Social Policy in a Cold Climate

Summary Working Paper 2

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Labour's Record on Health

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Labour came to power in 1997 urging voters to "save the NHS". How far were its commitments to invest in health care, tackle inequalities and improve public health realised during 13 years in government?

- There was significant real growth in public expenditure on health during each of Labour's three terms in office. Health spending as a proportion of GDP grew from 5.3 per cent in 1997/8 to 8.4 per cent in 2009/10, moving the UK to close to the European average.

- Labour's investment supported a substantial 'supply side' expansion of NHS inputs and outputs (such as staffing, services and healthcare activities). Whilst debates about value for money continue, revised Office for National Statistics estimates suggest that public service healthcare productivity increased by 6.2 percentage points between 1997 and 2010.

- Healthcare access and quality improved against a number of indicators and public satisfaction with the NHS increased. However, variations in hospital performance and sub-standard healthcare raised continuing concerns.

- Overall health outcomes continued to improve, including longer life expectancy, lower infant mortality and reductions in premature death rates for heart and other circulatory diseases and lung cancer. Suicide rates also fell, although progress stalled after 2007.

- Measures to reduce health inequalities had mixed results. Targets for closing the gap in life expectancy between deprived and other areas were missed. However, inequalities in infant mortality rates between socio-economic groups decreased towards the end of Labour's period in power.

- Progress tackling underlying behavioural, lifestyle and risk factors was limited. Obesity rates continued to increase, but smoking prevalence, an important priority, declined.

- The UK had a "mid" table position on OECD international health league tables in 2010. It ranked below the best performers and comparator countries on a number of indicators.

What were Labour's aims and goals?

Two high-level goals can be identified from Labour Party Manifestos and other key policy statements. These are:

- improving the NHS through a programme of healthcare investment, modernisation and reform
- improving overall heath outcomes and reducing inequalities.

What did Labour do?

In England, Labour's programme of healthcare modernisation and reform included setting central targets, stronger performance management and a new framework for healthcare inspection and regulation. There was increasing emphasis on achieving a wider range of service providers, greater competition between providers and patient choice. The 'purchaser/provider' distinction between commissioning bodies and providers of services was retained and further organisational decentralisation was introduced.

Labour's first term (1997-2001). On the eve of the 1997 General Election, Tony Blair memorably declared that voters had "24 hours to save the NHS". However, Labour's commitment to retain the outgoing Conservative government's expenditure plans meant substantial funding increases for the NHS were delayed until after 2000 (while plans for special health taxes were rejected). A healthcare modernisation and reform programme began, supported by an NHS Plan, primary legislation and review findings that included the Acheson Inquiry into Health Inequalities. Reforms included the creation of a Commission for Health Improvement (later the Healthcare Commission and subsequently merged with the Social Care Inspectorate to form the Care Quality Commission). The National Institute for Health and Care Excellence (NICE) was established to issue guidance on clinical and preventive health, while new services like NHS Direct, provided the public with health advice. Wider public health measures included a Food Standards Agency, Health Action Zones, and the Sure Start pre-school programme (see summary WP04). Formal assessment frameworks were introduced for the NHS reforms, including performance ratings and targets. Emphasis on the purchaser-provider split was maintained, while the Public Finance Initiative (PFI) was used to procure hospital building and other capital projects by drawing in private capital from outside the normal public expenditure framework.

Labour's second term (2001-2005). Developments included a "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

