of total healthcare expenditure in GDP was 17.6%. In the UK, the healthcare expenditure to GDP ratio was 9.6%, below that of other major Northern European countries such as Germany (at 11.6%) and France (11.6%) and the Netherlands (12.0%). But UK spending is now very similar to and slightly ahead of countries with primarily tax funded health care notably the Scandinavian, Spanish and Italian systems.

Comparison with the figures for 1997 shows the UK moving from being a country with a low total healthcare expenditure to GDP ratio to a country with a "mid-position" on the international league table. In 1997, the UK was ranked 25th of 34 OECD countries in terms of total health expenditure as a percentage of GDP, below the OECD average. By 2010, the UK was ranked 13th of 34 OECD countries, above the OECD average (Figure 3 ; c.f. Keep 2011).

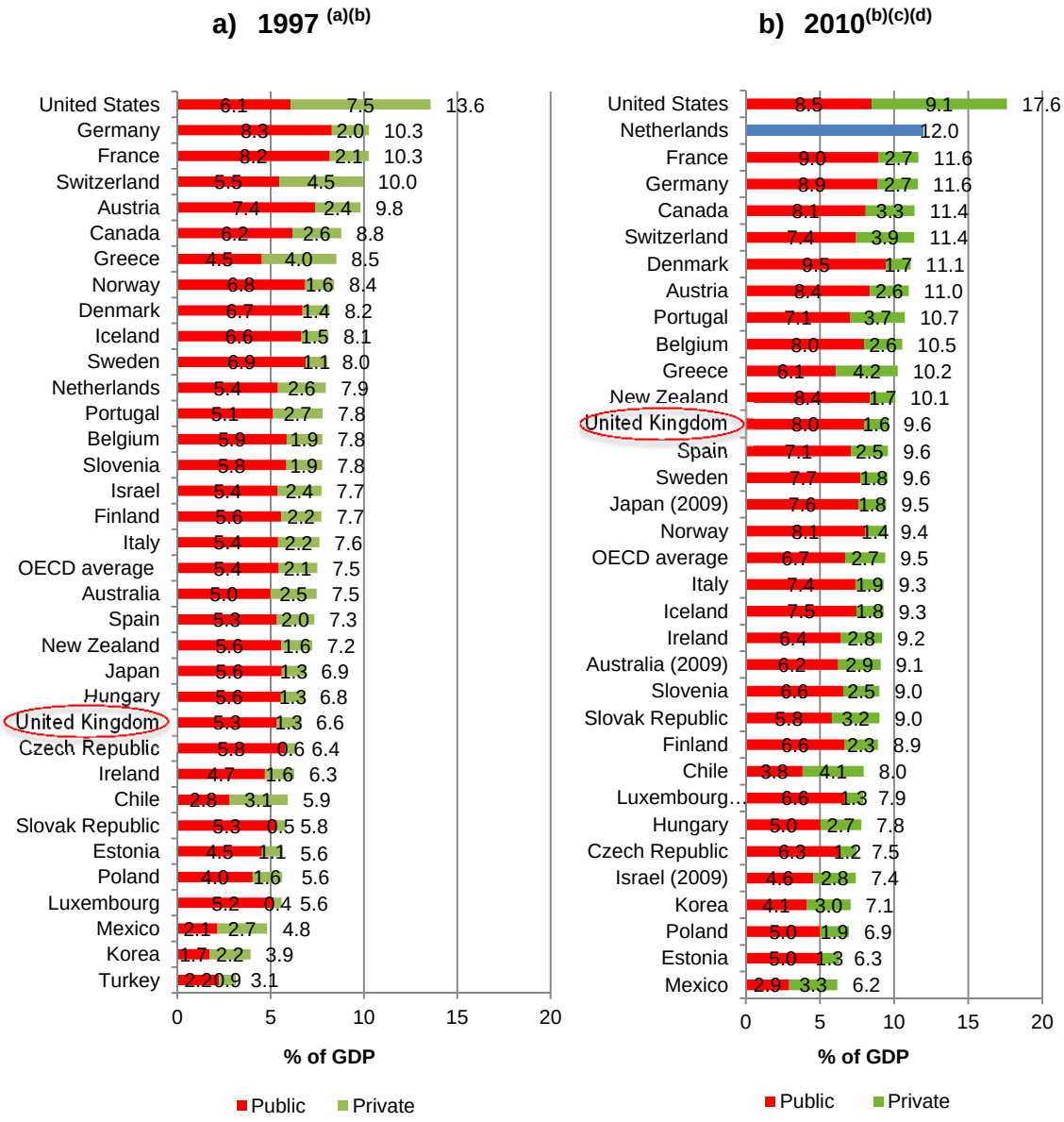
The data on total (public and private) expenditure on health can also be used to evaluate Labour's performance against the pledge in the 2001 Election Manifesto that 'over time we will bring UK health spending up to the EU average'. Figure 4 shows total expenditure on healthcare as a percentage of GDP for selected EU-15 countries over the period 1997 to 2010 (i.e. for selected countries that were member states prior to 2004) based on available data. The percentages have been calculated using the OECD Health Data 2012, with a EU-14 average (calculated as a simple average of the total healthcare expenditure to GDP ratios) of 8.1 per cent in 1997 rising to 10.2 per cent[1] in 2010. In the UK the share of total expenditure on healthcare in GDP increased from 6.6 per cent in 1997 to 9.6% in 2010, suggesting that the gap with the EU-14 average closed but was not completeoly eliminated over the period 1997-2010[ii].

Periodic evaluation of Labour's pledge to close the gap with the EU average healthcare has been undertaken by the Kings Fund and IFS using a slightly different methodology. This compares the UK and EU-14 data using a weighted rather than a simple average method[iii]. Applying this method, Kings Fund / IFS (2009) also concluded that the gap in the total expenditure on healthcare to GDP ratio between the UK and the EU-14 countries conserably reduced during Labour's period in power. We have updated this calculation for the 2010 data, and find that the weighted average of health expenditure as a proportion of GDP was 10.7% for the EU-14 countries (suggesting a slightly bigger gap with the UK than the simple average method)[iv].

[1] 2010 figure for total health expenditure as a proportion of GDP for EU-14 countries contains 2010 figures for all countries apart from Spain and Luxembourg where 2009 figures were used. Using only non-missing 2010 figures, the total healthcare expenditure as a proportion of GDP is 10.5

Changes in the ratio of total expenditure on healthcare to GDP over time are influenced by changes in the denominator (i.e. GDP) as well as changes in the numerator (i.e. total expenditure on healthcare). According to OECD analysis, health spending continued to rise faster than economic growth in most countries over the period after the onset of the economic downturn, resulting in a general tendency for total healthcare expenditure to GDP ratios to increase 2007-2009. Further, the rise in total health expenditure as a share of GDP has been particularly marked in countries hard hit by the global recession including Ireland and the United Kingdom (OECD 2011) although, by 2010, this ratio had fallen back (Figure 4).

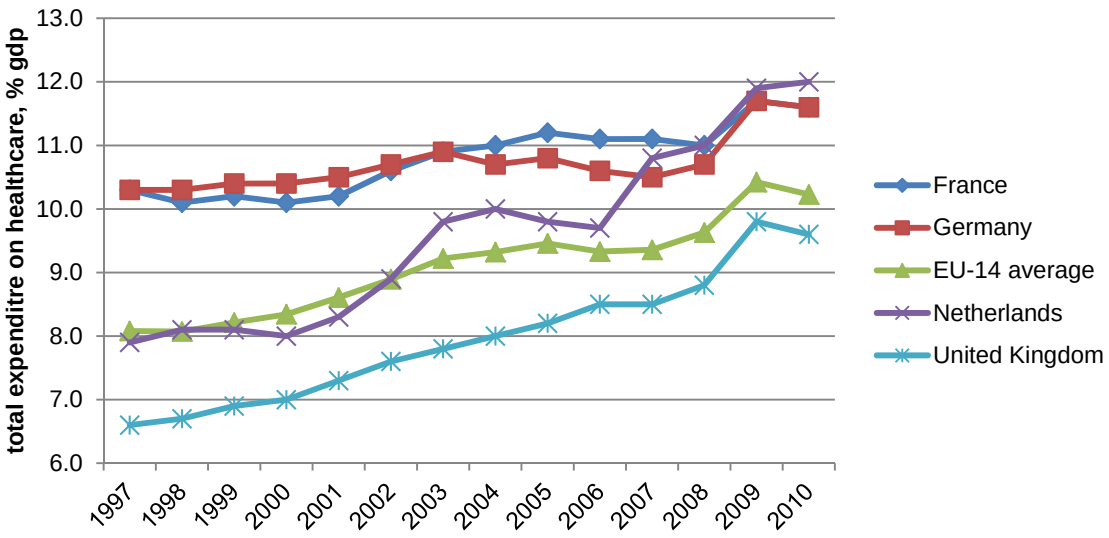
Figure 3: International comparisons of total (public and private) expenditure on health as a percentage of GDP



Source: OECD (2012)
Notes:

a. Figures are 1997, apart from for Estonia (1999)
b. OECD average is an arithmetic average for the OECD countries excluding UK
c. Figures are 2010 apart from for: Australia, Israel, Japan, Luxembourg - all 2009 figures; Turkey (2008)
d. No breakdown for public/private spending on health is available for Netherlands since 2002, so the total expenditure on health as a proportion of GDP is presented here for this country

Figure 4: International comparisons of total (public and private) expenditure on health as a percentage of GDP



Source: OECD (2012)

Notes:

a. EU-14 average is an arithmetic average for the is EU-15 countries excluding UK, based on non-missing data
b. OECD average is an arithmetic average for the OECD countries excluding UK. 2010 figure is based on non-missing figures for OECD countries in 2010 or nearest year (Australia, Israel, Japan, Luxembourg 2009 figures; Turkey 2008 figure)

The distribution and allocation of resources across the countries and regions of the UK

The funding settlements for the devolved administrations continued to be based on a system of block grants using the Barnett Formula throughout Labour's term in office (House of Lords Select Committee on the Barnett Formula 2009, Conolly et al al 2011). The Formula was introduced in 1978 and was based on population rather than a more sensitive measure of need (such as the weighted capitation formula used to distribute healthcare funds within England, discussed below). Historically, per capita resource allocations have been greater in Northern Ireland, Scotland and Wales compared with the England figures. Whilst it was widely anticipated that the application of the Barnett Formula would result in the gradual convergence of per capita resource allocation in the four countries of the UK over time, in practice this objective has not been achieved.

The Barnett Formula came under increasing criticism during Labour's period in office, with one influential report characterising the Formula as arbitrary and unfair and calling for its replacement by a new needs-based system for distributing funds within the UK. The House of Lords Select Committee on the Barnett Formulate also identified a weakness in the formula whereby annual increments are calculated using recent population figures but the baseline figures are not reassessed to take account of changing population patterns, resulting in a failure to take account of the needs of each of the countries and regions of the UK. The Committee anticipated that a move towards a needs-based

system of this type would result in recognition of lower needs in Scotland than in either Wales or Northern Ireland (House of Lords Select Committee on the Barnett Formula 2009, Conolly et al 2011).

The reasons for limited convergence of per capita public expenditure across the four countries of the UK over time are discussed in Connolly *et al* (2011: 11). The authors highlight the role of bi-lateral political negotiations with HM Treasury as an explanatory factor underlying the failure to achieve convergence, as well as the specification and application of the formula itself.

In Table 7 we report real identifiable public expenditure on health for each country within the UK using various editions of PESA. Due to changes in definitions and coverage that take place from one edition to another, HM Treasury advises against using figures from different editions of PESA to construct time series data (HM Treasury 2011). We are therefore limited in the way we analyse expenditure on health by country as these figures come in 5 year intervals of consistent data.

The figures in Table 7 suggest that public expenditure on health per capita has been consistently lower in England compared to Wales, Scotland and Northern Ireland throughout the Labour years. In 1998/9, nominal expenditure on health per capita was £995 in England, £1095 in Wales and Northern Ireland (15% higher than the England level) and £1160 Scotland (21.5% higher than in England). In 2009/10, nominal expenditure on health per capita in in England was £1877 in England, compared with £2040 in Scotland (8.7% higher than in England), £1973 in Wales (5.1% higher than in England) and £1924 in Northern Ireland (2.5% higher). The figures suggest narrowing of variations with the advantages in the devolved administrations falling rather than increasing during Labour's period in Government.

Resource allocations to local populations determined by their medical needs

Resource allocation is achieved within the English NHS through a funding formula (the weighted capitation index) whereby central funds are allocation between different local units (more recently, Primary Care Trusts, but previously Primary Care Groups, Health Authorities, District Health Authorities and Regional Health Authorities) as commissioners (previously providers) of health care. Since 1976, the funding formula for distributing funds across England has been based on the principle that resources should be allocated to areas on the basis of need, with the funding formula itself widely viewed as pivotal to achieving the goal of equitable access to healthcare (or 'equal access for equal need'). The evolution of the funding formula since 1976 can be characterised in terms of a gradual strengthening of the principle of equitable, needs-based resource allocation, with refinements over time to take account of area-based variations in population, costs, utilisation and need (Glennerster et al 2000, Glennerster 2012, 2012a, DH 2011a, House of Commons Library 2010 and Table 8).

During Labour's period in office there was a further refinement to strengthen the principle of equitable, needs-based resource allocation. The pre-existing needs based formula allocated funds to promote the objective of "equal access to healthcare for people at equal risk". In November 1998 Ministers announced a wide ranging review of the formula and introduced a second formal objective "to help reduce avoidable health inequalities". An interim 'health inequalities adjustment' (or HIA) based on the concept of 'years of life lost' was introduced. A further review was announced in 2005 which reported in 2008, with the Advisory Committee on Resource Allocation (ACRA) recommending a separate HIA component based on disability free life expectancy (the number of years form birth a person is expected to live which are free from limiting long-term illness and disability).

Table 7: Public sector expenditure on health by country in the United Kingdom, 1997/98 - 2009/10 (2009/10 prices)

	England			Scotland			Wales			Northern Ireland		
	real expenditure (£m)	per capita real expenditure	annual growth, %	real expenditure (£m)	per capita real expenditure	annual growth, %	real expenditure (£m)	per capita real expenditure	annual growth, %	real expenditure (£m)	per capita real expenditure	annual growth, %
					PESA 2004							
1997/8 (1)												
1998/9	48,577	995		5,891	1,160		3,174	1,095		1,837	1,095	
1999/2000	49,749	1,015	2.4	6,112	1,205	3.8	3,313	1,142	4.4	1,965	1,170	6.9
2000/1	54,488	1,107	9.5	6,543	1,292	7.0	3,540	1,218	6.8	2,148	1,277	9.3
					PESA 2006							
2001/2	59,530	1,204		6,939	1,370		3,684	1,266		2,213	1,310	
2002/3	63,697	1,283	7.0	7,723	1,528	11.3	4,127	1,414	12.0	2,375	1,400	7.3
2003/4	70,511	1,414	10.7	8,534	1,687	10.5	4,634	1,582	12.3	2,613	1,535	10.0
2004/5	76,344	1,524	8.3	8,682	1,710	1.7	4,849	1,647	4.6	2,710	1,584	3.7
					PESA 2011 (July)							
2005/6	81,071	1,606		9,482	1,861		5,149	1,745		2,913	1,689	
2006/7	82,357	1,622	1.6	9,686	1,893	2.1	5,342	1,804	3.8	3,064	1,759	5.2
					PESA 2011 (October)							
2007/8	87,321	1,709		10,193	1,981		5,525	1,856		3,201	1,820	
2008/9	91,590	1,780	4.9	10,355	2,003	1.6	5,658	1,892	2.4	3,356	1,891	4.8
2009/10	97,272	1,877	6.2	10,593	2,040	2.3	5,917	1,973	4.6	3,443	1,924	2.6

Source: Authors calculations using the following public health expenditure data: 1998/9-2000/01: HM Treasury (2004a, Tables 8.5a-8.7b); 2001/2-2004/5: HM Treasury (2006, Tables 7.6a-7.9b); 2005/6-2006/7: HM Treasury (2011b, Table 9.1); 2007/8-2009/10: HM Treasury (2011a, Table A.11). GDP deflator: HM Treasury (2011a) with reference year changed from 2010/11 to 2009/10.Population estimates: Office for National Statistics (2011b)

Notes:

a) No consistent figures for health expenditure alone in each country is available for the years 1997/8 to 2000/01. Expenditure figures for years 1997/8 to 2000/01 are consistently available only for health and personal social services together (PESA

b) 2003), 2004 PESA which is used here covers health separately from personal social services but does not have figures for 1997/8.

Table 8: Allocation based on medical need: Evolution of the weighted capitation formula to 2010, England

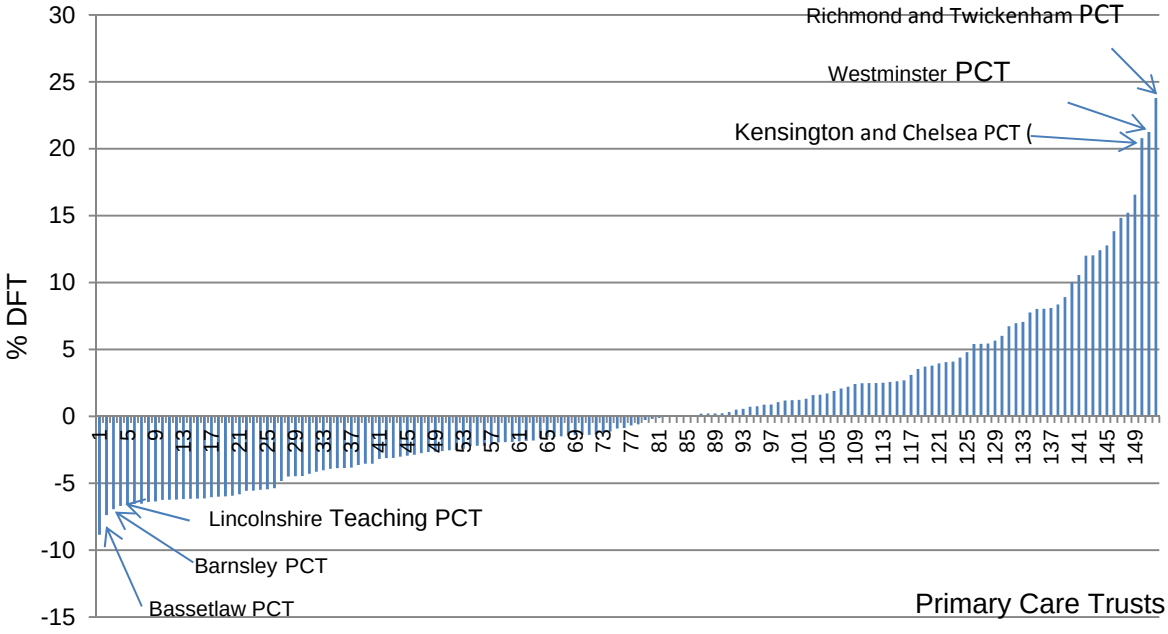
Prior to 1971/72	Allocation based on historical patterns of spending
Crossman Formula 1971/72-1976/77	Introduction of a new resource allocation formula which aimed to remove regional inequalities in hospital services – introduction of the principle of 'target allocations' towards which health authorities were moved over time.
Resource Allocation Working Party (RAWP) Formula 1977/78-1988/89	Interpreted the objective of resource allocation as achieving "equal opportunity of access to health care for people at equal risk". Formula was based on bed utilisation by age and gender plus an additional component which used standardized mortality rations (SMRs) as proxy measure for morbidity to identify addition health needs. A cost variation element was also introduced to the formula after 1981.
Small area utilisation modification (1990/91-1995/96) and York Formula 1996/7-2002/3	Incorporation of a further element to account for additional need with the introduction of the "small area utilisation approach" which took account of variations in utilisation of health care services by small area. The approach was criticised for being insensitive to unmet and differentially met need for health care services.
AREA Formula 2003/4-2007/08	Introduction of a Health Inequalities Adjustment (HIA) based on years of life lost. Improved on previously needs-based utilisation approach since 1) utilisation approach cannot capture unmet / differentially met need. 2) current patterns of utilisation are driven by the NHS's response to current patterns of health status which are not sufficiently focussed on reducing health inequality.
CARAN Formula 2009/10-	Refinement of the HIA. Separate HIA formula now based on disability free life expectancy at birth (initially based on 2005 figures) and weighted according to explicit Ministerial judgement (set by Labour at 15%).

Source: Based on Department of Health (2011a) House of Commons Library (2010), Glennerster (2012, 2012a)

The new HIA was included in the weighted capitation formula used for 2009-10 and 2010-11 target allocations. ACRA advised that it is not possible on a technical basis to determine the weight for the DFLE formula relative to the utilisation based need formula and Ministers decided in 2008 to give it a weight of 15% for 2009-10 and 2010-11 (DH 2011a:9-10).

In practice, PCTS in England do not achieve the target allocations determined by the weighted capitation formula immediately but are moved towards their targets over time. The rate of progress from the historic position (i.e. the opening allocation at the beginning of a fiscal year) and the target allocation for that year is determined by the so-called "pace of change" policy adopted by Government. Figure 5 shows the gaps between target allocations and achieved allocations (measured in terms of the percentage "distance from target" for each Primary Care Trust at the beginning of the 2010-11 financial year). The figure shows that of 151 PCTs, 81 achieved funding below the target based on the weighted capitation formula. Richmond, Westminster, Kensington and Chelsea top the list of those Primary Care Trusts receiving more than their target allocations (23.8%, 21.3% and 20.8% respectively), whilst the PCTS for whom the distance from target was greatest was Bassetlaw PCT, Barnsley PCT and Lincolnshire Teaching PCT at 8.8%, 7.4% and 6.9% respectively. From the equity perspective, a key issue facing Labour at the end of its period in Government was that many of the PCT's receiving less than their target resource allocation were designated 'spearhead areas'.

Figure 5: PCT resource allocation: Distance from target allocation (%), England, 2010/11



Source: Department of Health (2011), Table 10

In 2010 the NAO value for money report on health inequalities found that 68 per cent of PCTS in the 70 local authority spearhead areas would not receive their target allocations. Further, spearhead PCTs that are funded above their target level were exclusively in London, while spearhead PCTS in East Midlands and Yorkshire and Humber were furthest below target (NAO 2010: 30-31). The NAO report was followed up by an evaluation by the House of Commons Committee of Public Accounts (2010), which found that two thirds of PCTs in areas with the highest deprivation still did not receive their target allocations based on their need as determined by the funding formula. The Committee concluded that 'pace of change' policy had been slow.

Nevertheless, using the formula to allocate resources to local populations based on their medical needs results in considerable variation between per capita resource allocations between regions and PCTs. As Table 9 shows, per capita allocations in England averaged £1632 in 2010-11 and varied by region from £1901 in the North East to £1533 in the South West. Variations at the PCT level were also variable, with the highest per capita allocations to Islington PCT (£2350 per capita), City and Hackney Teaching PCT (£2136 per capita) and Liverpool (£2131 per head) and the lowest to Berkshire West PCT (£1367 per capita).

Table 9: Allocation based on medical need: impact of the formula on per capita allocation by region and PCT, England (£ per capita)

England	1632.161
By region	
North East SHA	1900.648
North West SHA	1868.263
Yorkshire and the Humber SHA	1694.904
East Midlands SHA	1385.796
West Midlands SHA	1712.374
East of England SHA	1446.330
London SHA	1849.258
South East Coast SHA	1621.264
South Central SHA	1137.526
South West SHA	1533.038
By PCT (lowest per capita allocations)	
Berkshire West PCT	1367.309
South Gloucestershire PCT	1370.299
Mid Essex PCT	1398.861
Leicestershire County and Rutland PCT	1402.984
Buckinghamshire PCT	1407.112
Bedfordshire PCT	1430.727
Oxfordshire PCT	1439.276
Cambridgeshire PCT	1445.699
By PCT (highest per capita allocations)	
Tower Hamlets PCT	2116.222
Blackpool PCT	2128.139
Hammersmith and Fulham PCT	2179.76
Liverpool PCT	2200.032
Knowsley PCT	2246.025
City and Hackney Teaching PCT	2275.476
Newham PCT	2320.061
Islington PCT	2350.018

Source: Department of Health (2011), Table 1

Labour's healthcare financing model

General taxation remained the primary source of NHS financing throughout the period. Alternative financing models including social insurance and a ring-fenced hypothecated tax model were actively considered in Labour's first term but ultimately rejected.

Nevertheless, as Table 10 shows, following Gordon Brown's 2002 budget announcements and national insurance measures, there was a marked change in the balance of financing of the NHS from general taxation on the one hand, and National Insurance on the other. Table 10 shows that the share of NHS funding from National Insurance rose from 12.1% in 2002 to

20.4% in 2003 and peaked the following year at 21.5% of total NHS funding - 9 percentage points higher than the 1997 figure. By 2009 the share of funding which came from National Insurance contributions had fallen back to 17.9% but was still considerably above the 1997 figure. Patients' payments (discussed above) remained a small proportion of total NHS income during all three Labour administrations, decreasing from 2.0% as a proportion of total finances at the start of the Labour term in office (1997) to 1.2% during Brown years (2007-2009).

Table 10: NHS sources of finance, United Kingdom, 1949 - 2009

Year (a)	Taxation		NHS contribution from National Insurance		Patient's payments (c)		Total NHS income (d)
	£m	%NHS (b)	£m	%NHS (b)	£m	%NHS (b)	£m
1949	437	100.0	-	-	-	-	437
1950	477	100.0	-	-	-	-	477
1960	671	77.5	118	13.6	43	5.0	866
1970	1,635	82.6	209	10.6	60	3.0	1,979
1980	9,951	88.4	1,042	9.3	264	2.3	11,257
1990	22,992	80.9	4,288	15.1	1,146	4.0	28,426
1997	39,064	85.6	5,691	12.5	906	2.0	45,660
1998	41,037	85.3	6,162	12.8	939	1.9	48,138
1999	44,569	85.3	6,690	12.8	1,006	1.9	52,264
2000	49,103	86.0	6,905	12.1	1,058	1.9	57,067
2001	54,116	86.0	7,610	12.1	1,166	1.9	62,892
2002	62,169	86.2	8,732	12.1	1,263	1.7	72,164
2003	62,608	77.9	16,391	20.4	1,349	1.7	80,348
2004	67,562	77.0	18,857	21.5	1,288	1.5	87,707
2005	75,803	78.5	19,510	20.2	1,271	1.3	96,583
2006	82,882	80.3	18,988	18.4	1,327	1.3	103,197
2007	89,662	80.0	21,081	18.8	1,391	1.2	112,135
2008	94,827	79.7	22,729	19.1	1,445	1.2	119,002
2009	102,541	80.9	22,679	17.9	1,479	1.2	126,699

Source: OHE (Hawe, 2011: 47) Table 2.5, drawing on Economic Trends (ONS), Government's Expenditure Plans (DH), Economic and Labour Market Review (ONS), Annual Abstract of Statistics (ONS), Freedom of Information (FOI) request to Department of Health (DH).

Notes:

a. All figures relate to calendar years.
b. %NHS refers to the percentage of total NHS funding from each source.
c. Patient charges for 2004 onwards are not comparable to earlier years, as reliable data for PDS in England and Wales are not available before 2004/05 and therefore data prior to 2004/05 are based on GDS patient charges alone. In 2005/06 there was a shortfall in patient charge income, in part attributable to PDS pilots income being based on the old GDS system of patient charges in England and Wales.
d. Prior to 1974 total NHS income includes services provided by former Local Health Authorities (LHAs). From 1979 onwards, services provided by LHAs were transferred to NHS.
e. All figures are in current prices.

5. Inputs and Outputs

In this section, we examine the nature and scope of the supply side expansion in publicly financed healthcare over the period 1997-2010 and comment on broad trends in supply relative to demand and need. There is general agreement that the increase in real public resources devoted to healthcare under successive Labour administrations was associated with a significant supply-side expansion over the period 1997-2010. However, there is less agreement over precisely how "big" the supply expansion was. Many analyses highlight that a significant proportion of the expansion in healthcare resources over the period 1997-2010 was effectively "absorbed" by increases in the salaries of nurses, doctors and other staff and other inflationary cost pressures such as pharmaceutical costs / clinical negligence claims (e.g. King's Fund and Sunday Times 14-17; Morse 2010; Wanless 2007: 90).

Key findings

- **How big was the supply side expansion?** There was a substantial expansion of healthcare supply over the period 1997-2010. Whilst debate continues about the extent to which cash increases were absorbed by increasing wages and salaries, indirect (expenditure based) estimates of volume growth suggest that the supply side expansion was substantial even when NHS specific wage costs and inflation are taken into account. According to official ONS (direct) estimates, the volume of publicly financed healthcare output grew by 97 percentage points between 1997 and 2010. Further, this estimate should be regarded as a lower-bound estimate of the volume of healthcare output growth over the period
- **The debate about healthcare productivity.** On-going political debates about whether the cash increases under Labour were well spent have been fuelled by suggestions that growth in healthcare inputs outpaced growth in outputs, with a consequent fall in productivity. Official ONS estimates which suggested a fall in productivity over the period have recently been revised. The most recent figures suggest that publicly financed healthcare productivity increased by 6.2 percentage points between 1997 and 2010. This estimate should be regarded as a lower-bound estimate of healthcare productivity growth over the period.
- **The changing balance of public/private provision.** According to official ONS estimates, the volume of healthcare goods and services that were publicly financed but that were provided *outside* the NHS increased by a factor of five during Labour's period in office. This finding is in line with broader shifts in the balance of provision of welfare towards publicly funded but privately delivered public services. Nevertheless, according to ONS analysis, the main contribution to the growth in the volume of healthcare goods and services during Labour's period in office was from growth in goods and services procured from *within* the NHS.
- **Supply, demand and need**. The growth in real healthcare output per capita significantly outpaced the growth in the population over 65, the population over 85, and the growth in real expenditure implied by demographic pressure alone.

How big was the supply side expansion?

Indirect estimates of the growth in healthcare supply

We begin with a discussion of trends in the growth of *volume* public sector expenditure on healthcare over the period 1997-2010. The *real* trends reported in Section 2 were calculated by deflating nominal (cash) figures using a GDP deflator, which was applied as a general measure of inflation in preference to other possible measures such as the retail price index or the consumer price index (which have a narrower scope). However, NHS-specific inflation often runs above inflation in the economy as a whole, with both wage inflation and increases in the costs of other inputs such as pharmaceuticals having a historic tendency to outpace the rate of increase of general inflation. For this reason, in Table 1 we also present a volume growth series which deflates the nominal sums using an NHS specific deflator (namely, the HCHS pay and prices deflator for England). The figures suggest that between 1997/8 and 2009/10 public sector expenditure on health in volume terms increased from £68.9 to £118.3 billion (an increase of £49.4 billion) in 2010 prices. This compares with a real terms increase from £57.3 to £118.3 billion (an increase of £61 billion) and a nominal terms increase from £44.5 to £118.3 billion (an increase of £76.8 billion). In other words, £27.4 billion (or 33.1%) of the nominal increase in public expenditure on health between 1997/8 and 2009/10 was "absorbed" by NHS-specific pay and price inflation.

The proportion of expenditure "absorbed" by NHS specific inflation suggested by these figures is somewhat smaller than that identified in an earlier Kings Fund evaluation covering the period 2002/3-2007/8. This found that applying an NHS-specific measure of inflation (again, the English HCHS pay and non-pay inflation measure) volume expenditure increased between 2002/3 and 2007/8 by around £24.3 billion, with around £18.9 billion (43.7 per cent) of the cash increase effectively absorbed in higher NHS-specific pay and prices. New employment contracts introduced for virtually all of the 1.3 million staff employed by the NHS were found to have contributed to the inflationary pressures, with follow on implications for productivity and other benefits. The main sources of the higher cost over this period were identified as being *Agenda for Change* (covering all nurses and non-clinical staff) and new contracts for hospitals doctors and GPs (Wanless et al 2007: xix and 90).

These and similar findings have prompted an important debate about the extent to which resource growth in health was absorbed by rising wage costs. However, in evaluating this argument, it is important to recognize that the faster wage growth after 2000 was not merely inflationary, given the real staff shortages in the mid-1990s and the need to maintain and recruit additional staff, as well as increased training and improvements in the quality of staffing in some areas (which should have improved the quality of healthcare outputs). Further, the findings presented in Table 11 are compatible with a picture of declining NHS-specific inflationary pressures over the Labour years, with cost pressures such as wage inflation easing off towards the end of Labour's period in Government. Finally, notwithstanding wage-push pressures, a picture of very substaqntial increases in volume / capacity is revealed by ONS direct estimates of healthcare input and output growth over the period, as will be discussed below.

Table 11: Nominal, real and volume public sector expenditure growth on health, United Kingdom, 1997/8-2009/10 and 2002/3-2007/8

	Change 1997/8-2009/10
Nominal increase (£ billion)	44.5-118.3
Absolute change (£ billion)	73.8
% pt change	165.8
Real increase (billions)	57.3-118.3
Absolute change (£ billion)	61
% pt change	106.5
Volume increase (billions)	68.9-118.3
Absolute change (£ billion)	49.4
% pt change	71.7

Source: Table 1

Notes: see notes to table 1

Official ONS estimates of healthcare inputs, outputs and productivity

Another way of pinning down the extent to which the rapid growth in expenditure on health was translated into a real expansion in the volume of healthcare "supply" is by looking at *direct* estimates of publicly funded healthcare inputs and outputs. Healthcare is "supplied" (or "produced") by transforming healthcare inputs (labour, goods / services and capital) into healthcare outputs (activities such as operations, consultations, diagnostic procedures etc.). Rather than relying exclusively on expenditure-based (or *indir ect*) estimates of volume growth, we report here on *direct* estimates of volume growth in these inputs and outputs themselves.

Improved direct estimates of publicly funded healthcare inputs and outputs have been developed by the ONS following the 2005 *Atkinson Review on the Measurement of Government Output and Productivity for the National Accounts* (Atkinson 2005). The latter made a series of recommendations on measuring the contribution of the public sector to volume-GDP for national accounting purposes. Economists have long-since grappled with how to measure the contribution of the output of the public sector to measures of volume-GDP, with the goods and services in question being provided either free of charge or at non-cost prices. The Atkinson Review addressed this problem. It criticised approaches that rely on "indirect" (expenditure-based) measures and that simply equate public service outputs with inputs; and highlighted the need for new direct estimates of public services inputs and outputs for national accounting purposes.

In addition, the Review set out a series of recommendations on the incorporation of a *quality-adjustment* into the measurement of public services output. These recommendations were based on the principle that improvements in quality as well as increases in quantity of public services should result in increases in measured public services output. The Review identified four main dimensions for understanding quality of healthcare drawing on Government objectives for healthcare set out in Public Service Agreements and other sources. These were saving lives and extending life span; preventing illness and mitigating its impact on the quality of life; speed of access to treatment; and the quality of patient

experience (paragraphs 8.7-8.11). The Review recommended that direct measures of public service of output capture and reflect these qualitative dimensions whilst recognizing that the qualitative element of measured public services output will require updating and re-specifying over time.

