4

Cutting the Wait—at Least for a While

The NHS's Assault on Waiting Times

Adrian Kay

Introduction

Although health policy was not an original feature of the attempt by New Labour to break from 'old' Labour politics in the UK, the alignment of political priority and policy analysis in government produced a successful period in the UK National Health Service (NHS). This chapter investigates one aspect of this, the case of the historically significant decline in waiting times for NHS services. Between 2000 and 2010, a policy mix was implemented that reduced the maximum waiting time from any referral of a patient by a general practitioner (GP) to treatment in hospital, if required, to eighteen weeks in almost all cases. This represented a significant performance improvement—equivalent waiting times in 2000 had been routinely over eighteen months.

Unlike welfare state politics generally in the UK, the NHS has always enjoyed strong political legitimacy. To those outside the UK, public attitudes to the NHS in the UK are often puzzling; typical was the bemused international reaction to parts of the opening ceremony for the 2012 London Olympics in which Oscar-winning director Danny Boyle had choreographed lines of dancing nurses and children in pyjamas jumping onto oversized hospital beds, all underneath a large 'NHS' sign. The 70th anniversary of the foundation of the NHS—5 July 2018—was widely celebrated in the manner of a significant royal birthday. One of Britain's leading poets, Owen Sheers, produced fresh work to mark the public occasion (Sheers 2018).

This deep public affection for the NHS has endured through several major reform episodes and organizational restructuring phases over the last thirty years and is an essential background condition to the case of improved waiting times between 2000 and 2010 presented in this chapter. The sources of this legitimacy are difficult to pinpoint precisely, and certainly there is no straightforward account based on output or performance legitimacy. There is something in the historical memory of immediate post-war Britain, the establishment of the NHS in 1948 as a collective endeavour by the first majority Labour government that continues to resonate. There is no mainstream political opposition to the NHS

Adrian Kay, *Cutting the Wait—at Least for a While: The NHS's Assault on Waiting Times*. In: *Great Policy Successes: Or, A Tale About Why It's Amazing That Governments Get So Little Credit for Their Many Everyday and Extraordinary Achievements as Told by Sympathetic Observers Who Seek to Create Space for a Less Relentlessly Negative View of Our Pivotal Public Institutions.* Edited by Mallory E. Compton and Paul 'T Hart, Oxford University Press (2019). © Oxford University Press. DOI: 10.1093/oso/9780198843719.003.0004

in UK politics; policy debate instead pivots on how well one is managing the NHS and success in framing reform as the preservation of its essential qualities.

This chapter investigates how this inherited dimension of legitimacy provided a political success anchor for an initially impromptu and highly contingent reform process to achieve notable programmatic improvement in waiting times in the NHS, where previously abandoned programmes were recombined in a strong emphasis on top-down targets alongside a significant boost in public expenditure eventually agreed by a strongly resistant Chancellor of the Exchequer (Minister of Finance), Gordon Brown.

Improving NHS Waiting Times: Assessing Success

The measurement of performance in a healthcare system as large and complex as the NHS is inevitably a multi-dimensional exercise, requiring different scales to capture separately each performance element. Further, attempts at creating aggregate composite indicators of performance always present a set of technical and philosophical questions. However, using the '3-P' evaluative framework from the introductory chapter, we can describe the reduction in NHS waiting times between 2000 and 2010 as a success in the following terms.

Political Success

Although the improvement in waiting times was temporary and, from 2013, under the Coalition government waiting time performance began to deteriorate on several measures, it contributed to the Blair government's electoral success (Kavanagh and Butler 2005). In electoral terms, increasing access to NHS services—reducing waiting times—was a salient issue and enjoyed widespread public support as a policy objective in the UK. The Labour government's success in this period contributed to its re-election in 2001 and 2005; the first time the Labour Party had won three consecutive general elections in British politics.

The political success of improved NHS waiting times endured. Early in David Cameron's tenure as leader of the opposition Conservative Party after the 2005 election, he committed to these reforms and maintaining funding levels in a big set piece speech (*The Guardian*, 4 January 2006). Even as the broader politics of public finance turned against Labour, particularly after 2008, there was bi-partisan commitment to NHS funding increases. Gordon Brown's 'golden rule', introduced in 1997, that taxes and current spending should match over an economic cycle was breached as UK public finances deteriorated markedly in the run up to the 2010 general election. Whilst the opposition crafted a politically successful narrative of the imperative for urgent deficit reduction, the NHS remained protected from the UK government's biggest post-war spending squeeze (Kmietowicz 2014).