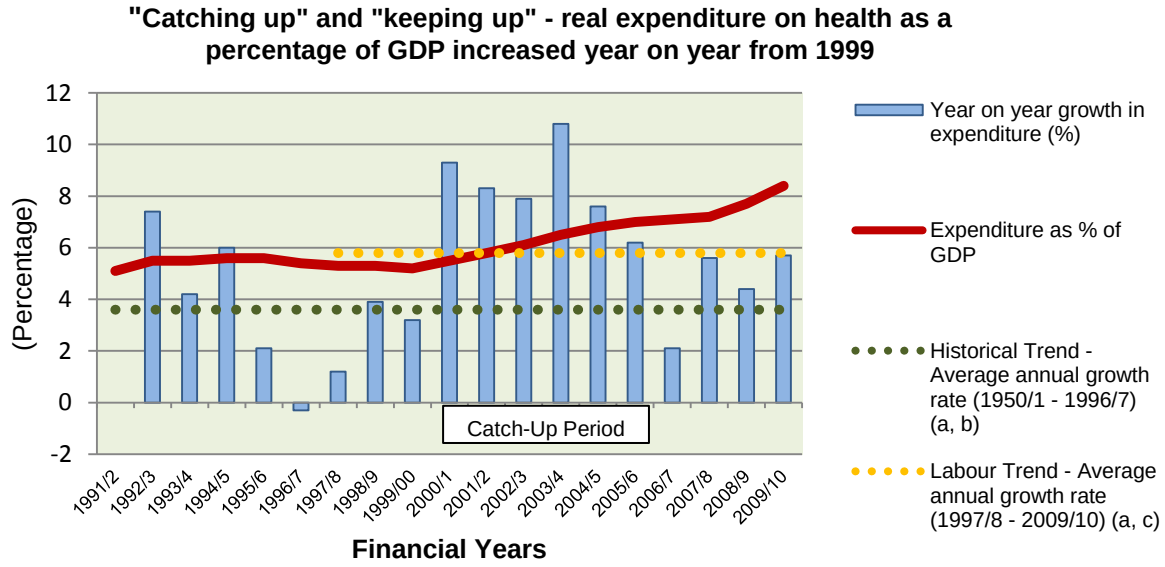
inequalities intervention tool, and a constitution for the NHS. Measures were taken to improve accountability for public health, including through local authority Local Area Agreements.

Devolution of governmental responsibility for health services meant policies across the UK increasingly diverged. Scotland, Wales and Northern Ireland put less emphasis on competition, choice and the purchaser/provider split. Prescription charges were retained in England but abolished in Wales with plans for their abolition in Scotland. A ban on smoking in public places was implemented in Scotland and Wales before it was introduced in England.

How much did Labour spend?

Throughout the UK there were significant increases in the resources allocated to health. The "catching up and keeping up" agenda after 2001 brought sustained increases in public service expenditure on health. Expenditure on health as a proportion of GDP increased from 5.3 per cent in 1997/8 to 8.4 per cent in 2009/10 (Figure 1).

Figure 1. Real public sector expenditure on health in the UK increased substantially during Labour's period in power



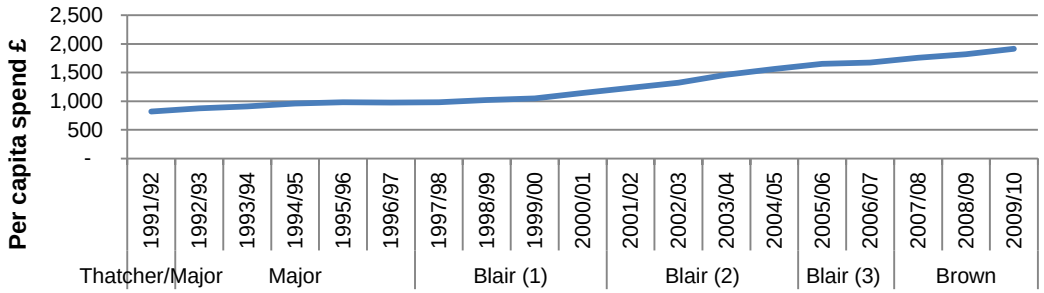
Sources: Nominal figures and GDP deflators are based on data in HM Treasury (2011a) with base year changed from 2010/11 to 2009/10. Historical trend based on figures in Harker (2011). Notes: (a) Average annual growth rates are calculated using a geometric mean. (b) Historical trend is in 2010/11 prices. (c) Labour trend is in 2009/10 prices.

International comparisons show that Labour's 2001 Election Manifesto pledge to bring UK health spending up to the EU average was fulfilled. An OECD estimate of total public and private health spending as a proportion of GDP across 34 industrialised countries in 2010 indicated an average of 9.6%. At 9.2% the UK was close to average, though still below a number of comparable countries, including France (11.6%), Germany (11.6%) and the Netherlands (12.0%). Expenditure per head doubled in real terms (Figure 2), significantly outpacing pressures from the growth in the population over 65 (including the very elderly) and the growth in real expenditure implied by demographic pressures alone.

