Published Online May 26, 2007

The new model NHS: performance, perceptions and expectations

Rudolf Klein*

London School of Economics, 12A Laurier Road, London NW5 1SG, UK

Objective: This article analyses the transformation of the National Health Service (NHS) in England from a command-and-control to a mimic market model.

Areas of agreement: Even while introducing market incentives and encouraging private providers, the new model preserves the essential characteristics of the NHS as a universal, tax-funded service free at the point of delivery.

Areas of controversy: The spectacle of famine among plenty—service cutbacks at a time when the level of spending on the NHS is at a rate unprecedented in its history—raises doubts about the competence of both local managers and central policy makers. Payment by results gives providers an incentive to maximize activity so prompting questions about the future rationing of resources and the role of the medical profession therein.

Areas to develop research: The implementation and effects of the policies already introduced and their modification in the light of experience.

Keywords: National Health Service/transformation/transitional strains/future challenges

The National Health Service (NHS) presents a puzzling picture. The Secretary of State for Health can confidently and accurately proclaim that the NHS is not only spending more but performing better than ever before in cutting waiting lists, improving services and outcomes. Yet the media are filled with reports of NHS trusts cutting staff, services and training budgets in desperate attempts to balance their books. A Labour Government which has made a bigger financial and reputational investment in the NHS than any of its predecessors is seeing the voter support for its guardianship of the service seeping away. It is, moreover, engaged in a race against time. Two critical deadlines are approaching. After 2008, the years of fiscal plenty for the NHS will come to an end. And in 2010, at the latest, there will be a General Election.

Accepted: April 18, 2007
**Correspondence to: Rudolf Klein, London School of Economics, 12A Laurier Road, London NW5 1SG, UK. E-mail: rudolfklein30@aol.com*

DOI: 10.1093/bmb/ldm013

In what follows, I will disentangle the different strands of the puzzle of the NHS in England. Following devolution, Scotland, Wales and Northern Ireland are following somewhat different paths[1] and this paper does not deal with their evolution or performance. For only in England has there been the radical transformation of the NHS which provides the theme for this paper. In what follows, the next section sets out the evolution of the emergent new model NHS. Subsequent sections examine the elements of the model in greater detail, analyse the nature and causes of the fiscal strains and, finally, discuss the future challenges and the implications thereof for relations between the government and the medical profession.

The transformation process

If the transformation of the NHS were the product of a consistent 10-year strategy pursued by the Labour Government since it first came into office in 1997, then by now, the new model health-care system would no doubt be on the road, fully tested and operational. In reality, the transformation is the product of serial policy learning.[2] The model that has finally emerged from an incremental, untidy process is, as we shall see, surprisingly coherent. But it is still being modified in the course of implementation: the process has been likened to re-designing a racing car even while it is roaring round the circuit. Any analysis therefore has to distinguish between the strengths and weaknesses of the emergent model and the transitional problems involved in introducing it.

It is not difficult, however, to identify the defining moment in the history of the present government's policies. On 16 January 2000, the Prime Minister, Tony Blair, pledged an increase in spending on the NHS which would bring funding for the service up to the average of the European Union. Subsequent budgetary decisions by the Chancellor of the Exchequer, Gordon Brown, set off the biggest and most sustained public spending spree in the history of the NHS, subsequently legitimized by the Wanless Report[3] which quantified the gap between the NHS's capacity, its own aspiration and the achievements of other European countries.

Table 1 shows the results of this decision to open the fiscal floodgates. By the end of fiscal year 2007/08, when the commitment to rapid expansion ends, the NHS's budget will have more than doubled since the Prime Minister's 16 January pledge. It has been an unprecedented rate of growth, roughly 7.5% annually in real terms. Two consequences for policy making followed. On the one hand, the extra funding created possibilities that had never existed before: it was the

Table 1 Spending on the NHS (current, excluding capital)

	£ million
1999/2000	40 755
2000/01	45 020
2001/02	52 070
2002/03	55 500
2003/04	61 965
2004/05	66 942
2005/06	74 081
2006/07	79 997*
2007/08	87 062*

*Planned spending.