Process Success

Assessing the case of improvements in NHS waiting times in *process* terms is not straightforward. At least initially the process appears highly contingent on a series of personal dynamics within the Labour government; triggered after almost three years in power by an impromptu announcement of extra financial resources by the Prime Minister Tony Blair on live TV rather than based on a carefully crafted strategy developed through thoughtful deliberation. Nevertheless, as the chapter discusses, there is evidence of subsequent political and bureaucratic leadership that supports a claim of process success.

Programmatic Success

In *programmatic* terms, success is much clearer cut. An underlying theory of NHS change was developed through a process of trial and error of different mixes of policy instruments guided consistently by top-down targets alongside allocations of substantial extra funding. This overarching programme was highly effective in marshalling the attention of the NHS around the policy issue of waiting lists. It also provided the means for discovering different policy mixes in terms of the use of incentives for improvement such as 'naming and shaming', patient choice and competition, organizational restructuring and commissioning.

The relationship between the three dimensions of success in the case is a sequence of politics to process to programme. Public demand for improved access to NHS services combined with the enduring political legitimacy of the NHS to produce conducive conditions for political leadership to prevail in lobbying for extra financial resources within government for the NHS and for waiting lists to be the central focus of reform efforts.

Finding Money for the NHS: Political Leadership at a Critical Juncture

The political leadership of Tony Blair as PM was successful in securing extra NHS resources against the wishes of the Chancellor of the Exchequer, Gordon Brown. Brown was not only the political head of historically the most powerful department in the UK government, HM Treasury (Brittan 1969; Talbot 2008), but also widely credited as the New Labour architect of the building of voter trust in the Labour Party's ability to manage the economy after their fourth successive election defeat in 1992. Self-styled as the 'Iron Chancellor', he operated with perennial concern that a single word out of place could undermine the Party's burgeoning reputation for fiscal competence (Campbell 2007). He became notorious (at least

among Labour backbenchers) during Labour's first two years in office for sticking rigidly to spending plans inherited from the previous Conservative government.

Blair's political success in committing the Labour government to increasing NHS spending significantly ahead of Brown's fourth budget as Chancellor in March 2000 was a politically significant event and trigger for the reform process. In one of the best insider accounts of the governmental dramas of New Labour, Rawnsley (2010: 77) quotes Brown as raging at Blair: 'You've stolen my fucking budget' in response to Blair's tactics in the budgetary process.

Winter crises in the NHS are a stock drama of British politics and the 1999–2000 version contained media reports of hospitals storing bodies in a freezer lorry because the mortuary was full. Alan Milburn, the Secretary of State for Health at the time, reports being convinced by that time that without a large increase in NHS expenditure a genuine modernization of the way the service operated was impossible (Milburn and Timmins 2002).

This was a critical juncture in the waiting times policy success. In what was initially an act of transactional leadership to appease restless Labour backbenchers, Blair pledged to bring NHS spending up to the EU average by 2006, an increase in the share of the UK national income devoted to the NHS of 1.5 percentage points, which implied annual cash increases of over 5 per cent in real terms each year, compared with an average NHS increase of 3 per cent over the previous two decades (Nicholas Watt in *The Guardian*, 17 January 2000; see also Table 4.1).

Blair's commitment was made on a Sunday morning live TV programme and was apparently impromptu. The commitment to a specific spending target was the catalyst for the waiting list reform process, in which Blair displayed a more transformational leadership style. Blair had complained publicly of 'the scars on

Table 4.1 NHS expenditure, 1999–2010 (in GBP bn, real terms using 2015 prices)

1999–00	70.4
2000–01	75.5
2001–02	82.1
2002–03	88.6
2003–04	98.2
2004–05	105.3
2005–06	111.0
2006–07	113.9
2007–08	118.2
2008–09	123.9
2009–10	130.0

Source: Institute of Fiscal Studies (2015), *Health Spending*.

my back' from trying to reform public services against the 'forces of conservatism' in his set-piece speech to the Labour Party conference in 1999 (*The Guardian*, 28 September 1999). A succession of junior health ministers had also been open with the claim that the NHS was too producer biased, organized as much for the convenience of its staff as its patients.

The commitment of substantial extra financial resources appears to have catalysed the reform process rather than the other way around. Since its election in May 1997, the Labour government had confined NHS policy to the dismantling of a suite of policy instruments introduced in the preceding Conservative government designed to create an 'internal market' in the NHS. During this period of historic increases in public expenditure, a series of policy mixes was eventually developed that were successfully implemented in terms of programmatic improvements in waiting list times.