Input growth

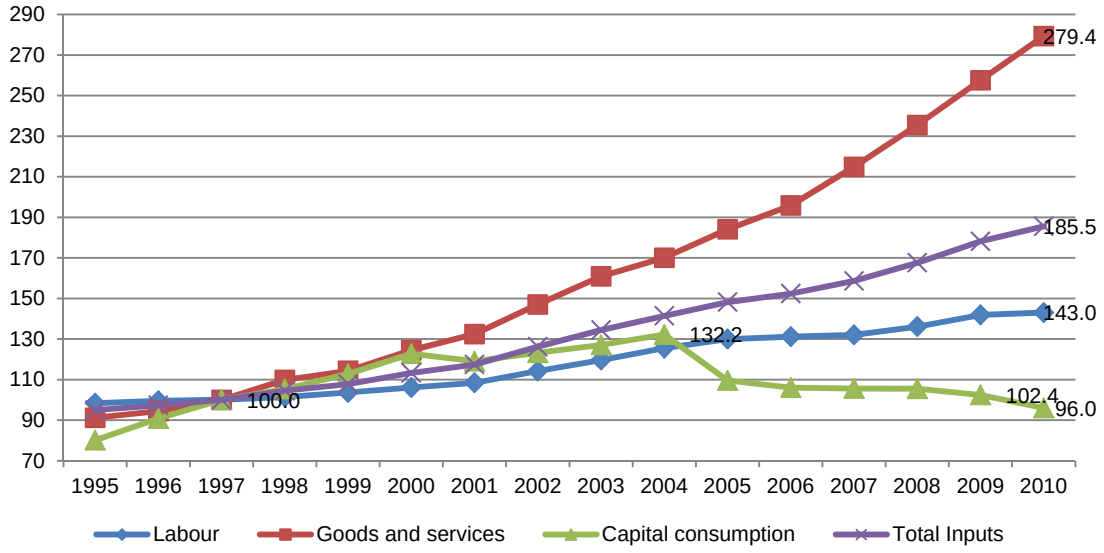
Figure 6 presents ONS direct estimates of publicly funded healthcare input growth covering Labour's period in office. The figures suggest that overall the volume of healthcare inputs goods and services used to "produce" healthcare increased by 85.5 percentage points over the period 1997-2010. The measure covers labour inputs (nurses, GPs, consultants etc.), goods and services (for example, GP-prescribed drugs, purchases of healthcare from non-NHS bodies, and other goods and services purchased and used in the provision of healthcare such as clinical supplies used in hospitals and GP surgeries, premises maintenance costs, and services provided under contract by dentists and pharmacists) and capital (e.g. buildings, computers and machinery).

According to ONS estimates and analysis, the volume of **labour** increased by 43 per centage points over the period 1997-2010. Labour inputs grow rapidly 2000-2004, coinciding with the implementation of the NHS Plan, Agenda for Change reforms and a period of expansion in recruitment. Growth in labour inputs then slowed down over the period 2005-2007 before picking up again 2008-2009 and levelling off in 2010. Growth in the volume of labour in HCHS outpaced growth in the volume of labour in other healthcare areas, with growth in the volume of qualified nursing and related staff contributinh most, followed by consultants and registrars and then by qualified health professionals, other qualified scientific, therapeutic and technical staff, support staff and management staff. The increase in the volume of the remaining eight staff categories, for example ambulance staff or doctors in training, was less marked but also positive (Massey et al 2012; Hardie et al: 2011).

The **volume of goods and services** such as pharmaceutical, dental and ophthalmic services, and intermediate consumption by hospitals and GP practices, rose by 179 percentage points over the period as whole. This figure includes growth in the volume of healthcare purchased from *outside* of the NHS (such as contracted-out services and through PFI arragements). The volume of **capital consumption** grew by 32 percentage points between 1997 and 2004, before declining over the period 2004-2010, with a four percentage point fall over the period as a whole. This figure reflects the amount of capital stock used each year and is made up of depreciation and other capital charges (Massey et al 2012; Hardie et al: 2011).

The ONS estimated input growth can be thought of as a cost weighted total of the three separate input volume indices for labour, capital consumption and goods and services (with each of the three types of input weighted by its share in overall healthcare expenditure). The largest expenditure share is from goods and services, which contributed to input growth most over the period (Massey et al 2012; Hardie et al: 2011).

Figure 6: Volume of Inputs by type of input, United Kingdom, 1995–2010, Index numbers



Source: ONS (Massey 2012: Figure 1 and Figure 1) with figures re-based to 1997=100

Output growth

The growth in the volume of publicly funded healthcare *outputs* under successive Labour administrations was also considerable. Again, we concentrate here on estimates of public services healthcare output growth reported by the ONS (Massey et al 2012, Hardie et al 2011). Building on the recommendations in the Atkinson Review, these estimes capture and reflect changes in the *quantity* of outputs (i.e. measured using a cost-weighted volume index covering more than 16,000 healthcare "activities" organized by resource groups) and changes in the *quality* of outputs (e.g. as indicated by changes in post-operative survival rates, hospital waiting times, patient experience etc.).

The growth in the *quantity* of publicly funded healthcare outputs is captured in Figure 7 below, rising over the period as a whole by a hefty 87.5 percentage points between 1997 and 2010. This figure reflects a 57.5 percentage point increase in the volume of HCHS activities (such as the number of hospital inpatient, day case and outpatient episodes), a 43.9 percentage point increase in the volume of FHS activities (such as GP and practice nurse consultations, publicly funded dental and sight tests) and a hefty 205 percentage point increase in the volume of GP prescribing activities.

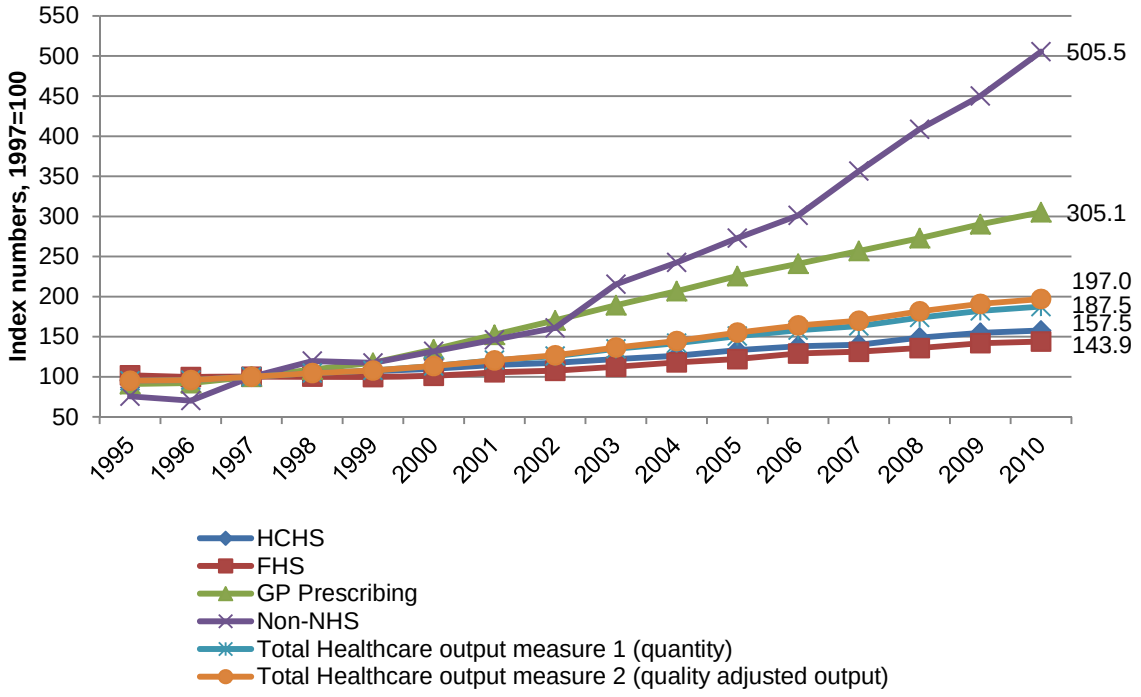
The fastest growing area of activity was in services funded by the NHS but provided by organisations in the private, voluntary or local government sector. This includes acute services, such as cataract removals and hip replacements provided by independent sector treatment centres and private hospitals; healthcare services provided within the community for older people, people with learning disabilities, people with mental healthcare needs; and packages of care for patients with long-term health conditions including within private nursing homes[v]. The introduction of additional new services such as NHS funded nursing

care in care homes, which began in England in October 2001, has been another driver of growth (Hardie et al 2011 Appendix B).

The ONS estimates suggest that the volume of non-NHS healthcare output increased by a factor of five over the period 1997-2010. This estimate is in line with broader research findings which suggest a medium-term shift towards publicly-financed, privately provided welfare (on which, see Hills 2011). Nevertheless, according to ONS analysis, the main contribution to the growth in the volume of healthcare goods and services during Labour's period in office was from growth in goods and services procured from *within* the NHS (Hardie et al 2011).

The components of quanity output volume are added together using their relative shares in overall government expenditure in healthcare in order to calculate the index of overall healthcare quantity growth. Although the growth in HCHS volume was more moderate than the increase in GP prescribing, a high expenditure share meant that HCHS was nevertheless the biggest contributor to overall growth in the volume of healthcare outputs.

Figure 7: Healthcare output (quantity output and quality adjusted output), United Kingdom, 1995–2010, Index numbers



Source : ONS (Massey 2012: Figure 4 and Figure 6, re-based by authors to 1997=100)

The ONS also publishes *quality*-adjusted publicly funded healthcare output estimates, taking account of the extent to which the healthcare system succeeds in delivering its intended outcomes. The ONS healthcare quality-adjustment currently has two main components: a component that approximates to extra quality-adjusted years arising from medical procedures (based on post-operative survival rates, health gain following procedures and changes in waiting times) and a component relating to primary medical care outcomes (adjusting for the proportion of patients on GP lists whose blood pressure / cholesterol is

maintained within target levels). In addition, a small further quality- adjustment is made to account for the extent to which services are responsive to user's needs (comprising 5 % of the overall quality adjustment, and based on patient experience surveys covering hospital inpatients, outpatients, mental health, primary care and emergency services).

As Figure 7 shows, the estimates suggest that quality-adjusted output rose at a faster rather than quantity-unadjusted output over the period 1997-2010, with quality-adjusted output almost 10 percentage points higher than quantity-unadjusted output by the end of the period. Taking account of the quality-adjustment, healthcare quality output is estimated by the ONS to have risen by more 97 percentage points over the period 1997-2010. Improvements to thirty-day survival rates, health gain following procedures and waiting time have made the most important contributions to rising quality. Outcomes from primary medical care and service responsiveness also improved over the period between 2003-04 and 2006-07, as patients in particular groups were given appropriate treatments, but has tailed off as targets for treatment have approached 100%. The responsiveness to patient needs component also made a positive contribution to the positive quality adjustment over the period as a whole (Massey 2012; Hardie et al 2011).

The debate about healthcare productivity[vi]

The ONS direct estimates of healthcare input and output discussed above form the basis of ONS healthcare productivity estimates. These estimates have in turn generated significant academic, political and media debate and are now central to the post-2010 health policy agenda. Whilst ONS estimates of healthcare productivity have been recently upwardly revised, political concerns have been raised about whether the real cash increases on healthcare under Labour were well spent - or whether Labour was profligate, spending too much whilst failing to extract sufficient value for money and productivity gains in return. Unfavourable comparisons between public sector healthcare productivity (and indeed public sector productivity more generally) and the record of productivity growth in the private sector over the period 1997-2010 have been highlighted. Whilst the need to extract productivity gains from the NHS as a response to the new fiscal climate and austerity were highlighted as early as 2009, the potential for effiency savings and productivity gains is now central to the post-2010 healthcare agenda.

ONS estimates of productivity published in 2011 suggested that healthcare productivity fell by 2.7 per cent from 1995 to 2009, an average annual fall of 0.2 per cent (Hardie 2011). Prior to this release, in 2010, a report by the National Audit Office drawing on official ONS productivity estimates concluded that significant extra real resources had been put into the NHS and that there had been significant imporvements including in relation to waiting times, healthcare associated infection rates, patient outcomes, reduced cancer mortality and the patient experience. However, productivity had fallen and that there remained significant variations in productivity between hospitals (NAO 2010). In the decade to 2010 "there has been significant real growth in the resources going into the NHS, most of it funding higher staff pay and increases in headcount. The evidence shows that productivity in the same period has gone down, particularly in hospitals" (Morse 2010).

Black (2012) subsequently challenged the accuracy of ONS estimates and suggested that a "myth" of falling productivity had come about because of the failure of Labour to defend its record. Grice (2012) in turn suggested that taking into account complexity and marginal uncertainty, the ONS estimates should be interpreted as suggesting that over a fifteen year

period healthcare productivity growth was not "far off flat". The key point, he proposed, is that whereas in the rest of the economy productivity rose considerably, similar productivity gains were not seen in the context of public sector healthcare (Grice 2012)[2].

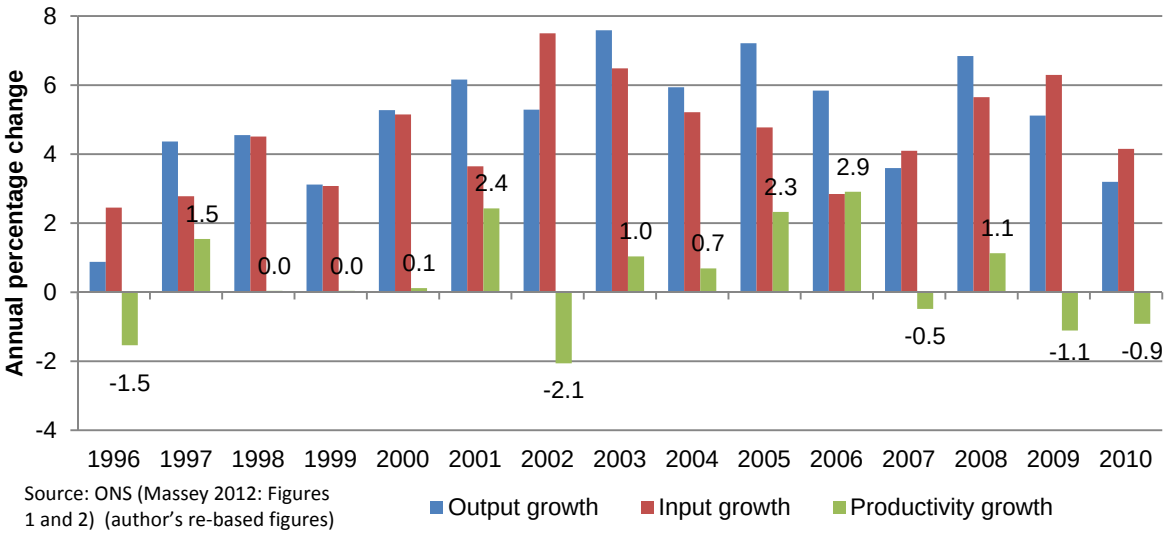
In interpreting these claims and counter-claims, it is critical to note that ONS are explicit that the healthcare input, output and productivity data are limited in important respects. Key limitations highlighted in earlier releases included the fact that not all activities were estimated by direct rather than indirect methods; that only 80% of healthcare activities were covered (with a possibility that critical areas of growth could be missed); and limitations in geographical coverage with an emphasis on England.

In late 2012, following a period of debate about the accuracy of ONS healthcare output and productivity estimates, a revised set of healthcare output estimates for the period 1995-2010 were published by ONS. The revisions were driven by a number of data improvements and changes in methodology. This included a new methodology for estimating the outputs of publicy funded healthcare suppliled by non-NHS organisations such as private companies, charities and local authorities. Previously, ONS had assumed that real expenditure allocated to non-NHS organisations is transformed into "healthcare activities" at the same rate as measured NHS activity. From late 2012, an "inputs=output" approach was adopted with expenditure allocated to non-NHS organisations (once deflated) now assumed to represent the equivalent growth in output volume (Massey 2012: 5-6).

These changes resulted in an important upward revision to ONS healthcare output and productivity estimates. The revised ONS productivity estimates are presented in Figure 8 alongside figures for input and output growth. Average annual productivity growth was estimated to be 0.4% per cent per annum between 1995 and 2010 in Massey (2012), compared with the previous estimate of average falls 0.2% per annum. The figures were interpreted by ONS as suggesting that for most of the 15 year period since 1995, productivity remained broadly constant with the growth in output volume broadly matched by growth in inputs volume. The increase over the period only yeilds an average annual growth rate of 0.4% and for this reason is characterised by the ONS as broadly constant.

Nevertheless, the revision is an important one and suggests that productivity increased rather than declined during Labour's period of power. Rebasing the series to 1997=100, the figures point towards an average annual growth rate in productivity of 0.5 per cent over the period 1997-2010, with productivity 6.2 percentage points higher in 2010 than it was in 1997.

Figure 8 Growth in healthcare inputs / outputs and productivity estimates, United Kingdom,1995–2010, Index numbers



Source: ONS (Massey 2012: Figures 1 and 2) (author's re-based figures)

Limitations and caveats

There are a number of important reasons for interpreting even the revised ONS estimates as providing conservative, lower bound estimates of healthcare output and productivity growth during Labour's period in power. First, the output estimates are likely to be affected by time lags. This might be particularly true in key areas of preventative health, such as investment in ICT. As a result, the full impact of increases in public expenditure on healthcare and supply side expansion on output may only be captured and reflected in indicators at a later date (Atkinson 2005, Pritchard n.d.).

Second, Glennerster points out that the current health quality adjustment has a relatively small weight and is health outcome (QALY) based. For example, quality increases due to waiting times improvements are measured entirely in terms of health gain. A broader approach that takes account of the broader economic and welfare benefits deriving from early treatment could potentially record much bigger gains in welfare from resources spent on waiting times (reflected, for example, in behavioural responses to extended waiting times, such as the purchase of private medical insurance) (Glennerster 2012).

Third, quality adjustment is only partial and many of the outcomes discussed in sections 5-8 of this report in particular are not covered, or are not adequately covered, by the existing ONS measures. For example, current quality adjustment covers hospital outcomes, primary care outcomes, waiting times and patient experience. The Atkinson Review called for further research on the measurement of healthcare quality. Atkinson (2009) has further argued that the performance of the NHS should be evaluated in the light of its objectives including tackling health inequality. He has proposed that ONS publish a measure of distributionally-adjusted healthcare output alongside the quantity and quality adjusted output measures, so that if policy has shifted resources towards services or areas benefiting the more deprived, then this would be reflected in a faster growth of adjusted output.

Fourth, the conceptual scope of the ONS healthcare quality-adjusted output measure focusses on health gains that are attributable to the healthcare system itself, and health gains attributable to broader policy interventions including housing, income distribution, health and safety measures and even smoking bans fall beyond its conceptual reach. For this reason, the Atkinson Review warned against the use of a healthcare output measure as an overall indicator of the success of government policy in achieving health outcomes. It suggested that other indicators (including outcome-orientated PSA indicators) also have a critical role to play. The Review concluded: "National accounts provide indicators of broad trends; to try to use them as microeconomic measures of public sector performance misunderstands their nature and limitations. National accounts are not a substitute for performance indicators, and there are risks in attempting to use them for such a purpose (Atkinson 2005: 8).

Building on this analysis, evaluating policy performance against the Government's own targets and indicators provides another entry point for thinking about policy effectiveness and efficiency. Our evaluations of health outcomes against key Public Service Agreement indicators in the sections of this report that follow are particularly relevant here. Indeed, the Public Service Agreement indicator, with their focus on broader outcomes were in fact

consciously intended to provide an alternative benchmark for evaluating Government performance to that provided by previous efficiency measures based on narrow characterisations of public sector output.

As Pritchard suggests, there are a number of different ways that a Government can evaluate its own performance and productivity is only one of them (Pritchard n.d.). Ideally, a broad measure of efficiency would capture the impact of public action on the achievement of goals (such as the expansion of health) rather than focussing exclusively on the output of public services (and therefore on maximising the expansion of underlying goods rather than maximising GDP). Building on this approach, Pritchard and Wallace (2011) compare the efficiency and effectiveness of healthcare systems in reducing mortality the USA, UK and 17 Western countries. They find that in cost-effective terms, i.e. economic input (expenditure) versus clinical output, the UK was one of the most cost-effective over the period 1979-2005. With regard to reduced adult mortality rates, five countries had greater mortality rate reductions than the UK, while 11 other countries had significantly lower falls than the UK (including the USA). With regard to efficiency (evaluated in terms of "expenditure on healthcare as a proportion of GDP: reduced mortality rate" ratios), the UK performed better than all other countries apart from Ireland. The UK achieved significantly bigger clinical reductions with below average and current GDPHE economic input. (Pritchard and Wallace 2011 2-6).

OECD analysis (Joumard et al 2010) provides a comparative evaluation of health system efficiency that focuses exclusively on healthcare outcomes (defined as those gains in the population's health status which can be attributed to health spending) rather than healthcare outputs (e.g. numbers of consultations and procedures undertaken). The UK is evaluated as being at the "less efficient" end of the spectrum within a cluster of countries with similar healthcare systems. However, the authors note that the results should be treated with caution since the results of expenditure and reform on outcomes may not yet be apparent.
In the broader literature, the Commonwealth Fund (Davis et al 2010) ranked the U.K. in overall second place in an evaluation of healthcare systems covering Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States). The UK was evaluated as ranked first in terms of health system efficiency, second in terms of equity and third in terms of quality of care.

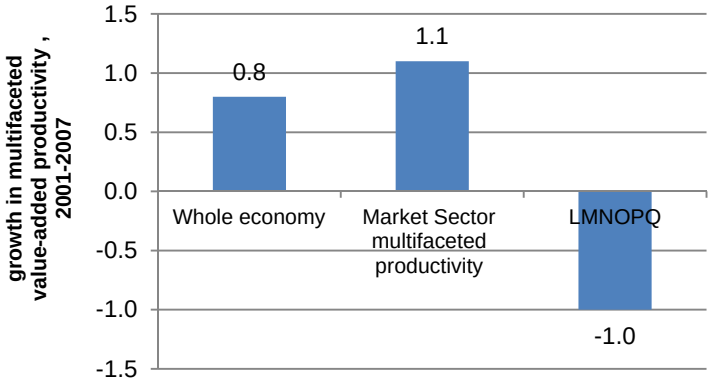
Are comparisons between public sector and private sector productivity growth valid and meaningful?

The problematic nature of drawing comparisons between public sector and private sector productivity growth is another key issue. Atkinson (2009) suggests that health services generally are likely to be characterised by diminishing returns over time (the so-called Baumol effect) given the labour intensive nature of publicly financed healthcare. He suggest that the "big story" when it comes to health productivity may not be so much that of declining public service output for health compared to increasing private sector productivity during the Labour years, but rather, why returns to investment in health have remained relatively high over such a long period. Similarly, the NAO report cited above acknowledges that healthcare productivity might be *expected* to fall during times of rapid input growth as the resulting increases in output may be relatively slower to achieve (NAO 2010:6).

Phelps (2010) sets out the difficulties in making strict comparisons between public sector and private sector productivity growth. Whereas the public services productivity figures reported above are gross-output / expenditure based estimates, the closest comparative estimates that are currently available are based on the concept of multifaceted value-added productivity for the whole economy, the market sector (based on the subset of industries that sell their output at economically significant prices and covering health excluding that part provided by state health services) and for the 'LMNOPQ' sector. The concept of 'LMNOPQ' is close to that of 'public services' and covers public administration and defence, health and social work, and othe social and personal services. However, there is some overlap between LMNOPQ and certain market sector activities such as private-sector and not-for-profit produced output which is sold directly to the personal sector are included within LMNOPQ. For example: private education and healthcare which is purchased by public authorities at economically meaningful prices but provided to NHS patients at zero or subsidized prices (e.g hip operations arranged by public authorities and provided free of charge at independent treatment centres).

Estimates comparing productivity in the whole economic, market sector and LMNOPQ sector were published by ONS in 2010. These suggested that annual growth in market sector multifaceted productivity between 2001 and 2007 was 1.1 per cent, whereas for the LMNOPQ sector it was approximately minus 1.0 per cent, and the figure for the whole economy of 0.8 per cent (Phelps 2010: paragraphs 3.11- 3.12 and 7.3-7.5).

Figure 9: Growth in multifaceted value-added productivity, average annual percentage change, United Kingdom, 2001 - 2007



Source: Phelps, 2010: 7

Other productivity estimates in the broader literature

In the broader literature, alternative productivity estimates published by the Centre for Health Economics suggest that the productivity of the NHS in England was broadly constant over the seven years 2003/4-2009/10. The estimates point towards commensurate increases in inputs and the quantity / quality outputs, with productivity increases averaging 0.1 per cent per year (Bojke *et al* 2012). The post-2010 "more for less" agenda is also underpinned by evidence of regional variations in productivity, with productivity per head found to range from

5% above the national average in the South West to 6.5 per cent below the national average in East Midlands in 2007/8 (Bojke et al 2011).

An alternative, systems / outcome level approach to evaluating healthcare efficiency is put forward in OECD (n.d.) and Joumard et al (2010). The authors recognize the importance of recent work to develop health output measures for national accounting purposes (and of new productivity meausres that have been developed in this context) whilst highlighting a key limitation, namely, that medical outputs (for example, hospital activities) may be produced efficiently, but still have only a very limited impact on population health status if they are not allocated adequately. They set out an alterantive methodology for deriving efficiency measures by relating health care outcomes to total (public and private) health care resources while controlling for socio-economic, lifestyle and environmental variables. Outcomes are defined as those gains in the population's health status which can be attributed to health care spending and are characterised in terms of both longevity and morbidity. Healthcare efficiency estimates for all OECD countries are presented using this methodology (although these are recognized as being subject to considerable uncertainty).
For the UK, the results suggest that are considerable effiency gains to be made, as measured by the number of years of life that could be saved if efficiency in the UK were to be raised to the level implied by the estimated efficiency frontier while holding inputs constant (under the assumption of non-increasing returns to scale) with potential savings to the public purse of 3% of 2017 GDP (above the OECD average).

Supply, demand and need

Our indirect estimates discussed above suggest 71.1% growth in healthcare volume expenditure over the period 1997/8-2009/10. Direct ONS estimates suggested that the volume of publicly funded healthcare output increased in quantity terms by 87.5 percentge points between 1997 and 2010. On both measures, there was considerable volume growth. But how big was the supply side expansion relative to demand for healthcare, population growth and other measures of need?

Demand for healthcare is generally modelled as depending on a complex combination of income, expectations, technology, demographics (the size and composition of the population) and needs. During the Conservative period in power (1979-1997), the growth in public sector volume expenditure on healthcare was *below* the growth in total personal income. If the income elasticity of demand for healthcare services is one or greater than one, with healthcare characterised as a luxury good (which continues to be debated), demand over this period would have been rising faster than supply, fuelling the widespread perception that the NHS was underfunded (Le Grand and Vizard 1998: 93). In contrast, during the Labour years, the growth in public sector volume expenditure on healthcare was significantly *above* the growth in both GDP and total household disposable income (Figure 10A). This relationship holds even taking account of population growth, with the growth of volume public services expenditure on health per capita also far outpacing the growth of GDP and household disposable income per head (Figure 10B).

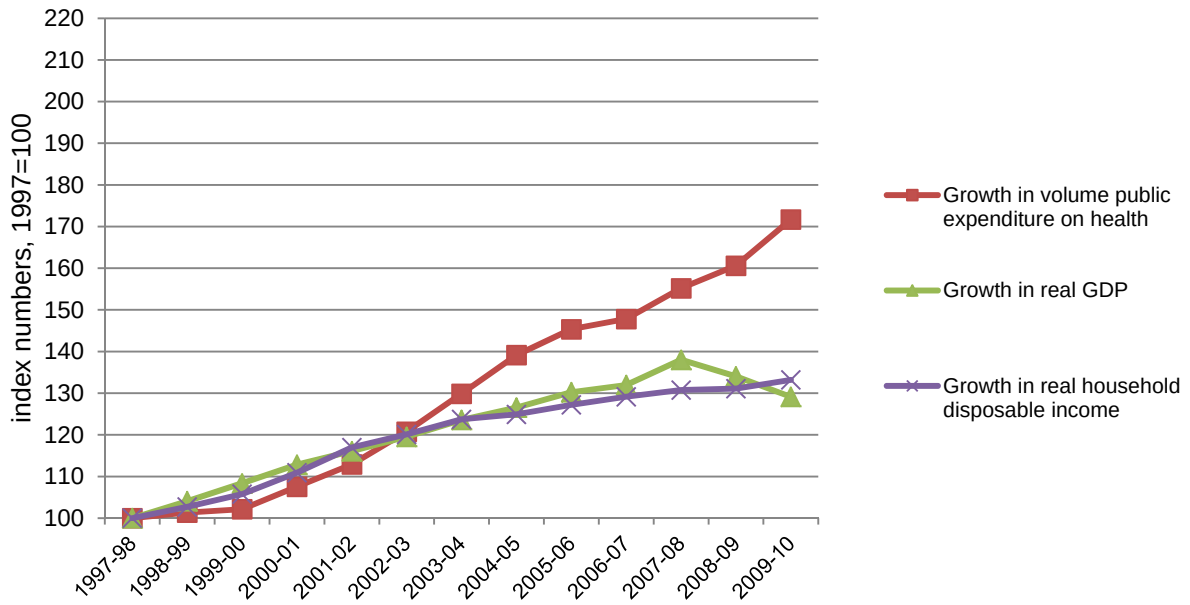
Health *need* is another complex concept. As will be discussed below, healthcare resources are allocated in England using a complex formula that captures different aspects of healthcare need (including demographics, utilisation, deprivation and health status). Here we apply a much cruder concept of need based on the growth of those aged over 65 and 85

within the population as a whole, together with a measure of demographic pressure, to comment on broad trends in the relationship between the growth in healthcare volume output with need and demographic change over time. Figure 10C compares both the growth of public services healthcare volume expenditure, and public services quantity-output growth, with need and demographic pressure. The Figure shows that the growth in public sector volume expenditure on healthcare also far outstripped the growth in crude measures of need (such as the growth of over 65s and over 85s).

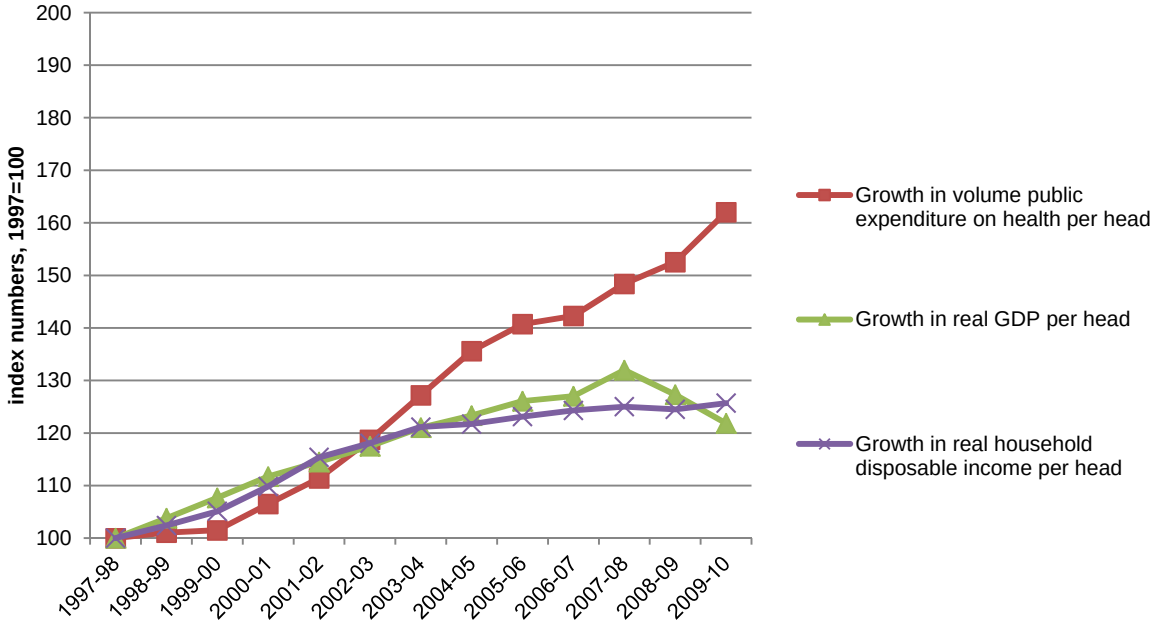
In principle, as well as comparing the growth rate of volume expenditure and population growth, it would be informative to estimate the growth of volume expenditure compared with the rate that would be required to keep in line with demographic pressure. An estimate of this type would in principle take account of *both* the different costs of different age groups *and* the relative growth of demographic pressure within each age band. For example: the relative costs of over 85s as well as the growth rate of the over 85s). Unfortunately, however, the age-cost published in DH Exposition Books are not constistent over time particularly in relation to their treatment of maternity costs (DH 2012). Therefore, it has not been possible to obstain consistent estimates of the the different costs of healthcare for different age groups (maternity, 0-4, 5-15, 15-64, 65-74-75-84, 85+) going back to 1997/8. However, crude analysis based on the age-cost curves for healthcare that are available suggest that the growth in volume expenditure over the period 1997/1998-2009/2010 considerable outpaced the sums that would have been implied by demographic pressure alone[vii].

Figure 10: Growth of healthcare supply compared with national income, need and demographic pressure

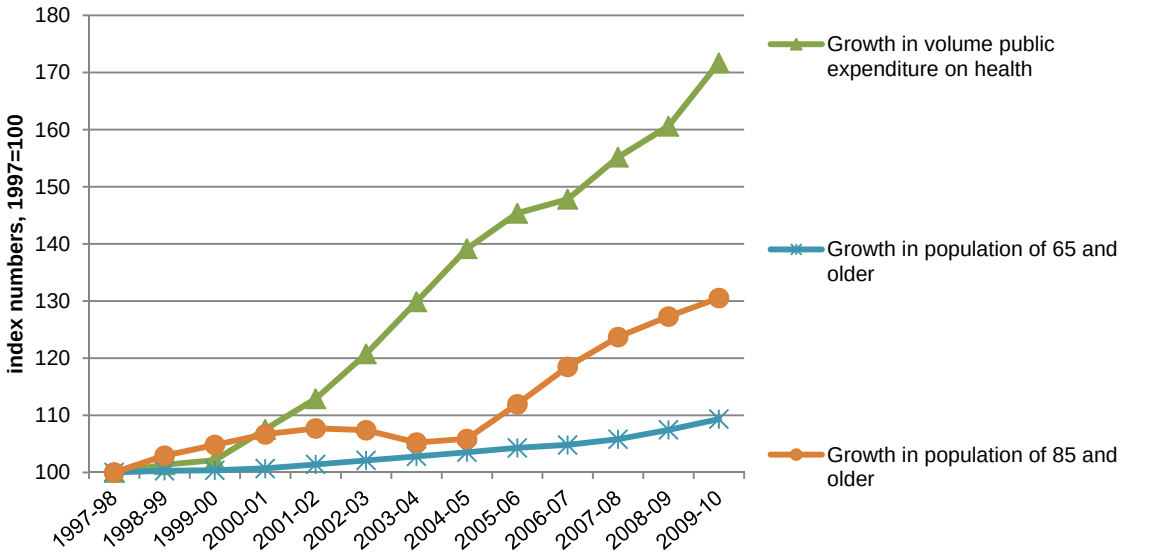
a) Growth rate of volume public services expenditure on health compared with GDP and household disposable income, United Kingdom, 1997 - 2010)



b) Growth rate of volume public services expenditure on health per capita compared with GDP per capita and household disposable income per capita, United Kingdom, 1997 - 2010



c) Growth rate of volume public services expenditure on health per capita compared with crude measures of need and demographic pressure, United Kingdom, 1997 - 2010



Sources:
Real public expenditure on health: authors calculations using nominal public expenditure figures and GDP deflators from HM Treasury (2011a) with reference year changed to 2009/10); real GDP: authors calculations using nominal GDP figures and GDP deflators from HM Treasury (2011a) with reference year changed to 2009/10; real household disposable income: Blue Book online resource, 2008 prices (ONS 2011d). ONS (2011b) population estimates; real household disposable income per head: Blue Book 2011 online resource, 1995 prices (ONS 2011d).
Volume public expenditure: Authors calculations. Nominal public expenditure figures from HM Treasury (2011a) and DoH (n.d.) HCHS inflation index, 2009/10. Persons over 65 and 85: ONS (2011b) Population estimates.