Sources: Department of Health (2005) Departmental Report, Cm 6524. Department of Health (2006)[5] Departmental Report, Cm 6814.

increase in capacity which made the subsequent policy changes possible.[4] On the other hand, it reinforced the pressure within the Government—from both the Prime Minister and the Chancellor—for the NHS to deliver. 'A step change in resources must mean a step change in reform', Tony Blair insisted.[6] The NHS was launched on a reform trajectory that no one could have anticipated when Labour took office in 1997.

The distance travelled can be illustrated by comparing three landmark White Papers, published in 1997, 2000 and 2002, respectively. The Government's 1997 White Paper—*The new NHS*[7] offered a mixture of New Labour pragmatism and Old Labour rhetoric in the name of 'modernisation'. Rhetorically, the White Paper repudiated the policies of the outgoing Conservative Administration. The internal market was to be abolished, so, too, was fundholding. In future 'Co-operation will replace competition'. But enter pragmatism: 'what counts is what works'. The split between providers and purchasers (or commissioners as they came to be known) remained. Fundholding became collectivized: Primary Care Groups, which have since evolved into Primary Care Trusts (PCTs), were to be responsible for commissioning the care needed by their populations. 'Such an approach provides a "third way" between stifling top down command and control on the one hand, and random and wasteful grass roots free-for-all on the other', the White Paper argued.

In the event, it was 'stifling top down command and control' that characterized the first years of Labour in office. The number of performance indicators multiplied. So did the number of targets, a trend across all government departments led by the Treasury. At the peak, NHS managers reckoned they had to meet 300-plus targets (ministers claimed a somewhat lower figure). And if targets were not met, there

were sanctions. An elaborate system for grading NHS trusts developed: depending on the number of stars they achieved trusts, were either rewarded by being given a longer leash by the Department of Health or punished by having a new management installed.

Three years later, 6 months after Blair's announcement, the Government published the longest shopping list for the NHS ever published: *The NHS Plan*.[8] This set out what the extra money would buy: 7000 extra beds, 7500 more consultants and 2000 more GPs, 20 000 extra nurses and more medical school places, as well as clean wards, better hospital food and modern IT systems in every hospital and surgery. The extra investment would mean, *The NHS Plan* promised, improved services for patients: among them, shorter waiting times, an end to the postcode lottery in the prescribing cancer drugs and shorter waits for heart operations. The NHS was to be 'redesigned around the needs of the patient'.

Apart from the new language of expansion, a heightened rhetoric of reform and a variety of organizational initiatives, *The NHS Plan* represented continuity with the past rather than providing a pointer to the future. The main themes that were to shape the new model NHS, patient choice and provider competition, were conspicuous by their absence. Only in one respect did *The National Plan* provide a pointer to the future. It repudiated Labour's traditional hostility to private providers. Tony Blair's government had already embraced the Private Finance Initiative—the use of private capital to build hospitals—introduced by its Conservative predecessor. Now it went one step further. If the capacity to treat patients was to improve quickly, then the resources of the private sector would be needed. Accordingly, 'new forms of partnership' were to be developed.

In April 2002, the Government published *Delivering the NHS Plan*.[9] This reflected a damascene conversion by the Secretary of State for Health, Alan Milburn, who had discovered the limitations of the command and control system that he and his predecessor had built up over the previous 5 years. The White Paper set out the main themes that were to shape policy in the years to come: a devolved NHS, a diversity of public, private and voluntary providers, payment by results and patients in the driving seat. In all these, patient choice was to be the key, fundamentally changing the balance of power in the NHS. In the course of 2002, a flurry of policy documents fleshed out the new vision: so, for example, launching the notion of Foundation Trust status to reward efficient NHS organizations by giving them autonomous status.[10]

Secretaries of State for Health came and went. Wave after wave of policy documents and guidance swept over the NHS. New NHS agencies were born and died. Initiative followed initiative. Extra features

were added to the design: such as practice-based commissioning[11]—GP fundholding in a new incarnation—and national standards against which the performance of trusts would be assessed.[12] Organizational tinkering continued. But the defining elements of the model did not change: patient choice, provider competition and payment by results. Given more capacity in the NHS, competing providers would have an incentive to attract custom; in turn, payment by result would ensure that efficiency and responsiveness to patient preferences will be rewarded. It was to be a market system with a difference: a regulated market in which the Central Government would define the framework within which providers and commissioners operated and independent regulators would monitor quality and standards. A politician-led NHS was to give way to a patient-led NHS. No longer would central performance management and target setting be the only or main driving force; instead, the new system would be 'self-improving'.[13] But as always, the Government insisted that the principles guiding the new model NHS would not change: it would continue to be a tax-funded, universal service offering comprehensive care in the pursuit of equity and social solidarity.