However, as a process, the assessment of success is less clear, mainly because the financial commitment came first and then the NHS reform plans followed suit. As a reform process, this carries risks because all health systems are a mixture of financial resources and real resources of medical care. Increasing the former without productivity-enhancing reforms of the latter risks costs inflation rather than increases in the volume or quality of services provided. There is a well-known risk of healthcare inflation exceeding inflation in the rest of the economy (Baumol 2012).

Even if assessment of serendipity on the process dimension falls some way short of 'success' perhaps in the circumstances this process was the only way to link political success to programmatic success. As discussed in the next section, by 2000 there had been a decade-long reform process in the NHS characterized by significantly financially constrained environments.

The TV commitment was an early example of what came to be called 'sofa government' in the later Blair years. His 'brainstorming' style of leadership, famously telling senior civil servants to 'Call me Tony', produced informal discussions among smaller groups of advisers without a formal cabinet process. It is hard to establish quite where the financial commitments to the NHS came from. But as Milburn himself later acknowledged, there was a strong transactional element to Blair's leadership: opinion polls at the time were suggesting that people saw reducing waiting times as a critical element of health even if NHS staff did not prioritize them (Milburn and Timmins 2002). What is clear is that the commitment of extra resources focused efforts strongly on reducing the maximum waiting times for outpatient appointments and inpatient treatments.

The so-called 'war on waiting' led by Blair in a transformational style, started with the development of the eighteen-week target that subsequently directed the process of developing a policy mix that was successful in programmatic improvement terms. In Milburn's account, the senior officials at the Department of Health pushed for twelve months as the target for 2005, but the maximum wait in Europe was about three months. A close friend of Alan Milburn, who became

Secretary of State for Health in October 1999, died of a heart attack while on a waiting list to see a cardiologist; Milburn reports this as catalysing his own personnel commitment to improving NHS performance on waiting times (Timmins and Milburn 2002). Quoted by Timmins in the *Financial Times* (13 March 2010), Milburn began to understand as Secretary of State 'that for the public, waiting was the thing'. Cutting waiting times was not necessarily what staff wanted but this was what the public mood demanded.

Milburn claims success in persuading Blair to make this financial commitment. The key internal political dynamic of the Labour government was an ongoing feud between Brown and Blair (Campbell 2007; Rawnsley 2010). In this case, being bounced on TV provoked fury from Brown. However, the sustained increases in health expenditure did eventuate and this was important backdrop to the subsequent reform process.

With the money secured, the first in a series of 'once-in-a-generation' NHS reforms was launched in the summer of 2000, followed by similar rhetorical flourishes in reforms of 2002, 2004, and 2006. Targets came ahead of other instruments in the policy mix; the 2000 version included commitments to no more than a four-hour wait in accident and emergency, no more than a three-month wait for an outpatient appointment by 2005, and no more than six months for an inpatient operation by the same date.

Contexts, Challenges, and Agents of Reform

Klein (1990: 700) refers to the relationship between the government and the medical profession in the UK in NHS policy as the 'politics of the double bed'—the government secured an electorally popular and important public service in exchange for the medical profession securing favourable terms and conditions (most notably in terms of pay).

There were two 'rules of the game' that underpinned the institution of the NHS double bed between 1948 and the mid-1980s. The first was that each actor should trust the other on both the process and substance of policymaking. Wistow (1992) talks of trust becoming 'embedded' in the NHS policy community. This trust supported a consensus on how business was to be conducted, as Jordan and Richardson (1987: 101) describe it: 'the process by which and the atmosphere within which policy-making is decided'. In particular, this meant the exclusion of other potential interests in healthcare policy, for example, public opinion, Parliament, the rest of Whitehall, and hospital managers. Ham (1992), Webster (1988), and Klein (2005) describe how this exclusion became heavily institutionalized after 1948. The British Medical Association (BMA) had privileged access and a central role at every stage of the policymaking process.

The second rule was to be bound by the implicit contract (Wistow 1992; Klein 2005) between the government and the medical profession. The contract was that the former respected clinical autonomy in how to use resources but the latter accepted that the decision on the overall level of resources, the budgetary constraint, was a matter for the government. It was on the basis of the observance of these two rules that the healthcare policymaking in the UK has been described as a policy community.