6. Healthcare Outcomes

In sections 5-9 we turn to an examination of trends in health outcomes 1997-2010. We begin here with a review of healthcare outcomes, including trends in access to healthcare, healthcare quality, satisfaction with health services, patient experience, and progress in eliminating variations in quality and sub-standard care. In line with the findings in section 3.3, we find a general picture of overall substantial improvement in healthcare quality and access. access and quality. Nevertheless, variations in quality and substandard practice, key issues when Labour came to power in 1997, remained key challenges and legacy issues in 2010.

Key findings

- There were substantial overall improvements in healthcare access and quality over period measured by a range of indicators.
- **Access to healthcare.** Waiting lists and waiting times improved dramatically and the number of GPs per head increased (although inequities in access to GPs between more and less deprived areas were not fully eliminated by 2010).
- **Healthcare quality.** There were significant improvements in healthcare quality including post-operative survival rates and reductions in avoidable **mortality.**
- **Patient experience and individual satisfaction.** Overall patient experience scores were high in a range of service areas. Overall satisfaction with National Health Services rose from lows of 36% in 1997 to highs of 71% in 2010.
- **Eliminating variations in hospital performance and poor quality healthcare** nevertheless remained a key concern at the end of Labour's period in power (for example, variations in standardized hospital mortality rates) with a growing body of evidence of poor treatment of vulnerable groups (e.g. older people, people with learning difficulties). Poor quality care was coupled with evidence of regulatory failure in some instances (e.g. Mid-Staffordshire Foundation Trust, as highlighted in the 2013 Public Inquiry).

Access to healthcare

Labour came to office in 1997 against a background of long and rising waiting lists and the reduction of both waiting lists and waiting times was a key objective of successive Labour administrations. The reduction of waiting lists and waiting times is widely viewed as a major success of the period and, as both waiting lists and waiting times fell, a series of progressively tougher targets were specified in successive Labour Party Manifestos and Public Service Agreements. The 1997 Labour Party Manifesto pledged to reduce waiting lists by 100,000 people, whilst the 2001 Labour Party Manifesto pledged to cut maximum waiting times by the end of 2005 for inpatients from 18 months to six months, and for outpatients appointments from six months to three months. The 2004 Spending Review (2004: 13) specified the following target for referral to treatment: "To ensure that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment" (to be evaluated in December 2008) (Department of Health, 2006: 11). This commitment was repeated in the 2005 Labour Party Manifesto, which further specified that average waiting times from GP referral for a hospital operation to the operation itself would reduce from nine to ten weeks (Labour Party 2005).

As Figure 11 shows, all of these targets were successfully achieved. In England, the number of inpatients waiting for treatment for more than 13 weeks (three months) continued to increase after Labour came into power in 1997 and peaked at approximately 700,000 people in 1998. The figure had fallen to 500,000 in 2001 and continued to fall until 2008, with a slight rise thereafter. The number of outpatients waiting for treatment following GP referral for more than 26 weeks (six months) fell to negligible numbers by 2006 and remained at zero for the rest of Labour's period in power. The number of outpatients waiting for treatment following GP referral for more than 13 weeks (three months) rose between 1999 and 2001 and fell thereafter, reaching negligible numbers by 2006. In December 2008, 92.8% of admitted and 97.1% of non-admitted patients were referred to treatment within 18 weeks.

Cooper et al (2009) argue that equity in relation to waiting times also improved during Labour's period in office. Their findings suggest that between 1997 and 2007 waiting times for patients having elective hip replacement, knee replacement, and cataract repair in England went down and that the variation in waiting times for those procedures across socioeconomic groups was reduced. Whereas in 1997 waiting times and deprivation tended to be positively related, they report that by 2007 the relation between deprivation and waiting time was less pronounced and that, in some cases, patients from the most deprived fifth were waiting less time than patients from the most advantaged fifth.

Additional targets relating to waiting times in accident and emergency, and for access to GPs, were also set early on during the first Labour term. The NHS Plan (2000) stated that "[b]y 2004 no-one should be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge" Department of Health (2000: 103). Figures recorded for the fourth quarter of 2002/3 (i.e. January to March 2003) suggest that 82.4% of people were waiting less than 4 hours in major A&E departments in England (Department of Health, 2003). This figure rose to 90.6% in the fourth quarter of 2003/4 (Department of Health, 2004) suggesting that this target was not achieved. At the end of Labour's period in power, in the fourth quarter of 2009-10, 96.9%[viii] of individuals in major A&E departments including the independent sector spent less than 4 hours there and 97.9% in all A&E / Minor Injuries Units / Walk in Centres (Department of Health, 2010b).

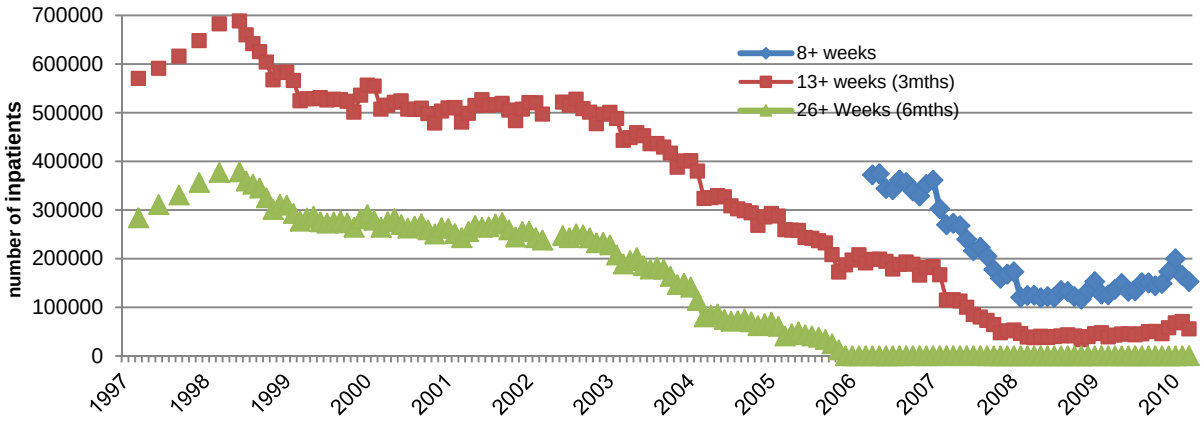
On access to GPs, an early committed stated that: "[b]y giving increased resources and support, the aim is that every practice will meet these standards [every patient being able to see a health care professional within 24 hours and a GP within 48 hours] by 2004" (Department of Health 2001: 8). The GP patient experience survey figures for 2007 suggest that 86% of patients reported that they had seen their GP within 48 hours (Department of Health, 2010a). Figures for 2009/10 suggest a fall in the proportion of those who reported seeing their GP within this time frame, with 80% of respondents indicating that the last time they tried to see a doctor "fairly quickly" they achieved access in practice within two weekdays (GP Patient Survey, various years 2010a and 2010c).

A key indicator of how successful Labour was in achieving the goal of *equitable* access to healthcare (or 'equal access for equal need') relates to the extent to which people living in disadvantaged areas of the UK experienced equal access to GPs. As discussed in Section 3.2, primary care services expanded during the Labour years. Figure 12 below shows the number of general medical practitioners in each country in the UK per 100,000 population

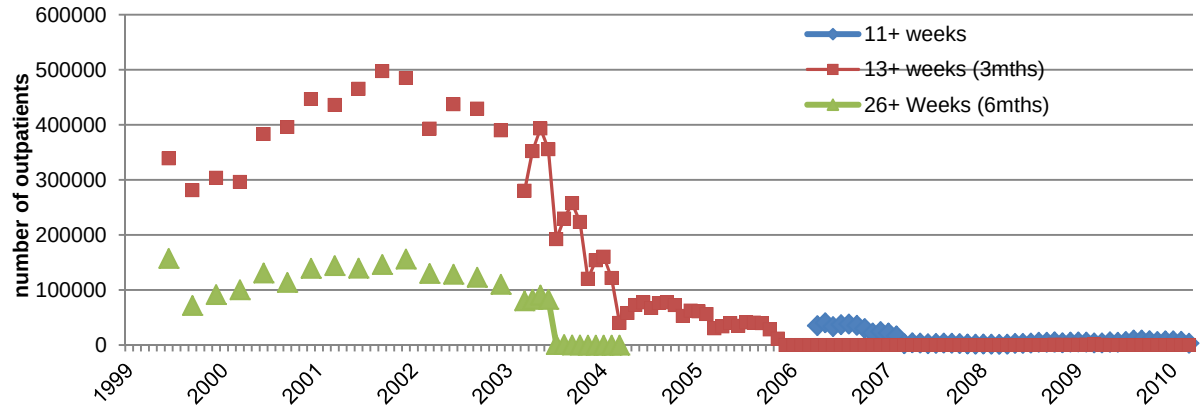
between 1985 and 2009. While Scotland maintained its lead in the number of GPs per 100,000 population throughout this period, England started at the bottom with the least numbers of GPs in 1985 but by 2004 had overtaken both Wales and Northern Ireland and retained its position up to 2009.

Figure 11: Waiting lists and waiting times, England

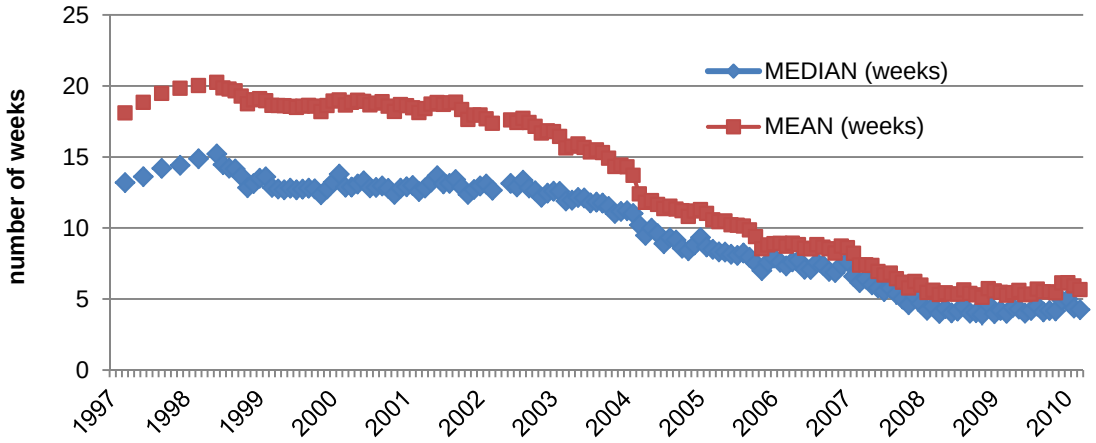
a) Number of inpatients waiting for treatment, 1997-2010 [(a) (b)]



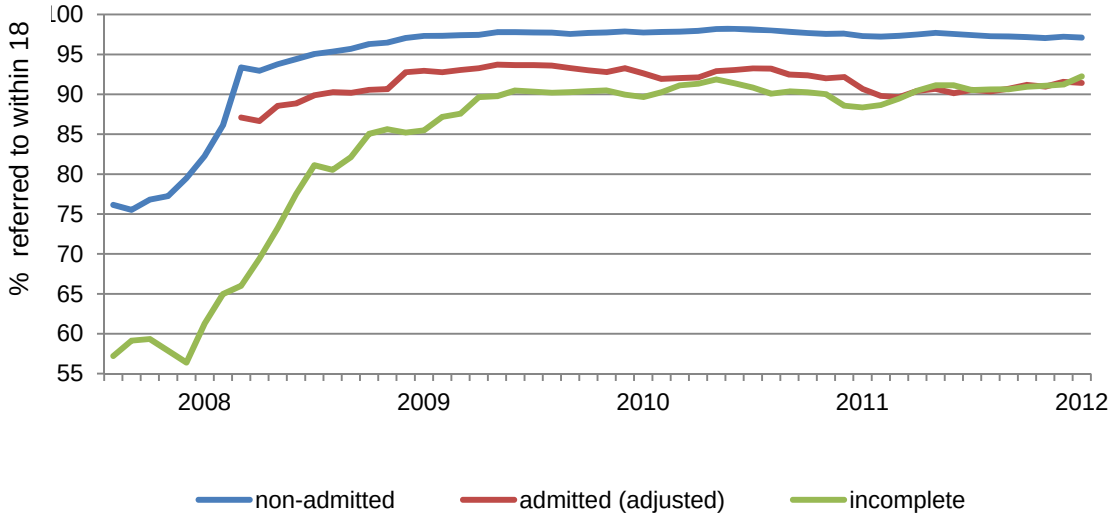
b) Number of outpatients waiting for treatment following GP referral, 1999-2010 [(a) (c)]



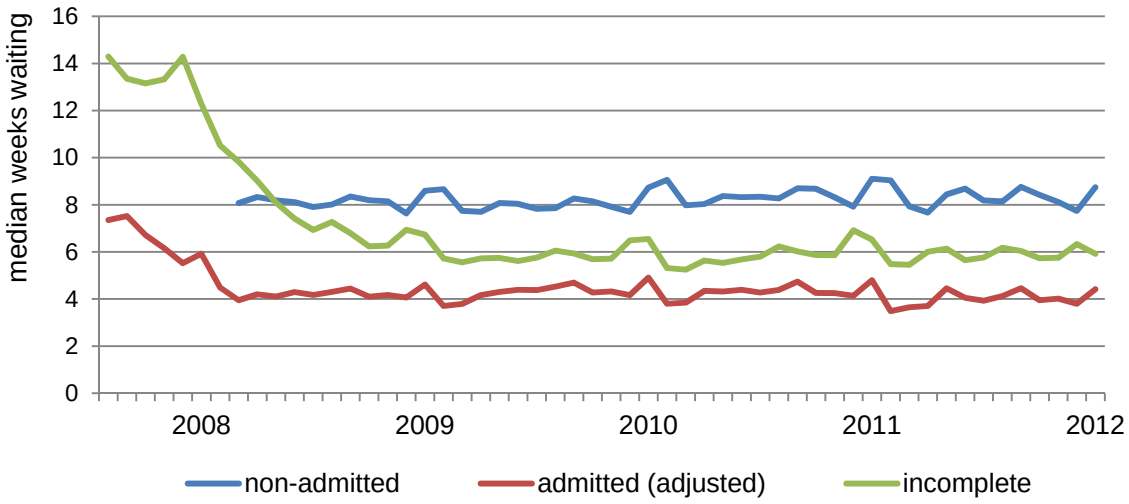
c) Median and mean number of weeks waiting for treatment (inpatients), 1997-2010 [(a)(b)]



d) Referral to treatment waiting times: proportion referred within 18 weeks, 2008-2012 [(a) (d) (e)]



e) Referral to Treatment waiting times: median weeks, 2008-2012 [(a) (d) (e)]

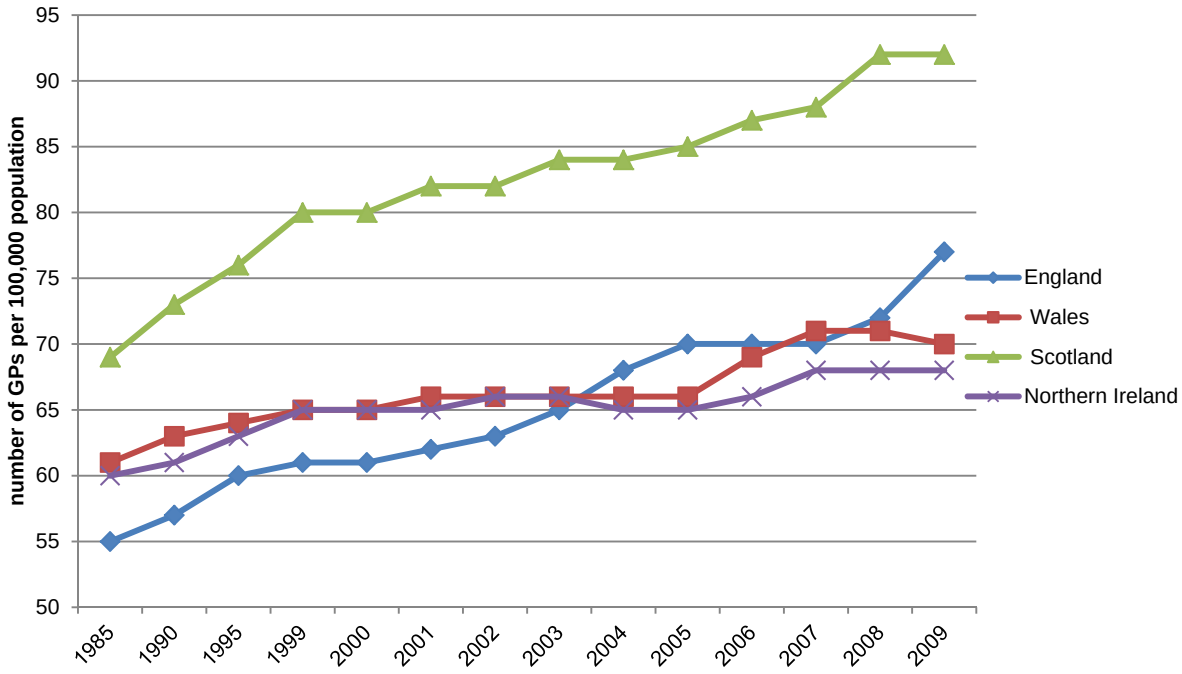


Source: A-C: Department of Health (n.d.) Inpatient and Outpatient waiting times; D and E: Department of Health (2011d).

Notes:

a. Commissioner based figures.
b. Monthly figures for years 1999 to 2009, starting in March 1999. For 1997 data is available every 3 months starting from March 1997. Figures for 2010 are for January to March.
c. Monthly figures starting from March 2003 each year to December 2009. For years 1999 to 2002 data is available every 3 months starting from June 1999. Figures for 2010 are for January to March.
d. Adjustments are made to admitted RTT pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer.
e. Percentage within 18 weeks is calculated using total number of pathways (known).

Figure 12: Number of general medical practitioners (1) (GPs including registrars) per 100,000 population, by country, United Kingdom, 1985 – 2009



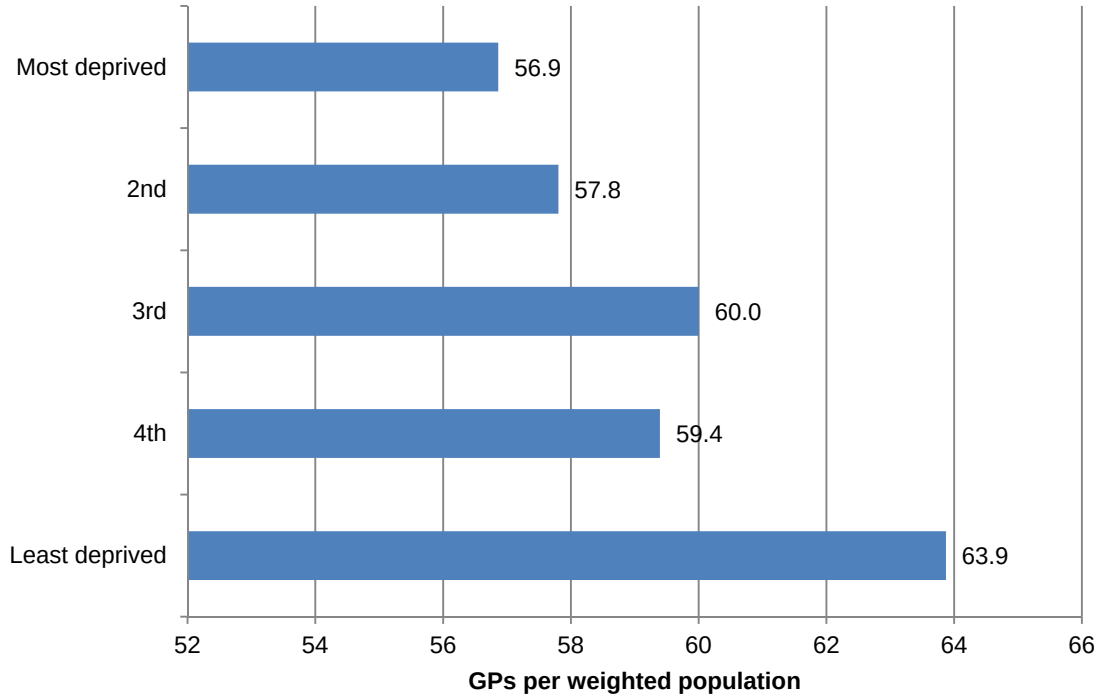
Source: OHE (Hawe et al, 2011: 122) Table 4.2

Notes:

a. Comprising all medical practitioners in general practice, including GP registrars (trainees) but excluding GP retainers.
b. Data for England and Wales are as at 1st October before 2000.
c. Data for Northern Ireland from 1996 to October before 2005.

Nevertheless, whilst the number of GPs per head increased whilst Labour was in power, analysis by the National Audit Office suggests that people living in disadvantaged areas still had poorer access to GPs than their counterparts in better off areas by the end of Labour's term in office. Figure 13 below shows the number of full-time equivalent GPs per 100,000 population *weighted for age and need*. The Figure shows that for people living in the fifth least deprived areas, there were 63.9 GPs per 100,000 (weighted) population. In contrast, for people living in the fifth most deprived areas, there were 56.9 GPs per 100,000 (weighted) population.

Figure 13: Full-time equivalent GPs per 100,000 population weighted for age and need, England, 2008 (a)(b)(c)(d)



Source: National Audit Office (2010: 36) Figure 14, using data points from National Audit Office Freedom of Information Request by personal communication

Notes:

a. Full-time equivalent figures from September 2008.
b. ** The weighted populations used Office for National Statistics 2007 mid-year population estimates.
c. Age and need weightings based on the method used for the Department's 2008-09 PCT revenue allocations for primary medical services.
d. Area deprivation was measured by the Index of Multiple Deprivation 2004.

Healthcare quality

Key indicators of hospital and primary care outcomes including 30 day survival rates, health gain following operative procedures (measured, for example, using QALYs) and primary health care outcomes over the period were discussed in Section 3.2. ONS statistics provide a picture of overall improvements in quality over the period, with healthcare quality growth outpacing quantity growth, and with hospital outcomes (rather than primary outcomes) contributing most to overall quality improvements.

The overall picture of improvement in healthcare outcomes is further supported by mortality indicators published by the NHS information centre which are used to monitor the success of the NHS in preventing potentially avoidable deaths following hospital treatment. The indicators measure mortality rates for patients, admitted for certain conditions or procedures, where death occurred either in hospital or within 30 days after discharge and cover operative procedures (nonelective surgery and Coronary artery bypass graft) and emergency

admissions (fractured proximal femur, myocardial infarction and stroke) for around 700 health and local government organizations in England. Analysis suggests that there have

been statistically significant year-on-year falls over a 10 year period in all the mortality rates analysed, except for fractured proximal femur which did not change significantly over time (NHS Information Centre n.d. A).

On mental health, Appelby's (n.d.) evaluation suggested that Government policy was particularly effective in bringing about service improvements. Key findings included evidence of significant investment in specialist mental health services with over 700 new mental health teams in the community offering home treatment, early intervention or intensive support; large increases in all the main staff groups; rationalisation of drug treatments; high levels of patient satisfaction; falls in general population suicide rates; falls in suicide amongst mental health in-patients and a general improvement in ward safety; and independent assessment by the WHO suggesting that England has the best mental health services in Europe.

A Kings Fund Report edited by Mays and Dixon (2011) provides an overall evaluation of Labour's market reforms. Building on the evaluation of the market reform programme established by the Department of Health *Health Reform Evaluation Programme* (2006-2010), the report evaluates the impact of key policies such as provider diversity, commissioning, Payment by Results, patient choice and regulation/systems management. On provider diversity, Allen and Jones (2011) find that a very limited number of private- and voluntary-sector organisations had entered the NHS market by 2010. They conclude from the small amount of available evidence that the performance (in respect of quality, in particular) of diverse providers was not inferior to that of NHS providers, and might be superior in some respects. On payment by results, Farrar et al (2011) suggest that evidence broadly supports the conclusion that payment by results (alongside the other New Labour reforms) was associated with reductions in unit costs without negatively impacting on quality. On commissioning, Smith and Curry (2011) highlight a number of weaknesses of PCTs as commissioning bodies. For example, as commissioners PCTs largely failed to reduce health inequalities; failed to fundamentally shift care out of hospitals into the community; and failed to have sufficient leverage over patterns of GP referrals.

A particular concern in the academic literature has been to establish whether or not increased patient choice and provider competition under Labour (particularly after 2006) had a positive impact on the *quality* of healthcare provision. Propper et al (2008b) report that the 1990s internal market had a *negative* impact on quality (measured by death rates following heart attack, i.e. myocardial infarction). Did Labour's healthcare reforms have a more positive impact on quality? A distinct body of research has examined empirically whether, with prices fixed under the 'payment by results' regime, the arrangements under Labour (with competition limited to quality) had a more positive impact on quality than the 1990s internal market (which had elements of both price and quality competition).

A number of evaluations of Labour's healthcare reforms have found evidence of the *positive* impact of patient choice and provider competition on healthcare quality. Burgess *et al* (2006: 539) found that whilst there is neither strong theoretical nor empirical support for the proposition that competition improves outcomes, there are nevertheless cases where competition has improved outcomes, with results critically depending on institutional design.

Propper et al (2008) note that pro-market reforms in the NHS in the 1990s were not accompanied by large drops in waiting times and evaluate impact of the new policy that emerged after Labour came to power in 1997 - namely, the policy of targets backed by

publication of waiting time data and sanctions for poor performance (characterised by the authors as "command and control"). The authors evaluate the effect of the English target regime for waiting times for hospital care after 2001 by undertaking a comparative analysis with Scotland, which did not adopt the target regime. They find that the regime in England lowered the proportion of people waiting for elective treatment relative to Scotland against a background of similar increase in resources.

Cooper et al (2011) test whether the introduction of patient choice and hospital competition in the English NHS led to faster improvements in clinical quality by looking at whether outcomes in high-choice areas improved at a significantly fast rate post-reform than in low-choice areas after all patients in England were given the ability to select their hospital. Using patient level data 2002-2008 they found that mortality fell more quickly (i.e. quality improved) for patients living in more competitive markets after the introduction of hospital competition in 2006, suggesting that hospital competition in markets with fixed prices can lead to improvements in clinical quality. Gaynor et al (2010) reinforces these findings, suggesting that patients took up choice when offered and that patient choice leads to lower mortality (measured by myocardial infarction and all-cause mortality). Bloom et al (2010) find that better management improves outcomes; and that management improves where there is competition.

Bevan and Skellern (2011:2) contend that compared with the 1990s internal market, the New Labour market was better structured to encourage improvements in clinical quality through the elimination of price competition, the provision of greater information on quality, the introduction of patient choice, and the provision of stronger providers (particularly Foundation Trusts) to increase market shares. However, Bevan and Fasolo (2011) suggest that there is only weak evidence that competition and choice improve performance (citing, for example, evidence published by the Audit Commission and Healthcare Commission) and argue that quality improvements are primarily driven by *reputation effects* rather than through choice and competition (quasi markets) *per se*. Considering the period 2000 to 2005, they find that in England "reputation effects" were a critical mechanism in achieving improvement and change. Such effects are characterised as being triggered by the publication of regular and publicly available reports that rank performance in ways that are easy for the public to understand. However, whereas in England policy aimed to achieve quality improvements through targets, hierarchy and reputation, policy in Scotland and Wales relied on altruism the provision of a private report to a provider – which is characterised by the authors as only a weak lever for quality improvement.

Some analyses suggest that the impact of patient choice on actual behaviour in practice was more limited than might be anticipated. Dixon *et al* (2010) suggest that although the majority of patients think that choice is important and were aware of their right to choose (after 2006), there was a strong propensity amongst patients to choose their local provider. Further, whilst a key reason for patients choosing a non-local provider was poor quality care, the authors found that choice did not act as a lever to improve quality. Dixon and Robertson (2011) claim that there is little evidence that patient choice has, as some feared, led to greater inequities in access to care. However, the authors also contend that there is also little evidence that

the introduction of patient choice resulted in increased provider responsiveness; and suggest that Government's should not rely on patient choice alone to drive quality improvement.

Cookson et al (2012) examine the effects of the Blair/Brown health reforms on *socioeconomic equity*. In order to examine the validity of claim that choice and competition might undermine socioeconomic equity in healthcare, they consider the evidence provided by three large-scale national studies designed to shed empirical light on this issue. A first study provides evidence on change in neighbourhood level socioeconomic equity in the utilisation of health care. The authors find that there was no substantial change in equity between 2001-02 and 2008-9 for nonemergency hospital admissions, outpatient admissions from 2004-5 and specific hospital procedures including hip replacement, senile cataract, gastroscopy and coronary revascularisation. A second study suggested that increased competition 2003-4 and 2008-9 had no substantial effect on socioeconomic equity in health care. A third study found that potential incentives for cream-skimming against socioeconomically disadvantaged individuals in the context of hip replacements were small, compared with incentives to select against elderly and co-morbidity patients. The authors conclude that the Blair/Brown reforms had little effect on socioeconomic equity in health care.

Nevertheless, the proposition that increased competition and choice has improved quality without having a negative impact on equity is not without its critics. Pollock *et al* (2011) have suggested that the findings in Cooper *et al* (2011) are "fundamentally flawed" because they confuse association with causality, and that other factors such as improvements in primary care and other treatments were the key drivers of quality improvement.

Patient experience and satisfaction

A key aim of the Labour Government was to improve patient experience. A new survey programme (the national patient survey programme) was introduced during Labour's first term and was the biggest of its kind in Europe. The programme was intended to facilitate user feedback and performance management, as well as to provide publicly available and transparent information on quality. A national target for improving patient experience was included in the Public Service Agreements, whilst the 2004 Comprehensive Spending Review specified a goal of securing "sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider". Trusts and PCTs were required to analyse their survey data to identify the low scoring components and plan and implement appropriate local improvement activities (2004 Spending Plan, 2004: 4).

Progress against the patient experience targets is evaluated using a composite indicator of patient experience covering five domains (access / waiting, safe / high quality / co-ordinated care, building closer relationships, a clean / comfortable / friendly place to be and better information / more choice). Table 12 below provides trends in patient experience for each service area (adult inpatients, outpatients, emergency services, primary care and mental health) broken down by each domain. The figures suggest relatively high scores for self-reported patient experience over the period 2002-2010 - although not necessarily an *upward* trend.

Table 12: Patient experience, England, 2002/03 to 2009/10

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Adult Inpatient survey								
Access & waiting		83.5		84.9	84.8	83.8	84.9	85
Safe, high quality, coordinated care		65.5		65.1	65.1	64.9	65.3	64.4
Better information, more choice		67.9		69.1	67.3	66.7	67.7	66.8
Building closer relationships		83.3		83.1	83.1	83	83.2	82.9
Clean, friendly, comfortable place to be		78.4		78.6	78.4	78.1	79.2	79.1
Overall		75.7		76.2	75.7	75.3	76	75.6
Outpatient survey								
Access & waiting[a]		68.2		69				72.5
Safe, high quality, coordinated care		83		82.2				83.2
Better information, more choice		77.2		77.3				79.1
Building closer relationships		86.4		86.5				87.3
Clean, friendly, comfortable place to be		69.7		68.5				70.9
Overall		76.9		76.7				78.6
Emergency Services survey								
Access & waiting	68.6		69.4				66.6	
Safe, high quality, coordinated care	74.7		74.7				75.1	
Better information, more choice	72.7		73.5				74.4	
Building closer relationships	78.9		80.4				81.3	
Clean, friendly, comfortable place to be	80.3		81				81.4	
Overall	75		75.8				75.7	
Primary Care survey[d]								
Access & waiting	67.6	68.5	69.8	69.3		69.4		
Safe, high quality, coordinated care	79.3	80.1	81.5	80.4		80.9		
Better information, more choice	81.6	80.7	80.7	79.7		80.5		
Building closer relationships	87.5	86.2	86.2	86		86.4		
Clean, friendly, comfortable place to be	69.5	69	69	69.5		70.1		
Overall	77.1	76.9	77.4	77		77.5		
Mental Health Services survey								
Access & waiting		80.5	80.3	79.7	80.1			
Safe, high quality, coordinated care		69.9	70.2	70.8	71.7			
Better information, more choice		60.7	61.8	60.8	62.0			
Building closer relationships		85.9	86.2	86.6	86.9			
Overall		74.2	74.7	74.5	75.2			
Primary Care								
Involvement in choice of provider[i,j,k]				27.3		42.7		
Involved in decisions about treatment [l,m,n]		-	77.1	-	-	-	76.0	-
Emergency services survey		-	81.7	-	-	-	-	82.3
Outpatients survey		70.9	-	71.9	70.9	70.3	71.3	71.0
Adult Inpatients survey		63.3	62.7	63.5	63.7	64.2	-	-
Mental health services survey		82.1	82.5	81.9	-	82.9	-	-
Primary care survey[o]		-	77.1	-	-	-	76.0	-

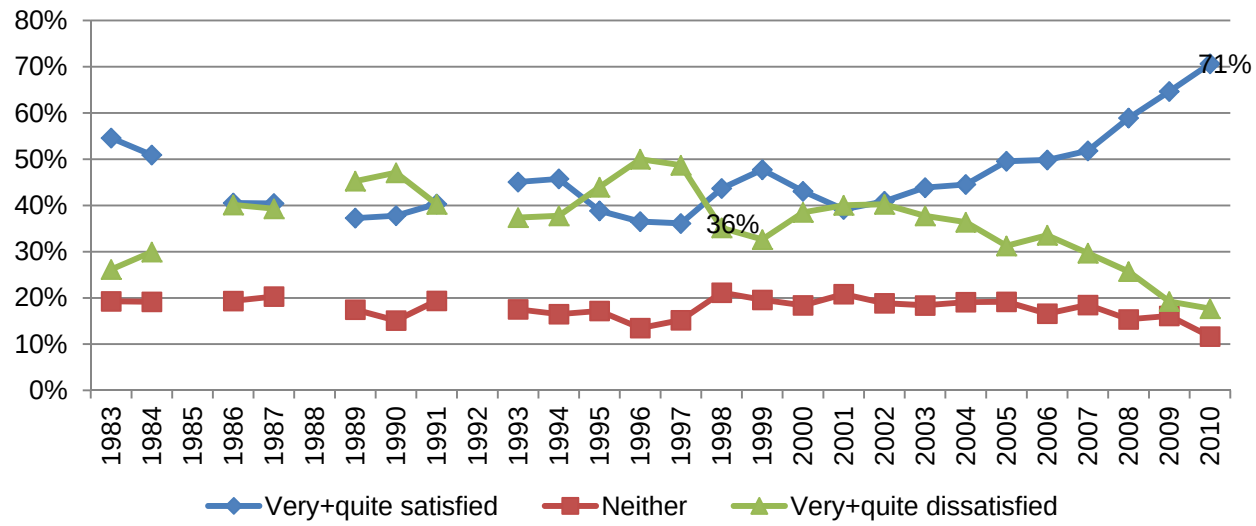
Source: National Patient Survey Programme (Department of Health 2010c) [Adult Inpatient and Outpatient surveys, Emergency Services survey, Primary Care survey and Mental Health Survey; involvement and choice about treatment). For Primary Care: National Patient Survey Programme for years except 2005-06 and Department of Health Primary Care Survey for 2005-06 (Department of Health 2010c).

