THE NHS: Are the Reforms Working?

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The Prime Minister, Tony Blair, has repeatedly challenged the British public to judge his Government on the performance of the NHS. In January 2002, for instance, he accepted that his government may stand or fall on the reform of the NHS: 'things are starting to get better, and they will be dramatically improved. I am so confident of that, let me say this: if the NHS is not basically fixed by the next election, then I am quite happy to suffer the consequences. I am quite willing to be held to account by the voters if we fail'.[1]

Even Polly Toynbee and David Walker, in a panegyric to the Blair administration that sets out to show how the government has 'immunised itself from the charge' that there is 'nothing to show for the big increases in spending',[2] are forced to concede that an improved service is not the inevitable outcome of greater expenditure. 'The government itself said that by 2004 the NHS had become bloated,' the authors cede, 'at least to the extent that £6.5bn worth of efficiency gains could be squeezed out'. They acknowledge that John Reid nearly had 'an attack of apoplexy' when, in October 2004, the Office for National Statistics found productivity in the NHS had been falling, despite the huge increases in spending.[3] Toynbee and Walker point to improved personal care, expensive new medicines, and higher wages; but, although they are prepared to accept the diseconomies of restructuring and the disruption of IT schemes,[4] they dismiss outright the accusation that money is being misspent on management.

However, according to the NHS Boardroom Pay Report 2005, the pay of NHS chief executives rose 70 per cent in ten years, while nurses' pay only went up by 50 per cent. The NHS accounts in the year to March 2004 show that the average salary of chief executives in England was £107,500, with the fattest cat of them all being the chief executive of Hammersmith Hospitals who was awarded £212,500 last year. The King's Fund states that 'In comparison to [other] staff groups... pay levels for NHS trust chief executives and other boardroom staff are significantly higher.' In contrast, the King's Fund draws on research by the Royal College of Nursing to show that, while pay levels for directors of NHS primary health care trusts have been escalating, and within just one year (2003/04) their average salary went up 28 per cent, almost 45 per cent of nurses in London have a second job in order to increase their income.[5] 'NHS management has increased significantly since Labour came to power. Between 1993 and 2003, the number of managers rose by 12,376 (from 21,434 to 33,810), representing an increase of 58%... Managers as a percentage of total NHS staff rose by 32% (from 2.5% of total NHS staff in 1997 to 3.3% of total NHS

staff in 2003).'[6] Even if that percentage seems relatively small, it remains significant enough to fuel concerns about the excessive allocation of funds to bureaucrats.

Productivity

Inasmuch as this corrects the notion that greater spending on healthcare would *automatically* improve outcomes, this is important; but there is nevertheless strong evidence for a direct relationship between inputs and outputs in certain areas, and the overall impression gained from the OECD's latest publication of health data is that the quality of the UK's underfunded healthcare compares unfavourably with the other countries in the study.[7]

UK healthcare spending as a proportion of Gross Domestic Product (GDP) has increased rapidly in recent years. The English NHS spending doubled between 1997 and 2005. The 2004 Spending Review shows spending in 1996/97 in England was £33bn. In 2004/05 it was £69.4bn and in 2005/06 £76.4bn. This year, total spending on the UK public health sector will be more than £81.1 billion.[8] While the 2000 figure was 7.3 per cent, which was 'lower in the United Kingdom than in other comparator countries except Japan',[9] data for 2002 show that spending is now 7.7% of GDP; and with levels increasing 7.5 per cent a year, UK health spending is expected to rise to 9.4 per cent of GDP in 2007/08.[10] However, between 1980 and 2001 spending on health as a percentage of GDP rose less quickly in the UK than elsewhere. In 2002, according to the Wanless report – 'a devastating analysis and justification for huge extra spending'[11] – the UK's accumulated under-investment was £267 billion.[12] Even now, after all the publicity surrounding government investment in the NHS, the UK remains well short of France (9.7%) and Germany (10.9%) in particular, and following rapid growth in the late 1980's the United States is way out ahead.[13] As the King's Fund has recently reported, 'the UK still lags behind many other countries in terms of the proportion of the GDP spent on health.'[14]

Health expenditure per capita is another measure of the resources devoted to healthcare. Although certain caveats should be taken into account, including a range of demographic factors and variations in exchange rate, expenditure per head can be correlated with health status[15], for increased expenditure is associated with improved health outcomes.[16] On this calculation the UK is again significantly below par, with some 86 per cent of the average for the five European countries covered. Only Italy ranks behind the UK; Germany, Sweden and France all perform better. At the top end of the scale, health spending in the US reached 14.6 per cent in 2002 ($5267 per capita), almost 140 per cent above the OECD average ($2144).[17]