It is the breakdown of this policy community that created the context conducive the waiting list reforms of New Labour. The Conservative government of John Major had introduced a range of NHS reforms in April 1991, the outcome of an extended and bitter reform process initiated by Margaret Thatcher after winning a third general election in June 1987. There is a consensus in the historical commentary on the NHS that these were the first significant reforms in its history (Webster 1998; Ham 1999; Klein 2005). They were designed to improve performance, including on waiting times, by addressing long identified weaknesses in its centralized management structure. As Wistow (1992: 59) put it, resource allocation within the NHS was 'determined largely by the sum of the individualistic behaviour of individual doctors rather than through a hierarchical process of resource management'.

The two 'rules of the game' of the healthcare policy community were not observed in this reform process. First, the trust between the government and the BMA on how business was to be conducted broke down. Second, the 'implicit contract' between the government and the BMA that set out the areas in which it was appropriate for each to take political action was not respected.

New Labour policy mixes on waiting lists strongly echo, and in most cases, are the direct descendants of the attempts by the Major government to compensate for the lack of 'the right economic signals' by introducing new incentive structures. The Major reforms were designed to encourage provider units and NHS staff to meet the 'limitless demand' for state-funded healthcare within a cash-limited, public budget (Thatcher 1993: 606). To this end, the reforms introduced an 'internal market' for NHS services, which separated the purchasing and provision of healthcare interventions, and allowed GPs to elect to hold a cash-limited budget for the purchase of a limited range of secondary care, staffing and pharmaceutical services (GP fundholding).

The NHS internal market, including the GP fundholding element, was abolished by the Labour government elected in May 1997 and marked the extent of its ambition on health policy reform until 2000. Nevertheless, the experience of NHS reform in the early 1990s was a key contextual factor in which waiting list policy developed after 2000. Notably the policy ideas around commissioning which emerged after 2002 have their direct origins in GP fundholding.

The internal market had been introduced and abolished without policy-makers having any useful evidence of its effects (Kay 2001). For example, the GP

fundholding scheme was abolished despite 57 per cent of GPs having opted to be fundholders by 1997/98. This figure had increased in every year of the scheme and was a proxy for the increasing acceptance of the scheme among GPs.

The Conservative government had decided against any appraisal, early evaluation, or piloting of the internal market, partly due to fears that the medical profession would sabotage such an enterprise in the aftermath of the very public battles with the BMA in the process of introducing the NHS internal market. Throughout the period 1991–7 the Labour Party, as the official opposition, maintained its commitment to abolish the internal market if elected to power. In a variety of contexts, it consistently made the claim that the GP fundholding scheme had created a 'two-tier' NHS. The accusation that fundholders had preferential access to secondary care, whilst it may have been true, was never actually substantiated. The major fundholding literature reviews (Petchey 1995; Baines et al. 1997; Gosden and Torgenson 1997; Smith et al 1997; Louden et al. 1998; Smith and Wilton 1998; Ham 1999) suggested that the evidence on the desirability and effectiveness of the scheme was both limited and equivocal when fundholding was abolished by the Labour government. Instead, the motivating factor for abolition seems to have been the history of fundholding as a political issue.

The Labour government's first Secretary of State for Health, Frank Dobson, suspended entry into the fundholding scheme in May 1997 and instructed hospitals to introduce common waiting lists for fundholding and non-fundholding patients. Six months later, the government published a white paper, *The New NHS: Modern, Dependable*, with proposals for a replacement. The 1998 National Health Service Act abolished the key elements of the internal market, and introduced Primary Care Groups (PCGs). Despite this being the zenith of commitments to evidence-based policymaking in UK government, there was no provision for: (i) the piloting of PCGs before their implementation; or (ii) a systematic evaluation of the fundholding scheme before its replacement.

Although Labour's plans allowed GP fundholding to be abolished without, in principle, discarding the effective aspects of the scheme, the absence of a systematic evaluation has meant that conclusive evidence on what aspects of the initiative worked was not available to the government or to PCGs. In the absence of clear evidence, many of the main policy mixes of the internal market, including fundholding recast as 'world class' commissioning after 2002, were never completely abandoned. Their redundancy was temporary and they were reintroduced into the NHS policy agenda in different ways and forms from the summer of 2000 onwards.

Evidence-based policymaking requires a degree of trust to exist between policy-makers and the part of society that is the subject of policy. In the case of the NHS internal market, there was an absence of trust in the relationship between the BMA and the government. Two main reasons account for this. First, the

scheme was the subject of strong party political opposition and the Conservative government had a long-held suspicion that the BMA had been working in 'unspoken alliance' with the Labour Party. Second, the scheme itself was deliberately divisive of GPs; it produced two groups, the fundholders and the non-fundholders. In a climate without trust, any evidence would inevitably be the subject of political manipulation, or in the current terminology, 'spin'.