Notes:

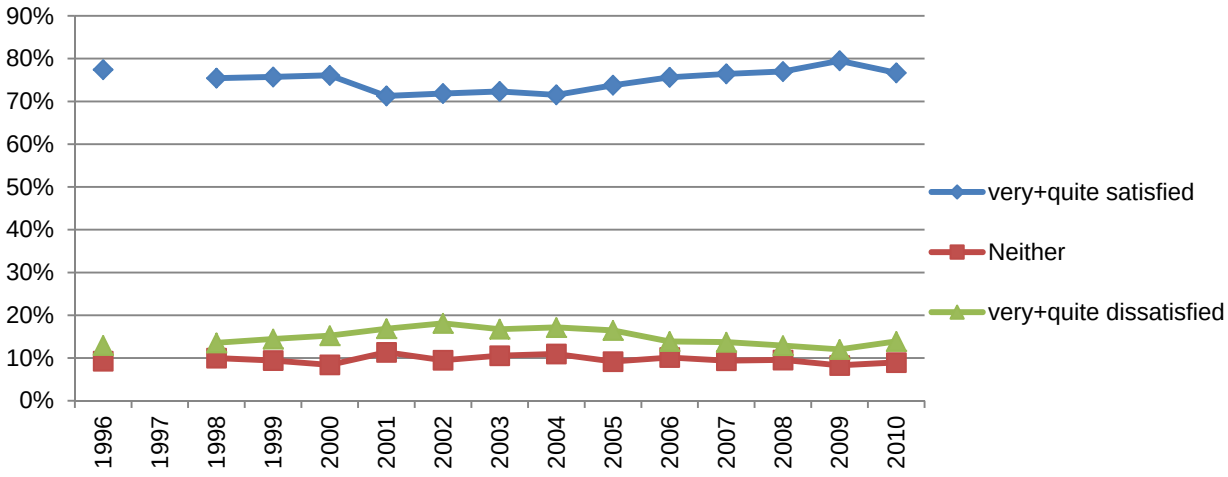
a. The scoring regime used for the question about length of wait for an appointment (question A1 in 2002-03 and question 1 in 2004-05) has been adjusted from that published by the contractor appointed to run the NHS Survey Advice Centre, to allow comparison across years.
b. There were substantial changes in the wording of a question related to arrival in the accident and emergency department. (question B1 in 2002-03 and question 3 in 2004-05). Results are not directly comparable for these two years. The scoring regime for this question has also been adjusted from that published by the contractor appointed to run the NHS Survey Advice Centre.
c. Due to the substantial changes within the access & waiting domain (see note b), overall aggregated domain scores for these two years are not directly comparable
d. Care should be taken when comparing results from 2002-03 with later years. The 2002-03 survey asked a series of questions regardless of the healthcare professional seen by the patient, whilst later surveys ask specifically about seeing a doctor. The 2002-03 figures have been adjusted by removing those respondents who indicate that they did not see a doctor. Results therefore may not be directly comparable.
e. For 2002-03, the scoring regime used for questions about length of wait for an appointment (Question A3), the length of wait to be seen (Question B4) and whether someone told the respondent how long they would wait (Question B5) differs from that published by the contractor appointed to run the NHS Survey Advice Centre.
f. Figures for access and waiting should not be compared for 2002-03 and later years. A change in the ordering of options in one question (Question A3 in 2002-03 and A2 in 2003-04) is likely to have had a large impact on the results.
g. Due to the substantial changes within the access & waiting domain (see note f), overall aggregated domain scores for these two years are not directly comparable
h. Figures for better information, more choice should not be compared for 2003-04 and 2004-05. Changes in the wording of one of the questions means that results are not comparable. Overall aggregated domain scores for these two years are not directly comparable.
i. Involvement in choice of provider: age-gender standardised score
j. In 2005/06 patients were asked the question "The last time you were referred to a specialist, were you given a choice about where you were referred (i.e. which hospital)?". A response of "Yes" was scored 100, a response of "No, but I would have liked a choice" was scored 0 and a response of "No, but I did not mind" scored 0.
k. In 2007/08 patients were asked the question "When you were referred to see a specialist were you offered a choice of hospital for your first hospital appointment?". A response of "Yes" was scored 100 and a response of "No" was scored 0.
l. Patients were asked the question "Were you involved as much as you wanted to be in decisions about your care and treatment?", A response of "Yes, definitely" was scored 100, a response of "Yes, to some extent" was scored 50 and a response of "No" was scored 0.
m. Cells containing a hyphen (-) indicate that the survey was not conducted in that particular year
n. Surveys in different settings are conducted on different patient groups and sometimes with differently worded questions. Results from different settings should not be compared
o. The score for the Primary Care Survey 2005/06 was based on a small national survey, carried out in exactly the same way as the National Patient Survey Programme but with a smaller sample size. Differences from earlier years may not be statistically significant.

Figure 14: Satisfaction with health services (based on British Public Attitudes Survey), Great Britain

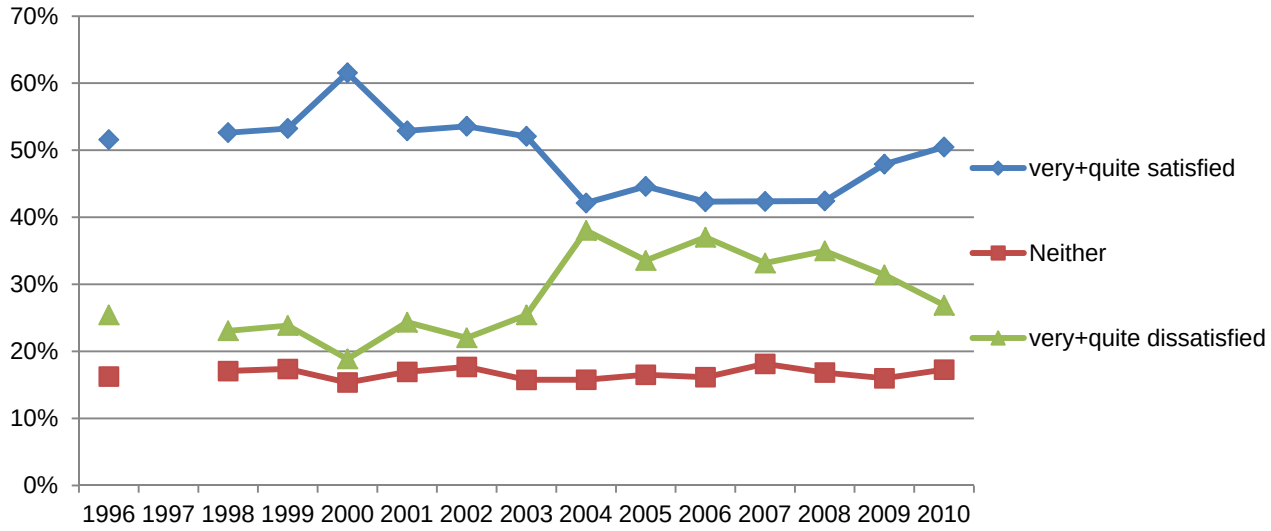
a) Overall satisfaction with National Health Services, 1983 to 2010(a)



b) Satisfaction with NHS - local doctors or GPs (b)(c)



c) Satisfaction with NHS - local dentists (c)(d)



Source: British Social Attitudes Information System

Notes:

a. Question wording: How satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?
b. Question wording: How you are with the way in which each of these parts of the National Health Service runs nowadays…local doctors or GPs?
c. The responses may not add up to 100% within each year due to missing responses and "don't know" responses.
d. Question wording: How you are with the way in which each of these parts of the National Health Service runs nowadays…National Health Service Dentists?

Secondary analysis of the patient experience survey data provides evidence of variations in patient experience by key characteristics such as sex, ethnicity, education levels, self-reported health and trust type (for example, Commission for Health Improvement 2004, Healthcare Commission (2005, 2006), Ipsos-MORI (2008), DH (2009), Sizmur (2011) and Raleigh *et al* (2012). Burchardt and Vizard (forthcoming) highlight evidence of significantly worse adult inpatient experience of dignity and respect, and of involvement in treatment and care decisions, amongst those reporting a longstanding limiting illness or disability (based on 2010 data). Vizard (2012) reports on adult inpatients who need help with eating who do not receive enough help from staff with eating meals using the 2006 data, finding that 33 per cent of those who are over 81 and who report having a longstanding limiting illness or disability identify themselves as not having received sufficient help from staff with eating during their hospital stay.

Statistics from the British Social Attitudes Survey point to a trend of sustained increases in overall satisfaction with the NHS during Labour's period in power. The run up to the 1997 General Election was characterised by low and declining levels of satisfaction (with satisfaction levels running at less than 40%). The trend of declining satisfaction reversed after Labour came to power in 1997, although satisfaction levels fell back between 1991 and 2001. After 2001, with resources and capacity expanding and waiting lists and times falling, satisfaction with the NHS began to rise again, with 70% of respondents indicating that they were quite or very satisfied with the way that the NHS is run in 2010 (Figure 14A).

Satisfaction with GP services was high and stable over the period 1998-2010, whilst satisfaction with dental services were lower and declining through much of the period, but with an upturn after 2008 (see Figure 14BC).

Variations in healthcare quality and sub-standard care

A central plank of Labour's NHS investment, modernisation and reform programme when Labour came to power in 1997 was to put into place a set of programmes and strategies that aimed to eliminate unacceptable variations in quality and eliminating sub-standard practice. A key driver of quality improvement were the new strengthened inspection and regulation processes. Feedback on quality through annual performance rating and health check exercises by the Healthcare Commission suggested overall high levels of compliance with national core standards. NHS performance ratings 2008-09 provide ratings for core standards compliance by trust type. Compliance rates for acute and specialist trusts were rated at 95%; PCTs as commissioners of services at 97%; and PCTs as providers of services at 96% (Care Quality Commission (2009c: Appendices A and H , England only).

Nevertheless, variations in quality and instances of poor quality care remained a key concern at the end of Labour's period in power. Continued concerns in this area were underpinned by new data on variations in performance, such as the Dr Foster series presented in Table (13), which suggested that the hospital standardized mortality ratio varied from 72 (University College London Hospitals NHS Foundation Trust / Royal Free Hampstead NHS Trust) to 117 (Hull and East Yorkshire Hospitals NHS Trust) and Buckinghamshire Hospital Trust (118). These variations are striking and highlight the possibility of variations in outcomes that are not readily accounted for by, for example, poverty or social deprivation, suggesting the persistence of ineffective institutions that had still not been effectively tackled toward the end of Labour's period in power (Glennerster 2012).

The Dr Foster series is not without its critics and raise the need for indicators of variations in death rates that take account of contextual information. The publication of the Dr Foster series has been followed up by new information on variations in death rates published by both the Care Quality Commission (formerly, the Healthcare Commission) and the NHS Information Centre, alongside new contextual information on health need. The new Summary hospital mortality indicator (SHMI) is the ratio between the actual number of patients who die following a treatment at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The indicator provides an indication of whether individual trusts are conforming to the national baseline of hospital-related mortality, with mortality within a trust is described as either 'as expected', 'lower than expected' or 'higher than expected'. In 2011, 14 trusts had a SHMI value categorised as 'lower than expected' (NHS Information Centre n.d. B).

Review processes such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) consistently identified deaths that were associated with shortcomings in healthcare over the period 1997-2010. Feedback from inspectorates and regulators including the Healthcare Commission (formerly the Commission for Healthcare Improvement, and now the Care Quality Commission) and the Health Ombudsman continued to identify poor quality care throughout the period. In a landmark case, the Healthcare Commission carried out an investigation into apparently high mortality rates in patients admitted as emergencies to Staffordshire NHS Foundation Trust in 2008. The investigation found that the trust did not have a system to monitor outcomes for patients and therefore failed to identify high mortality rates among patients admitted as emergencies. Dr Foster's Hospital Guide 2007 had shown that the trust had a hospital standardised mortality ratio (HSMR) of 127 for 2005-06 (i.e. a higher than expected rate). Whilst the trust had established a group to look into mortality, the focus had been on whether the high rate was a consequence of poor recording of clinical information. Commenting on the national picture and lessons for other organisations, the investigation recommended that in the future trusts should be able to get access to information on comparative mortality and other outcomes and for trusts to conduct objective and robust reviews of mortality rates and individual cases data (Healthcare Commission 2009, Candler et al 2011).

The establishment of new healthcare regulatory machinery was an early move under the first Labour administration. Bevan (2011) provides an evaluation of the effectiveness of healthcare regulation over the period 1997-2010. Noting that regulation was viewed as a major driver of quality under Labour, he finds strong evidence that the star-rating regime used by the Commission for Healthcare and Improvement (CHI) and the Healthcare Commission (together with sanctions for failure to hit targets and rewards for success) had an important impact in improving the reported performance of the English NHS. This conclusion is reached based on shorter hospital waiting times and ambulance response times, both over time and as compared with the performance of the NHS in the other three countries of the United Kingdom. However, Bevan contends that evidence of quality improvement resulting from two other regularly instruments (clinical governance reviews and the annual health check) is less strong. Further, he highlights failure to detect substandard care and evidence of regulatory failure in some instances (e.g. mid Staffordshire). He concludes that the need for effective regulation of the quality of care of publicly owned providers - which he contends will continue to dominate supply even with pluralism of delivery, including a rolling programme of inspections based on visits - emerges from the Labour period as a key legacy issue.

The role and adequacy of the inspectorates and regulators in identifying poor practice and enforcing minimum standards has itself come under scrutiny in the wake of these events, with the launch of *The*

Mid Staffordshire NHS Foundation Trust Public Inquiry. The long-awaited Public Inquiry Report highlighted the spectre of regulatory as well as management failure, with substandard care remaining undetected. The Report also pointed to the role of targets in creating perverse incentives, with managers focusing on reducing waiting lists and waiting times, whilst neglecting standards of basic care. The *Independent Inquiry into Care Provided By Mid Staffordshire NHS Foundation Trust 2010* (Francis Review) had previously catalogued substandard care including:

- Patients left in excrement in soiled bed clothes for lengthy periods;
- Assistance not provided with feeding for patients who could not eat without help;
- Water was left out of reach;
- In spite of persistent requests for help, patients not being assisted in their toileting;
- Wards and toilet facilities left in a filthy condition;
- Privacy and dignity, even in death, being denied;
- Triage in A&E was undertaken by untrained staff;
- Staff treating patients and those close to them with what appeared to be callous indifference.

Reporting in 2013, the subsequent Public Inquiry concluded: "There was … an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets; achieving financial balance and seeking foundation trust…Statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes" (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013)[3].

[3]Reports of the Mid-Staffordshire NHS Trust Independent Inquiry, available at http://www.midstaffsinquiry.com/ and the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, available at http://www.midstaffspublicinquiry.com/ (both accessed June 2013).

7. Overall Health Outcomes

In this section, we move on from the discussion reviewing the outcomes of the healthcare system itself to an evaluation of Labour's progress in improving overall health outcomes such as life expectancy, infant mortality, cancer mortality, circulatory mortality and suicides. We find that these outcomes continued their longrun tendency to improve over the period 1997-2010, with infant mortality reaching historic lows in all four constituent countries of the UK, and important accelerations in the rate of improvement in relation to some key health outcomes (for example, in relation to circulatory mortality) in England. Labour's overall targets to improve life expectancy and reduce specific cause mortality from cancer and circulatory disease are on course to be met (with one year's data outstanding).

Key findings

- There were important improvements in overall population outcomes over the period 1997-2010, with a remarkable reductions in circulatory disease mortality and further reductions in mortality from lung cancer and suicide.
- **Life expectancy.** Overall life expectancy continued its long run tendency to improve over the period 1997-2010 and Labour's target to improve overall life expectancy was virtually achieved based on a data window 1995-1997 / 2008-2010 (England only, with one year's data outstanding).
- **Infant mortality.** Overall infant mortality reaching historic lows in all four constituent countries of the UK.
- **Circulatory mortality.** A reduction in circulatory disease mortality was a major achievement of the period with a 52% reduction in three-year average circulatory disease mortality per 100,000 men under 75 between 1995-1997 / 2008-2010 (England only). Targets to reduce overall circulatory mortality were met.
- **Cancer mortality.** The overall cancer mortality rate also fell during the period (with a 22% fall over the period 1995-1997 / 2008-2010) and with important reductions for some specific cancers (e.g. a decline in the lung cancer mortality rate for men). Targets to reduce mortality from cancer were met (based on data for the period 1995-1997 / 2008-2010, England only).
- **Suicide.** Labour's target for reducing overall mortality through suicide (or undetermined intent) was missed despite a 13% reduction in the age standardized rate whilst Labour was in power (based on figures for 1995-1997 / 2008-2010). The age-standardized suicide rate per 100,000 males over 15 increased in 2008 and 2009, in line with increases in other European countries in the wake of the financial crisis and economic downturn.

Table 13: Hospital Standardised Mortality Ratios, England, 2009/10

Lower than expected mortality	Ratio	Higher than expected mortality	Ratio
Royal Free Hampstead NHS Trust	72	Barking, Havering and Redbridge University NHS Trust	116
University College London Hospitals NHS Foundation Trust	72	Buckinghamshire Hospitals NHS Trust	118
East Kent Hospitals University NHS Foundation Trust	79	City Hospitals Sunderland NHS Foundation Trust*	114
Imperial College Healthcare NHS Trust	80	Derby Hospitals NHS Foundation Trust	112
Bradford Teaching Hospitals NHS Foundation Trust	81	East Sussex Hospitals NHS Trust*	110
Cambridge University Hospitals NHS Foundation Trust	81	George Eliot Hospital NHS Trust*	113
Salford Royal NHS Foundation Trust	84	Hull and East Yorkshire Hospitals NHS Trust	117
St George's Healthcare NHS Trust	84	Isle of Wight NHS Primary Care Trust*	115
The Whittington Hospital NHS Trust	84	Mid Cheshire Hospitals NHS Foundation Trust	114
Aintree University Hospitals NHS Foundation Trust	85	Northampton General Hospital NHS Trust*	112
Frimley Park Hospital NHS Foundation Trust	85	Pennine Acute Hospitals NHS Trust**	110
Plymouth Hospitals NHS Trust	86	Royal Bolton Hospital NHS Foundation Trust**	116
University Hospitals Bristol NHS Foundation Trust	86	Shrewsbury and Telford Hospital NHS Trust*	117
West Middlesex University Hospital NHS Trust	86	South London Healthcare NHS Trust*	109
Mid Staffordshire NHS Foundation Trust	87	Southport and Ormskirk Hospital NHS Trust*	113
North West London Hospitals NHS Trust	87	The Dudley Group of Hospitals NHS Foundation Trust	115
Barnet and Chase Farm Hospitals NHS Trust	88	The Royal Wolverhampton Hospitals NHS Trust*	116
Barts and The London NHS Trust	89	University Hospitals Birmingham NHS Foundation Trust	109
Taunton and Somerset NHS Foundation Trust	89	Western Sussex Hospitals NHS Trust*	107
Ashford and St Peter's Hospitals NHS Trust	90		
Epsom and St Helier University Hospitals NHS Trust	90		
North Bristol NHS Trust	90		
The Newcastle upon Tyne Hospitals NHS Foundation Trust	90		
Leeds Teaching Hospitals NHS Trust	91		
Maidstone and Tunbridge Wells NHS Trust	92		
Sheffield Teaching Hospitals NHS Foundation Trust	92		

Source: Dr Foster (2010).

Notes: *Denotes trusts which did not have high HSMRs last year. **Denotes trusts with high HSMRs for the past six years. According to the Dr Foster report,: the HSMR is one of the most commonly used measures of overall mortality for trusts and looks at those conditions which account for the vast majority of deaths in hospital (80 per cent). The table compares the number of deaths at the trust with an estimate of the number that would happen if mortality ratios were in line with the national average. This takes into account a patient's diagnosis, age, admission method and other characteristics. If a trust has the same number of deaths as estimated, it is given a score of 100. If it has 10 per cent more deaths, it is given a score of 110, or for 10 per cent fewer deaths a score of 90 (Dr Foster 2010: 11).

Life expectancy and infant mortality

Overall targets for life expectancy were also specified in the 2004 Comprehensive Review (Department of Health, 2006: 3) and in the 2007 Public Service Agreement / Delivery Agreement 18 (HM Government 2007). The overall life expectancy target stated: "[b]y 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women " (DH 2006: 1; HM Government 2007: 19). Trends in overall life expectancy and inequality are set out in Table 14, which shows that life expectancy at birth increased over the period by four years for men and 2.9 years for women (to 78.4 years for men and 82.4 years respectively) in 2008-2010. The figures suggest that the overall life expectancy targets were achieved or almost achieved in 2008-2010 for both men and women (with one years' data outstanding).

Variations persisted in life expectancy within the constituent countries of the UK during Labour's period in office with life expectancy for both males and females remaining higher in England, Wales and Northern Ireland than in Scotland in 2008-2010 (Table 15). According to ONS analysis, there is growing evidence of a life expectancy North-South divide, with people in the south of England experiencing higher life expectancies than those in Scotland and the North of England, with Blackpool, Lancashire, Salford, Manchester Teaching, Blackburn with Darwen Teaching and Liverpool figuring along with Greater Glasgow & Clyde, Western Isles and Ayrshire & Arran in the list of health authorities with the lowest life expectancies in 2007-2009. ONS data on life expectancy for 65 local authority areas in England, Scotland and Wales suggest that life expectancy was highest in Kensington and Chelsea and lowest in Glasgow City in each period between 2004–06 and 2008–10, with the gap between the local areas with the highest and lowest life expectancies increasing between 2004–06 and 2008–10 (ONS 2011afg).

Table 14: Life expectancy, 1995-97 – 2008-10, England (a)

	Males	Females
1995-97	74.5	79.6
1999-01	75.6	80.3
2000-02	75.9	80.6
2001-03	76.1	80.7
2002-04	76.5	80.9
2003-05	76.8	81.1
2004-06	77.2	81.5
2005-07	77.5	81.7
2006-08	77.7	81.9
2007-09	78.0	82.1
2008-10	78.4	82.4
Change since 1995-97	+3.9	+2.8
Percentage change since 1995-97	+5.2	+3.5

Source: Department of Health (2011c: 6) Table
Notes: (a) Based on Interim Life Tables

Table 15: Life expectancy at birth (years): by sex, England, Scotland, Wales and Northern Ireland 2008-2010

Males	78.58
Females	82.57
Wales	
Males	77.62
Females	81.82
Scotland	
Males	75.85
Females	80.43
Northern Ireland	
Males(P)	77.07
Females(P)	81.52

Source: ONS 2012d

Infant mortality

On infant deaths under one year, variations persisted in the infant mortality rate between the countries of the UK, with a rate of 4.3 per 1000 live births in England in 2010 compared with a rate of 4.0 per 1000 live births in Wales, 3.7 in Scotland and 5.7 in Northern Ireland (ONS 2012c).

Table 16: Infant mortality rate (deaths under 1 year per 1,000 live births), constituent countries of the UK (a)(b)

	United Kingdom (c)	England and Wales	England	Wales	Scotland	Northern Ireland (d)
1997	5.9	5.9	5.9	5.9	5.3	5.6
1998	5.8	5.7	5.6	5.7	5.6	5.6
1999	5.8	5.8	5.7	6.4	5.0	6.4
2000	5.6	5.6	5.6	5.2	5.7	5.0
2001	5.5	5.5	5.4	5.5	5.5	6.0
2002	5.3	5.3	5.3	4.7	5.3	4.6
2003	5.3	5.3	5.3	4.1	5.1	5.2
2004	5.1	5.1	5.1	5.1	4.9	5.3
2005	5.1	5.0	5.0	4.3	5.2	6.1
2006	5.0	5.0	5.0	4.1	4.5	5.1
2007	4.8	4.8	4.8	5.3	4.7	4.9
2008	4.7	4.8	4.7	4.1	4.2	4.7
2009	4.6	4.7	4.6	4.8	4.0	5.1
2010	4.3	4.3	4.3	4.0	3.7	5.7

Source: ONS (2012c)

Notes:

a. All figures are based on the number of deaths registered in the year.
b. Figures for the United Kingdom, England and Wales, Scotland and Northern Ireland represent country of occurrence.
c. Infant mortality rates for the United Kingdom are calculated by including births in Northern Ireland to non-residents in the denominator.
d. The infant mortality rate for Northern Ireland represent the rate per 1,000 live births includes non-Northern Ireland resident births.

Table 17: Infant mortality rates, England (Government Office Regions), Scotland (NHS area Boards) and Wales (Wealth Local Health Boards), 2009

	Infant mortality rate (a)
England	
North East	3.8
North West	4.9
Yorkshire and The Humber	5.5
East Midlands	5.1
West Midlands	6.0
East of England	4.0
London	4.5
South East	3.9
South West	4.0
Scotland (b)	
Ayrshire & Arran	4.6
Borders	2.6
Dumfries & Galloway	3.3
Fife	5.8
Forth Valley	4.2
Grampian	3.3
Greater Glasgow	3.9
Highland	3.8
Lanarkshire	3.0
Lothian	3.4
Orkney	5.0
Shetland	-
Tayside	6.7
Western Isles	-
Wales (c)	
Betsi Cadwaladr University	5.7
Powys Teaching	*4.0*
Hywel Dda	*3.9*
Abertawe Bro Morgannwg University	*3.3*
Cwm Taf	5.6
Aneurin Bevan	4.6
Cardiff and Vale University	5.3

Sources: England: ONS (2010b), Scotland: General Register Office for Scotland (2010) Table P2; Wales: ONS (2010b)

Notes:

a. Infant deaths per 1,000 live births. Infant deaths include deaths under one year.
b. Provisional data
c. Mortality rates calculated from fewer than 20 deaths are distinguished by italic type as a warning that their reliability as a measure may be affected by the small number of events.

Variations by geographical region were also pronounced within the four constituent countries of the UK. In England the highest infant mortality rates were in the West Midlands and Yorkshire and the Humber, whilst in Wales the highest rates were in Betsi Cadwaladr University and Cwm Taf, and in Scotland in Tayside and Fife (Table 17).

Circulatory disease and cancer mortality

Targets for reducing substantially the mortality rates from the "major killers" by 2010 were set out in the 2000 Spending Review. These included reducing mortality from heart disease by at least 40% in people under 75", from cancer by at least 20% in people under 75, and from suicide and undetermined injury by at least 20 %. Delivery of the targets was planned through the National Service Frameworks for Coronary Heart Disease and Mental Health, and the National Cancer Plan" (HM Treasury 2000).

The reduction in mortality from circulatory diseases was a major achievement of the period. Academic research covering 800,000 men and women who suffered heart attacks between 2002 and 2010 found that fewer heart attacks occurred in later years and, of those that did occur, fewer were fatal. Improvements in NHS care and better prevention measures were identified as having contributed to the decline (Smolina et al 2012). Building on the 1998 PSA, a circulatory disease mortality target specified in the 2004 PSAs aimed to "[s]ubstantially reduce mortality rates [by 2010]… from heart disease and stroke and related diseases by at least 40% in people under 75" (DH 2006: 1-2). Success against the target is evaluated using as a baseline year the average of the European age standardised rates for 1995-97 and the 2009-2011 average (Department of Health 2006: 2). As Table 18 shows, the death rate from circulatory disease in England was 67.3 per 100,000 population in 2008-10, comprising a hefty decrease of 52.4% since 1995-97 in England as a whole.

A new cancer mortality target was also specified in the 2004 PSAs, building on the National Cancer and the earlier National Cancer Plan, setting out the goal of "substantially reduc[ing] mortality rates [by 2010]…from cancer by at least 20% in people under 75". Success against this target is evaluated using as a baseline year the average of the European age standardised rates for 1995-97 and the 2009-2011 average (Department of Health 2004: 1-2) (Department of Health 2006: 2). The figures for 2008-10 show that the rate of deaths from cancer in people under 75 in England was 110.1 deaths per 100,000 population. This is a decrease of 22% per cent since 1995-7 (see Table 19) suggesting that the overall cancer mortality target will be met (with one year of data outstanding).

As discussed in Section 1, the landmark Cancer Plan (2000) was the first of a series evidence-based national frameworks designed to drive up quality and embed best practice nation-wide. This was followed up by a new Cancer Reform Strategy aiming to improve cancer services in 2007 (DH 2007b). A key aim of Labour's programme of policies was to eliminate poor quality practice and reduce variations in access, quality and outcomes both within the UK and between the UK and comparator countries (reflected in the relatively low position of the UK international league tables such as cancer care). What evidence is there that these interventions improved cancer outcomes over the period?

According to Cancer Research UK, the European age-standardised incidence rates for all cancers in Great Britain increased by 20% in males and 40% in females during the period 1975-1977 and 2007-2009, with almost this entire rise occurring before the late 1990s. Over the period 1998-2000 and 2007-2008, the incidence rates increased by just 3% and 5% respectively) (Cancer UK 2012a). The percentage change in incidence rates show varying trends by cancer type and sex. For example,

amongst common cancers, the European age-standardized three year average incidence rates for lung cancer declined for men by 16% between 1998-2000 and 2007-2009, whereas for women this figure increased by 6%. The rates for stomach cancer fell for both men and women, but the rates for breast cancer for women increased by 6%; and for prostate cancer for men by 32% over the same period (Cancer UK 2012b).

Table 18: Circulatory Diseases Mortality, ages under 75, for males, females and all persons, England, 1995-97 – 2008-10

	Three-year average mortality rate per 100,000(b)		
Time period	**Males**	**Females**	**Persons**
1995-97	198.3	89.6	141.3
1999-01	160.1	72.5	114.5
2000-02	151.4	68.3	108.2
2001-03	143.7	64.8	102.8
2002-04	135.6	60.6	96.7
2003-05	127.1	56.4	90.5
2004-06	118.4	52.2	84.2
2005-07	111.2	49	79.1
2006-08	105.1	46.3	74.8
2007-09	99.4	43.2	70.5
2008-10	95.2	40.9	67.3
Change since 1995-97	-103.2	-48.6	-74.1
Percentage change since 1995-97	-52.0	-54.3	-52.4

Source: Department of Health (2011c: 17) Table 4

Notes:

(a) Original data source: ONS (death registrations for ICD9 390-459, ICD10 I00-I97; and mid-year population estimates)

Table 19: Cancer mortality, ages under 75, for males, females and all persons, England, 1995-97 – 2008-10

	Three-year average mortality rate per 100,000(b)		
	Males	**Females**	**Persons**
1995-97	160.8	124.5	141.2
1999-01	144.7	114.7	128.7
2000-02	142.1	112.7	126.5
2001-03	139.5	110.3	124.1
2002-04	136.5	108.3	121.6
2003-05	132.9	106.5	119.0
2004-06	130.4	105.1	117.1
2005-07	128.2	103.9	115.5
2006-08	126.3	102.7	113.9
2007-09	124.0	101.2	112.1
2008-10	121.9	99.3	110.1
Change since 1995-97	-38.8	-25.3	-31.1
Percentage change since 1995-97	-24.1	-20.3	-22.0

Source: Department of Health (2011c: 14) Table 3

Notes:

a. Original data source: ONS (death registrations for ICD9 140-208, ICD10 C00-C97; and mid-year population estimates)

Mental health and suicide

Mental health was another early priority for Labour, as reflected in the NHS plan, the National Framework for Mental Health and the 2000 Spending Review target to reduce deaths through suicide and undetermined injury. The latter was reaffirmed in the 2004 PSA, which included a target to substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%. Success is evaluated against this target based on three year moving averages using the average of the European age standardised rates for 1995-97 as a base year and the rate of 2009-2011 as the target year (Department of Health 2006: 2, 2011c).

Table 20 shows that the rate of suicide in 2008-10 was 7.9 persons per 100,000, which is a 13.4% decrease from the 1995-97 baseline figure of 9.2 deaths, indicating an improvement in the general population mortality rates from suicide and injury of undetermined intent during Labour's period in power. However, progress against this indicator stalled after 2007. The rate was broadly unchanged after 2005-07 and the decline betweeen 1995-97 and 2010 fell short of the target reduction of 20%.