The most cogent evidence correlating expenditure and productivity concerns medical resources, to the extent that increased availability has a beneficial impact on medical outputs. Zeynep Or has demonstrated that 'a 10 per cent increase in doctors, holding all other factors constant, would result in a reduction in premature mortality of almost four per cent for women and about three per cent for men.'[18] Jeremy Hurst of the OECD and Gaetan Lafortune accept that 'empirical evidence... suggests that higher doctor numbers are significantly associated with lower mortality, after controlling for other determinants of health.'[19] And in its 2003 report, *International Health Comparisons*, the NAO cites Or's work in declaring that the number of doctors per 1,000 of population is the second most important variable after occupation in terms of explaining variations in premature mortality.[20]

While the statistics need careful interpretation, the UK ranks at the bottom with 1.8 per 1,000 – considerably below the mean of 2.5[21] – and even though the number rose steadily in the period between 1980 and 2000, and total NHS employment in England was 22 percent higher in 2003 compared with 1995,[22] the reported provision in other countries has generally increased at a faster rate.[23] It is not merely a question of doctors in general, but also of specialists, that matters. It has long been accepted, for example, that cancer care is under-resourced. Professor Karol Sikora, former head of the World Health Organisation's Cancer Programme, has shown that 'Britain has fewer radiotherapists per head than Poland and fewer medical oncologists than any country in Western Europe.'[24] Similarly, 'Hungary and the United Kingdom have the lowest number of neurologists, 0.4 per 100,000 population, likely reflecting the lower spending on health care of these two countries, while Japan and Korea are the countries with the largest numbers of neurosurgeons per 100,000 population, 4.6 and 2.9 respectively.'[25]

As well as having the lowest reported number of doctors per head, the UK has the second lowest reported number of practising nurses in relation to the population. While Germany and Sweden have 9.3 and 8.4 nurses per 1,000 of population, the UK has 5.3, and in Europe only Italy is lower with 4.5. Consequently, although the UK in fact fares reasonably well on acute admission rates and is above all the other European countries in terms of its provision of nurses per acute day, it scores poorly overall.[26] It would not be difficult to blame a combination of absolute underfunding and resource misallocation.

Composite measures

The Office for National Statistics recently reviewed the method of measuring overall NHS productivity and came up with a more refined measure covering the period from 1995 to 2003. It compares NHS outputs on one measure with NHS inputs on two different measures. Health outcomes are measured in terms of a variety of indicators and can be defined as 'those changes in health status strictly attributable to the activities of the health system'.[27] Having found that output had increased by 28 per cent and inputs had grown by 32 per cent on one measure and 39 per cent on the other, the ONS concluded that the average annual change in NHS productivity between 1995 and 2003 was between -1 and zero per cent.[28] When the data were fed through a series of permutations and subjected to thorough examination, a decrease of anything between 3 per cent and 8 per cent was observed in NHS productivity from 1997 to 2003.[29] These figures raise questions about the value for money that taxpayers are getting for their investment.

Academics at the LSE have tried to develop a better measure of overall health system achievement, their hypothesis being that a measure of health attainment more closely linked to the healthcare system would produce a systematically different ranking. The World Health Report of 2000 ranked countries according to 'disability adjusted life expectancy', which deducts a proportion of the expected years of life to allow for the reduced quality of life resulting from disability.[30] Ellen Nolte and Martin McKee compared the results of the WHO report with a new ranking of health attainment: 'mortality amenable to health care'. The two measures produced substantially different results and the UK's performance was poor. On the measure that assumed half of the deaths due to ischaemic heart disease to be the result of poor health care, the UK came 19th out of 19 countries. It had been tenth out of 19 on the WHO measure. When ischaemic heart disease was excluded, the UK was 18th out of 19.[31]

The available data can rarely disentangle the health system effects from other effects, such as socio-economic or environmental factors and, since healthcare systems are complex, making judgements about their performance overall is complicated. It is largely due to the difficulty of making such distinctions that it is necessary to consider single indicators separately. All the same, as the following analysis of waiting lists, productivity and hospital acquired infection shows, the individual measures of performance reflect the assessments and confirm the rigour of the aggregate measures.