As Hunter (1998: 133) puts it, in the UK 'Health policy has been driven by a mix of ideology, fashion and pragmatism but never by evidence.' The internal market episode illustrates the process problems associated with attempting to formulate health policy in the absence of reliable data on the effects and cost-effectiveness of new initiatives and those already in place. Policy-makers may have no means of identifying the strengths and weaknesses of the policy initiatives that they introduce, or determining what elements of existing policies should be incorporated into future schemes. Of course, what is required for a more evidence-based approach to policymaking is a detailed analysis or model of the significant motors of change in NHS general practice. However, to produce such work requires a commitment by government to systematic policy evaluation and a period of policy stability not observed in the NHS since the mid-1980s.

In political assessment terms, the major consequence of the internal market was a changed political context of NHS reform. Smith (1993: 165) suggests that: 'for most of the postwar period, the relationship between the government and the doctors can be characterised as a closed policy community'.

The NHS policy community between 1948 and the end of the 1980s favoured incremental and limited change because radical change threatened the consensus on which the community was based. These marginal adjustments to policy were developed through high level, closed, and routine relations with senior civil servants who shared a commitment to that policy. Within the healthcare policy community, 'conventional wisdom has emphasized the dominant nature of professional rather than political or managerial influences' (Wistow 1992: 51). This led Rhodes (1988: 78) to label the situation as a particular type of policy community, a 'professionalised network'. The medical profession enjoyed a large pool of political resources: notably control of technical and specialist knowledge. The perception of the medical profession as apolitical (in party political terms at least) helped give the views of the BMA a moral authority and make them, potentially, highly influential in public opinion (Klein 2005).

The institutional context also helps explain the political strength of the medical profession in Britain. The NHS is a publicly funded healthcare system, with publicly owned hospitals. From 1948, successive governments had relied on doctors to deliver healthcare policy. For this reason the healthcare policy community came to be highly institutionalized after 1948 with the medical profession having a central role at every stage of the policymaking process (Webster 1988; Ham 1992; Klein 2005).

Klein (2005), Smith (1993), and Wistow (1992) all suggest that the enactment of the 1991 NHS reforms, and GP fundholding in particular, unsettled the policy community in healthcare. The style of both the NHS Review and the subsequent enactment of the NHS and Community Care Act provided the threat. Kay (2001) argues that development of GP fundholding is the first observable indication of the breakup of the NHS healthcare policy community. Further, the development of the GP fundholding scheme was not based on evidence but rather guided by a 'folk theorems'; and this lack of an evidence-based approach was a consequence of the collapse of the healthcare policy community and has become typical of health policy reform in the UK over the subsequent quarter of a century.

The decision by the incoming New Labour government to abolish the internal market did not solve the problems of the NHS. Indeed, the salient challenge of waiting lists continued as queues grew unabated. As Alan Milburn observed, staff working in NHS wrestled with the consequences of significant ongoing organization changes from the introduction and abolition of the internal market and did not see waiting lists as the highest policy priority (Timmins 2010).

Reform Design and Choice

Despite Gordon Brown's initial strong resistance to Tony Blair's January 2000 financial pledge, the outturn was an unprecedented rate of growth in NHS spending of almost 7.5 per cent annually in real terms in the subsequent six years. This was the context to the policy design process on NHS waiting time reduction. The extra funding served to increase NHS capacity, something which was acknowledged in the publication of the Wanless Report (Wanless 2002) to the Treasury. The report set out detailed empirical analysis of the chronic underfunding of the NHS both comparatively but also in terms of pressures that changing health needs of the population placed upon the service. The conversion of financial resources into extra capacity to provide medical care facilitated policy design options that had not been previously available. However, politically, it had the effect of reinforcing internal pressure in the government for the NHS to deliver meaningful improvements in waiting times. The mantra that a 'step change in resources must mean a step change in reform' was repeated publicly by the Prime Minister, Chancellor of the Exchequer, and the Secretary of State.

The additional money and attendant politics put the NHS on an unexpected policy reform path three years after Labour taking office in 1997. The internal market and GP fundholding had been abolished in 1998 with a stress on cooperation replacing competition in the 1997 White Paper. Yet, importantly for the policy design process after 2000, the split between providers and purchasers (commissioning as it came to be known) remained in place. The idea of fundholding as a policy instrument endured in the PCGs, which soon evolved into

Primary Care Trusts (PCTs) and were to be responsible for commissioning the care needed by their populations. The 1997 NHS White Paper had argued that this represented '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' (quoted in Klein 2007: 41).