Table 20: Deaths from suicide and injury of undetermined intent for males, females and persons, England, 1995-97 and 1999-01 to 2008-10

	Three-year average mortality rate per 100,000(a)		
Time period	**Males**	**Females**	**Persons**
1995-97	14.1	4.5	9.2
1999-01	14.4	4.5	9.3
2000-02	13.7	4.3	8.9
2001-03	13.3	4.2	8.6
2002-04	13.0	4.3	8.6
2003-05	12.9	4.3	8.5
2004-06	12.5	4.2	8.3
2005-07	12.1	3.8	7.9
2006-08	12.0	3.7	7.8
2007-09	12.2	3.6	7.9
2008-10	12.2	3.7	7.9
Change since 1995-97	-1.9	-0.7	-1.2
Percentage change since 1995-97	-13.2	-16.6	-13.4

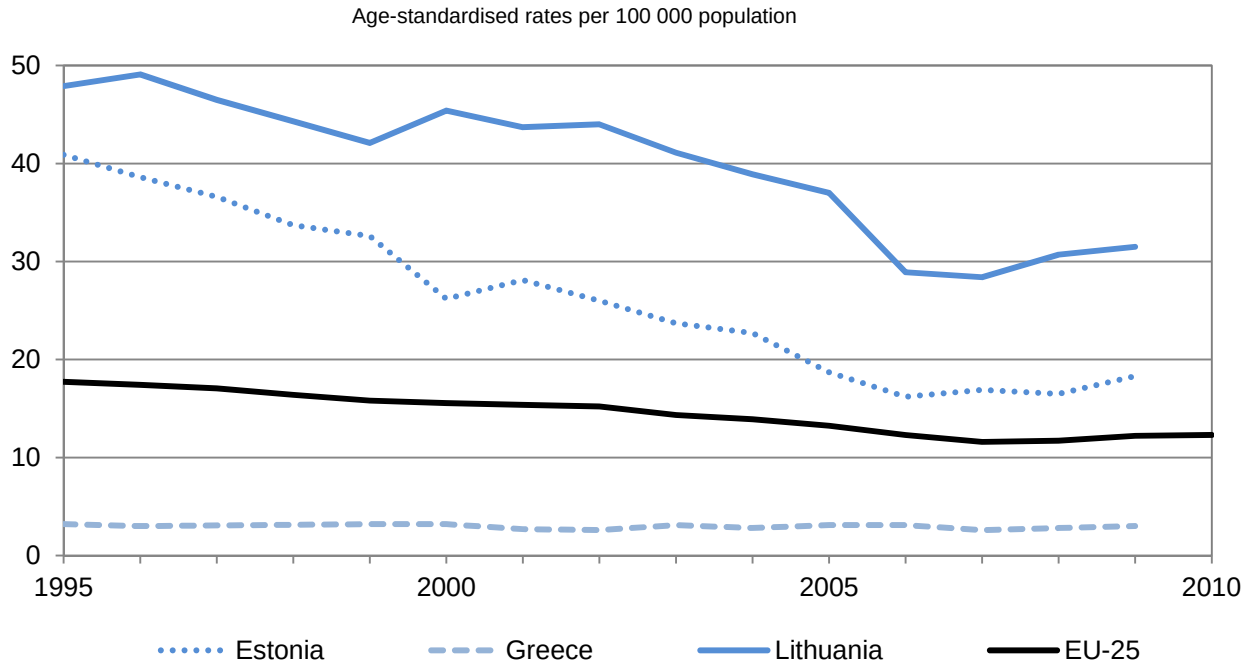
Source: Department of Health (2011c: 20) Table 5

Notes:

a. Change figures are calculated based on unrounded mortality rates.
b. Directly age-standardised mortality rate, based on European Standard Population.
c. Original data source: ONS (death registrations for ICD9 E950-E959, plus E980-E989, excluding E988.8, ICD10 X60-X84, Y10-Y34 (Y33.9 is excluded until 2006); and mid-year population estimates)

Several studies examine the impact of the financial crisis and economic downturn that began in Autumn 2007 on suicide in European countries. A number of these suggest that the steady decline in the suicide rate experienced in many EU countries in the years up to 2007 was immediately reversed. Stucker et al (2011) provide evidence on the rates of suicide in people aged 0-64 years in each part of the EU, indexed on 2007, the last complete year before the economic crisis, and relating these to changes in adult employment rates. The authors highlight that in both old and new EU Member States, official unemployment did not increase until 2009, after the banking crisis. In contrast, a steady downward trend in suicide rates, evident in both groups of countries before 2007, reversed at once. The 2008 increase was less than 1% in the new Member States, but in the old ones it increased by almost 7%. In both groups of countries, suicides increased further in 2009 and among the countries studied, only Austria had fewer suicides in 2009 than in 2007.

Figure 15: Trends in suicide rates, selected European countries 1995-2010

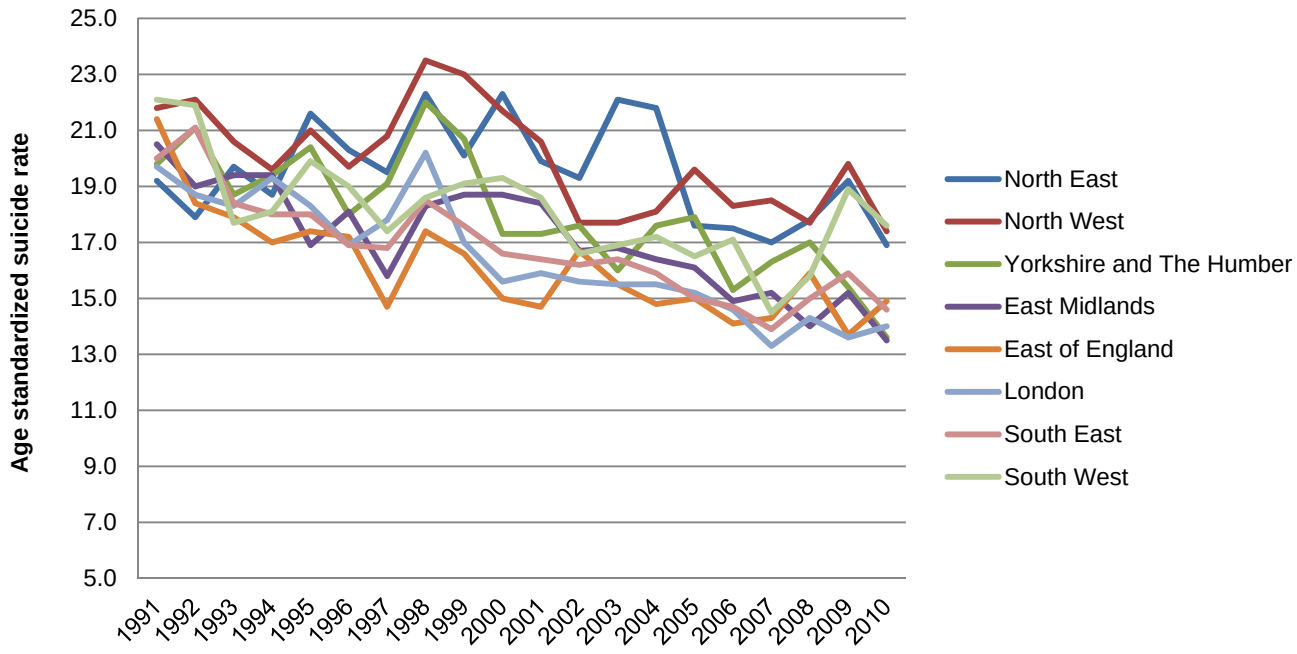


Source: OECD (2012) based on Eurostat Statistics Database.

Note: Data are age-standardised to the WHO European standard population.

In the English context, the moving average figures up to 2008-2010 presented in Table 21 suggest a stalling of progress rather than a reversal in trend following the financial crisis and economic downturn. However, reporting by sex and individual year provides a somewhat different picture, with a significant increase in the rate of suicides amongst men aged 15 and over between 2007 and 2009 (Figure 15). Trends in age standardized suicide rates vary by age group and region, with notable statistically significant rises over the period 2007-2009 for men aged 45-75 year olds and in South West England (Figure 16 and ONS 2012f). Barr et al (2012) drill down on the impact of the financial crisis in the UK context. They find that regions with the largest rises in unemployment have had the largest increases in suicides, particularly amongst men.

Figure 16: Age-standardized suicide rates per 100,000 males, English regions, 1991 - 2010



Source: ONS 2012f Notes – see below

Table 21: Age standardized suicide rates per 100,000 population, males age 15 and over, England, 1991-2010

Year	Rate per 100,000 population	Lower confidence limit	Upper confidence limit	Number of deaths
1991	20.2	19.6	20.9	3,778
1992	20.0	19.4	20.7	3,756
1993	19.0	18.4	19.6	3,561
1994	18.5	17.9	19.1	3,507
1995	18.8	18.2	19.5	3,558
1996	17.8	17.2	18.4	3,412
1997	17.5	16.9	18.1	3,327
1998	19.8	19.2	20.5	3,777
1999	19.1	18.4	19.7	3,670
2000	18.1	17.5	18.7	3,497
2001	17.5	17.0	18.1	3,421
2002	16.8	16.2	17.4	3,292
2003	16.6	16.1	17.2	3,298
2004	16.5	16.0	17.1	3,295
2005	16.1	15.6	16.7	3,251
2006	15.4	14.9	15.9	3,131
2007	14.9	14.3	15.4	3,043
2008	15.8	15.3	16.4	3,263
2009	16.1	15.5	16.6	3,330
2010	15.1	14.5	15.6	3,165

Source: ONS 2012f

Notes
1.Rates per 100,000 population standardised to the European Standard Population.
2 Figures are for males aged 15 years and over.
3 Figures exclude deaths of non-residents.
4. Figures are for deaths registered in each calendar year.

7. Inequalities in Health Outcomes

In this section, we evaluate Labour's progress in tackling inequalities in health outcomes over the period 1997 to 2010. We find that progress was limited, with variations in health status by population sub-group proving challenging to reduce, and the disparities increasing in some cases (for example, increasing relative gaps in life expectancy and cancer / circulatory mortality between areas with the highest income and health deprivation and the English average). Deep inqualities in health outcomes remained in 2010, as highlighted in the Marmot Review. However, health inequality targets that were specified in terms of *absolute* rather than *relative* gaps have been easier to achieve, and targets to reduce the absolute gaps in cancer and circulatory mortality inequality are on course to be met (with one year's data outstanding). A "good news" story is that the infant mortality inequality target (focusing on inequality by occupational social class) - which appeared unlikely to be met in a series of previous evaluations - was met in 2008-2010 (with one year's data outstanding).

Key findings

Reducing inequalities in population health outcomes proved challenging, although the closure of the infant mortality gap by social class is an important "good news" story of the Labour years.

- **Life expectancy.** A target to reduce life expectancy inequalities was specified in terms of reducing the relative gap between areas with the worst health and deprivation ('spearhead' areas) and the England average. For both men and women: absolute and relative gaps increased and the target was not met (based on a data window 1995-1998-2008/2010, England only).
- **Infant mortality.** A target to reduce infant mortality inequalities was specified in terms of reducing the relative gap between the routine / manual occupational groups and the all England average. Progress was initially slow and both the absolute and relative gaps initially increased. However, there was a rapid fall in the relative gap toward the end of Labour's period in power, and the most recent data suggests that the absolute and relative gaps fell by 42% and 25% respectively over the period 1997-99 / 2008-2010 as a whole (England only). This is a "good news" story: the relative gap Labour's target - which was not looking on course to be met at the time of the 2010 General Election - was achieved (with one year of data outstanding).
- **Circulatory mortality.** Labour's target for circulatory mortality was specified in terms of reducing the absolute gap between areas with the worst health and deprivation ('spearhead' areas) and the England average. The absolute gap improved during Labour's period in power and the target was met based on a data window 1995-1997 / 2008-2010 (England only). However, the relative gap increased by 15.2 per cent over this period.
- **Cancer mortality.** Labour's cancer mortality target was specified in terms of reducing the absolute gap between 'spearhead' areas and the England average. The absolute gaps improved and the target was met based on a data window over the period 1995-1997 / 2008-2010 (England only). However, relative gaps increased by 13.4 per cent of this period.

Inequalities by area deprivation and social class

Life expectancy

The persistence of inequalities in population health outcomes was highlighted at the beginning of Labour's period in power in the Acheson Report (1998) and at the end of Labour's period in power in the Marmot Review (2010). An overall picture is provided in Table 22, which shows that stark inequalities in life expectancy and disability-free life expectancy remained in 2006-2009, with life expectancy and disability-free life expectancy for males at birth of 81.4 years and 69.4 years respectively for individuals living in the least deprived areas compared with figures of 73.3 years and 54.6 years for individuals from the most deprived quintile. Whereas individuals from the least deprived areas can expect to live 85% of their lives disability free, this figure drops to 74 % for those living in the most deprived areas.

Health inequalities policy under Labour put particular emphasis on targeting the disparities between 'spearhead areas' and the England average. A life expectancy inequality target was specified in the 2004 Comprehensive Review (Department of Health, 2006: 3) and in the 2007 Public Service Agreement / Delivery Agreement 18 (HM Government 2007). This aimed "[s]tarting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the "worst health and deprivation indicators" and the population as a whole" (DH 2006; HM Government 2007: 23). Performance against this indicator is evaluated using a 1995-97 baseline based on three year moving averages up to 2009-2011, based on a relative gap measure.

Trends against the target are set out in Table (23) and Figure (17). The figures show that there was also progress within the former 'spearhead' areas, with life expectancy increasing by 3.8 and 2.6 years for men and women respectively over the period 1995-97 to 2008-10. However, with the rate increasing in areas with the worst health and deprivation lagging behind the all England rate, inequality increased. The relative gaps increased for both men and women over this period from 2.57% and 1.77% to 2.61% and 2.00% respectively. The figures imply that the life expectancy inequality target is not on course to be met (although a final verdict will require the 2009-2011 data). The absolute gaps between the 'spearhead areas' and the all England average also increased.

The all-cause mortality rate is used by the Department of Health as a supplementary indicator to monitor current overall mortality trends, and was included as an indicator both in the NHS performance framework (as a Vital Sign) and local authorities performance frameworks from 2006. Table 24 shows that all age and all-cause mortality rates have been improving since 1995-97 with figures for both areas with the worst health and deprivation and England as a whole showing a reduction in all-age-all-cause mortality rates to 2008-10. The picture on trends in inequalities here is mixed, with the relative gap between the England average and areas which had the worst health and deprivation increasing over the period whilst the absolute gaps declined (particularly for men).

Table 22: Inequality in Life expectancy (LE) and Disability-free life expectancy (DFLE) for males at birth by area deprivation quintile, England, 2001-04 to 2006-09

	2001-04*			2002-05*			2005-08*			2006-09*		
	LE	DFLE	Proportion of life disability free (%)	LE	DFLE	Proportion of life disability free (%)	LE	DFLE	Proportion of life disability free (%)	LE	DFLE	Proportion of life disability free (%)
1 - Least deprived	79.7	67.9	*85.2*	80.0	67.3	*84.2*	81.0	69.3	*85.5*	81.4	69.4	*85.3*
2	78.3	65.0	*83.0*	78.6	64.3	*81.7*	79.7	66.6	*83.5*	80.0	66.8	*83.4*
3	77.1	63.5	*82.4*	77.3	63.4	*82.0*	78.4	65.1	*83.0*	78.8	64.9	*82.3*
4	75.1	59.6	*79.3*	75.4	59.7	*79.2*	76.3	62.1	*81.4*	76.6	61.8	*80.7*
5 - Most deprived	71.9	54.0	*75.1*	72.2	54.2	*75.0*	73.0	54.7	*74.8*	73.3	54.6	*74.4*
Range (Least/Most deprived)	7.8	13.8	~	7.8	13.2	~	8.0	14.6	~	8.0	14.8	~
Ratio (Least/Most deprived)	1.11	1.26	~	1.11	1.24	~	1.11	1.27	~	1.11	1.27	~
Slope index of inequality (SII)**	9.4	16.5	~	9.4	15.4	~	9.7	16.2	~	9.8	14.7	~
Relative Index of Inequality (RII)***	1.1	1.2	~	1.1	1.2	~	1.1	1.2	~	1.1	1.2	~

Source: ONS 2012e

Notes (from ONS 2012e):

* Figures from overlapping periods, e.g. 2001-04 and 2002-05, are not comparable. Comparable periods e.g. 2001-04 and 2005-06, are indicated by consistent cell shading in this table.

** The SII represents the absolute inequality in health (years), taking into account all adjacent quintiles of area deprivation.

*** The modified RII represents the ratio of the predicted SII value to the LE or DFLE value of the least deprived areas with 1 added to this value. For the period 2001-04, there was a DFLE value of 1.24. As the value exceeds 1 the outcome measure is interpreted as "desirable" (i.e. more disability-free life years than fewer) this shows a relative 1.24 fold inequality gradient between the least and most disadvantaged areas. When examining the difference in the health gap between discrete time periods, the RII is not sensitive to underlying changes in the prevalence of LLSI and mortality rates and therefore represents a more reliable measure of the health gap.

Table 23: Life expectancy: inequalities between 'spearhead' areas and all England averages, 1995-97 to 2008-10

	Based on sub-national (abridged) life tables (b)			
Males	LE for England	LE for areas with the worst health and deprivation (a)	Absolute gap (c)	Relative gap (d), %
1995-97	74.6	72.7	1.9	2.57
1999-01	75.7	73.7	2.0	2.62
2000-02	76.0	74.1	1.9	2.55
2001-03	76.2	74.2	2.0	2.61
2002-04	76.5	74.5	2.0	2.60
2003-05	76.9	74.9	2.0	2.61
2004-06	77.3	75.3	2.0	2.63
2005-07	77.7	75.6	2.1	2.68
2006-08	77.9	75.8	2.2	2.76
2007-09	78.3	76.1	2.2	2.75
2008-10	78.6	76.5	2.1	2.61
Change since 1995-97	+4.0	+3.8	+0.1	+0.04 (e)
Percentage change since 1995-97	+5.3	+5.3	+6.8	+1.4
Females				
1995-97	79.7	78.3	1.4	1.77
1999-01	80.4	78.9	1.5	1.85
2000-02	80.7	79.2	1.5	1.85
2001-03	80.7	79.2	1.5	1.87
2002-04	80.9	79.4	1.5	1.90
2003-05	81.1	79.6	1.6	1.92
2004-06	81.6	79.9	1.6	1.97
2005-07	81.8	80.2	1.6	1.98
2006-08	82.0	80.4	1.7	2.05
2007-09	82.3	80.7	1.6	1.99
2008-10	82.6	80.9	1.7	2.00
Change since 1995-97	+2.9	+2.6	+0.2	+0.23 (e)
Percentage change since 1995-97	+3.6	+3.4	+17.0	+12.9

Figure 17: Relative and absolute gaps in life expectancy between 'spearhead areas' and the England average – males, 1995-97 to 2008-10

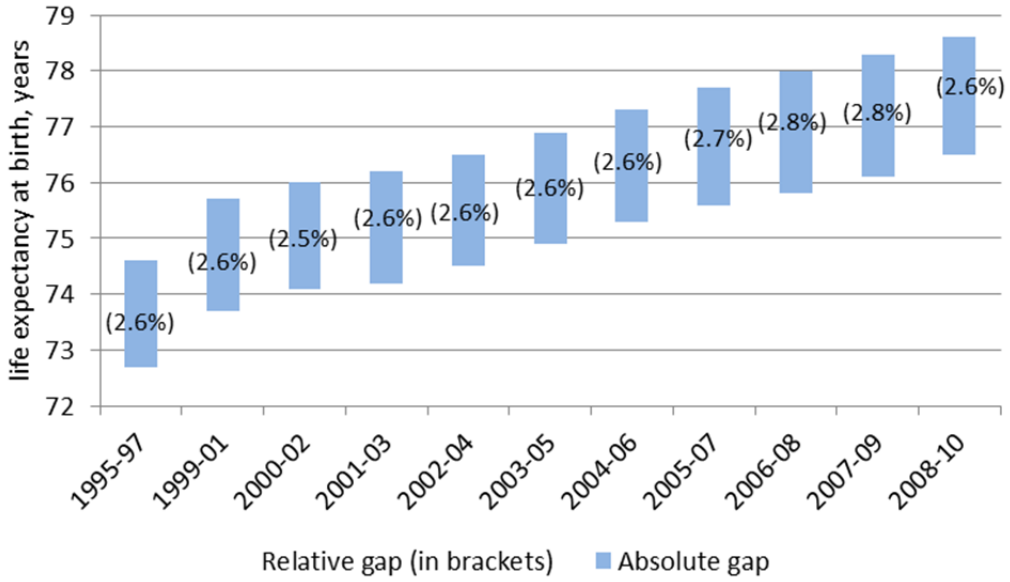
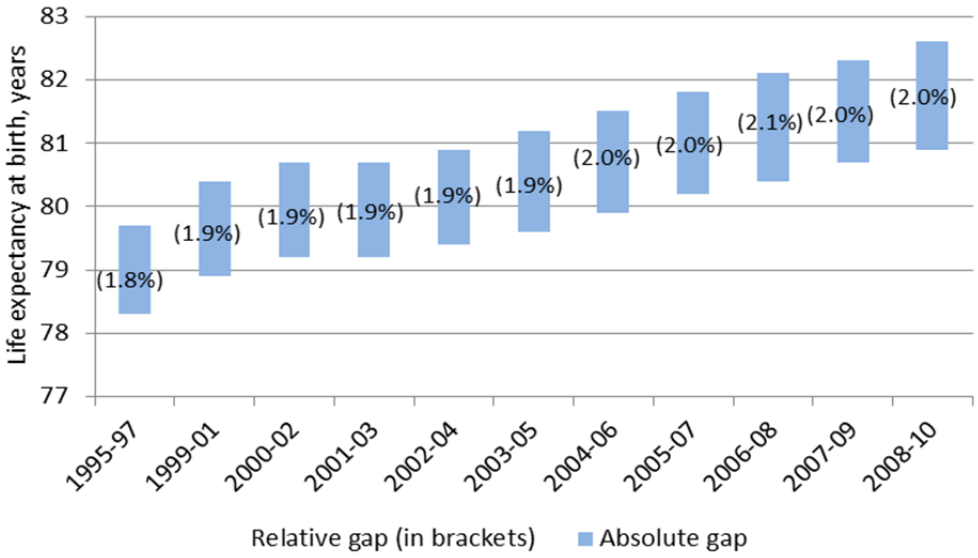


Figure 18: **Relative and absolute gaps in life expectancy between 'spearhead areas' and the England average - females, 1995-97 to 2008-10**



Source: Department of Health (2011c: 6 and 8) Table 1

Notes:

a. Gap and change figures are calculated based on life expectancy figures rounded to 2dp.
b. Local authorities which had the worst health and deprivation, based on life expectancy and mortality data for 1995-97 and the 2004 Index of Multiple Deprivation. See section A4i of the technical notes (Annex A) for further information Department of Health 2011).
c. Interim Life Tables provide the definitive life expectancy figures for England. Sub-national life expectancy data are produced using a slightly different methodology (see section A2 of the technical notes in Annex A for further details), so England figures based on the sub-national life tables are used to enable comparison with figures for the areas with the worst health and deprivation on a consistent basis. The two sets of figures for England may differ very slightly (normally by less than 0.1 years).
d. Difference in life expectancy between England and the areas which had the worst health and deprivation.
e. Difference in life expectancy between England and the areas which had the worst health and deprivation as a percentage of the England life expectancy.
f. Percentage point difference.
g. Original data source: ONS (life expectancy data based on death registrations and mid-year population estimates).

Table 24: **All-Age-All-Cause Mortality rates for males and females, England and the areas which had the worst health and deprivation (a), 1995-97 and 1999-01 to 2008-10**

All-Age-All-Cause Mortality (AAACM) – Males	**Three-year average** mortality rate per 100,000(b)			
Time period	England	Areas with the worst health and deprivation (a)	Absolute gap (c)	Relative gap (d), %
1995-97	931.1	1073.4	142.3	15.3
1999-01	844.8	978.5	133.8	15.8
2000-02	822.4	951.4	129.1	15.7
2001-03	807.3	938.1	130.8	16.2
2002-04	788.4	915.1	128.7	16.4
2003-05	761.5	888.2	126.7	16.6
2004-06	732.0	856.5	124.5	17.0
2005-07	710.0	835.1	125.0	17.6
2006-08	692.1	819.4	127.3	18.4
2007-09	673.5	797.3	123.8	18.4
2008-10	656.0	771.2	115.2	17.6
Change since 1995-97	-275.2	-302.2	-27.1	+2.3
Percentage change since 1995-97	-29.6	-28.2	-19.0	+15.0(e)

All-Age-All-Cause Mortality (AAACM) - Females	**Three-year average** mortality rate per 100,000(b)			
Time period	England	Areas with the worst health and deprivation	Absolute gap (c)	Relative gap (d), %
1995-97	606.4	681.9	75.5	12.40
1999-01	567.9	642.4	74.5	13.10
2000-02	556.0	629.8	73.8	13.30
2001-03	552.9	628.7	75.8	13.70
2002-04	543.5	520.5	77	14.20
2003-05	531.9	609.2	77.3	14.50
2004-06	512.2	659.8	77.6	15.20
2005-07	500.2	576.6	76.5	15.30
2006-08	490.5	568.8	78.1	15.90
2007-09	478.3	553.4	75.1	15.70
2008-10	467.0	541.5	74.4	15.90
Change since 1995-97	-139.3	-140.4	-1.0	+3.5(e)
Percentage change since 1995-97	-23.0	-20.6	-1.4	+28.0

Figure 19:Three year average All-age-all cause mortality rates, for males, comparing England and the areas which had the worst health and deprivation, 1995-97 to 2008-10

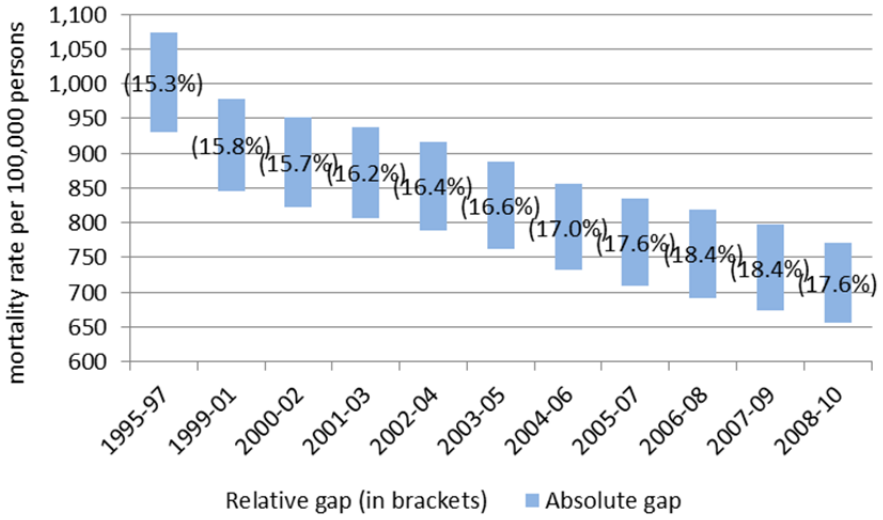
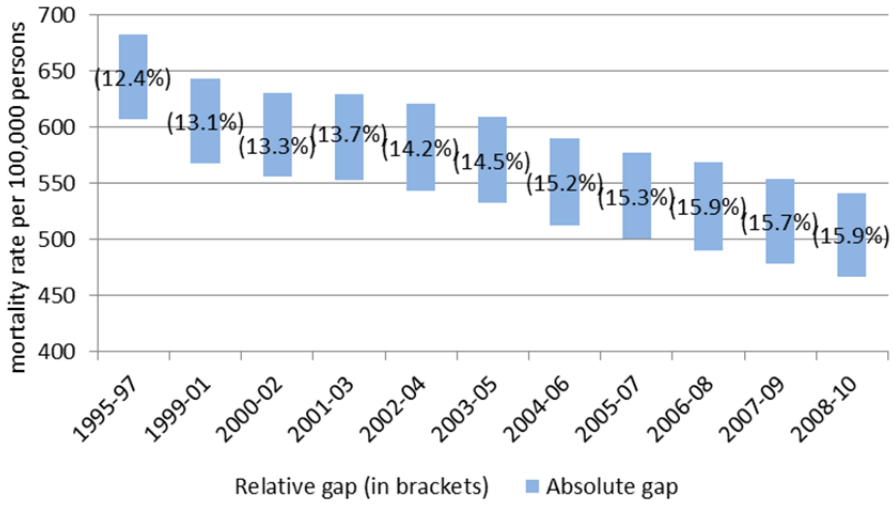


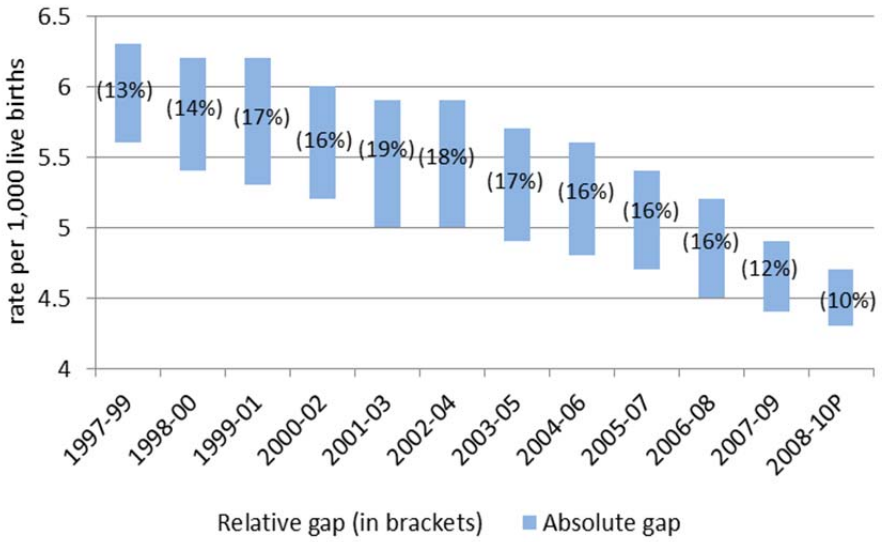
Figure 20:Three year average All-age-all cause mortality rates, for females, comparing England and the areas which had the worst health and deprivation, 1995-97 to 2008-10



Source: Department of Health (2011c: 10 Table 2)
Notes:

a. Local authorities which had the worst health and deprivation, based on life expectancy and mortality data for 1995-97 and the 2004 Index of Multiple Deprivation.
b. Directly age-standardised mortality rate, based on European Standard Population.
c. Difference in rates between England and the areas which had the worst health and deprivation.
d. Difference in rates between England and the areas which had the worst health and deprivation as a percentage of the England rate.
e. Percentage point difference.
f. Original data source: ONS (death registrations and mid-year population estimates).
g. Gap and change figures are calculated based on unrounded mortality rates

Figure 21: **Absolute and relative gaps in infant mortality rates between routine and manual group and the average for all groups, England and Wales, 1997-99 to 2008-10 (c,e)**



Source: 1997-1999 data and 2002-04 to 2009-10 data: Department of Health (2011b: 6) Table 1b; 1997-99 to 2001-03 data: Department of Health (2009) Table 1

Table 25: Infant mortality (a): Routine and Manual group (b) compared with average for All groups (inside marriage / joint registrations, three year averages), England and Wales, 1997-99 to 2008-10 (c,e)

	Infant deaths per 1,000 live births (d)			
	Routine and manual	**All (inside marriage / joint registrations) (h)**	**Absolute gap (j)**	**Relative gap (k)**
1997-99	6.3	5.6	0.7	13%
1998-00	6.2	5.4	0.8	14%
1999-01	6.2	5.3	0.9	17%
2000-02	6.0	5.2	0.8	16%
2001-03	6.0	5.0	0.9	19%
2002-04	5.9	5.0	0.9	18%
2003-05	5.7	4.9	0.8	17%
2004-06	5.6	4.8	0.8	16%
2005-07	5.4	4.7	0.7	16%
2006-08[i]	5.3	4.5	0.7	16%
2007-09[i]	5.0	4.4	0.5	12%
2008-10P[i]	4.7	4.3	0.4	10%
Change 1997-99 to 2008-10 (l)	-1.6	-1.3	-0.3	-3.0
Percentage change 1997-99 to 2008-10	-25%	-23%	-42%	-25%

Notes:

a. Gap and change figures are calculated based on unrounded mortality rates.
b. 2008-10 data are provisional. Earlier periods reflect the latest final figures, and so may differ slightly from data reported previously.
c. Data for 2001 onwards is based on NS-SEC classification which was introduced in 2001 to replace the Registrar General's Social Classification (RGSC). To take account of this change in classification, the formulation of the target was changed from "manual" social class to "routine and manual" groups. A time series back to 1994 was constructed to be on an equivalent basis and is based on an approximation to NS-SEC (NS-SEC 90) available for use with data prior to 2001. See Department of Health (2009) Annex for further details.
d. Based on infant deaths successfully linked to their birth records
e. NS-SEC based on father's occupation at death registration
f. Information on father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth
g. Figures for live births in NS-SEC groups (i.e. not including figures for All and Sole registrations) are based on a 10 per cent sample coded for father's occupation
h. Based on births inside marriage or outside marriage registered jointly by both parents, including cases where father's occupation was not stated
i. Based on all births, including cases where father's occupation was not stated
j. Students; occupations inadequately described; occupations not classifiable for other reasons; never worked and long-term unemployed
k. Infants born inside marriage or outside marriage jointly registered by both parents.
l. For 2008 and 2009, most of the figures use published Child Mortality Statistics. However, figures for NS-SEC class 7 (used in calculating figures for the 'Routine and Manual' group) and the 'Other' category were provided directly from ONS.
m. Difference in rates between All and Routine and Manual group.
n. Difference in rates between All and Routine and Manual group as a percentage of the all rate percentage point difference.

Infant mortality

The infant mortality rate inequality targets included in the 2004 Comprehensive Review (Department of Health, 2006: 3) and repeated in Public Service Agreement / Delivery Agreement 18 (HM Government 2007) specified that "[s]tarting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the "routine and manual" socioeconomic group and the population as a whole" (HM Government 2007: 23). The base line year for the target was the three year average rate for 1997-1999, with progress evaluated by three year moving averages and overall success measured in terms of the three year moving average for the years 2009-2011.

The relative gap in infant mortality between the routine and manual group and the population as a whole increased between 1997-99 and 2001-03 from 13% to 19% and was then persistently high for a number of years. The relative rate recorded for 2006-08 remained at 16% and at the time of the 2010 General Election most analyses suggested that Labour would not meet its infant mortality inequality target. However, since then the gap has narrowed, and 2009-10 figures show that it was now 10%, which is 25% lower than at baseline. The figures suggest that the target is on course to be met (although a final verdict will require the 2009-2011 data).

Cancer and circulatory disease mortality

The cancer mortality inequality target included in the 2004 PSA aimed at "a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole". Success against the target is evaluated using as a baseline year the average of the European age standardised rates for 1995-97 and the 2009-2011 average (Department of Health 2004: 1-2) (Department of Health 2006: 2). Unlike the life expectancy and infant mortality targets, the cancer mortality target is evaluated using absolute gap measure.

Trends against this target are reported in Table 26 and Figure 22. The absolute gap between the population of England as a whole and those who live in areas with the worst health and deprivation was 20.7 deaths per 100,000 population in 1995–7, reducing to 18.3 by 2008-10. This represented a

Table 26: **Cancer mortality, ages under 75, all persons, England and the areas which had the worst health and deprivation (a), 1995-97 and 1999-01 to 2008-10**

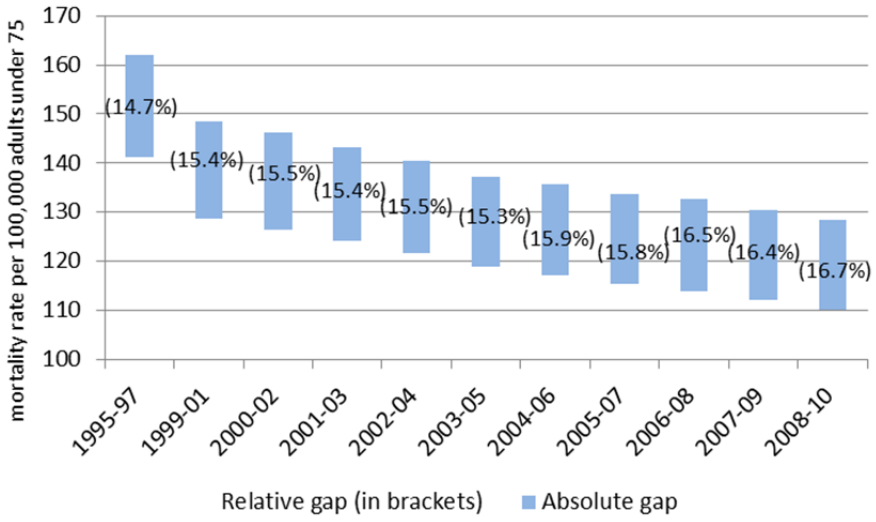
	Three-year average mortality rate per 100,000(b)			
	England	Areas with the worst health and deprivation (a)	Absolute gap (c)	Relative gap (d), %
1995-97	141.2	161.9	20.7	14.7
1999-01	128.7	148.6	19.9	15.4
2000-02	126.5	146.1	19.6	15.5
2001-03	124.1	143.2	19.1	15.4
2002-04	121.6	140.5	18.9	15.5
2003-05	119.0	137.2	18.2	15.3
2004-06	117.1	135.6	18.6	15.9
2005-07	115.5	133.7	18.2	15.8
2006-08	113.9	132.7	18.8	16.5
2007-09	112.1	130.4	18.3	16.4
2008-10	110.1	128.4	18.3	16.7
Change since 1995-97	-31.1	-33.5	-2.4	+2.0(e)
Percentage change since 1995-97	-22.0	-20.7	-11.6	+13.4

11.6% narrowing of the absolute gap, suggesting that the 2004 target will be met (although a final evaluation will require the 2009-2011 data). Inequality measured by the relative gap deteriorated.