Performance and perceptions

Leaving aside possible future dividends of self-improvement, what has the NHS delivered under the performance management regime of targets and sanctions? No simple answer to that question is possible, given that there is no way of summarizing the NHS's many, heterogeneous activities and the various dimensions of performance (access, quality, outcomes) on one index. But a rough and ready answer is provided by the Healthcare Commission's annual review of the state of healthcare. The 2006 report[14] concluded that 'patients are seeing real improvements in health care services'. And the report gave various examples. As far as access was concerned, maximum waiting times had been cut to 13 weeks for outpatient treatment and 6 months for surgery, while most people were being treated quickly in A&E departments. As far as quality was concerned, more women were being screened and treated earlier for breast cancer with a better chance of survival. As far as outcomes were concerned, fewer people were dying from cancer and heart disease, thanks in part to improved access and quality.

It would of course be quite extraordinarily astonishing if there had been no improvements given the extra billions pouring into the NHS. So the real question is whether the scale of improvements was commensurate with the scale of investment: about which more below.

Table 2 Public and patient views, 2005

To what extent, if at all, do you agree or disagree with the following statements?	% agree	% disagree
The government has the right policies for the NHS	26	44
The NHS is providing a good service nationally	54	23
My local NHS is providing me with a good service	68	14
I was satisfied with my last visit to hospital	81	9

Source: Ipsos-Mori (2006)[15] *Understanding Public and Patient Attitudes to the NHS*, August.

First, though, it is important to note that there were areas of the NHS, as the Healthcare Commission noted, left behind the tide of general improvement: for example, mental health. And given the range of variation in performance as between different trusts, the NHS was never short of examples of poor practice and poor management. Similarly, emergent issues demanded attention: notably hospital-acquired infections. And it is these examples and issues which tend selectively to dominate the media, so prompting the Healthcare Commission report to conclude: 'Overall, the state of healthcare is a lot better than media headlines suggest'.

It is the asymmetry as between the attention given by the media to good and bad news which helps to explain another phenomenon. This is the gap between NHS performance and the public's perceptions of that performance. Generally high satisfaction by service users and strong support for the NHS as an institution do not translate into public approval of government policy. The point emerges strongly from a study of public and patient attitudes conducted by Ipsos-Mori for the Healthcare Commission.[15] As Table 2 shows, only 28% of the public think that the government has the right policies, whereas 68% are happy with their local NHS and 81% were satisfied with their last visit to hospital. In short, media-filtered information is at odds with personal experience. Nor is there much confidence that the future will be any better: the study reports that 'The net proportion of those who think the NHS will get better over the next few years has generally been in decline since 2002, and reached the lowest ever recorded level in early 2006'.

So far, then, the Government is failing to get a political dividend for its investment in the NHS. The point is reinforced by the answers given by the public when asked about NHS finances in April 2006. Just under one-third (29%) still thought that the NHS was under-funded. Almost two-thirds (64%) thought that the NHS had enough money, but that too much money was being wasted. Only 4% took the view that the NHS was adequately funded and that the money was well

spent. Given the baroque complexities of NHS finance—the subject of the next section—public bewilderment is not surprising.

What explains famine among plenty?

Starting in the financial year 2005/06 and continuing into 2006/07, the headlines told the story of an NHS cutting back on staff and services because of a threatened deficit. Despite the extra billions, the NHS apparently could not keep within budget. The Secretary of State for Health, Patricia Hewitt, staked her reputation on getting it back into line even while her Cabinet colleagues were lobbying against reconfiguration plans prompted by the pressure to make savings. In the event, the 2005/06 over-spend turned out to be little over £500 million, loose change in the NHS's £74 billion budget and a figure which would be a source of envy in other health-care systems. So why the insistence on balancing the books, whatever the political cost?