However, it was command and control—or targets and terror—that dominated initially in the policy design process after 2000. Klein (2007) reports that NHS managers estimated they had to meet 300-plus targets at one point. There was a highly-developed system of rewards and punishments for performance on the targets for reducing waiting lists. The 2000 NHS White Paper, *The NHS Plan*, was clear that the extra resources would mean reduced waiting times, bring an end to the postcode lottery in access to drugs, and lead to a more 'patient-centred' NHS.

The strength of the political commitment to an aggressive target-based policy to reduce the very long waiting lists for non-emergency care in the NHS was a change from 1997. Maximum waiting times, rather than total numbers waiting, were set on an annual basis, monitored monthly, and reduced each year. The 2000 NHS reform imposed the target on NHS hospitals in England of no patients waiting for inpatient treatment for more than eighteen months by the end of March 2001. The target was then scheduled to decrease annually by three months until the maximum waiting time was six months by the end of 2005.

Performance against targets was published widely and used as the basis for direct sanctions and rewards. Managers of poorly performing hospitals could be fired, while managers of high performing hospitals were granted greater autonomy in how they managed their hospitals and the freedom to keep certain surpluses. In policy design process terms, there were several distinctive features of this target-driven performance regime in the NHS. First, the targets were set over several years and scheduled to increase over time. Second, the penalties for failure to achieve these targets were judged by some experts as strong enough for the epithet 'targets and terror' and compared to the targets set for managers of state enterprises in pre-reform Soviet Russia (Bevan and Hood 2006).

Despite the visible political commitment from the Prime Minister to the targets in the 2000 NHS Plan, in policy design terms it arguably represents continuity from the 1997 White Paper—a shift to more highly powered incentives for performance improvement rather than fundamental change in the NHS. In the policy design process, the controversial ideas of patient choice and competition only came two years later when the government published its third major White Paper of its then five-year tenure, *Delivering the NHS Plan* (Department of Health 2002). Milburn and Timmins (2002) report this as the critical juncture in their understanding of the reform design process, where Milburn—as Secretary of State for Health—accepted the limitations of the command and control system that he and his predecessor had developed steadily since 1997. By the summer of 2001, while the very longest waits were beginning to be eliminated, it appeared

that the extra financial resources allocated to the NHS were still not producing a significant increase in activity, in terms of the number of patients who were being seen and treated.

The centralized approach to managing the NHS from Whitehall was being questioned inside and outside the Labour government (Greener et al. 2014). The policy design process began to involve the development of options for other policy instruments to complement top-down targets and tough performance management. Policy ideas were revived from the abandoned inheritance from the Conservative government internal market reform efforts in the 1990s.

A recognition of the limits of top-down approaches to an organization on the scale of NHS England in the party which introduced the NHS is significant. It touched on a perennial theme in NHS policy and politics of devolving power, and arguably touched on big questions of decentralization of the UK state more broadly. The oft-quoted dictum of the Labour cabinet minister who led the introduction of the NHS in 1948, Aneurin Bevan, was that if a hospital bedpan is dropped in a hospital corridor in Tredegar (his South Wales constituency), the reverberations should echo around Whitehall. As described below, any deviation from this was controversial in Old Labour circles as a seeming abandonment of principles of territorial equity and tantamount to surrendering democratic control in favour of unaccountable hospital managers, still further the thin end of the wedge of full-scale privatization of the NHS. Decentralization in the NHS remains an important and ongoing agenda of 2018 health policy discussion in the UK.

The 2002 White Paper set out the main NHS policy trajectories for the rest of the New Labour period in office: a devolved NHS, a diversity of providers competing, payment by results, and patient choice as the central value to be represented in policy. In doing so, the balance of political power within the NHS was tilted: for example, in the concept of Foundation Trust status to reward efficient NHS primary care and secondary care organizations by granting them autonomy. Practice-based commissioning—GP fundholding in 1990s terminology—and national standards against which the performance of trusts would be assessed were also introduced.

In terms of the policy design to reduce NHS waiting times, the central policy instrument for performance management was a system of star ratings. This was applied to hospitals from 2001; each organization being evaluated was given a score on a scale of 0 to 3 stars based on performance on a limited range of key targets as well as against a wider range of targets and indicators on a balanced scorecard. Six of the nine key targets concerned waiting lists and one of the three domains, patient focus, in the balanced scorecard was dominated by data reported against waiting time targets. Hospitals that failed to achieve key targets were rated zero and publicly 'named and shamed' as failing. The possible sanction on hospital chief executives was losing their jobs. Timmins (2010) reports that among chief executives of NHS hospitals, the waiting time goals were better known as P45

targets. In the UK, a P45 is the tax form given to an employee when they stop working for an organization. It is used colloquially to mean being sacked. Six of the twelve chief executives of hospital trusts given zero rating in 2001 were sacked. Organizations that performed well on both the key targets and the balanced scorecard, and achieved the highest rating of three stars, were rewarded by being publicly celebrated for being high performing and ceded various forms of earned autonomy (Bevan and Hood 2006).