Waiting lists

Due to the fall in overall NHS waiting lists – people waiting for admission to hospital – from 1,158,000 in 1997 to 857,000 by September 2004, the Department of Health has deployed waiting lists as key evidence of an improvement in performance. Waiting 'had been the single most complained-about feature of the NHS since the days of Nye Bevan,' according to the authors of *Better or Worse?*, 'and now it was ending.'[32] Elsewhere, they claim that '[e]xtra money had taken the waiting out of wanting to be treated.'[33] But if the NAO's July 2001 document *Inpatient and Outpatient Waiting in the NHS* endorses the opinion that waiting lists are 'a key measure of performance', it also introduces a note of scepticism. For 'there has been a considerable debate about the adequacy of waiting lists and times as a measure, the impact of initiatives to reduce waiting lists and what waiting list statistics actually indicate.'[34]

The NAO was at the time prepared to give the NHS the benefit of the doubt. While trusts were 'not completely consistent in what they include on waiting lists', and while the NAO could not be assured 'of the complete accuracy' of the figures, it did accept the defence that 'attempts to cut waiting lists have to contend with a dynamic situation'.[35] The report then went on to say that the 'extra resources that have become available to the NHS since its foundation have made it possible for more people to enjoy a wider range of operations', the consequence being that 'that very success has led to more people coming forward for treatment.'[36] Later that year, however, the NAO changed its tune dramatically. In December 2001, it published a report entitled *Inappropriate Adjustments to NHS Waiting Lists* which concluded that: 'Nine NHS trusts inappropriately adjusted their waiting lists for some three years or more, affecting nearly 6,000 patient records. For the patients concerned this constituted a major breach of public trust and was inconsistent with the proper conduct of public business.'[37]

By March 2003, when the Audit Commission produced a report entitled *Waiting List Accuracy*, things had hardly improved. The Commission found that while waiting lists for patients with possible breast cancer were generally well managed, 'there was evidence of deliberate misreporting of waiting list information' at three trusts and in a further 19 trusts auditors found evidence of reporting errors – deriving from inadequate policies, procedures or operational systems for collecting or recording data; and ineffective, wrongly set up or poorly integrated IT systems – in at least one of six performance indicators.[38] The report concluded that the fraudulent actions were 'disturbing'; that 'data quality varies widely'; that 'a number of trusts were found to be operating in ways that seem weighted away from the interests of patients'[39]; and that where mistakes were not made

intentionally 'trusts could and should be doing [more] to reduce the likelihood of reporting errors'.[40]

As recently as March 2004, the King's Fund was announcing that 'the true scale of such inappropriate adjustments across the NHS is unknown',[41] which at the very least implies that any evaluations of the 'considerable achievement' of having generally made waiting times 'shorter than at any time in the history of the NHS' should be treated with caution. Success, the report said, has been 'patchy, with Wales and Northern Ireland, for example, experiencing growing problems with their waiting times.'[42] In February 2005, the King's Fund produced another report, entitled *Cutting NHS Waiting Times*, which found that confidence in the current figures might be misplaced. It states that 'there has been some success in reducing very long waiting times but average waiting times have changed very little.'[43] In addition, it argues that NHS waiting time reduction policies have relied on 'the incorrect view that waiting lists represented a backlog that could be removed by temporary initiatives' when in fact 'sustainable reductions must rely on long-term policies designed to respond to a range of factors.'[44] The publication closes with the point that 'important issues concerning the goals of policies on waiting times, demand management and the development of more appropriate targets focusing on access to care still need to be addressed.'[45]

Nevertheless, in the context of emergency care, Toynbee and Walker are determined to present waiting time management as almost uniformly triumphant. 'Despite a large increase in numbers seen during the winter (of 2003-04),' they affirm, 'waits in accident and emergency had been cut, 96 per cent of patients seen within four hours. Waiting on trolleys for admissions was rare – always more likely to be the result of some local concatenation of circumstances than system failure.'[46] Such figures, not incorrect, deceive by the incompleteness of the picture they present. In the week ending March 31 2003, the Department of Health conducted a pre-announced audit of A&E waiting times in A&E departments in England, and, in response to concerns voiced by the Health Services Journal that trusts would marshal 'unsustainable resources' in order 'to meet the A&E target',[47] the BMA conducted a survey of A&E waiting times.