NHS funding was drawn mainly from taxation. The early idea of a specific, hypothecated tax to fund the NHS tax was dropped, but the contribution made to NHS funding from National Insurance payments was increased from 12.1 per cent in 2002 to 20.4 per cent in 2003, before falling back to 17.9 per cent by

2010. The relative share of private expenditure as a proportion of real total expenditure on health fell from 19.6 per cent in 1997/8 to 16.8 per cent by the end of Labour's time in office. Income from patient charges remained a limited source of funding.

Figure 2. Per capita health public services expenditure increased to £1,915 a year in 2009/10



Source: HMT
Note: 2009-10 prices

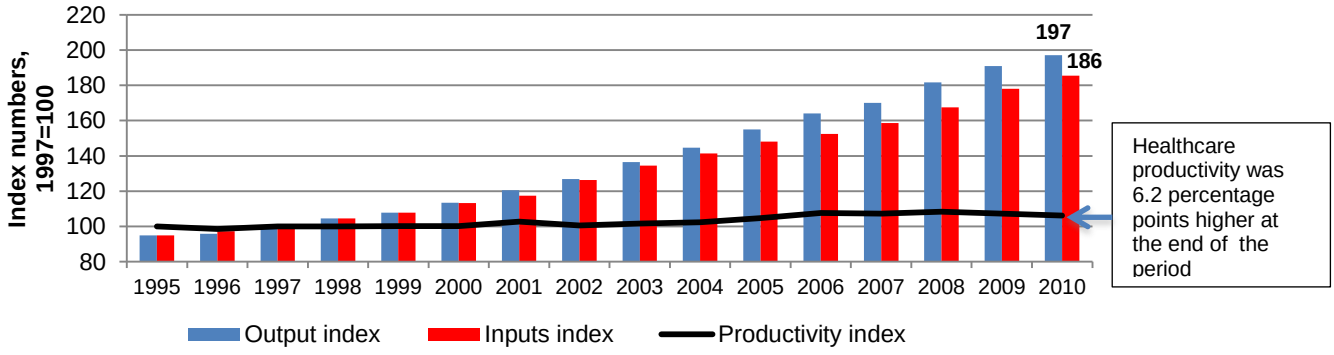
How was the money spent?

Labour's investment in health funded a substantial expansion of NHS staffing, services and healthcare activities

Official Office for National Statistics (ONS) estimates suggest a substantial expansion in the volume of healthcare inputs (including medical and support staff, goods and services) and outputs (for example, medical actvities, procedures and consultations) (Figure 3). ONS analysis suggests that whilst staffing levels expanded, the biggest proportionate increases in inputs were in goods and services, such as prescribed drugs and clinical supplies. Another notable trend was a five-fold expansion in the volume of publicly-financed goods and services provided by non-NHS providers. However, goods and services from within the NHS continued to make up the majority of new provision.

Continuing political debate about whether Labour's large cash injections into the NHS were money well spent has been fuelled by suggestions that NHS activity did not grow as fast as expenditure. ONS direct estimates of healthcare productivity have recently been revised upwards. These suggest a 6.2 percentage point increase over the period, rather than a small decline. Moverover, there are reasons for regarding this as a lower bound estimate. For example, ONS healthcare output estimates might be affected by time lags and are sensitive to the nature of quality-adjustment. Other limimations are that ONS measured output is not distributionally adjusted and captures only those improvements to health that are attributable to the healthcare system itself.

Figure 3. ONS estimates and analysis suggest the volume of healthcare inputs and outputs expanded substantially, with productivity increasing by 6.2 percentage points



Source: ONS 2012, rebased to 1997 =100 by authors

What was achieved?

Healthcare access and quality improved against a number of indicators, but variations in performance and sub-standard care raised continuing concerns

Waiting lists and waiting times improved dramatically under Labour and the number of GPs per head increased. However research by the National Audit Office suggests that inequalities in access to GPs between more and less deprived areas were not fully eliminated by 2010.

Other significant improvements in healthcare quality, according to the ONS, included better post-operative survival rates and reductions in avoidable mortality. Overall patient experience scores were high in a range of service areas. According to the British Social Attitudes Survey, public satisfaction with National Health Services rose from 36 per cent in 1997 to 71 per cent in 2010. A body of research evidence (albeit contested) suggests that efforts to increase competition and choice in England helped to improve quality without negatively impacting on equity.