Following Labour's initial success with its literacy and numeracy strategy, Blair had created a Delivery Unit in Number 10 headed by Michael Barber. Its purpose was to drive through his key public sector reforms, not just for health, but for education, crime, and transport. The unit tracked progress on waiting times almost daily. Barber (2007) reports that critical to progress on waiting times through top-down targets was that Blair held scheduled monthly meetings with Milburn to take stock of progress on waiting times using real time data. Milburn then pressed the department's civil servants who in turn pushed hospital chief executives on performance problems. Some of these executives report getting weekly phone calls from the government; when they struggled to redesign services to reduce waiting times, specialist teams were assigned 'to help them'. For both Barber and Milburn (Barber 2007; Milburn and Timmins 2002) the scheduled monthly attention of the Prime Minister on waiting times really mattered in terms of performance. For these two key actors, the 'brutal' performance management regime (Bevan and Hood 2006) represented the first time in NHS history that there was a clear line of sight in accountability terms from the Prime Minister down to hospital chief executives in charge of delivery of medical care at the street-level.

From 2002 onwards, the policy design process took a highly controversial turn. The 2002 White Paper signalled a series of policy instruments to promote competition and choice in the NHS. Although presented as the next phases in the 'war on waiting' (Harrison and Appleby 2005), the introduction of privately run surgical units, known as independent sector treatment centres, to treat NHS patients was bitterly contested. Further controversy followed with the creation of Foundation Trusts—free-standing hospitals no longer directly answerable to Whitehall and run autonomously as businesses with ultimate responsibility for their own performance. And finally, patients were given the right to choose where they were treated, initially within the NHS, but then at any private hospital prepared to take them at the NHS price. After a very slow start, the numbers of people taking advantage of this right began to grow.

This was deeply unpopular within parts of the NHS and, even in 2018, this period of reform is sometimes regarded by critics of New Labour as the beginning of the privatization of the NHS. The BMA referred to the 'commercialization' of the NHS and saw this as the slippery slope idea that private companies should make profits out of healthcare. It was also unpopular with many Labour

backbenchers. However, most of these choice and competition reforms could be achieved through existing ministerial powers rather than requiring new legislation. With Blair committed to a more market-like approach to reforming public services more generally, successive secretaries of state for health continued to implement internal market type reforms. The significant policy design for which primary legislation was needed—the creation of Foundation Trusts—produced some of the biggest backbench rebellions of Blair's time as Prime Minister. There were nine rebellions during the passage of the Health and Social Care (Community Health and Standards) Act that established Foundation Hospital Trusts.

This mix of policy instruments made the difference in reducing waiting times to the shortest in the NHS's sixty-year history by 2010. The extra spending went throughout the NHS and large pay rises. There is no available estimate on how much specifically went on waiting lists for elective surgery (which accounts for about 12 per cent of total expenditure) but it was clearly focused.

Delivery, Legitimacy, and Endurance of the Waiting Times Reduction Effort

In 1997, Sir Michael Barber was the key figure in setting the recently elected Labour government's initial targets on literacy standards as Head of the Standards and Effectiveness Unit under David Blunkett at the Department for Education and Employment. He became head of the Prime Minister's Delivery Unit in the second term of Tony Blair but left government for a consultancy career after Blair's third election victory in 2005. He was the New Labour face of a whole set of implementation routines in Whitehall and credited with introducing a widely-lampooned bureaucratic vocabulary: New Labour ministers talked in terms of trajectories of travel, stocktakes, delivery reports, and traffic light systems. The term 'deliverology', initially a pejorative term coined by senior civil servants for Barber's endeavours and personal style, became a firmly established neologism in the administrative history of this period of UK government.

Barber (2007) gave an insider account of the use of targets for programmatic success even if, politically, the UK media was wont to ignore successes against target and instead concentrated exclusively on the manipulation of statistics in the presentation of performance and the outright failures. He explains in his personal account of this period that there was relatively little attention given to the accuracy or validity of performance data on which the target system was based. Many experts highlighted the problems reconciling and/or linking administrative and survey data on health service waiting times (Bevan and Hood 2006). However, for Barber, the targets focused attention with a clear success definition, expressed political priority, and forced honest and sometimes uncomfortable conversations about bad news and surprises. Routine oversight was the priority over measurement accuracy.