The reason is that if a market-driven NHS is to work, it requires strict financial discipline. In the past, an elaborate and opaque system of brokerage and financial rescue packages from the Department of Health has meant that trusts could run deficits year after year, accumulating notional debts that they were unlikely ever to be able to pay off. So, for example, the Royal West Sussex Trust and Suffolk West PCT ran up consecutive deficits of, respectively, over £20 million and £17 million over a 3-year period.[16] But if trusts are not obliged to break even—if they can expect to be rescued whenever they run into trouble—what incentive is there for commissioners to purchase economically or for providers to be efficient? The model has to be that of Foundation Trusts which in time are supposed to become the norm across the NHS: autonomous bodies, nominally accountable to their local communities but in practice accountable to an independent regulator, Monitor.[17] If Foundation Trusts do not demonstrate continued financial and managerial competence—necessary conditions for achieving their status in the first place—Monitor intervenes to ensure that they balance their books.

Much of the NHS's financial turbulence would thus appear to reflect a transitional problem, aggravated by poor local management. Equally, and perhaps more significantly for the future, it also reflects poor national policy management. The financial pressures that led an increasing proportion of trusts into deficit cut across the NHS. The reasons for these pressures are complex, as recognized by the House of Commons Health Committee's report on deficits,[18] on which this analysis draws in what follows. First, the NHS has proved all too successful in recruiting extra staff, hiring more than planned.

Table 3 The rise in NHS staff numbers

Staff (headcount)	1997	2005	% increase
Consultants	21 474	31 993	48.9
Registrars	11 909	18 006	51.2
GPs	29 389	35 302	20.1
Qualified nurses	318 856	404 161	26.8
Allied health professionals	45 022	51 316	35.7
Ambulance staff	14 941	18 117	21.3
Managers	22 173	39 391	77.7
Administrative and clerical	160 479	233 174	45.3

Source: House of Commons Health Committee.[18]

Table 3 shows the rate of increase. Second, generous new contracts negotiated with the medical profession meant that 'hospital doctors and general practitioners can work fewer hours and still be better off—so in effect the NHS is paying more for less'.[19] Third, the cost of these contracts and awards to other staff was seriously under-estimated: in 2005/06, the unpredicted extra cost was roughly the same as the NHS's total deficit.

Other factors also increased fiscal turbulence. Expensive PFI hospital-building projects locked trusts into making repayments to the private financiers, even though the introduction of payment by results made their own income uncertain. In its anxiety to attract new private operators, the Government committed PCTs to pay for procedures at Independent Sector Treatment Centres at a price above the NHS rate and regardless of whether patients used them. And while targets might improve performance, they not only had perverse effects[20] but they often were an expensive way of buying such improvements. As the Royal Statistical Society had warned some years earlier:

> It is usually inept to set an extreme-value target, such as 'no patient shall wait in accident and emergency for more than four hours 'because as soon as one patient waits in A & E for more than four hours, the target is foregone and thereafter irrelevant. Typically, avoiding extremes consumes disproportionate resources.[21]

The cost of managing the NHS also rose. Although the Government made much of the fact that management costs had fallen as a proportion of total spending and that Department of Health staff had been radically cut, Table 3 shows that the number of managers expanded faster than any other category of NHS staff. And what the table does not show is the very considerable sum spent on management consultants.

Increased expenditure can of course be justified if it leads to more effective management. However, the evidence suggests that the challenge of spending so many extra billions overwhelmed NHS management both locally and nationally, inflating costs.[22] Although the improvement in the NHS's performance (however measured) may be real and substantial, it has lagged behind the rate of extra spending. Public perceptions are not inaccurate in this respect: expectations aroused by ministerial drum-beating about the extra billions have yet to be matched by performance.