The reduction in mortality from circulatory diseases was a major achievement of the period. A circulatory mortality inequality target specified was included in the 2004 PSAs, which aimed at "a 40% reduction in the [absolute] inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole (Department of Health 2006: 1-2). Success against the target is evaluated using as a baseline year the average of the European age standardised rates for 1995-97 and the 2009-2011 average (Department of Health 2006: 2).

Trends are reported in Table 27 and Figure 23, which show that there was an impressive 50.9% fall in the death rate from circulatory disease in 'spearhead' areas. However, the rate of improvement in "spearhead areas" nevertheless lagged behind the rate of improvement in the all England average, with a 52.4% fall. As a result, the relative gap again increased over the period 1995-97-2008-10. However, the absolute gap between the worst health and deprivation group and the population of England as a whole, the basis of the target, did fall - from 36.7 deaths in 1995-97 to was 20.1 deaths per 100,000 population in 2008-10 (a 45.2% decrease). This figure suggests that the target was met in 2008-2010 (although a final verdict requires the 2009-2011 data).

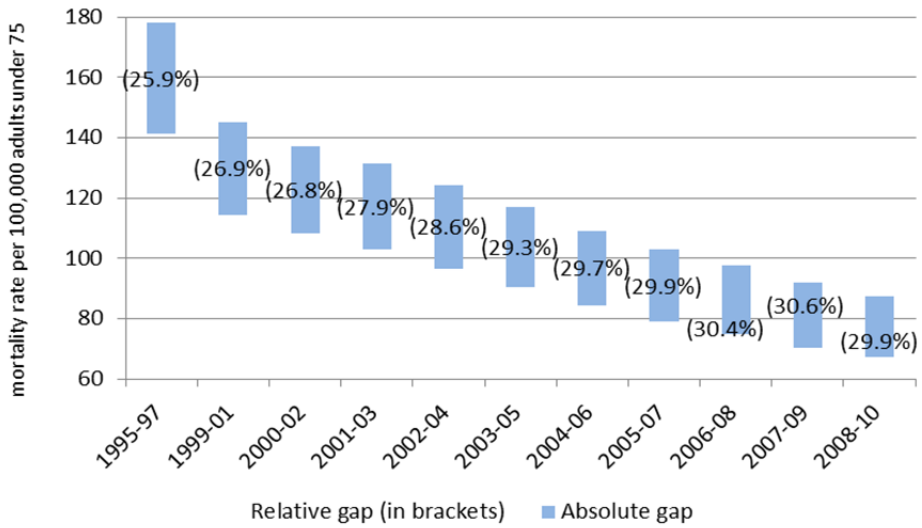
Figure 22:Three year average Mortality rate from cancer, comparing England and the areas which had the worst health and deprivation, 1995-97 to 2008-10



Source: Department of Health (2011c: Table 3)
Notes:

a. Local authorities which had the worst health and deprivation, based on life expectancy and mortality data for 1995-97 and the 2004 Index of Multiple Deprivation.
b. Directly age-standardised mortality rate, based on European Standard Population.
c. Difference in rates between England and the areas which had the worst health and deprivation.
d. Difference in rates between England and the areas which had the worst health and deprivation as a percentage of the England rate.
e. Percentage point difference
f. Original data source: ONS (death registrations for ICD9 140-208, ICD10 C00-C97; and mid-year population estimates)
g. Gap and change figures are calculated based on unrounded mortality rates.

Figure 23: Three year average Mortality rate from Circulatory Diseases, comparing England and the areas which had the worst health and deprivation, 1995-97 to 2008-10



Source: Department of Health (2011c: Table 4)

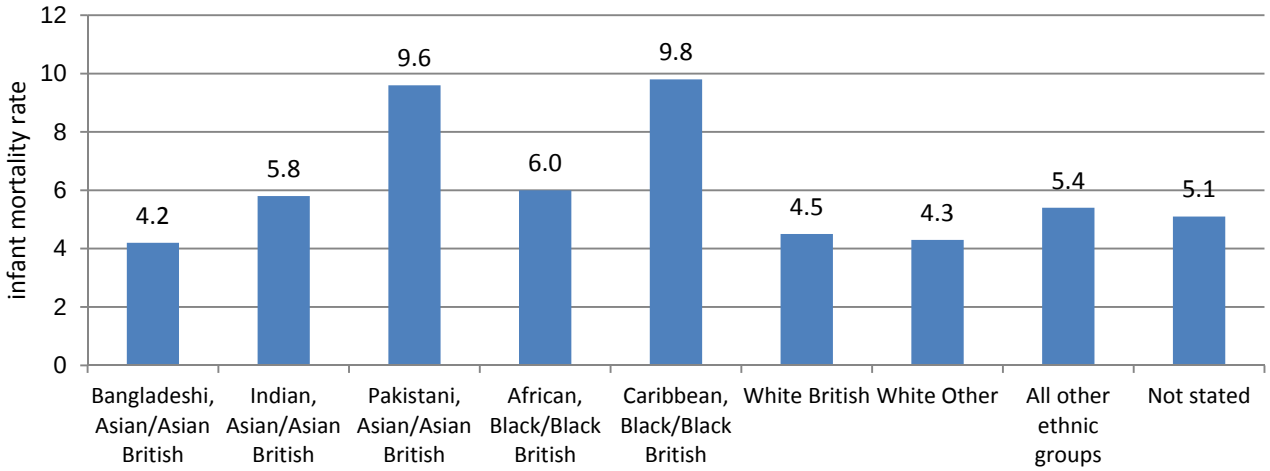
Table 27: Circulatory Diseases Mortality, ages under 75, all persons, England and the areas which had the worst health and deprivation (a), 1995-97 and 1999-01 to 2008-10

Time period	England	Areas with the worst health and deprivation (a)	Absolute gap (c)	Relative gap (d), %
1995-97	141.3	178.0	36.7	25.9
1999-01	114.5	145.3	30.8	26.9
2000-02	108.2	137.3	29.1	26.8
2001-03	102.8	131.5	28.7	27.9
2002-04	96.7	124.4	27.7	28.6
2003-05	90.5	117.0	26.6	29.3
2004-06	84.2	109.2	25.0	29.7
2005-07	79.1	102.8	23.7	29.9
2006-08	74.8	97.5	22.7	30.4
2007-09	70.5	92.1	21.6	30.6
2008-10	67.3	87.4	20.1	29.9
Change since 1995-97	-74.1	-90.6	-16.6	+4.0(e)
Percentage change since 1995-97	-52.4	-50.9	-45.2	+15.2

Notes:

a. Gap and change figures are calculated based on unrounded mortality rates.
b. Local authorities which had the worst health and deprivation, based on life expectancy and mortality data for 1995-97 and the 2004 Index of Multiple Deprivation. Directly age-standardised mortality rate, based on European Standard Population.
c. Difference in rates between England and the areas which had the worst health and deprivation.
d. Difference in rates between England and the areas which had the worst health and deprivation as a percentage of the England rate.
e. Percentage point difference.
f. Original data source: ONS (death registrations for ICD9 390-459, ICD10 I00-I97) and mid-year population estimates)

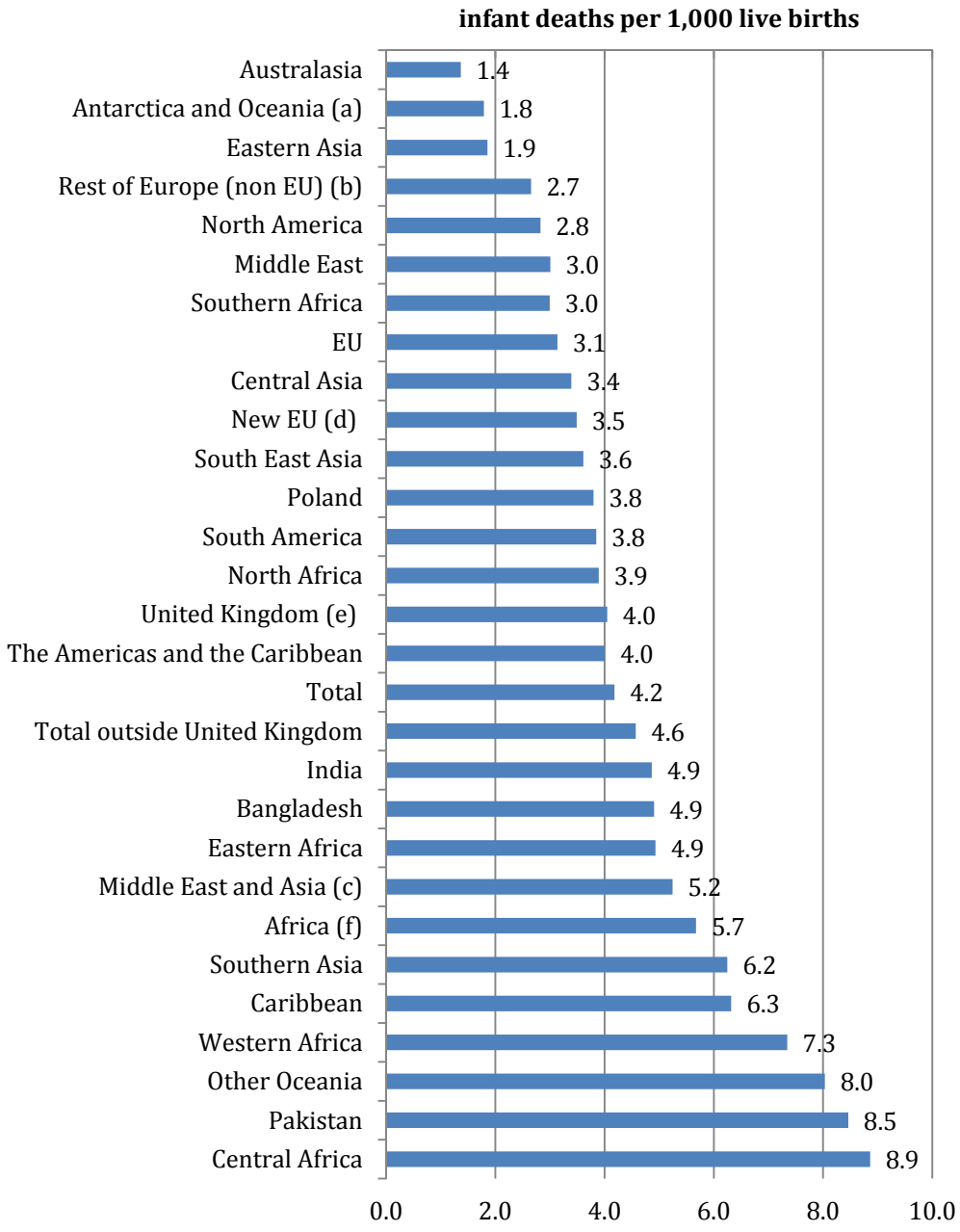
Figure 24: **Infant mortality rate, England and Wales, 2005**



Source: Office of National Statistics (2008) Table 1, Notes:

a. Deaths per 1,000 live births b. Other group in includes: Chinese, Other Asian, Other Black, Other, and all Mixed group

Figure 25: **Infant deaths per 1,000 live births by mother's country of birth, 2010**



Source: Office of National Statistics (2011c) Table 5

Notes:

a. Includes Antarctica and Antarctica and Oceania not otherwise stated. These are not included in any subdivision of Antarctica and Oceania hence the subdivisions will not sum exactly to the Antarctica and Oceania total
b. Includes Europe not otherwise stated.
c. Includes Asia (except Middle East) not otherwise stated. This is not included in any subdivision of Middle East and Asia hence the subdivisions will not sum exactly to the Middle East and Asia total.
d. The 'New EU' constitutes the twelve countries which have joined the European Union since 2004. The twelve countries which have joined the European Union since 2004 are included in both the New EU and the EU categories.
e. Including Isle of Man and Channel Islands.
f. Includes Africa not otherwise stated. This is not included in any subdivision of Africa hence the subdivisions will not sum exactly to the Africa total.

Health inequalities by ethnicity and country of birth

Whilst Labour's health inequalities targets were generally specified in terms of disparities by area deprivation (the so-called "spearhead area" approach) disparities by social class, policy documents also highlighted the importance of addressing health inequalities by additional characteristics such as gender, ethnicity and disability. New equality standards introduced during Labour's period in office also resulted in an increased emphasis on health inequalities by additional characteristics (with successive waves of equality legislation establishing positive duties on public authorities, including health commissioners and providers, to give due regard to the promotion of equality by gender, race and age as well as by disability).

With new data linkages, important new evidence relating to variations in in infant mortality rates by ethnicity and mother's country of birth also emerged over the period. Data linkage evidence for 2005 showed that the disparities were particularly high for the Pakistani/Asian/Asian British group (9.6 per 1000 live births) and the Caribbean/Black/Black British group (9.8 per 1000 live births) compared with their White British counterparts (4.5 per 1000 live births) (Figure 24). Rates by mother's country of birth were particularly high for mother's from Central Africa, Pakistan, Western Africa and the Caribbean (with rates of 8.9, 8.5, 7.3 and 6.3 per 1000 live births respectively in 2010 (Figure 25).
New forms of monitoring such as the Count Me In Census were also introduced as a specific response to equalities legislation. Findings from the 2010 Census raise concerns about unmet need for mental health services amongst the Black and Black/White Mixed groups, as indicated by statistically significant differentials in admission rates, detention rates, seclusion rates, length of stay and referral from the criminal justice system. Other recent research highlights barriers to healthcare (including lack of access to GP services) amongst Gypsies and Travellers, as well as stark inequalities in outcomes for this group compared with age-sex matched comparators on a range of standardised general health status measures (Parry et al. 2004).

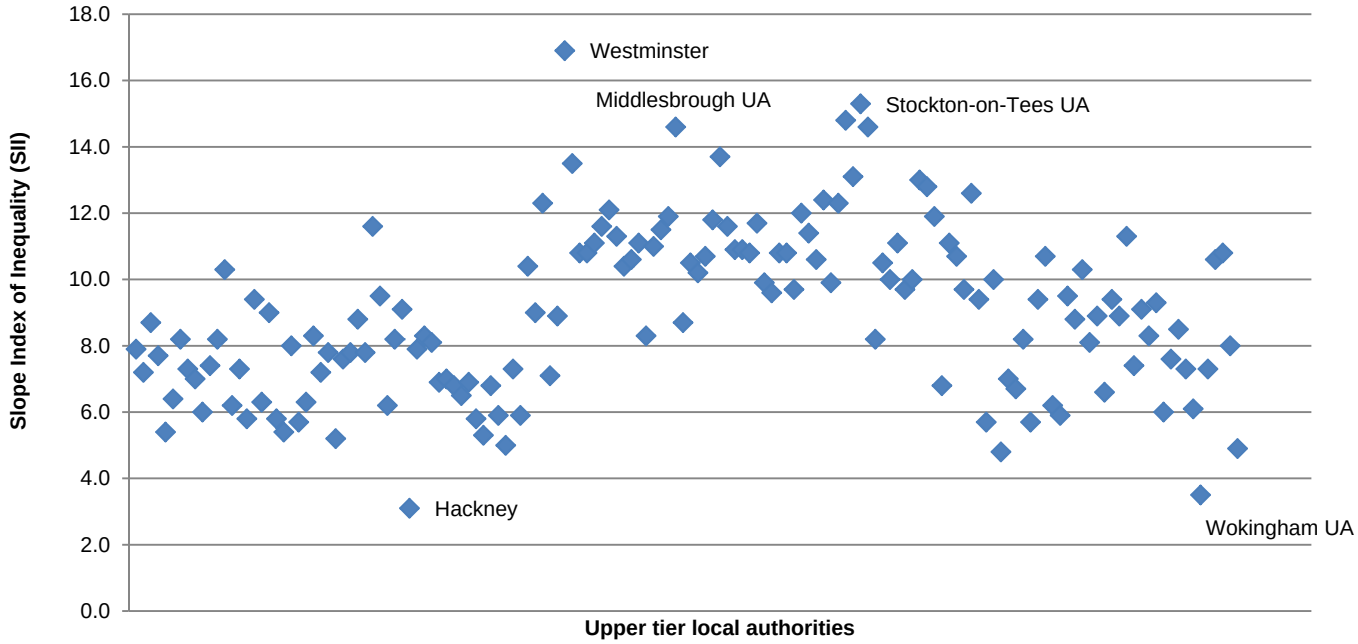
Marmot and beyond

Labour's "spearhead approach" to tackling health inequalities was itself criticised in the Marmot Review for being insensitive to inequalities *within* areas. The new set of Marmot indicators developed in 2010 address this concern by including indicators of health inequalities *within* areas including an indicator of *within-area* inequality in life expectancy. New data reporting against these indicators covers upper tier local authorities, which include counties, unitary authorities, metropolitan country districts and London Boroughs. Scores for the 'slope index of inequality' (SII) for life expectancy at birth are calculated by grouping lower layer super output areas (LSOAs) within local authorities in England into deciles based on 2007 Index of Multiple Deprivation scores. The final SII score represents the gap in years of life expectancy between the best-off and worst-off individuals within the local authority (UCL Institute of Health Equity 2012; UCL Institute of Health Equity and London Health Observatory 2012ab).

Based on this method, the SII score was found to range from 3.3 to 16.9 for men 2006-2010. The upper-tier local authority with the highest SII score was Westminster, where the life expectancy gap for men was estimated to be 16.9 years, followed by Stockton on Tees (with a figure of 15.3 years) and Middlesbrough (14.8 years) whilst the London Borough of Hackney had the lowest SII score (3.1 years) (Figure 26). The greatest regional inequalities were found to be in the North East (UCL Institute of Health Equity and London Health Observatory 2012ab). The Marmot analysis includes separate reporting for London. The Marmot +2 years reporting exercise highlighted that in four boroughs

(Southwark, Camden, Tower Hamlets and Westminster) life expectancy for the best-off men is more than 10 years higher than for the worst-off men (London Health Observatory (2012b).

Figure 26: Slope Index of Inequality for life expectancy at birth for men, upper-tier local authorities in England, 2006-10



Source: Marmot Indicators 2012 (UCL Institute of Health Equity and London Health Observatory 2012a)

As highlighted in the Marmot Review, disparities in life expectancy by occupational social class also remained stark during the Labour years, with a male expectancy of 80.4 years during the period 2002-2006 for males from higher managerial and professional occupational groups, compared with 74.6 years for those from routine occupations. For females, the figures were 83.9 years and 79.7 years respectively.

The implementation of the 'spearhead approach' was also criticised in evaluations by the Health Select Committee and the National Audit Office. The former praised the Labour Government's explicit commitment to reducing health inequalities and viewed the specification of health inequality targets, underpinned by specific policies, as an important milestone. However, it found little evidence that specific interventions including Health Action Zones, the Sure Start programme and 'spearhead status' had reduced health inequalities. Although the second Sure Start evaluation published in 2008 showed more benefits of Sure Start than the previous evaluation, the programme was only evaluated as impacting on five of the 14 outcomes measured relating to health and development (Select Committee on Health 2009, para. 120-140). The Committee did, however, identify some evidence that where Sure Start was better linked with local health services outcomes were stronger (Select Committee on Health 2009, para. 133-135) and other analyses also point to Sure Start health outcomes as being relatively positive (e.g. Eisenstadt 2012).

Table 28: **Life expectancy by NS–SEC class, England and Wales, 1997-2001 and 2002-06**

	Males		Females	
	1997-2001	**2002-06**	**1997-2001**	**2002-06**
NS-SEC	Life exp.	Life exp.	Life exp.	Life exp.
At birth				
Analytic classes				
1. Higher managerial & professional	78.8	80.4	82.6	83.9
2 Lower managerial & professional	78.2	79.6	82.2	83.4
3 Intermediate	76.8	78.5	81.5	82.7
4 Small employers & own a/c workers	76.6	77.8	80.8	82.6
5 Lower supervisory & technical	75.3	76.8	79.5	80.4
6 Semi-routine	74.0	75.1	79.6	80.6
7 Routine	72.6	74.6	78.6	79.7
Range highest- lowest	6.2	5.8	4.0	4.2

Source: ONS 2011e

In other evaluations, the National Audit Office praised Labour's health inequalities commitments whilst criticising the failure to effectively make health inequalities a "top priority" for NHS delivery systems and performance management before 2006. The decisive development in moving forward in 2006 was the inclusion of health inequalities as a top six NHS priority and the introduction of a health inequalities performance indicator for the NHS. The reorganization of PCTs to make them better aligned with local authorities was also key, since the latter had needed a better infrastructure to tackle the health inequalities agenda. However, little time was left for these actions to have an impact before the 2010 target date (NAO 2010: 9). A Kings Fund Review (Dixon et al 2011) found that the *Quality and Outcomes Framework* had had limited impact on health inequalities. The Framework was found to be a barrier to PCTs commissioning primary care that is sufficiently focused on the health needs of the local population. The authors recommended a shift of incentive systems focus from general practice providing services to general practices taking responsibility for population health and reducing inequalities.

Labour's own review of the implementation of its health inequalities strategy, *Ten Years On* highlighted a key success of the period as establishing public health as a key strategic health objective and the need for a longer time framework (for example, to 2030) for evaluating the overall achievements of the period. The review also identified lack of effective mechanisms to promote practical joint working between interested organisations including local authorities and the NHS at the local level (i.e. PCTs) as holding back progress before 2006. NHS reorganization also sometimes resulted in disrupted priorities and networks (DH 2009a: 1-20).

The decentralization agenda and a move towards local responsibility for public health emerge from the period as key legacy issues. Joint Strategic Needs Assessments and Local Area Agreements, which became statutory requirements in 2008, were intended, *inter alia*, to strengthen accountability for reducing inequalities in health outcomes. The new measures reflected concerns that health inequalities targets had been insufficiently aligned with other targets, and that levers and delivery systems for implementation had been insufficiently coordinated and too weak (NAO 2010: 10; DH 2008 9-12, 2009a 20).

More generally, Sassi (2009) notes that the persistence of health inequalities during the Labour years is a cause of concern to those who had hoped that the unprecedented effort and resources devoted to tackling health inequalities since 1997 might narrow or at least halt the progression of such inequalities. However, health inequalities have been rising over many years and lifestyle and behavioural risk factors are deeply embedded. So perhaps it would have been naïve to expect a major reversal of this trend over a relatively short time span.

8. Lifestyle, Behavioural and Risk Factors

In this section, we take forward the examination of trends in health outcomes 1997-2010 with an evaluation of progress in tackling underlying lifestyle, behavioural and risk factors such as smoking, obesity and teenage pregnancy. We find that changing behaviour proved challenging for the Labour Government. However, smoking prevalence, a major priority for Labour, did fall.

Key findings

Tackling underlying behavioural, lifestyle and risk factors proved challenging between 1997 and 2010 although smoking prevalence, a major priority for Labour, did fall.

- **Obesity** continued its medium term tendency to increase between 1997 and 2010. An early target to halt the increase in child obesity in children by 2004 was not met. However, there was some evidence of a halt in the increase in child obesity towards the end of Labour's period in power (between 2006-08 and 2008-2010).
- **Teenage pregnancy.** The under 18 conception rate fell from 46.6 per 1000 females aged 15-17 in 1998 to 35.4 in 2010. However, Labour's target to reduce teenage pregnancy, which aimed at a 50% reduction in teenage pregnancies, was not met.
- **Smoking.** Labour's target to reduce the overall smoking prevalence rate was met and a further target to reduce the disparity between the overall population smoking prevalence rate, and the rate for individuals from the manual occupational groups, was achieved in 2007. However, the smoking prevalence rate amongst individuals from the manual occupational groups subsequently increased and the figure was above target in 2010.

Smoking and alcohol

The Government's health targets also included indicators relating to overall smoking prevalence and to the gap in smoking prevalence by social class. The 2004 Comprehensive Spending Review included targets to "[t]o reduce adult (16+) smoking rates to 21% or less by 2010" and to reduce "prevalence among routine and manual groups to 26% or less" by 2010. The target was reaffirmed in the 2007 Public Service Agreements, with progress evaluated using General Household Survey data using the financial year 2002-03 as a baseline and 2010-11 as a final year (HM Government, 2004: 13, HM Government 2007: 24, DH 2006: 5).

Table 29 below shows that at the baseline year, 2002, 26% of adults smoked and this figure increased to 33% amongst the routine and manual group occupational group. By 2007 it appeared that the target had been met, with prevalence rates dropping to 21% of all adults and 26% of those in routine and manual jobs. However, in 2008, 2009 and 2010, the rate for routine and manual occupations increased again to above 26%.

Tackling alcohol consumption proved challenging. Between 1998 and 2006 the proportion of men and women exceeding recommended alchol thresholds remained broadly stable. After 2006, trends for men and women diverged somewhat. The proportion of men consuming more than the recommended four units on the heaviest days drinking in the last wek did not show substantial change 2006-2010. However, amongst women there was an improvement, with a decrease between 2006 and 2011 in the proportion consuming more than the recommened three units (Health and Social Care Information Centre 2008 2012bc).

Table 29: Prevalence of cigarette smoking among adults, by gender and socio-economic classification, England, 2001-2010

	2001	2002	2003	2004	2005[4]	2006[5]	2007[5]	2008[5]	2009[5]	2010[5]
All adults										
All classifications[6]	27	26	25	25	24	22	21	21	21	20
Managerial and professional	19	19	18	19	17	15	15	14	15	13
Intermediate	27	26	26	24	23	21	20	21	19	20
Routine and manual	33	31	32	31	31	29	26	29	28	27
Men										
All classifications[6]	28	27	27	26	25	23	22	21	22	20
Managerial and professional	21	20	20	20	18	17	16	15	15	15
Intermediate	29	27	28	26	24	22	21	21	20	20
Routine and manual	34	32	34	32	32	32	28	31	29	27
Women										
All classifications[6]	25	25	24	23	22	21	19	20	20	19
Managerial and professional	17	17	17	17	16	14	14	14	14	12
Intermediate	26	25	24	22	22	20	18	21	18	19
Routine and manual	31	31	30	30	29	28	24	27	27	27

Source: General Lifestyle Survey 2010 (Health and Social Care Information Centre (2012, table 2.9)
Notes:
(1) Aged 16 and over
(2) From 2001 the National Statistics Socio-Economic Classification (NS-SEC) was introduced for all official statistics and surveys. It replaces Social Class based on occupation and Socio-Economic Group (SEG)
(3) Based on the current of last job of the house hold reference person
(4) 2005 data includes last quarter of 2004.5 data due to survey change from financial year to calendar year.
(5) Results for 2006. 2007, 2008 and 2009 and 2010 include longitudinal data.
(6) Respondents whose household reference person was a full time student, had an inadequately described occupation, had never worked or was long-term unemployed these are not shown as separate categories but are included in the total.

Obesity, diet and exercise [ix]

The 2004 PSA included a target on childhood obesity that specified as a goal "[h]alting the year-on-year rise in obesity among children under 11 [2-10 year olds] by 2010, in the context of a broader strategy to tackle obesity in the population as a whole" with joint responsibilities apportioned to the Department of Health, Education and Skills and Culture, Media and Sport)" (DH 2006: 6; HM Treasury 2004). Success against this target is evaluated using a weighted average for 2002-04 and 2009-2011 using Health Survey for England data.

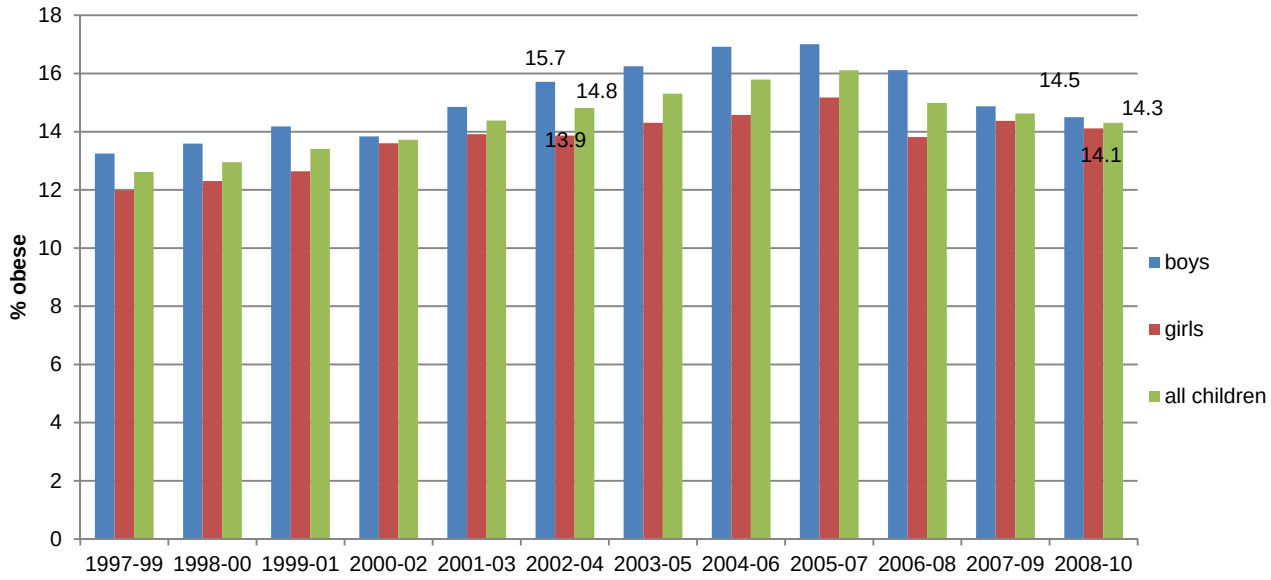
Table 30 below shows that the proportion of children who are overweight, including obese, has been rising since 1995 for 2-10, 11-15 and 2-15 year olds. Obesity rates for children aged 1-2 years increased from 10.1 per cent of children in 1995 to 17.3 per cent in 2005, falling off a little to 14.6 per cent in 2010. The rate for children aged 11-15 increased from 14.7 per cent in 1995 to 25.5 per cent in 2004, again falling off to 18.3 per cent in 2010.

In terms of progress against the 2004 target, Figure 27 provides information on trends based on a three year moving average. Comparing trends between 2002-2004 and 2008-09, the proportion of children under 11 who were reported to be obese was 14.8% in 2002-04 and 14.3% in 2008-10, representing a small decrease in the proportion of obese children in this age group. The proportion of obese boys decreased from 15.7% to 14.5% and girls increased from 13.9% to 14.3% over this period
.

In 2007, a new PSA relating to childhood obesity was introduced. This aimed "to reduce the number of obese and overweight children to 2000 levels by 2020" (HM-Treasury, 2007). This shift was accompanied by a change in approach whereby the focus is not solely on obesity but also on promoting healthy weight and healthy lives (Cross-Government Obesity Unit, 2008: 9).

The prevalence of obesity amongst adults continued its medium term tendency to increase during Labour's period in office, with obesity rates of 26% for both men and women in 2010 in England (see Figure 28 below). Whilst the new target set out in the Comprehensive Spending Review in 2007 focussed on childhood obesity, it was recognised that "weight is a problem that affects adults as well as children" and "excess weight problems in children can only be tackled in concert with tackling them in the whole family, and society more broadly" (Cross-Government Obesity Unit, 2008: 9). This was also reflected in the earlier PSA (2004) where childhood obesity was set to be addressed "in the context of a broader strategy to tackle obesity in the population as a whole" (HM Treasury, 2004: 13). However, no precise target was specified for adult obesity since a 1992 white paper (Department of Health, 1992) which aimed to reduce obesity prevalence rates in England to 6% for men and 8% for women by 2005 (base years 1986-87).

Figure 27: **Three year average prevalence of obesity among children, England, 1997-99 to 2008-09**



Source: Health Survey for England (The Information Centre 2011a, Table 4)

Notes: see notes to table above

Table 30: Prevalence of obesity in children by age (% of all children), England, 1995 to 2010

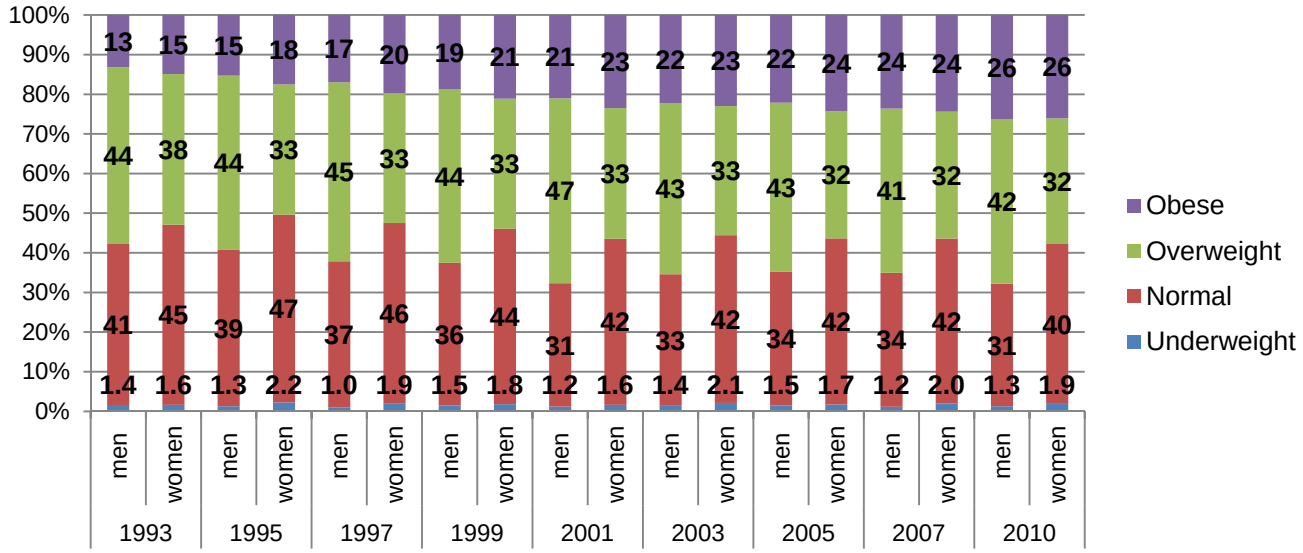
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
2-10																
Overweight	12.9	12.8	12.7	13.8	14.0	12.8	15.2	13.5	14.6	14.8	14.6	12.8	13.6	13.4	13.9	13.6
Obese	10.1	10.9	11.1	11.9	14.9	12.1	13.3	15.8	14.1	14.6	17.3	15.5	15.5	13.9	14.4	14.6
Overweight including obese	23.1	23.7	23.8	25.7	28.8	24.9	28.5	29.3	28.7	29.4	31.9	28.3	29.2	27.3	28.3	28.2
11-15																
Overweight	14.1	14.5	14.2	15.4	14.5	12.6	16.1	15.0	15.6	16.2	15.0	15.9	15.4	15.7	14.6	15.5
Obese	14.7	15.0	16.1	17.2	16.8	18.7	18.5	20.0	21.3	25.5	20.8	17.6	18.8	19.5	17.7	18.3
Overweight including obese	28.8	29.5	30.3	32.6	31.3	31.3	34.7	35.0	36.9	41.7	35.8	33.5	34.2	35.2	32.3	33.8
2-15																
Overweight	13.3	13.4	13.2	14.3	14.1	12.7	15.5	14.0	15.0	15.4	14.8	14.0	14.3	14.3	14.2	14.3
Obese	11.7	12.2	12.8	13.7	15.5	14.5	15.2	17.4	16.9	18.9	18.6	16.3	16.8	16.0	15.7	16.0
Overweight including obese	25.0	25.6	25.9	28.0	29.7	27.2	30.7	31.4	31.9	34.3	33.4	30.3	31.1	30.3	29.8	30.3

Source: Health Survey for England (Health and Social Care Information Centre 2011a, Table 4)

Notes:

a. In 2008 the definitions for children who were overweight or obese were revised from those used in previous years to correct an error which meant that small numbers of children that should have been classified as either 'overweight' or 'obese' were omitted from these categories because of rounding of age and BMI thresholds. In no cases were results significantly different from those presented previously. This table uses the new definitions for all years.
b. All years were weighted to adjust for the probability of selection, and from 2003 non-response weighting was also applied.