The results showed that 'in the majority of A&E departments efforts were directed at meeting the government's target at the expense of clinical quality, staff wellbeing, and broader objectives such as developing long-term improvements in capacity.'[48] Among a range of specific criticisms, it stated that 'low priority patients were being seen at the expense of the seriously ill and traumatised', with the result that 'waiting room patients [were] very angry that lower priority [were] being seen first'.[49] Furthermore, the BMA

found, 'patients were being "rushed through"' so that some 'had been moved before being adequately assessed or stabilised, or sent to the wrong specialty'. There were, too, reports that 'computer records have been altered, so that A&E waiting times have been falsified to avoid patients going over the 12 hour trolley wait'. Not only were 'existing staff, especially senior doctors and emergency nurse practitioners... exhausted and disillusioned that funding and resources have not been continued,' but there was also 'increased stress and bullying of senior medical staff.' Clearly, more than a passing connection can be made between this demoralisation and the observation that 'staff can get so preoccupied with meeting the targets they miss the bigger picture regarding what's best for the patient'.[50] In March 2004, it was still the case that reducing waiting times 'raised concerns amongst some consultants that they have been pressured by NHS managers to treat less urgent patients in front of more urgent cases in attempts to meet targets.'[51] 'As NHS managers joke, reducing waiting times is the "P45 target" – fail to achieve them and you can start to look for another job.'[52] Even Professor Sir George Alberti, the emergency services 'tsar', has indicated that emergency care staff should concentrate more on improving care in their departments rather than just on meeting targets, and admitted that there is still some way to go to reach his vision for the service.[53]

Since information about performance is vital for service improvement, and many groups, including patients, hospital doctors, GPs, health service managers, politicians and regulators, and the wider public, depend on the information, it is important that they can be confident in its accuracy. As the Audit Commission stated in its report *Waiting List Accuracy*, 'reliable information about performance is the bedrock of service improvement'[54]. Yet there is cause for concern if 'the true scale of... inappropriate adjustments across the NHS is unknown',[55] not only because of incompetence but also fiddling of the figures. On 4 December 2004, the BMJ reported that James Johnson, chairman of the BMA Council, told the House of Commons Public Administration Select Committee 'that the government's claims to be giving patients more choice was in practice limited to a small area of policy: the reduction of waiting times for inpatients.'[56] A comparative analysis carried out by the OECD supplements the evidence, for it not only found that the UK's supply of technologies and facilities was unimpressive, with among the longest waits for both CT scans and MRI, but also that situations of inequitable access were arising where patients were able to skip public sector queues.[57] Mr Johnson said that the government is using patient choice as a means to drive down costs: it 'is clearly being employed as an economic concept...'[58] It would clearly be unwise to rely on politicised waiting lists for an assessment of the NHS.

Cancellations

As Chris Grayling, the Conservative health spokesman, has pointed out, there is strong evidence of a link between Labour's target of a maximum four-hour wait in accident and emergency departments, and a subsequent increase in cancellations of non-emergency operations.[59] In order to ensure that patients do not wait more than four hours between arriving and being treated, more are being admitted straight to hospital, which in turn leads to an increase in cancellations for planned operations because of a shortage of bed space. In February 2000, the NAO found that bed unavailability was the most common cause of cancelled operations, with beds occupied by new emergency cases or patients whose discharge has been delayed.[60] 'Some 70 per cent of NHS acute trusts' told the NAO 'that the intended bed being occupied by a new emergency admission was the most common cause of a cancelled elective operation.'[61] Although at the time the UK had fewer beds per 1,000 of population (3.3) than Germany (6.4), Italy (4.5), France (4.2) and Australia (3.8),[62] it is most likely, not that there was an absolute shortage of beds, but that, as the chairman of the House of Commons public accounts committee said, the findings were 'symptomatic of poor bed management.'[63]

As with waiting lists, the sheer unreliability of the data makes it difficult to determine with any exactitude the degree of the problem. The Audit Commission has found that: 'Many trusts had incorrect or confused policies for how to record DNAs [Did Not Attends] and cancellations. A typical example would be where, when recording outpatient appointments cancelled by the trust, the waiting time was reset incorrectly to the cancellation date rather than being left as the date the referral was received originally'.[64] The Department of Health figures indicate that cancellations have been rising steadily from 50,505 in 1997-98 when the present government started its tenure to 66,303 in 2003-04. In those years there have been 15,798 more cancellations – or an increase of 31.2 per cent. Figures to Q3 in 2003-04 (46,238) and 2004-05 (47,010) suggest that the numbers are still rising, although some fluctuation should be permitted. The Patient's Charter states that a patient's elective operation should not be cancelled by the hospital on or after admission, for non-medical reasons, and that where it does occur, the hospital is required to treat the patient within one month from the date of cancellation. Although the number not admitted within twenty-eight days of cancellation rose dramatically from 7250 in 1997-98 to 19,087 in 2001-02, there has been a decrease again, down to 6270 in the year 2003-04.[65]