However, variations in hospital performance and sub-standard healthcare remained key concerns at the end of Labour's term. 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 population health outcomes improved…

Life expectancy continued its long-running tendency to improve over the period 1997-2010. As a result, Labour's target to improve overall life expectancy was virtually achieved. Infant mortality also reached historically low levels in the four constituent countries of the UK.

Another improvement over the period was a reduction in premature deaths from heart disease, strokes and other circulatory diseases, with a 52 per cent reduction in (three-year) average mortality per 100,000 men under 75 between 1995-1997 and 2008-2010. Targets in England for reducing overall circulatory mortality were met. The overall cancer mortality rate fell by 22 per cent over the same period, including a notable decline in the lung cancer mortality rate for men. English targets for reducing overall mortality from cancer were also met.

However, a target for reducing mortality through suicide (both actual and 'undetermined intent') was missed, despite a 13 per cent reduction in the age-standardised rate. The stalling of progress against this indicator after 2007 reflected more general trends in Europe, with improvements in suicide rates over a sustained period turning around in the wake of the financial crisis and economic downturn.

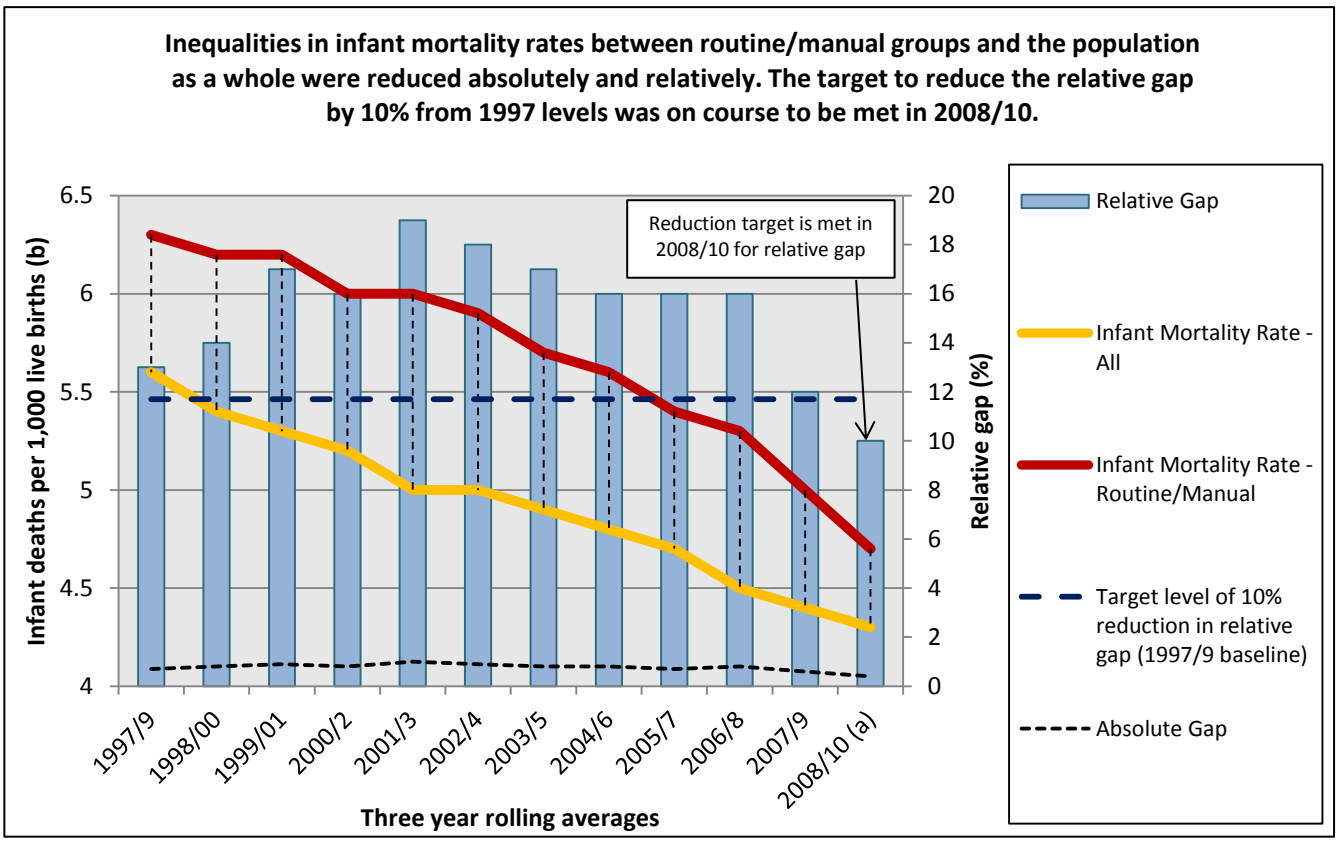
… but strategies to reduce health inequalities had mixed results