Figure 28: Body Mass Index (BMI) by sex, adults, England, 1993-2010



Source: Health Survey for England (The Information Centre 2011b, Table 4)

Notes:

a. Data up to 2002 are unweighted; from 2003 onwards data have been weighted for non-response
b. All adults from core and boost samples in 2005 were included in analysis of 65-74 and 75+ age groups but only the core sample was included in the overall total
c. Underweight = BMI less than 18.5
d. Normal = BMI 18.5 to less than 25
e. Overweight = BMI 25 to less than 30
f. Obese = BMI 30 or more (includes morbidly obese)

Fruit and vegetable daily mean portion consumption amongst adults was 3.4 in 2001 rising marginally to 3.8 2006 before falling back again to 3.6 in 2010. Physical activity rates did however increase. The prevalence rate for low physical activity amongst all adults was 38% in 1997. However, low activity rates fell amongst almost all age groups over the period and stood at 34 % in 2008. The percentage of adults meeting physical activity recommendations rose, from 26 % in 2007 to 34% in 2008 (Health and Information Centre HSE 2012b).

Teenage pregnancy and risk factors amongst young people

The 2004 Review also included a target relating to teenage pregnancy, committing the Government to "[r]educing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (Joint target with the Department for Education and Skills)". Success against this target is evaluated using a base line rate in 1998 of 46.6 conceptions under 18 per 1000 females aged 15-17 (Department of Health 2006: 7) and a target year rate of 23.3 conceptions under 18 per 1000 females aged 15-17 in 2010. ONS data suggests that this target was not met, with an under 18 conception rate in England of 35.4 in 2010.

Table 31: Under 18 conceptions (numbers and rates), England, 1998-2010

	Number	Rate
1998	41,089	46.6
1999	39,247	44.8
2000	38,700	43.6
2001	38,461	42.5
2002	39,350	42.7
2003	39,553	42.1
2004	39,593	41.6
2005	39,804	41.3
2006	39,170	40.6
2007	40,366	41.8
2008	38,783	40.5
2009	35,966	38.2
2010	32,552	35.4

Source: ONS (2012a) Table 6

Notes:

Rates are per 1000 female population aged 15–17 and have been calculated using the 2010-revised mid-year population estimates for 2006, 2007 and 2008. Rates may therefore differ from those previously published

There were important improvements in smoking, drinking and drug use among young people aged 11-15 in England over the period 2001-2011. Results from a survey of secondary school pupils aged 11-15 are reported in Fuller (2012). Drug use fell from 29% in 2001 to 17% in 2011 with similar declines in pupils who reporting taking drugs in the last year and the last month. The proportion of pupils who had tried smoking fell to 25%, the lowest level since the survey began in 1982, and the prevalence of regular smoking had halved since its peak in the mid 1990s. The proportion of pupils between 11 and 15 who drank alcohol in the last week feel from 26% in 2001 to 12% in 2011.

Cross-cutting analysis by social class

Recent research by EHRC confirms the general picture of significant variations in population health outcomes, and in underlying risk and lifestyle and behaviour factors, by occupational social class. Individuals from the routine and manual group, and those who have never worked or are long-term unemployed, performing worse on a range of objective and subjective health indicators using Health Survey for England. Statistically significant worse outcomes are recorded for longstanding limiting illness and disability, mental health, subjective (self-reported) health, smoking, physical activity, fruit and vegetable consumption, and obesity (see Table 32).

Table 32: Variations in health outcomes by occupational social class, England

	Limiting longstanding illness or disability 2010		Poor mental health (defined by GHQ12 score 4+) 2010		Self-rated health (health rated as bad or very bad) 2010		Current smoker 2010	
	%	Base (a)	%	Base (a)	%	Base (a)	%	Base (a)
Higher managerial and professional	17	925	12	858	3	1972	12	1317
Lower managerial and professional	20	1908	14	1754	4	6418	14	4268
Intermediate	25*	1077	14	981	6	925	16	
Small employers and own account workers	24*	705	12	619	7	1908	24*	
Lower supervisory and technical	29*	659	14	583	9*	1077	28*	639
Semi-routine	26*	1536	17*	1368	8*	705	24*	1310
Routine	31*	1083	17*	917	12*	658	32*	731
Never worked and long term unemployed	36*	150	24*	93	14*	1536	14	454
Other	6*	224	14	198	1*	1083	13	443

	Alcohol - exceeded recommendations(b) 2010		Physical activity – less than recommendations (c) 2008		Fruit consumption – less than recommendations(d) 2010		Overweight or obese (e) 2010	
	%	Base (a)	%	Base (a)	%	Base(a)	%	Base(a)
Higher managerial and professional	41		63	1485	64	925	66	785
Lower managerial and professional	40	1952	64	3390	69*	1908	68	1609
Intermediate	31*	6366	70*	1966	73*	1077	62	910
Small employers and own account workers	37		56*	1278	72*	706	68	587
Lower supervisory and technical	35*		59	1229	79*	660	68	549
Semi-routine	30*	923	65	2733	78*	1536	62	1296
Routine	32*	1903	63	2043	82*	1083	64	852
Never worked and long term unemployed	18*	1073	78*	469	74*	150	54	104
Other	18*	704	59	404	80*	224	24*	189

Source: EHRC 2013 using Health Survey for England, Notes:

(a)Base refers to unweighted base

(b) Derived variable based on types of alcohol drunk on heaviest drinking day in last week and converted to units. Recommendations are exceeded if consumption of alcohol is greater than four units for men, and greater than three units for women.

(c) Recommended level of activity is 30 minutes exercise 5 times per week or more

(d) Recommended fruit and vegetable consumption is five portions of fruit and vegetables eaten on previous day

(e) BMI based on actual height and weight measurements taken during the interview

9. The UK's International Position

In this section, we finish our evaluation of health outcomes 1997-2010 with an examination of progress in addressing the UK's international position. A key priority in 1997 was to address the UK's relatively low position on international league tables in relation to key outcomes. We discuss here how successful policy was in improving the UK's position, looking at both healthcare outcomes and population health outcomes. We find that progress was disappointing and that the UK only had a "mid" table position on a range of outcome indicators in 2010.

The discussion in this section is based on OECD international comparative data on health. It is important to note that OECD highlight important limitations of the data, including in relation to data consistency and variable reporting and recording practices in different countries. Comparisons are based on the latest year of data or in some cases on the *latest available data.* It is therefore important to note that the comparisons of the UK's position in international OECD tables are limited in important respects and that the data supports only a crude evaluation of progress made in addressing the UK's international position in relation to health between 1997 and 2010. Further details of data limitations and comparability are provided in relevant OECD publications.

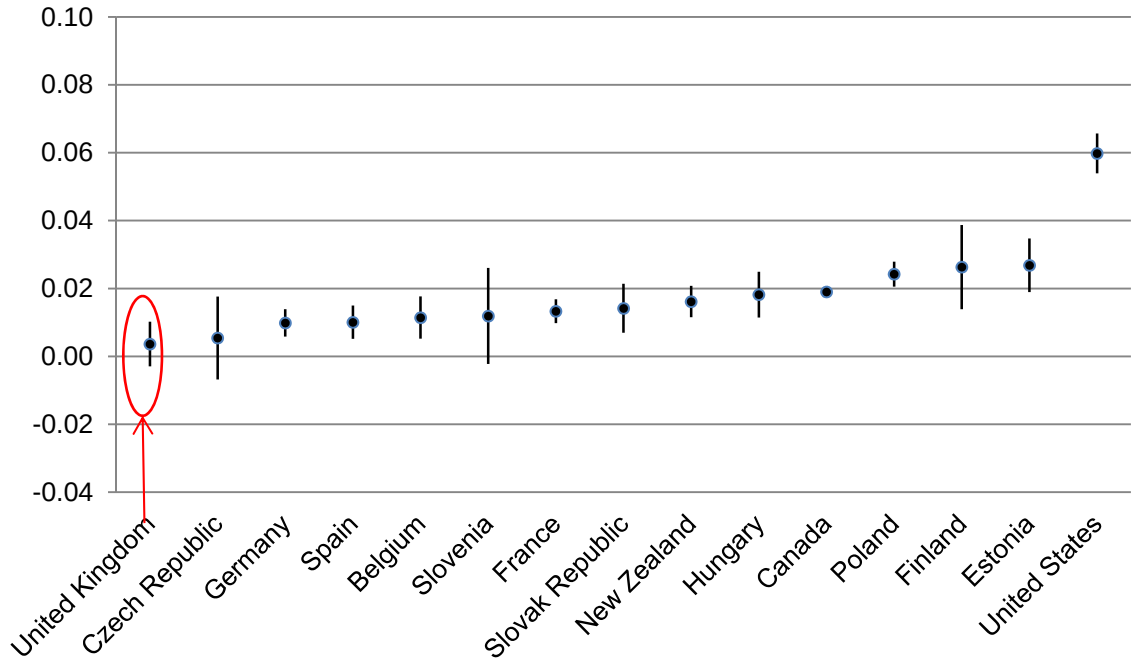
The overall evaluation that emerges from the OECD data – that progress in improving the UK's international position relative to comparator countries was limited – is in line with that in Murray et at (2013). This evaluation was based on the Global Burden of Disease Studies for 2010 and 1990 for the UK and 18 other comparator nations (the original 15 members of the European Union, Australia, Canada, Norway, and the USA; henceforth EU15 +). The authors found that despite overall improvements in life expectancy over time the UK performed significantly worse than the EU15+ for age-standardised death rates, age-standardised "years of lost life" (YLL) and life expectancy in 1990, and its relative position had worsened by 2010. The performance of the UK in terms of premature mortality was found to be persistently and significantly below the mean of EU15+.

Healthcare outcomes

OECD analysis suggests that access to doctors by income deprivation in the UK is highly equitable by international standards. The OECD evaluates healthcare system equity based on a horizontal inequity index – a measure of inequality in health care use – for the probability of a doctor visit (covering GPs and specialists). The probability is unequal if the horizontal inequity index is significantly different from zero, favouring low income groups when it is below zero, and high income groups when it is above zero. The index is adjusted for differences in need for health care, because health problems are more frequent and more severe among lower socioeconomic groups. Based on this measure, doctor visits were more likely among higher income persons in 12 of 15 countries. The United Kingdom was one of three countries where, given the same need, high income people were as likely to see a doctor as those with low income (OECD 2011).

- **The UK's international position.** Disappointingly, whilst a number of outcome indicators improved during Labour's period in power, the advances did not amount to a "race to the top" of international league tables. By 2010, the UK can be characterised as having a "mid" table position on international tables and remained below the best performers, comparator countries and the OECD average for a range of outcomes.
- **Healthcare access.** Access to healthcare was equitable in the UK in 2010 by international standards.
- **Healthcare quality.** The UK had a disappointing "mid" table positioning in 2010 in relation to a number of healthcare outcomes compared with OECD countries.
    - **Relative survival rates for stroke and heart disease:** Case fatality for acute myocardial infarction and for ischemic and haemorrhagic stroke remained below that in the best performing OECD countries.
    - **Relative five-year cancer survival rates:** Cancer survival in the UK remained below the OECD average for some specific cancers including breast cancer, cervical cancer, and colorectal cancer.
- **Population health outcomes.**
    - **Life expectancy:** There was a negligible improvement in the UK's international ranking for life expectancy for men (with the UK moving from 14th to 13th position amongst 34 OECD countries) between 1997 and 2010. There was a slight worsening for women, with the UK dropping from 20th to 24th position.
    - **Infant mortality.** The UK's infant mortality rate ranking dropped from 19th to 25th position amongst 34 OECD countries 1997 to 2010.
- **Heart disease and stroke mortality.** The UK had a mid-table position in relation to the age-standardized mortality rate for ischaemic heart disease for men. It was ranked 19th out of 33 OECD countries (based on data for 2010 or nearest available period). This was a higher rate than the France and the Netherlands. At the same time, it was a similar rate to Germany and Sweden, below the rate in US and below the OECD (33) average.
- **Cancer mortality.**
    - The improvement in the UK's international standing in relation to age-standardized all-cancer mortality for women whilst Labour was in power was negligible (with the UK moving from 29th to 28th position in the table between 1997 and 2010 amongst OECD 33 countries). For men, the UK's position remained unchanged at 17th position.
    - International rankings for specific-cause cancer mortality in 2010 were variable by cancer type and sex. Age-standardized mortality rates for colorectal cancer for men and women, and for cervical cancer for women, were below the OECD average. Age standardized mortality rates for lung cancer for women, for breast cancer (for women) and prostate cancer (for men) were above the OECD average and stand out as particular concerns.
- **Lifestyle, behaviour and risk factors.**
    - **Obesity.** The UK was ranked within worst performing cluster of OECD countries for obesity prevalence in 2010.

Figure 29: OECD horizontal inequity index for probability of a doctor visit (with 95% confidence interval), 15 OECD countries, 2009 (or nearest year)



Source: OECD estimates (2011b : 139).

Notes:

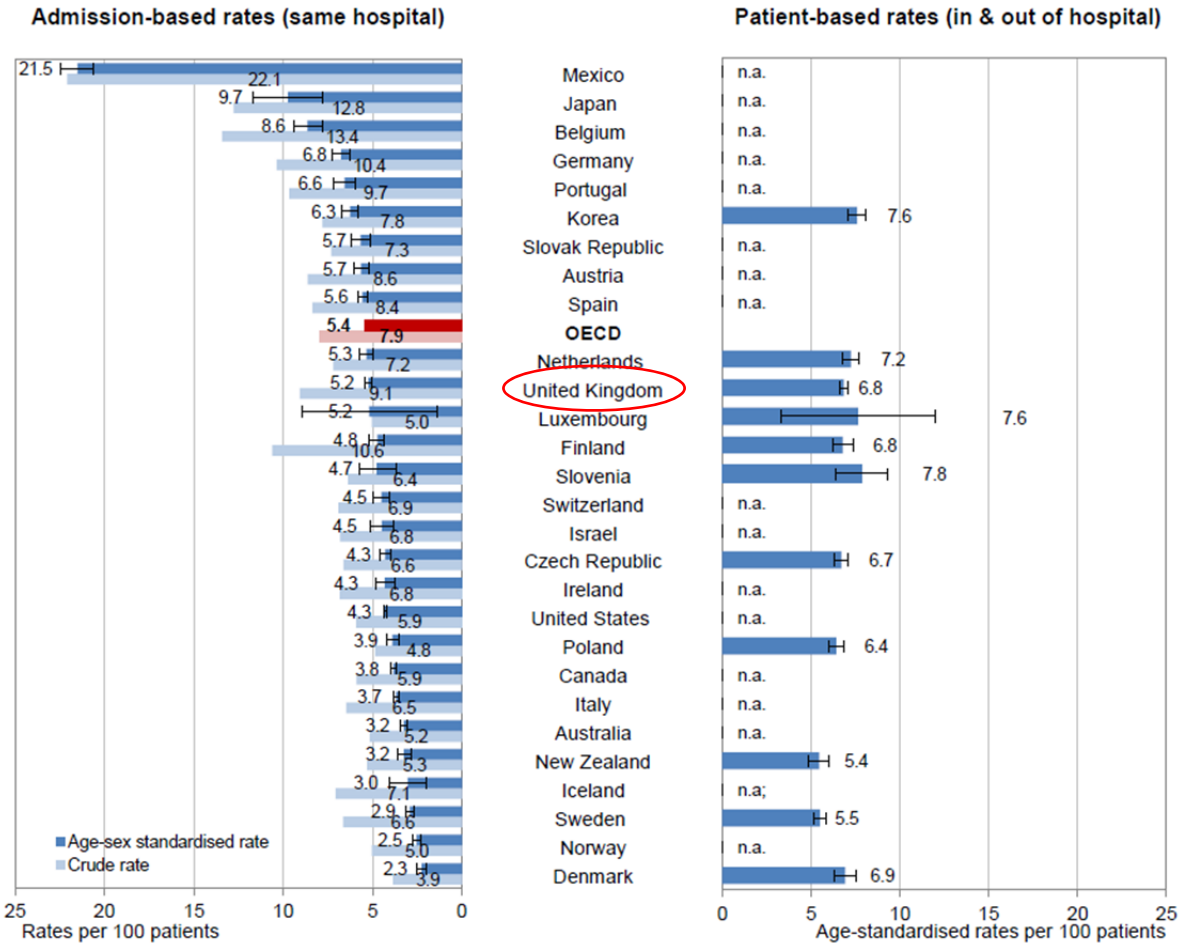
a. The probability of a doctor, GP or specialist visit is inequitable if the horizontal inequity index is significantly different from zero.
b. The index favours low income groups when it is below zero, and high income groups when it is above zero.
c. The index is adjusted for need.
d. See original for details of data limitations and comparability provided by OECD

The admission based age-sex standardized same-hospital case-fatality rate for deaths within 30 days after admission for acute myocardial infarction in 2009 in the UK was at around the OECD average (with the UK in 18th place out of 28 OECD countries in relation to admissions-based same hospital case mortality). In relation to patient-based (in and out of hospital) case-fatality, the UK was ranked in 5th place out of 11 OECD countries. The UK's use of coronary angioplasty per 100,000 of the population was just less than the OECD average in 2009 (although the OECD note that different classification systems and recording practices may be particularly important here (OECD 2011b: 91). The age-sex standardized in-hospital case-fatality rate for deaths within 30 days after admission for ischemic stroke was relatively high by international standards (UK was in 23rd place out of 27 OECD countries, above the OECD average). The rate for hemorrhagic stroke was just above the OECD average (with the UK was in 14th place out of 27).

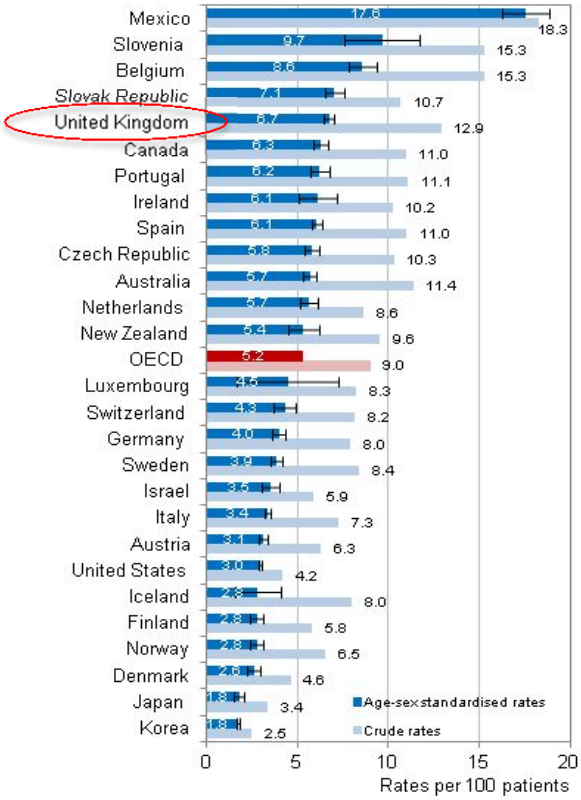
Figure 30: **Stroke and heart disease in OECD countries: 30 day case-fatality rates, 2009 (or nearest year)**

Admissions based (same hospital) case-fatality rates within 30 days after admission for acute myocardial infarction, 2009 (or nearest year) [(b)]

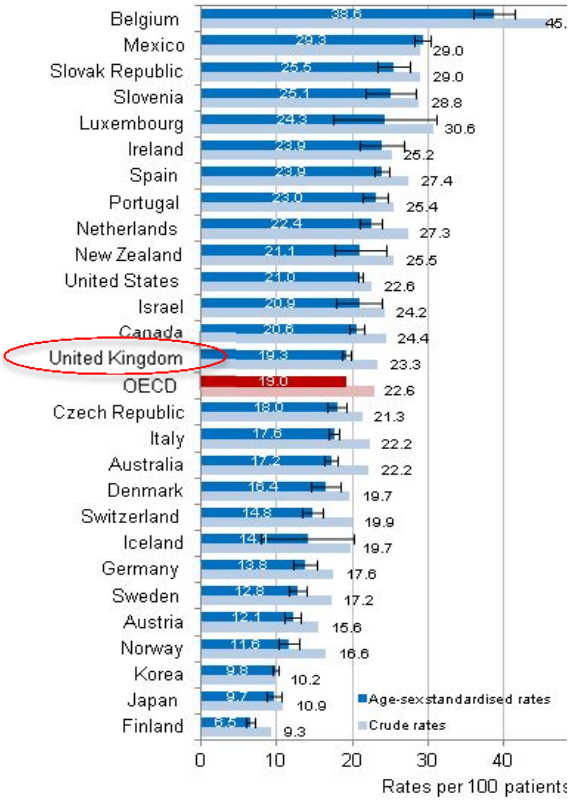
Patient based (in and out of hospital) case-fatality rates within 30 days after admission for acute myocardial infarction, 2009 (or nearest year) [(b)]



In-hospital case-fatality rates within 30 days after admission for ischemic stroke, 2009 (or nearest year) [a] [b]



In-hospital case-fatality rates within 30 days after admission for hemorrhagic stroke, 2009 (or nearest year) [a][b]



Source: OECD (2011b: 109-112)

Notes:

(a) 95% confidence intervals are represented by H.

(b) Rates age-sex standardised to 2005 OECD population (45+) for 2009 or the nearest year for which data is available. Data for Sweden, Netherlands, Belgium 2007; United States, Switzerland, Portugal, Japan 2008.

(c) OECD average includes UK

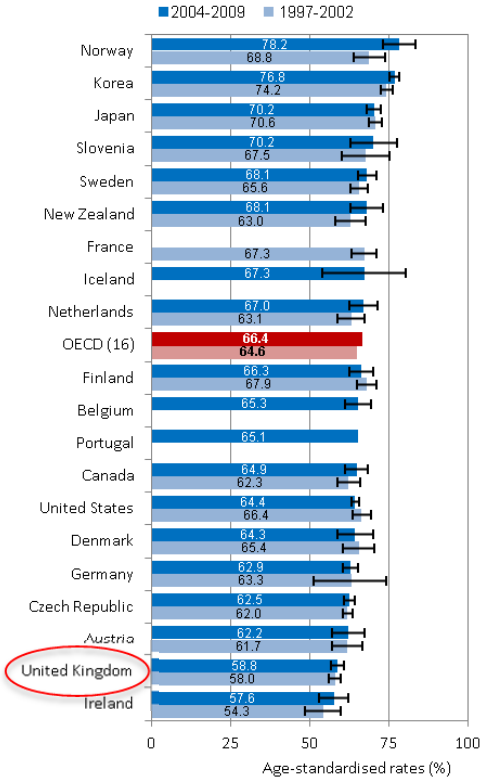
(d) See original for details of data limitations and comparability provided by OECD.

Relative five-year survival cancer survival rates also remained disappointingly below compared with the best performing OECD countries for some specific cancer types. For example, despite an important improvement in the relative five-year survival rate for breast cancer in 2004-2009 compared with 1997-2002 in the UK, the five-year relative survival rate remained below that in the United States, Norway and Finland, Sweden and Germany. For cervical cancer, breast cancer and colorectal cancer, the UK was ranked towards the bottom of the table of OECD countries in terms of relative five-year relative survival rates (based on data for 2004-09 or nearest period, see Figure 31)[4].

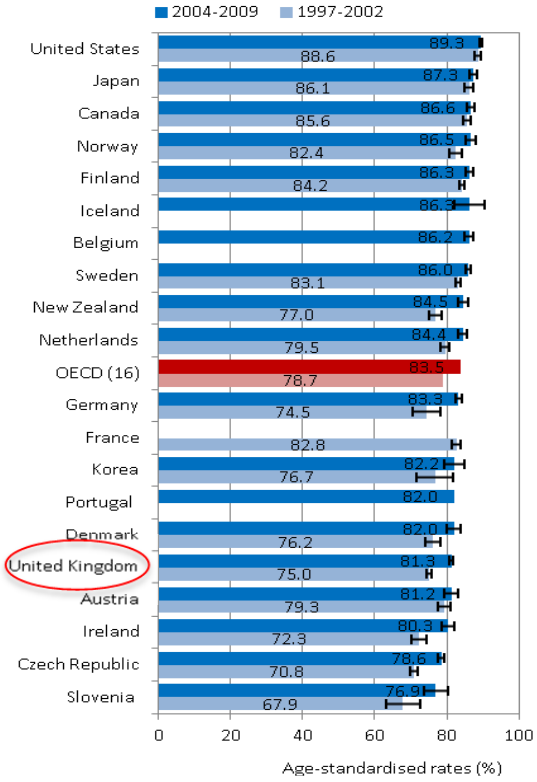
[4] In terms of cancer diagnostics, however, screening coverage for cervical cancer was high by international standards, second only to the US, and for mammography screening was well above the OECD average in 2009 (OECD 2011c)

Figure 31: Cancer relative survival rates in OECD countries

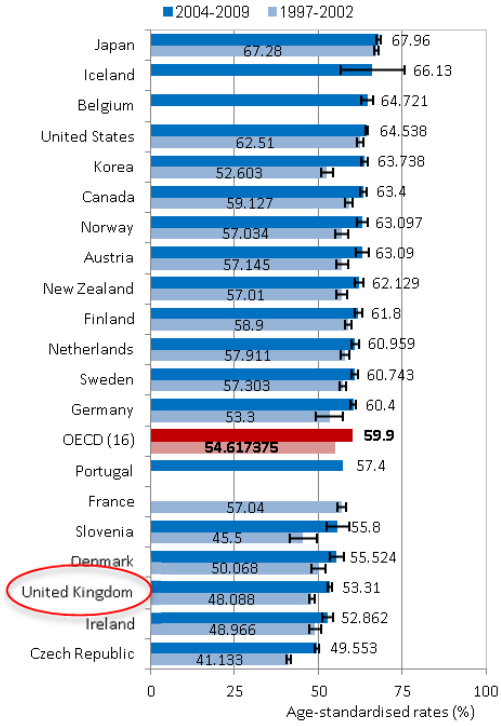
(A) Cervical cancer five-year relative survival rate, females,1997-2002 and 2004-09 (or nearest period)



(B) Breast cancer five-year relative survival rate, females, 1997-2002 and 2004-09 (or nearest period)



(C) Colorectal cancer five-year relative survival rate,1997-2002 and 2004-09 (or nearest period)



Source: OECD (2011b: 119-123)

Notes: (a) 95% confidence intervals represented by H

(b)See original for details of data limitations and comparability provided by OECD

Whilst the quality of the OECD comparative health outcomes figures is subject to debate, two key recent studies present more robust international cancer survival comparisons. The Eurocare-4 study analysed survival of cancer patients in 23 European countries (European Journal of Cancer, Volume 45, No 6 2009). The study suggested that in relation to age-adjusted five year survival for all cancers combined, the UK fell below a cluster of high performing countries (including Sweden) and an intermediate cluster of countries (including Austria, Belgium, France, Germany, the Netherlands. Switzerland and Italy) (Sant et al 2009: 937). However, the Eurocare-4 analysis was only based on patients diagnosed up to 2002 (with the above findings based on patients diagnosed 1995-1999 and followed to 2003). Another study, the International Cancer Benchmarking Partnership (ICBP), provides a more recent evaluation for the period between 1995 – 2007. The study compares one and five year cancer survival rates in the UK) (England, Wales and Northern Ireland, but excluding Scotland) with Canada, Australia, Sweden and Norway Denmark for four types of cancer (lung, bowel, breast and ovarian cancer). Survival was found to have improved for all four cancers in all six countries over this period. However, survival was found to be persistently lower in the UK and Denmark than in the other countries studied. Further, based on five year cancer survival rates, whilst the UK's gap with the highest performing country closed for breast cancer, the gap did not close for ovarian cancer and colorectal cancer, whilst the gap for lung cancer increased (Coleman et al 2011: 130-131; Foot and Harrison 2011: 5).

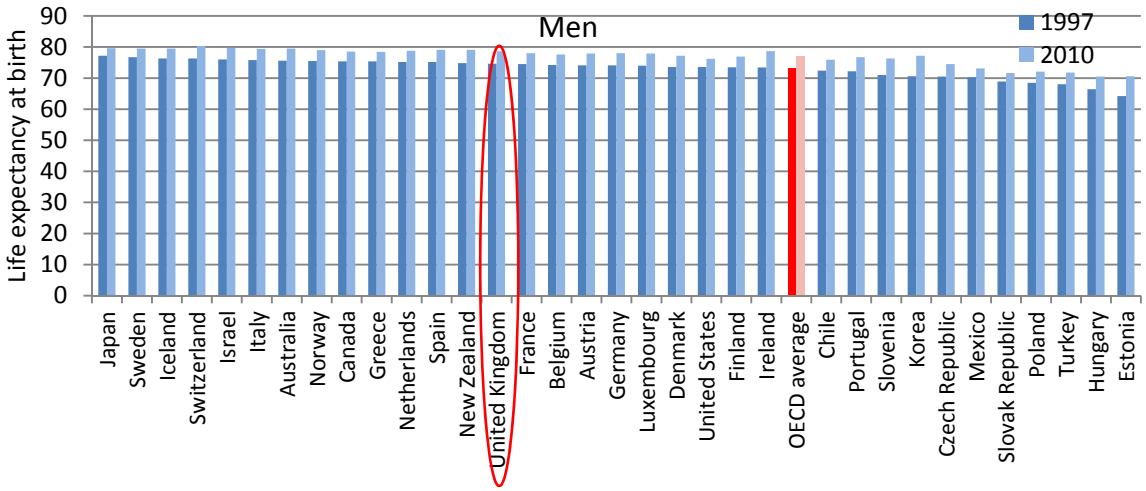
The authors of both the ICBP and the follow-up Kings study remain reasonably positive in terms of their overall evaluation of the UK's cancer strategy during Labour's period in power. According to the ICBP study, "[s]urvival was already improving in England by 2000, but evidence suggests some acceleration in the trend during 2004-2007, after full implementation of the cancer plan (Coleman et al 2011: 128). Foot and Harrison suggest that "there is … some evidence that the rate of overall improvement in cancer survival has accelerated slightly between 2004 and 2007 … This might reflect the national policy focus on cancer since the NHS Cancer Plan was published in 2000" (2011: 3).

Health outcomes and risk factors

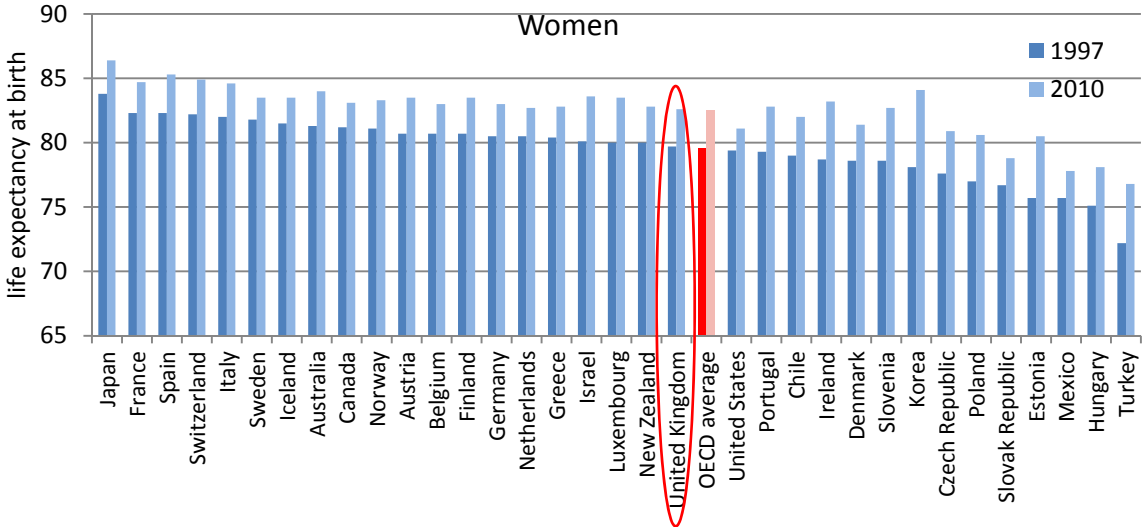
Figure 32 compares life expectancy in the UK with life expectancy in a broader set of OECD countries. In relation to male life expectancy, the UK moved from 14th to 13th position amongst 34 OECD countries between 1997 and 2010. For female life expectancy, the UK moved from 20th position to 24th position of 34 OECD countries between 1997 and 2010 (OECD Health Data 2011b).