However, beating the 24-hour cut off point means that the hospital is not obliged to treat the patient within one month of cancellation. The *Sunday Times* has calculated that the NHS may be cancelling more than twice as many operations at short notice than the government has acknowledged. The paper said that the figures disclosed in reports prepared by individual hospital trusts contradict ministers' claims that 66,000 operations are cancelled a year, with the figure instead estimated to be at least 132,000.[66] Frustratingly, '[t]here are no national data on the number of operations cancelled before the date of admission', and the proportion of operations cancelled varies across NHS acute trusts.[67] That said, there are some hospitals which do collect this information. For example, the Royal Shrewsbury Hospitals NHS Trust cancels around five operations before the day of admission for every one operation it cancels on the day.[68] Early cancellations were widespread in other trusts. According to a study published last year by the health scrutiny panel of Worcestershire county council, only 856 of the 1,791 operation cancelled in 2003 were called off within 24 hours of the appointment. Jonathan Fielden, vice-chairman of the BMA's consultants' committee, said: 'This is not uncommon. When managers are faced with losing their jobs if they miss a target they will find any way to get round that target.'[69] Clearly, the claim that Labour has abolished 'hidden' figures does not stand up to close examination[70].

Productivity

The World Health Organisation stated in 2000 that 'Better health is of course the *raison d'etre* of a health system.'[71] Life expectancy partly reflects the performance of the health care system, although the figures are not generally considered persuasive because mortality is affected so many non-medical factors beyond the scope of the health system.[72] A recent study by the National Audit Office, based largely on 2002 OECD data, looks at how the UK compared with nine other advanced countries. The UK performs poorly: for life expectancy at birth the UK comes ninth out of the ten countries. The World Health Organisation uses another measure, the 'potential years of life lost', which assumes that all deaths before age 70 are premature. It calculates the number of people who died before the age of 70 per 100,000 population. Because the UK comes seventh out of the ten countries compared, the NAO cautions, '[t]his illustrates the dangers of relying on single indicators to draw conclusions'; yet the UK is still notable in performing towards the bottom of the range.[73]

Infant mortality – deaths of babies aged under one year per 1,000 live births in the same year – is considered to be an important measure of an effective system. This is largely

because declining levels can be explained by better ante and post-natal care and widespread immunisation against diseases – 'influences', as the NAO says, 'within the control of health policy makers.'[74] The results of recent research indicate, for example, all else being equal, that a 10 per cent increase in the number of doctors would result in almost a 6 per cent decrease in perinatal mortality and a 6.5 per cent decrease in infant mortality.[75] Despite formulating a hypothesis that suggests a compliment to the UK – that publicly funded systems provide more equitable health service provision[76] – it was tenth out of the ten countries compared.

Since, as the NHS Cancer Plan recognises,[77] the quality of medical intervention is a key determinant, cancer mortality statistics provide another important indicator. Despite falling rates of cancer deaths, the UK again performs badly. An examination of the trend over the last two decades reveals that, in the last year of complete comparisons, the UK and New Zealand jointly had the highest cancer death rates and the UK has the highest rate for breast cancer. An alternative calculation, that of death rates for all cancers against a standardised age profile designed to take account of the different demographics in the comparator countries, also reveals that the UK has relatively high death rates. The rate is 2.5 per cent higher than France, 5 per cent higher than Germany, and 18 per cent higher than Sweden, the country with the lowest cancer death rate among those compared by the NAO.[78]

The most comprehensive international data about the value added to healthcare systems relate to cancer survival rates. The standard measure is the percentage of cancer patients alive five years after treatment. Yet again, '[t]he performance of England is consistently at or near the bottom of the league, alternating bottom position with Scotland.'[79] The latest evidence of cancer survival rates comes from the EUROCARE-3 study, which compares results in 22 European countries up to 1999. Survival rates are given for 19 countries, based on survival for 5 years after diagnosis. Separate figures are given for England, Scotland and Wales. All are below the European average for all cancers. England was below the European average for survival rates from liver cancer[80], below average for breast cancer survival,[81] had the lowest survival rates for lung cancer (along with the lowest proportion of small cell lung cancer patients receiving chemotherapy[82]) and among the lowest survival rates for prostate cancer.[83] Overall, England comes 11th out of 19 and Scotland 12th for survival rates among men, and England is 12th and Scotland 13th for women.[84]