The challenge to come

Problems of transition to the new model NHS remain. Like other health-care systems that have introduced payment by results, the NHS has found implementation difficult: the tariff has been revised once already and is likely to be go through more incarnations. The rhetorical commitment of moving from targets to standards remains to be translated into action.[23] There may be fewer targets, but ministers have nailed themselves firmly to the cross of achieving such headline targets as a maximum 18-week wait between GP referral and treatment by 2008.[24] To the extent that the new model NHS pre-supposes also new patterns of service delivery—with a switch towards community based services and co-ordinated patient pathways cutting across primary and secondary care—so the constituencies of support for existing institutions has to be overcome: no easy task, as demonstrated by the opposition, public and professional, to reconfiguration proposals.[25]

Managing these and other transitional problems is difficult enough. But the real challenge may be posed by the dynamics of the new model once it is fully operational. In simple terms, the risk is that it will crank up demand for health care and drive up spending just when the good year have come to an end for the NHS. Given payment by results, provider trusts have an incentive not only to attract as many patients as possible but also to diagnose and treat them in such a way as to maximize their income. In short, there are, for the first time in the history of the NHS, incentives to over-treat: a phenomenon familiar in the USA and other health-care systems based on payment by results (more accurately defined as payment by activity, since money flows irrespective of outcomes).

Balancing the provider trusts in the new model are the commissioners: PCTs. Working within the budgets allocated to them by Central Government, they now spend about 80% of the NHS budget. It is their responsibility to purchase health care on behalf of their populations. In the past, PCTs were acknowledged to be, with some

exceptions, weak and ineffective purchasers: if anyone was in the driving seat, it was the providers. Accordingly, the Government cut the number of PCTs by half in 2006—there are now 152—on the assumption that larger organizations would have the requisite managerial expertise and fiscal muscle required of them if the new model is to work according to expectations. Not only will PCTs have to control the demands generated by existing hospital trusts but they will also have to develop the new patterns of care required to diminish dependence on those providers. So the critical question is whether PCTs will measure up to these expectations in time to meet the deadlines faced by ministers.

It is not an easy question to answer. PCTs can (and do) refuse to pay provider bills if these exceed the contracted-for activities. But it is difficult to see how this power can be exercised given unlimited patient choice (the 2008 target): by definition, PCTs will not be able to contract in advance for what in theory at least could be unpredictable, open-ended patterns of demand. In practice, of course, the Government may be assuming, probably correctly, that although a majority of the public favour the principle of choice, its actual exercise will be restrained and largely guided by GPs. In turn, PCTs have strengthened their control over what GPs do. Prodded by the Central Government, they have set up systems—variously known as referral management centres or assessment panels—to scrutinize GP referrals and to decide whether to approve them or to divert patients to alternatives.[26]

But increasing control over GPs seems at odds with another strand of government policy: which is to give more control to GPs by introducing practice-based commissioning. Under this system, GP practices are allocated budgets out of which they are responsible for buying care for their patients. The logic of this is clear: working within defined budgets, GPs have an incentive to take resource constraints into account when taking their clinical decisions. In short, rationing decisions are—as always in the history of the NHS[27]—transmuted into clinical decisions and, as such, largely invisible politically. It remains to be seen whether the two strands of policy are compatible: will resentment at the loss of autonomy implied by having their decisions reviewed undermine the willingness of GPs to take responsibility for budgets?

A more general point follows from this. The Government is dependent on the medical profession for the implementation of its plans. If new patterns of work and new ways of organizing care are to be introduced, then the co-operation of doctors as well as other professionals is essential. If the collision between the momentum of the past spending spree and the austerities of an era of slower growth compels hard decisions to be taken about resources—whether by implementing the

guidance of the National Institute for Clinical Excellence or local priorities—then once again the engagement of the medical profession will be essential. But this cannot be taken for granted. The Government has showered the medical profession with money, as we have seen. Medical dignitaries have been involved in the process of policy design and delivery. Yet medical morale is low and suspicion of government policy is high. This is an international phenomenon, so cannot be ascribed exclusively to what is happening in the NHS. It appears to reflect a perceived loss of professional autonomy, as patient power is invoked as a counterweight to provider power and as the pursuit of targets reinforces managerial authority.