Deep inequalities in health remained in 2010, as highlighted by the Marmot Review. A target to reduce inequalities in life expectancy was specified by the Labour government in terms of reducing the relative gap between areas with the worst health and deprivation (known as 'spearhead' areas) and the England average. However, absolute and relative gaps for both men and women increased and the target was not met.

A target for reducing infant mortality inequality was specified in different terms of reducing the relative gap between the lowest occupational groups ('routine/manual') and the all-England average. Progress

was initially slow and both gaps initially increased. However, there was a decline in inequality against this indicator towards the end of Labour's period in power. As a result, the absolute and relative gaps fell by 42 per cent and 25 per cent respectively between 1997-99 and 2008-2010.

Figure 4. Reductions in infant mortality rates



Source: Department of Health, 2009, 2011. Notes: Gap and change figures are calculated based on unrounded mortality rates, England and Wales. (a) 2008-10 data are provisional. (b) Infant mortality rate is based on infant deaths successfully linked to birth records. (c) Target year was for 2010 and final assessment of the realisation of the target requires the 2009-11 rolling-average (d) Figures are for inside marriage/joint registrations, England and Wales. (e) Uses NS-Sec classifications after 2001 and appropriate approximations prior to this data.

A target for reducing inequality in mortality rates for circulatory diseases 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 narrowed during Labour's period in power and the target was met. However, the relative gap increased by 15.2 per cent. A target for reducing cancer mortality inequality 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. However, relative gaps increased by 13.4 per cent.

Progress in addressing behavioural, lifestyle and risk factors was limited

Obesity rates remained on a rising trend between 1997 and 2010. However, there was 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). Rates of physical exercise saw some improvement. Consumption of fruit and vegetables initially improved, but fell back after 2006. Tackling alcohol consumption proved challenging, although amongst women the proportion exceeding recommendations decreased between 2006 and 2011.

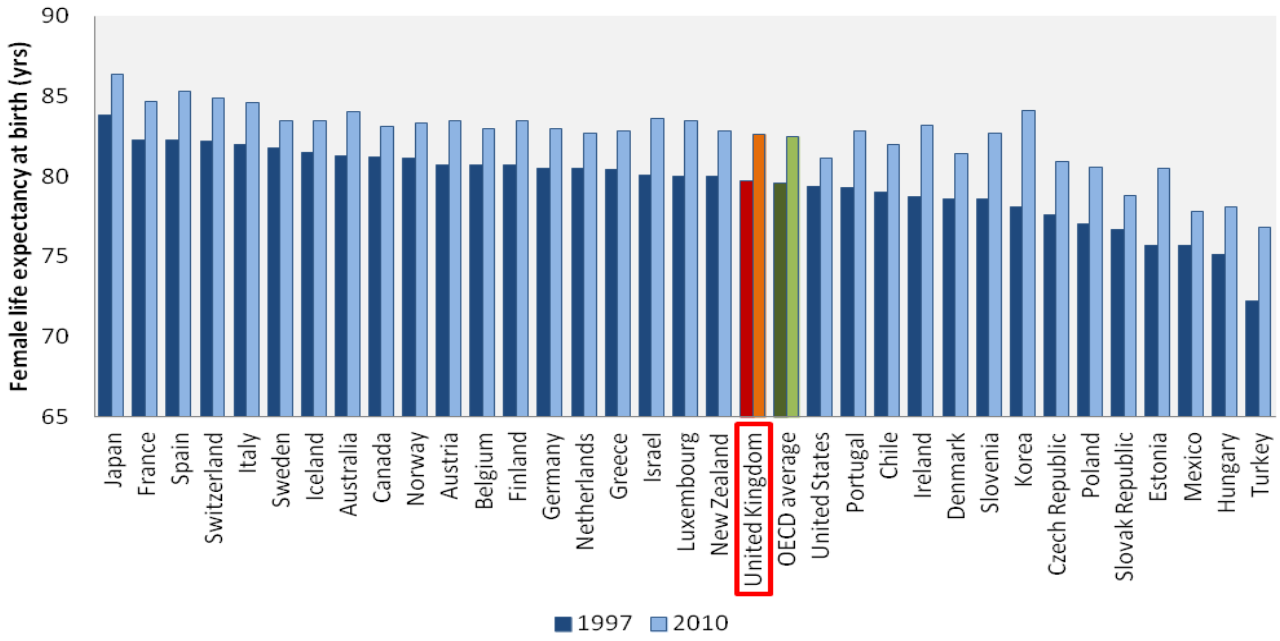
A target to reduce the overall prevalence of smoking was met. A targeted reduction in the disparity between the rate for the general population and among individuals from manual occupational groups was also achieved in 2007. However, the prevalence rate among manual workers subsequently increased, taking the figure above target by 2010.