Figure 32: Life expectancy (at birth) by sex in OECD countries, 1997 and 2010 (or nearest year)

a) Men (a, b)



b) Women (a, b)



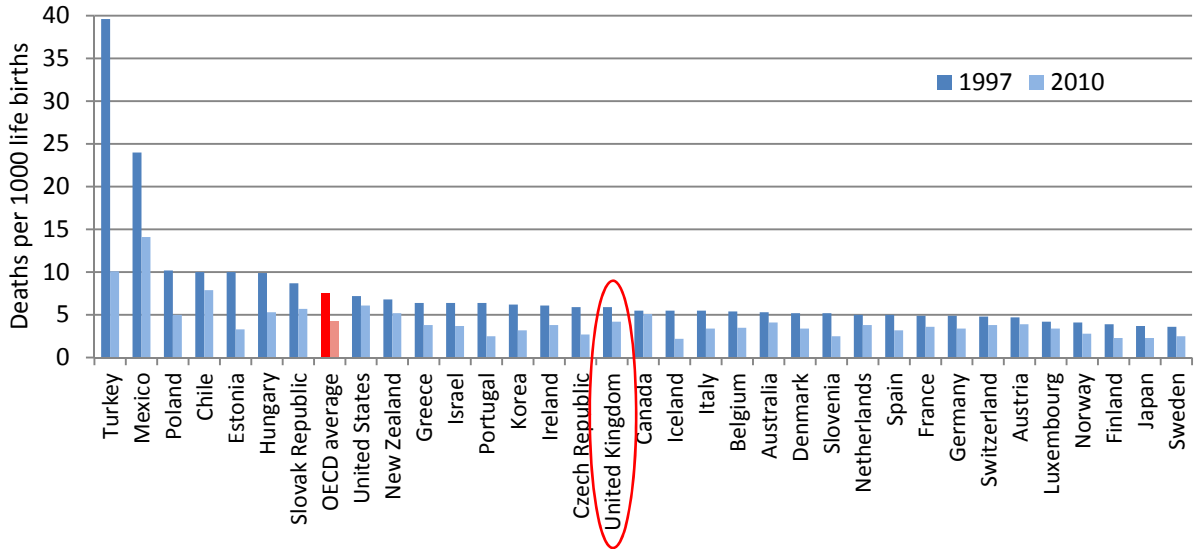
Source: OECD 2012

Notes:

(a) OECD average includes UK
(b) All figures are for 2010 except for Italy (2009) and Canada (2008)
(c) See original for details of data limitations and comparability provided by OECD

Notwithstanding the overall improvements in the infant mortality rate over the period in all of the constituent countries of the UK, and the achievement of historic lows in 2010, other countries were also making improvements and the UK in fact dropped its position in the international infant mortality rate league table from 19th to 25th position amongst 34 OECD countries over the period 1997 to 2010. The UK rate of 4.2 per 1000 live births in 2010 compared with low rates of 2.2 and 2.3 per 1000 live births (Iceland and Japan), 3.6 and 3.4 per 1000 live births in France and Germany, and an estimated 6.1 per 1000 live births in the US (see Figure 33).

Figure 33: Infant mortality, deaths per 1,000 live births, OECD countries, 1997 - 2010



Source: OECD (2012)

Notes:

All are for 1997 apart from Korea (1999); all figures are for 2010 apart from Canada (2008); Chile and New Zealand (2009)

See original for details of data limitations and comparability provided by OECD

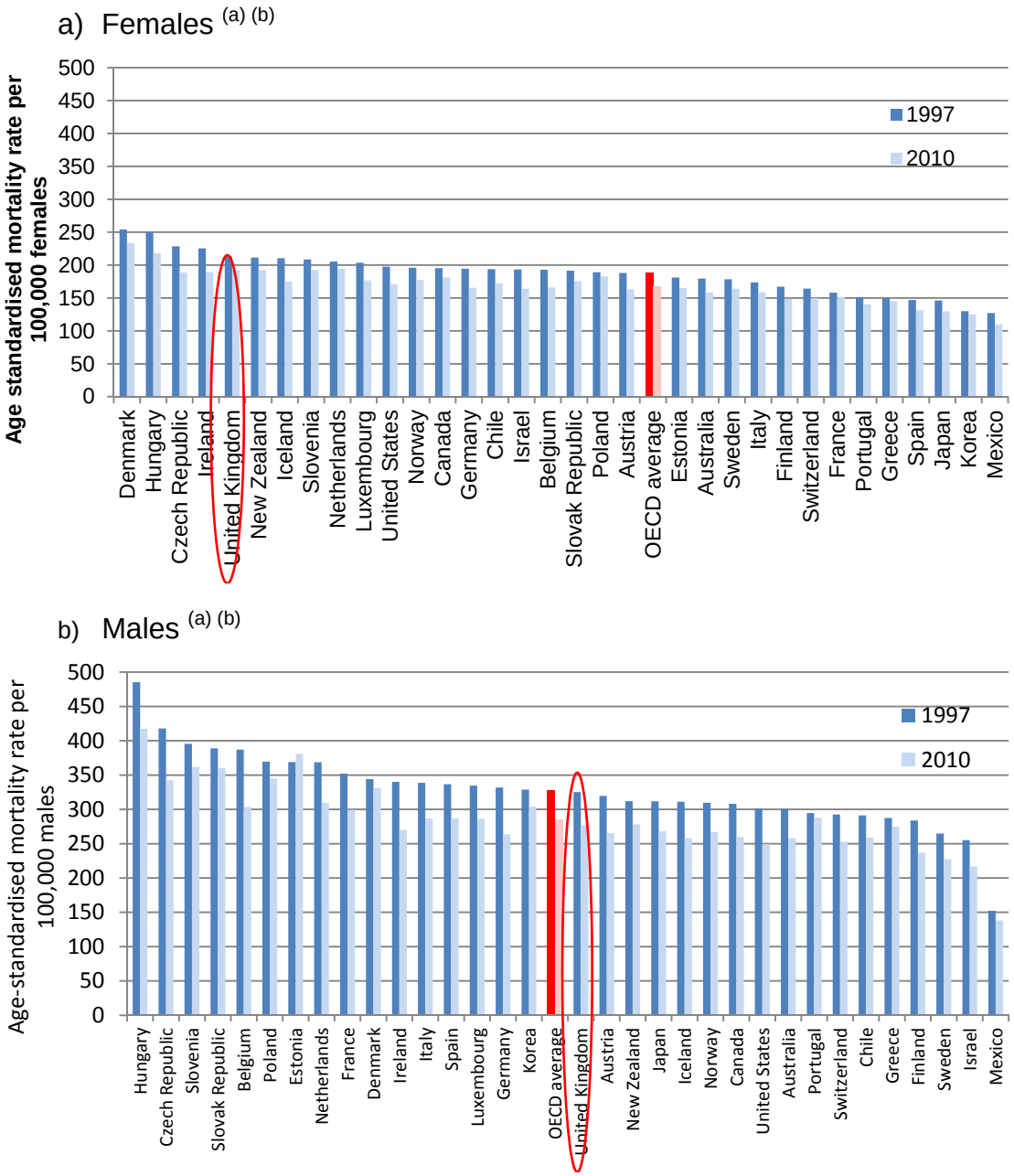
In relation to circulatory and heart disease mortality, the UK can also be characterised in broad terms as having a mid-table position. For example, in relation to the ischaemic heart diseases mortality rate for men, the UK was ranked 19th out of 33 OECD countries (based on data for 2010 or nearest available period). This was a higher rate than the France and the Netherlands. At the same time, it was a similar rate to Germany and Sweden, below that in US and below the OECD (33) average.

Whilst the UK's position in relation to a number of key cancer indicators improved over the period 1997-2010, these improvements did *not* amount to a "race to the top" of international league tables; and the UK's performance in relation to some cancer types remained disappointing at the end of Labour's period in office. Figure 34 presents age standardized all cancer mortality (malignant neoplasm) rate for OECD countries in 1997 and 2010 for women (panel A) and for men (panel B). For women in the UK in 1997, the age standardized all cancer mortality rate was 213.2 per 100,000 females. This rate was above those in comparator countries such as the United States, France and Germany and above the OECD average, with the UK in 29th position amongst 33 OECD countries). For men in the UK in 1997, the age standardized all cancer mortality rate was 325.2 per 100,000 males, with the UK at approximately the OECD average level and in 17th position compared with the same group of countries. By 2010, the age standardized all cancer mortality rate had improved for both women and men in the UK to 192.4 per 100,000 females and 277.2 per 100,000 males respectively. However, there was a negligible improvement in the UK's international standing for women (with the UK moving to 28th position in the table) whilst for men the UK remained in 17th position.

In terms of specific cancer mortality, the international picture in 2010 remained variable by cancer type and sex. Age-standardizded mortality rates for colorectal cancer for men and women, and for cervical cancer for women, were below the OECD average. Age standardized mortality rates for lung

cancer for women, for breast cancer (for women) and prostate cancer (for men) were above the OECD average for countries for which information was available and stand out from the international league tables as particular concerns (Figure 34)[5].

Figure 34: All cancer (Malignant neoplasms) mortality rates, OECD countries, 1997 and 2010 (or nearest year)

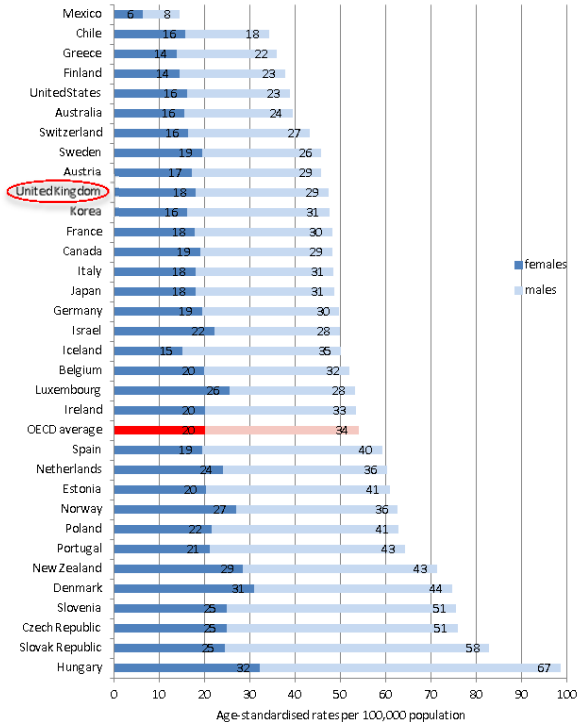


Source: OECD 2012
Notes:

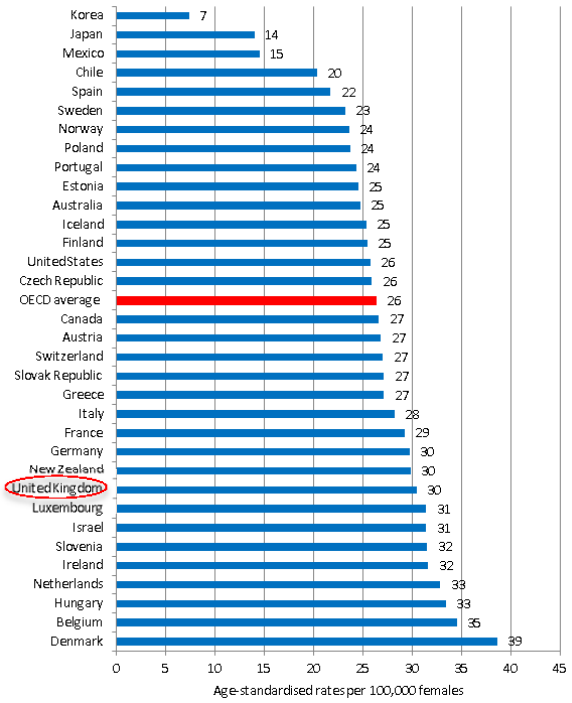
a. 1997 figures: all figures are for 1997 apart from Poland (1999)
b. 2010 figures: All figures are for 2010 apart from Belgium and Denmark (2006), Switzerland (2007), New Zealand and United States (2008); Canada, Chile, France, Greece, Hungary, Iceland, Israel, Italy and Luxemburg (2009)
c. See original for details of data limitations and comparability provided by OECD

Figure 35: Specific cancer mortality rates in 33 OECD countries

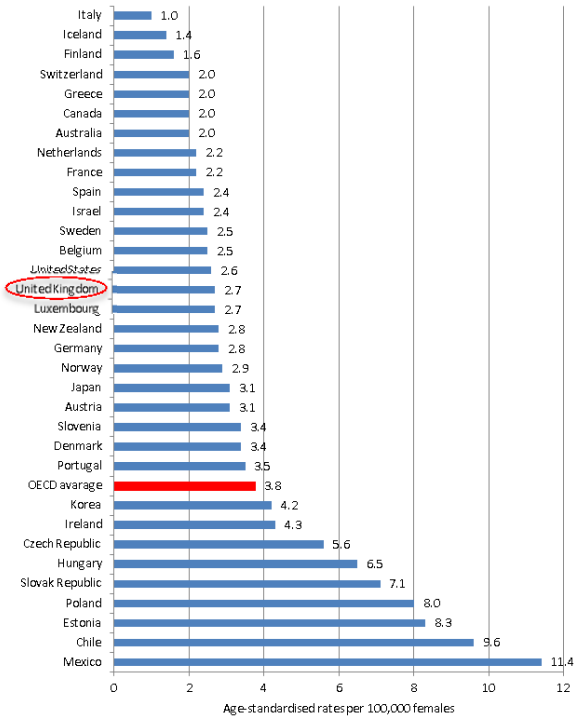
(A) Colorectal cancer mortality rates, males and females, 2010 (or nearest year)



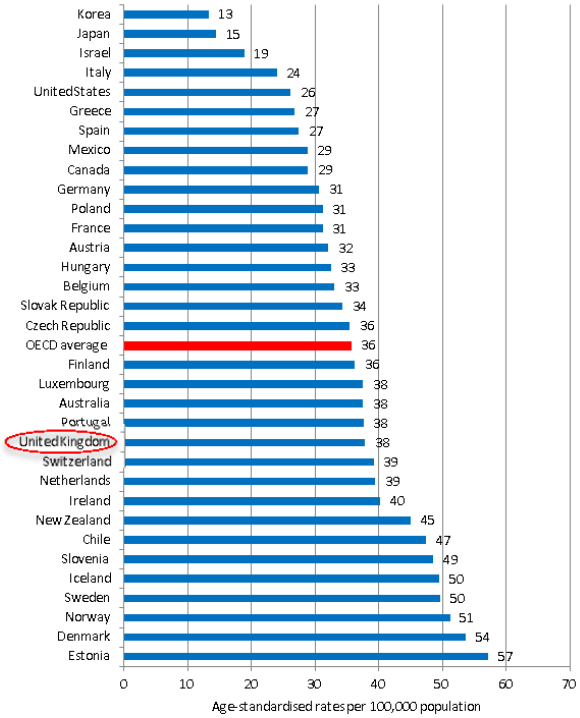
(B) Breast cancer mortality rates, females, 2010 (or nearest year)



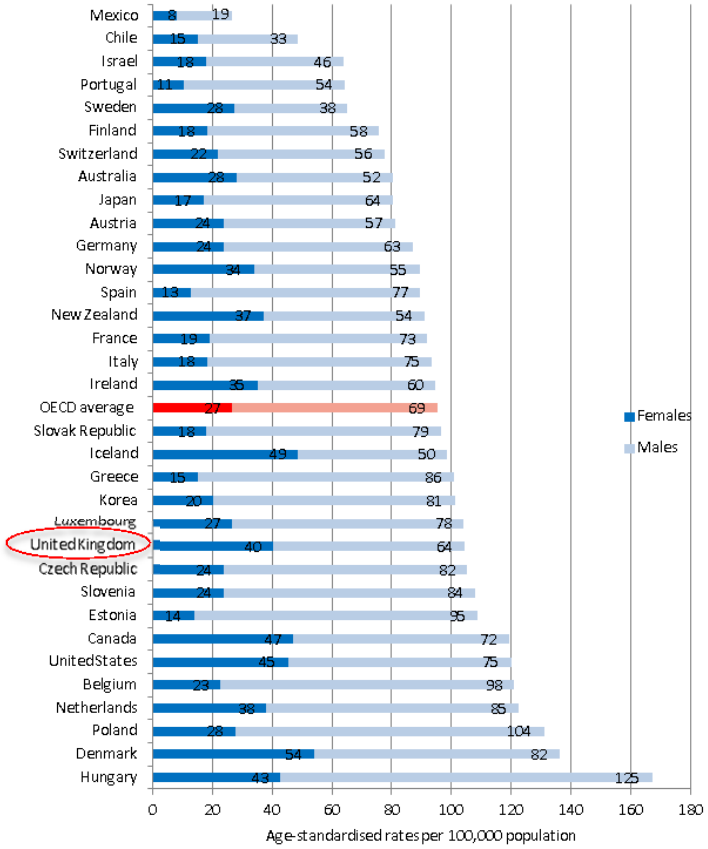
(C) Cervical cancer mortality rates, females, 2010 (or nearest year)



(D) Prostate cancer mortality rates, males, 2010 (or nearest year)



(E) Lung cancer mortality rates, males and females, 2010 (or nearest year)



Source: OECD (2012)
Notes:

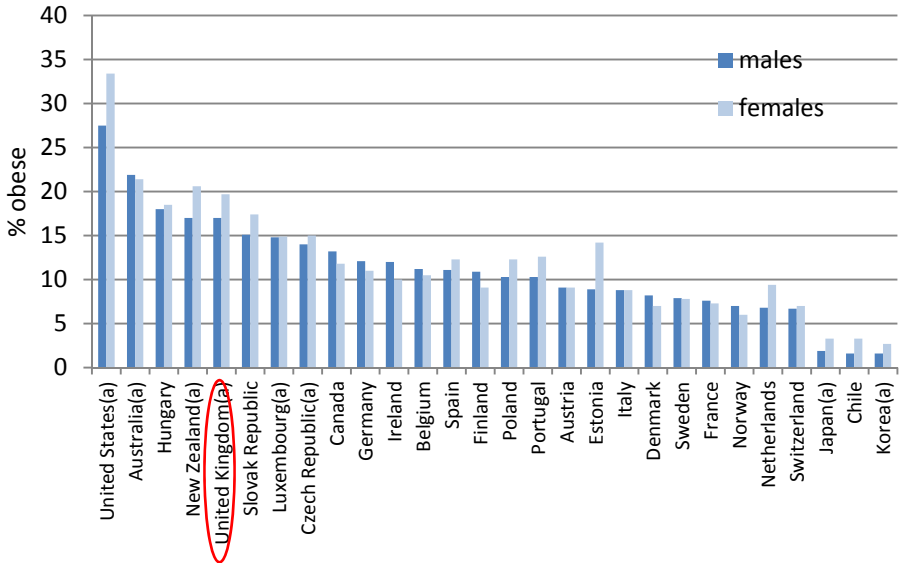
a. Data for 2010 or nearest year. Belgium, Denmark 2006; Switzerland 2007; New Zealand, United States 2008 Canada, Chile, France, Greece, Hungary, Iceland, Israel, Italy, Luxemburg 2009
b. OECD average includes UK
c. See original for details of data limitations and comparability provided by OECD

On lifestyle, behavioural and risk factors, the UK was ranked 17th out of 29 OECD countries for alcohol consumption (litres per capita, 15+) in 2009 and 11th out of 21 OECD countries in terms of the percentage of smokers aged 15+ (OECD 2012). According to OECD analysis, whilst the decline in the percentage of smokers aged 15+ over the period 1999-2009 was substantial, a lower percentage decline was achieved than in Denmark, Norway or Switzerland (OECD 2011b: 51).

According to OECD analysis, obesity rates have doubled or even tripled in many countries since 1980. Further, in more than half of OECD countries, fifty percent or more of adult the population is now overweight or obese. Amongst the adult population, the highest obesity rate is in the United States with New Zealand and Australia ranked second and third and the UK fourth. Japan and Korea have the lowest rates, although the OECD note that obesity is also rising in these two countries" (OECD 2011b: 8).

Obesity is directly measured in some countries and self-reported in other countries, making precise comparisons difficult. The data in Figures 36 and 37 below combines direct measurement and self-reported obesity estimates and is limited in this respect. Based on this data, UK men were in the 24th position out of 28 OECD countries for obesity (1st place - having the lowest obesity prevalence) in 1997 and in 26th position by 2010. UK women's relative position among the same number of the OECD countries has also become worse between 1997 and 2010 going from 25th place to 26th during that period.

Figure 36: Prevalence of obesity among men and women, selected OECD countries, 1997 (or nearest year)

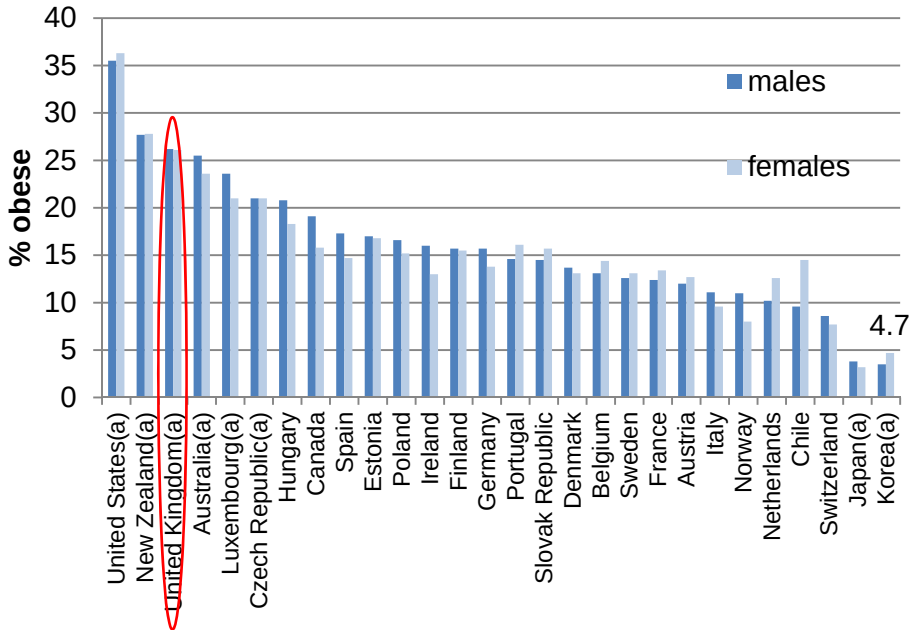


Source: OECD (2012)

Notes:

a. BMI based on measured height and weight during health examinations; in other countries these are self-reported. The latter are generally lower and less reliable. These differences limit data comparability.
b. Figures for Iceland, Norway, Korea, Slovak Republic are for 1998
c. Figures for Australia, Austria, Germany, Italy are for 1999
d. Figures for Chile, Czech Republic, Hungary, United States are for 2000
e. See original for details of data limitations and comparability provided by OECD

Figure 37: **Prevalence of obesity among men and women, selected OECD countries, 2010 (or nearest year)**



Source: OECD (2012)

a. BMI based on measured height and weight during health examinations; in other countries these are self-reported. The latter are generally lower and less reliable. These differences limit data comparability.
b. Figures for Austria, Portugal are for 2006
c. Figures for Australia, Ireland, Slovenia, Switzerland are for 2007
d. Figures for Belgium, Czech Republic, Norway are for 2008
e. Figures for Chile, Germany, Greece, Hungary, New Zealand, Poland, Slovak Republic, Spain are for 2009
f. See original for details of data limitations and comparability provided by OECD

10. Conclusions: Overall Evaluation and Looking Forward

The current paper has examined Labour's record on health over the period 1997-2010. Like the other papers in this series, the paper has attempted to provide a consistent and systematic basis for comparisons by focussing on a conceptual chain beginning with high level goals and policies, and then moving on to look at resources, inputs / outputs, and outcomes. Achievements and challenges under Labour have been evaluated in terms of the expansion of good health (that is, the capability to be healthy, free form premature mortality, illness, disease, disability and injury), health equity (that is, the extent to which good health is distributed equally across individuals and groups) and efficiency (defined broadly, as the success of Government policy in achieving the goal of good health for all, but including the efficient use of resources and productivity).

Three overall evaluations of progress under Labour were undertaken by Kings Fund over the period 1997-2010. A first evaluation, an audit of the NHS over the period 1997-2005 found that public expenditure commitments had been honoured; huge progress had been made in relation to waiting lists and access to care, with particular improvements in the three major areas prioritized by Government (heart disease, cancer and mental health), and major improvements to buildings. However progress on preventive measures such as reducing smoking and improving diet was slow and whilst there had been a 'step-change' in NHS performance in the sense of a "significant shift of gear, with more and better services", the NHS as a whole had not yet been transformed. There were still important problems to be solved, there was no firm evidence to show that Labour's reforms had produced a marked difference in health outcomes, and it was too early to evaluate the impact of competition and choice on outcomes. Nevertheless, the review concluded that "[o]verall, in our view, the results of this audit are very positive. The ambition for the NHS has been appropriately high. There has been unprecedented investment …[and] significant improvements in most areas that the Government has focused policies on" (Kings Fund 2005).

In a second Kings Fund evaluation, Wanless et al (2007) found that the implementation of key Government health policies had been slow and uncertain, with some initiatives, such as patient choice, not yet fully implemented and others, such as practice-based commissioning, not fully worked out. As a result, targets and central direction remained the main drivers of the system. Organizational change was anticipated as having future benefits, but had often caused disruption. The Government had been correct to make service redesign a key policy, for example, by introducing national service framework. Whereas prior to Labour coming into power, there had been insufficient specialisation in areas such as cancer care and the need for larger, specialist units had been neglected by previous administrations, the NHS Plan and the national service frameworks signalled a shift towards bigger, more specialist units. Whilst clinical governance had been strengthened but its impact on performance was hard to detect. The implementation of ICT had been slow, with its main anticipated benefits not achieved. Whilst healthcare efficiency gains can come about through technological innovation and Labour's terms in office were characterised by attempts to upgrade ICT within the NHS, the failure to achieve the ICT efficiency gains foreseen in the original Wanless Review (2002) was a major failure of Labour's period in office. Public health policy formation was assessed as having been piece-meal and modest, although there had been reductions in smoking and improvements in levels of physical activity and diet (Wanless et al 2007 xxvi-xxvii).

A third Kings Fund evaluation on the eve of the 2010 General Election assessed Labour's programme of investment, modernisation and reform over the period 1997-2010. The authors highlighted advances in high-quality safe care based on available evidence, with notable improvements in access to cardiac surgery and recommended standards of stroke care, as well as progress in waiting times

for cancer diagnoses and treatment, improvements in the quality of surgery and access to cost-effective drugs for patients with cancer. These improvement were identified as contributing to falling mortality for cardiovascular disease, as well as improving mortality and survival rates for several cancers (although in some areas cancer mortality and survival rates nevertheless still lagged behind those of other European countries). Mental health services were also found to have improved significantly, with increased access to specialist early intervention and crisis resolution teams for acute illness. Other improvements including reductions in waiting times, improvements in access to healthcare including primary care, strengthened accountability mechanisms and clinical governance. However, progress towards equity in health outcomes had been elusive. The report concluded that "[s]ince 1997 there has been considerable progress in moving the NHS towards being a high-performing health system". Further, "[t]he use of targets has been criticised, but they have also brought benefits to patients including shorter waiting times" and that one of the Government's most striking contributions has been to set up independent regulators of health (Thorlby and Maybin, Kings Fund 2010).

The overall conclusion of Mays and Dixon (2011) is that by 2010 the English NHS was still some distance away from functioning as a fully-fledged provider market for publicly financed care. Further, the impact of market-related effects on quality was modest compared with the overall improvements in the performance of the NHS from 1997 associated with other policies, such as service modernisation and targets. The fears of opponents in relation to negative equity effects had not materialized. However, Labour's programme of market reforms was implemented against a background of record real terms public expenditure growth and a context of workforce and supply side expansion. Looking forward, given the new context of recession, austerity and fiscal adjustment, with little or no increase in NHS budgets, the authors suggest that a key question for the upcoming period is whether the benign impact of competition and choice will be sustained in the Cold Climate?

Another overall evaluation by the Nuffield Trust (Connolly et al 2011; xv-xviii) suggests that policy divergence in the four countries of the UK in the context of similar resource increases and shared "ends" or "goals" (including that of improving quality) provides "natural experiment" evidence on the impact of competition and choice. Commenting on the period up to 2006, the authors suggest that in all four countries there were large increases in spending and staffing, falls in the crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff, and particularly in England, reductions in waiting times. The authors note a number of difficulties in undertaking consistent comparisons of outcomes (including in relation to waiting times), the authors highlight the following findings:

- England had the lowest per capita funding for the NHS but generally made better use of its lower level of resourcing in terms of shorter waiting times and higher crude productivity of its staff.
- Comparisons of the outcomes of the devolved countries with the English regions (where the data is comparable) show that the devolved countries tend to be outliers (i.e. outside the distribution of the English regions).
- Comparing Scotland with English regions showed that Scotland had the highest standardized mortality rates, lowest life expectancy and highest levels of expenditure.
- Comparing Wales and Northern Ireland with English regions showed that Wales and Northern Ireland had longer waiting times for hospital, and lower crude productivity of hospital medical and dental staff, and nursing, midwifery and health visiting staff than any English region (excluding London for some measures)

We conclude from the analysis in this paper that in many respects Labour's record on health was an impressive one. Substantial returns on Labour's large-scale investment in the National Health Service were achieved and were reflected in measures of healthcare quantity, quality and satisfaction. Given the "big picture" of massive supply expansion, the elimination of capacity constraints; improvements in a range of quality indicators and a remarkable increase in overall satisfaction with the NHS, the gains in terms of what was extracted from an extra 3% of GDP were substantial. In 1997, the public were highly dissatisfied with the NHS, with long waiting lists, pressure for more expenditure on healthcare and demand for private medical insurance going up. By the end of period, waiting lists and waiting time were down, demand for private medical insurance was down, and satisfaction with the NHS was running at more than 70%.

However, on the downside, variations in quality and performance remained a key concern in 2010. Greater regulation itself helped to generate a growing body of empirical evidence on sub-standard care and the spectre of regulatory failure, as highlighted in the Mid Staffordshire NHS Foundation Trust Public Inquiry, is a key legacy issue given the pivotal role of inspection and regulation within Labour's healthcare modernisation model and given the post-2010 direction of travel of NHS reform. Deep health inequalities also remained in 2010, as highgighted in the Marmot Review. Whilst most overall health outcomes improved at population level, the task Labour set itself of reducing health inequalities yielded mixed results against the targets that were set. Whilst smoking prevalence declined, progress in addressing lifestyle, behavioural and risk factors was limited and the UK's position on international health outcomes league tables remained disappointing. The UK lagged behind the best performers and comparator countries for a range of outcomes in 2010.

There are also on-going debates whether the the injection of real resources into the NHS over the period money 1997-2010 was money well spent. Was Labour profligate, with the Government failing to extract sufficient returns for taxpayers investment? Despite the latest evidence that productivity in health services did not decline (as previously thought) debates about how far Labour's investment in the NHS was money well spent seem set to continue. The potential for extracting productivity gains from healthcare in a period of limited resources has become a key legacy issue which is central to the post-2010 public policy agenda.

We have highlighted in this paper a number of reasons why official ONS productivity figures are limited, and have noted that Baumol effects might in any case be anticipated due to the labour intensive nature of healthcare services. Notably, some improvements in population health and public expenditure beyond the healthcare system itself are excluded from the ONS measured of healthcare output. As a result, the incremental contribution to individual and / or collective welfare of flagship public health measures under Labour such as the ban on smoking in public places are not captured by ONS measured healthcare output. Yet a key legacy of the Labour years may be the insight that "value for money" for the taxpayer lies in low cost public policy interventions of this type that aim to achieve long-term behavioural change and a reduction of population risk factors through a re-allocation of individual rights and responsibilities.

Taking official ONS statistics at face value, of four possible descriptors (do a lot / spend a lot; do a little / spend a lot; do a lot / spend a little; do a little / spend a little), Labour can be crudely characterised as "spending a lot whilst doing a lot". A preferred trajectory might well have been "doing a lot" whilst "spending a little". And some might have preferred Labour to have "done even more" for the same expenditure. However, taxpayers under Labour got "more for more" rather than "less for more" or "less for less" under Labour.

Other key legacy issues include the question of fiscal sustainability. Labour's period in office coincided with a relatively benign period in terms of broader contextual variables including both the macro-economic fundamentals and demographic pressure. Notwithstanding the financial crisis that began in the Autumn of 2007 and the economic downturn and recession that followed, overall economic performance under Labour 1997-2010 was strong overall with sustained economic growth and economy-wide productivity gains post-1997 (Corry et al 2011). This backdrop of sustained economic growth was the backdrop to unprecedented expenditure growth on healthcare.

The 2007 Comprehensive Spending Review assumed that GDP would continue its steady growth and expenditure plans were set on this basis Hills (2011: 599). Total managed expenditure on public services and total public sector expenditure on healthcare continued to grow in real terms in 2008/9-2009/10 against a backdrop of contracting GDP. Whilst public expenditure on health services has been relatively protected under the Coalition, the 2010 General Election nevertheless represented a seismic break-point for health services in terms of the UK's economic and fiscal climate.

Further, demographic pressure 1997-2010 was also not as unfavourable as the trends projected for the upcoming period with predicted rises in the dependency ratio and the retirement of the baby-boom generation forecast to put additional increasing pressure on public services in general and health services in particular after 2014. Whilst the working population grew and the general population aged during the Labour years, real increases in resources and volume could nevertheless be more readily translated into increased healthcare output per head / per unit of need. Looking forward, the implications of long-term demographic change are that, in order just to stand still in terms of per capita output, increases in real resources will be required (Appely et al 2011 and Office Budget Responsibility 2012).

The economic downturn and recession together with the implementation of fiscal austerity measures are therefore coinciding with an acceleration of adverse trends in terms of demographic pressure. The combination of these factors raise the possibility of the growth in real resources lagging behind demographic pressure in the period to come.

Other key variables that will be monitored in the up-coming period include healthcare financing, delivery and performance management. Labour's healthcare financing model remained a mainly general tax based one over the period 1997-2010, albeit with an increasing role for national insurance. To date, there has been no significant change to this. Patient charges remained low and alternative financing arrangements such as a hypothecated health tax were not taken forward. Will this now change?

On delivery, where Labour took steps to encourage a wider range of healthcare providers, the Health and Social Care Act 2012 seeks a radical acceleration of the process. Notwithstanding the shift towards publicly financed, privately / voluntarily delivered healthcare under Labour, ONS analysis suggests that the overall contribution of non-NHS provision to the overall growth in healthcare supply remained lower than that of publicly-funded publicly-supplied healthcare over the period 1997-2010. This balance in the public / private provision of healthcare now looks set to undergo a much more substantial transformation.

Further, as Mays and Dixon (2011) note, Labour sought greater competition and choice in the NHS against backdrop of sustained spending increases and supply side expansion. Organisational reforms, new approaches to commissioning and decentralization that Labour introduced gradually are now being taken further and faster by the Coalition. Can fundamental organizational change be successfully delivered by the Coalition Government in a period of downturn and resource constraints?

There is evidence, albeit contested, that the impact of competition and choice appear to have had positive quality effects whilst not adversely affecting equity under Labour. Questions now arise about the impact of further market reform will be in an era of fiscal consolidation and tighterning. The consequences of the on-going healthcare reform programme for access, quality and equity will require careful scrutiny.

Other key issues arise from the critique of central targets to drive policies on health. The targeting regime of PSAs has been dropped. What will be the consequences for overall accountability? Responsibilities for public health have been decentralized. Will this strategy be successful in reducing health inequalities? The public inquiry into Mid-Staffordshire NHS Foundation Trust raised important questions about sub-standard care, the enforcement of minimum standards and the effectiveness of regulation. How will the Coalition respond?

The underlying objective of the current paper has been to provide context for these on-going developments in health and a later paper in the series will evaluate health policy under the Coalition Government and the impact of fiscal retrenchment. Other papers will examine other major social policy areas including education, children's services, neighbourhood renewal and tax / benefit. A final paper will draw together the findings and examine the broader implications for social policy up to 2015.

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