Winning over the medical profession may thus be the biggest challenge facing the Government before the next General Election. Not only is this essential if the performance of the NHS is to continue to improve, but is also essential if public perceptions of that performance are to improve. The media may provide the searchlight of publicity that concentrates on the NHS's failings. But very often, it is NHS professionals who are directing that searchlight to advertise their own grievances. And however much ministers quote statistics of improving performance, it is what doctors and nurses say to the media that shapes public views. For the public believes doctors but not politicians: 85% net of the public trust doctors to tell the truth, whereas 53% net do not trust government ministers.[28] So perhaps the best hope for ministers is to lower public expectations by explaining just how difficult it is to bring about change in such a complex institution as the NHS, moulded by history and part of the nation's mythology.

References

1 Greer SL (2004) *Territorial Politics and Health Policy: UK Health Policy in Comparative Perspective*. Manchester: Manchester University Press.
2 Klein R (2006) *The New Politics of the NHS: From Creation to Reinvention*, 5th ed. Oxford: Radcliffe Publishing.
3 Wanless D (2001) *Securing Our Future Health: Taking a Long-Term View*. Interim Report. London: HM Treasury.
4 Stevens S (2004) Reform strategies for the English NHS. *Health Aff*, **23**, 37–44.
5 Department of Health (2005) *Departmental Report*. London: The Stationery Office, Cm 6524; Department of Health (2006) *Departmental Report*. London: The Stationery Office, Cm 6524.
6 Prime Minister (2000) *Statement on the National Health Service*, Press Notice, 22 March, London.
7 Secretary of State for Health (1997) *The new NHS: Modern-Dependable* London: The Stationery Office, Cm 3807.
8 Secretary of State for Health (2000) *The NHS Plan*. London: The Stationery Office, Cm 4818.
9 Secretary of State for Health (2002) *Delivering the NHS Plan*. London: The Stationery Office, Cm 5503.

10 Department of Health (2002) *A Guide to NHS Foundation Trusts*. London: DoH.
11 Department of Health (2004) *Practice Based Commissioning: Engaging Practices in Commissioning*. London: DoH.
12 Department of Health (2004) *National Standards, Local Action*. London: DoH.
13 Department of Health (2005) *Health Reform in England: Update and Next Steps*. London: DoH.
14 Healthcare Commission (2006) *State of Healthcare 2006*. London: Healthcare Commission.
15 Ipsos-Mori (2006) *Understanding Public and Patient Attitudes to the NHS: Research Review Prepared for the Healthcare Commission*. August 2006, http/:www.ipsos-mori.com/polls/2006/pdf/healthcarecommission.pdf (accessed 24.01.07)
16 Audit Commission (2006) *Learning the Lessons from Financial Failure in the NHS*. London: Audit Commission.
17 Day P, Klein R (2005) *Governance of Foundation Trusts*. London: The Nuffield Trust.
18 House of Commons Health Committee (2006) *NHS Deficits*. First Report of Session 2006–07. London: The Stationery Office, HC 73.
19 Maynard A, Street A (2006) Seven years of feast, seven years of famine: boom to bust in the NHS? *Br Med J*, **332**, 906–908.
20 Bevan G, Hood C (2006) Have targets improved performance in the English NHS? *Br Med J*, **332**, 419–422.
21 Royal Statistical Society Working Party on Performance Monitoring in the Public Service (2004) *Performance Indicators: Good, Bad and Ugly*. London: RSA.
22 Bosanquet N, de Zoete H, Haldenby A (2007) *NHS Reform: The Empire Strikes Back*. London: Reform.
23 Ham C (2005) From targets to standards: but not just yet. *Br Med J*, **330**, 106–107.
24 Department of Health (2006) *The NHS in England: The Operating Framework for 2007/08*. London: DoH.
25 Day P, Klein R (2007) *The Politics of Scrutiny: Reconfiguration in NHS England*. London: The Nuffield Trust.
26 Clews G (2006) Destination unknown—which way now for GP referrals? *Health Service J*, 14.
27 Klein R, Day P, Redmayne S (*1996*) *Managing Scarcity: Priority Setting and Rationing in the National Health Service*. Buckingham: Open University Press.
28 Ipsos-Mori (2006) *Health Matters*, **Winter/Spring**, 5.