The situation regarding deaths from circulatory diseases – cardio-vascular diseases including ischaemic heart disease, myocardial infarction and cerebro-vascular disease – is

equally as worrying. UK death rates are highest, second highest and third highest respectively across the group of countries for these three circulatory conditions.[85] Despite recent improvements, internationally the death rate from Coronary Heart Disease (CHD) in the UK is relatively high. Among developed countries only Ireland and Finland have a higher rate than the UK. While the death rate from CHD has been falling in the UK it has not been falling as fast as in some other countries.[86] The statistics show that victims of heart disease, stroke or breast cancer in Britain die early, and perhaps unnecessarily, compared to other western countries. Worse still, it seems that access to care is being limited according to age. Roger Dobson, a regular contributor to the BMJ, reports on an international study that found the proportion of health spending on those aged 65+ in England and Wales is not keeping track with that in other countries.[87]

Where stroke is concerned, the UK is literally in a league of its own. When the OECD Age-Related Diseases (ARD) team reported in 2002 on in-hospital mortality and one-year case mortality for stroke patients, it found that there were few differences between the countries, with the exception of the UK. Fatalities in the UK over the first seven days were approximately twice the average for all age groups, making it the only country in the study classed as having high death rates. These data do not, though, reflect the total continuum of care which includes care outside the hospital setting: to do that, it is necessary to also account for non-hospital deaths by using case fatality rates. These rates were lowest in Denmark and highest by far in the UK, and the OECD observed that the UK stood out for its poor performance.[88] A year later, the OECD found that relatively speaking things had scarcely improved. For age-standardised mortality rates, the UK was high – behind only Hungary and Japan – and while the rates were decreasing they were not doing so as fast as elsewhere. 7-day hospital mortality was substantially higher than in any other country in the survey for all age categories, both male and female, with the gap widening for 30-day hospital mortality,[89] and of the 11 countries included in the study, only the UK was labelled as exhibiting high fatality rates.[90]

Hospital acquired infection

Hospital acquired infections are infections that are neither present nor incubating when a patient enters hospital. According to the NAO in February 2000, Britain has the worst record in Europe. At any one time, 9 per cent of patients – equivalent to at least 100,ooo infections a year – had an infection that had been acquired during their hospital stay. The effects varied from an extended length of stay and discomfort to prolonged or permanent disability and, in at least 5,000 patients a year, death. These infections were costing the

NHS as much as £1 billion a year and around 15 per cent could be prevented by better application of good practice, releasing resources of £150 million for alternative NHS use.[91] In the same year, the Committee of Public Accounts concluded that the lack of grip on the extent and costs of hospital acquired infections impeded NHS trusts in targeting activity and resources to best effect. In addition, it claimed that a root and branch shift towards prevention would be needed at all levels of the NHS if hospital acquired infection were to be kept under control. But in his December 2003 report, *Winning Ways*[92], the Chief Medical Officer stated that such data as are available show that the degree of improvement has been small.

A major obstacle to tackling the spread of antibiotic resistant bugs is that while patients and staff prefer hospitals which are visually clean, this will only have a minimal impact on the spread of MRSA. Even the Department of Health's Patient Environment Action Teams (PEATs) only assess cleanliness on visual criteria. Many more hospitals are now rated 'good' by the PEATs, but over the same period (2001-02 to 2002-03) rates of MRSA (0.17 per 1000 bed days) have not changed, according to the MRSA surveillance scheme, and between 1993-2002 the number of deaths increased fifteen-fold.[93]

Many of the conclusions of previous NAO reports were repeated in July 2004. *Improving patient care by reducing the risk of hospital acquired infection: A progress report* found that good practice with respect to the prevention, control and management of hospital acquired infection needed to be more widely known and that there was a lack of basic comparative information on infection rates. It expressed concern that there appeared to be a growing mismatch between what was expected of infection control teams and the staffing and other resources allocated to them, and identified considerable scope for improving performance. 'Implementation of our and the Committee's recommendations has been patchy... wider factors continue to impede good infection control practice and there has been limited progress in improving information on the extent and costs of hospital acquired infections. Progress in preventing and reducing the number of infections acquired while in hospital continues to be constrained by the lack of data, limited progress in implementing a national mandatory surveillance programme that meets the needs of the NHS, and a lack of evidence of the impact of different intervention strategies.'[94] The upshot is, as Michael Howard said on 16 February 2005, that 'you are more likely to die of an infection you pick up in hospital than to be killed on Britain's roads'.