Efforts to reduce the number of teenage pregnancies saw a fall in conception rates from 46.6 per 1000 females aged 15-17 in 1998 to 35.4 in 2010. However, an ambitious target aiming at a 50 per cent reduction was missed.

The UK had a "mid" table position on OECD international health league tables in 2010

The UK was ranked below the best performers and comparator countries against a number of indicators in 2010. For example, life expectancy improved in other countries as well as the UK, and there was negligible improvement in the UK's international ranking. On male life expectancy at birth, the UK's international ranking moved from 14th to 13th position amongst 34 OECD countries between 1997 and 2010. On female life expectancy, the UK moved down the league table from 20th to 24th position (see Figure 5). Other international comparisons remained disappointing, including the relative survival rates for stroke and heart disease, and for breast cancer, cervical cancer and colorectal cancer. The UK was ranked within worst performing cluster of OECD countries for obesity prevalence in 2010.

Figure 5. The UK's position on international league tables for women's life expectancy remained disappointing



Source: OECD 2012. Notes: OECD average includes UK. All figures are for 2010 except for Italy (2009) and Canada (2008)

Conclusions

Labour achieved substantial returns on its large-scale investment in the National Health Service in terms of improvements in measures of healthcare quantity, quality and satisfaction. However, variations in quality and performance remained, with well-publicised concerns about incidents involving sub-standard care, coupled with regulatory failure. Meanwhile, as overall health outcomes improved at population level, the task Labour set itself of reducing health inequalities proved challenging and yielded mixed results. Progress in addressing lifestyle, behavioural and risk factors was also limited and the UK's position on

international health league tables remained disappointing. 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.

One of the first acts of the Coalition Government was to launch a major programme of healthcare reform. The Health and Social Care Act 2012 prompted a protracted political debate and is resulting in a transformation of the way that the NHS operates. Organisational reform, decentralisation of the NHS and the introduction of General Practitioner commissioning groups are being accompanied by devolution of responsibilities for public health. These changes are being implemented in the context of public spending reductions on a very large scale in response to the financial crisis and economic downturn that began in 2007. While funding for health has, in principle, been protectively 'ring-fenced', there have been far-reaching consequences for the trajectory of NHS funding. The period of significant and sustained year-on-year, real terms increases in spending has come to a rapid halt.

Labour's healthcare financing model was mainly based on general taxation, and there has been no significant change to this. However, where Labour took steps to involve a wider range of healthcare providers, the Health and Social Care Act 2012 seeks a radical acceleration of the process. Labour sought greater competition and choice in the NHS against backdrop of sustained spending increases and supply side expansion. Questions are now being asked about their impact against the backdrop of austerity. Organisational reforms and new approaches to commissioning that Labour introduced gradually are now being taken further and faster by the Coalition. The consequences for healthcare 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?

We intend to address these issues as the relevant data becomes available, using a similar conceptual framework to evaluate the Coalition's record on health in a follow-on paper.

Further information

The full version of this paper - Labour's Record on Health, Polly Vizard and Polina Obolenskaya - is available at http://sticerd.lse.ac.uk/dps/case/spcc/WP02.pdff This is one of a series of papers produced as part of CASE's research programme *Social Policy in a Cold Climate* (SPCC). The research, concluding in 2015, examines the effects of the major economic and political changes in the UK since 2007, focusing on the distribution of wealth, poverty, inequality and social mobility.

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