Conclusion

Whether judged according to expenditure, waiting lists or the various gauges of productivity, things in the NHS do not look good. Even the sympathetic King's Fund, in its recent audit of the NHS under Labour, has concluded that 'the NHS as a whole has not yet been transformed. There are still important problems to be solved and there is as yet no firm evidence to show that Labour's reforms have produced a marked difference in health outcomes.'[95]

Notes

1 *The Guardian*, 28 January: 2002. http://society.guardian.co.uk/print/0,3858,4344349-106632,00.html

2 Polly Toynbee and David Walker, *Better or Worse? Has Labour Delivered?* London: Bloomsbury, 2005, p. 11. Hereafter: '*Better or Worse?*'

3 *Better or Worse?* p. 37.

4 *Better or Worse?* pp. 37-39.

5 King's Fund, *Has the Government Met the Public's Priorities for the NHS? A King's Fund briefing for the BBC 'Your NHS' Day 2004*, London: King's Fund, March 2004, pp. 12-13. Hereafter: '*BBC "Your NHS" Day 2004 briefing*'.

6 King's Fund, *An Independent Audit of the NHS Under Labour (1997-2005)*, London: King's Fund, 2005, p. 62. Hereafter: '*Audit of the NHS Under Labour*'.

7 The United States, Germany, France, Canada, Australia, Italy, New Zealand, Sweden and Japan. See: *OECD Health Data 2004*, Paris: OECD, 2004. Hereafter: '*Health Data*, 2004'.

8 HM Treasury *2004 Spending Review*, London: HM Treasury, 2004, pp. 93, 100. http://www.hm-treasury.gov.uk/media/801/75/sr2004_ch8.pdf

9 National Audit Office, *International Health Comparisons*, London: NAO, 2003, pp. 3-4. Hereafter: '*Health Comparisons*, 2003'.

10 *Health Comparisons, 2003*, p. 4.

11 *Better or Worse?* p. 14.

12 Wanless, D., *Securing our Future Health: Taking a Long-Term View*, *Final Report*, HM Treasury, 2002.

13 Health Data, 2004.

14 *Audit of the NHS Under Labour*, p. 15.

15 Domenighetti, G., Quaglia, J., 'Comparisons internationales', in Kocker, G., and Oggier, W., *Système de santé Suisse 2001/2002*, Concordat des assureurs-maladie, 2001.

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20 *Health Comparisons*, 2003, p. 9.

21 See also: Derek Wanless, *Securing Our Future Health: Taking a Long-Term View*, *Interim Report,* HM Treasury, 2001.

22 *Public Service Productivity: Health*, London, ONS: October 2004, p. 15. Hereafter: 'ONS, 2004'.

23 *Health Comparisons*, 2003, p. 10.

24 Sikora, K., 'Cancer survival in Britain', *British Medical Journal*, 1999, pp. 461-462.

25 Moon *et al*, 2003, p. 21.

26 *Health Comparisons*, 2003, pp. 9-16.

27 Hurst, J., 'Performance measurement and improvement in OECD health systems: overview of issues and challenges', in *Measuring up: improving health system performance in OECD countries,* OECD: Paris.

28 ONS, *Public Service Productivity: Health*, London: ONS, October 2004, pp. 1-2.

29 ONS, 2004, pp. 21-25.

30 World Health Organisation, *The world health report 2000. Health systems: improving performance*, WHO: Geneva, 2000. Cited in Nolte, E. and McKee, M., 'Measuring the health of nations: analysis of mortality amenable to health care', *British Medical Journal*, 327: 1129 (15 November: 2003).

31 Nolte, E. and McKee, M., 'Measuring the health of nations: analysis of mortality amenable to health care', *British Medical Journal*, 327:1129-32 (15 November: 2003).

32 *Better or Worse?* p. 13.

33 *Better or Worse?* p. 15.

34 National Audit Office, *Inpatient and Outpatient Waiting in the NHS*, London: NAO, July 2001, p. 1.

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