The devolution process launched by Blair's government immediately after election has been avoided hitherto in the chapter. It is part of the waiting times story. Following referenda in Scotland and Wales in September 1997, the Scottish Parliament and National Assembly for Wales were established with management of the delivery of healthcare devolved such that analysts talked of four NHSs (Greer 2004). As such, devolution in the UK offers some potential for a natural experiment to reveal some evidence that the 'targets and terror' of New Labour (England) was successful in programmatic terms.

The analysis presented by Propper et al. (2008, 2010) shows waiting times having fallen far faster in England than in either Wales and Scotland in the decade after devolution. Both devolved administrations received broadly similar increases in NHS spending in real terms as England though a mixture of bureaucratic by-passes of the Barnett formula and local decisions over the allocation of block funds. Both Scotland and Wales had higher NHS expenditure per capita baselines in 2000. All three adopted similar waiting time targets. However, only in England were these accompanied by the strong top-down performance management and 'naming and shaming' described above.

In the literature that looks at Scottish and Welsh devolution in the NHS, there is a seam of research looking at differential impacts of waiting times targets. Alvarez-Rosete et al. (2005) and Bevan and Hood (2006) examined trends at the England, Scotland, and Wales level. Hauck and Street (2007) undertook a detailed analysis across three English hospital trusts and one Welsh hospital trust close to the border between Wales and England. Propper et al. (2008) looked at differences between England and Scotland and estimated difference-in-difference models of the proportion of people on the waiting list at three points in the waiting times distribution (the proportion who waited over 6, 9, and 12 months). Besley et al. (2008) compared waiting times for hospitals in Wales with those in England.

Each of these peer-reviewed publications suggests that the waiting times targets and associated performance regime did reduce waiting times in England. Propper et al. (2008) estimate the effect of the English target regime for waiting times by a comparative analysis with Scotland, which did not adopt the target regime. They report that the 'targets and terror' regime after 2000 in England lowered the proportion of people waiting for elective treatment relative to Scotland. In a follow-up study as a natural experiment, Propper et al. (2010) examined whether the falls in waiting times had been the result of gaming and diversion of activity or had produced adverse effects on the quality of medical care. Their finding was unequivocal: the use of targets as a policy instrument backed by performance management succeeded in meeting the goals of reducing waiting times without diverting activity from other less well monitored aspects of healthcare and without decreasing patient health on exit from hospital.

In Scotland, in contrast, the Scottish Executive (responsible for health policy) had chosen not to adopt this target regime. Instead, from devolution in 1999, it

focused on the abolition of the 1990s internal market and the re-introduction of a professionally-led, integrated system based on concepts such as managed clinical networks (Alvarez-Rosete et al. 2005). Targets played little role. In Wales, not using NHS targets and performance management was celebrated as a highly visible demonstration of 'clear red water' between Welsh First Minister, Rhodri Morgan and Tony Blair. Instead, the Old Labour approach of top-down organizational restructures were the preferred policy instrument in Wales.

How far competition and choice—which the Scots and Welsh also eschewed—made a difference in waiting time performance is more debated (Greener et al. 2014). The number of NHS operations carried out by the independent sector treatment centres and private hospitals is very small compared with the NHS's own activity. The existing published studies on the question—Propper et al. (2008); Harrison and Appleby (2005, 2009); Bevan and Skellern (2011); Cooper et al. (2012); Miller et al. (2012)—are inconclusive on the nature and scale of the role patient choice and competition plays in the policy mix. There is some limited evidence to suggest that competition between hospitals may improve the quality of care (Propper et al. 2008, 2010).

Anecdotally, there is expert opinion from NHS insiders that choice and competition produced a fear that hospitals would lose patients and affected performance. Duncan Selbie, the NHS performance director for much of the 2000s was quoted in the *Local Government Chronicle* (20 September 2012) suggesting that this was an important part of the policy mix. Timmins (2010) reports further anecdotal evidence to back up this view. For example, Mike Parish, chief executive of Care UK, one of the independent sector treatment centre providers, recalls a conversation with an NHS hospital chief. 'I asked him why his activity and productivity had gone up. "Well," he said, "we don't want one of those bloody ISTCs on our doorstep".'

Governing the NHS by Performance Targets: Analysis and Conclusions

As a tax-funded service, the NHS had always been more centralized than other healthcare systems. Bevan's dictum about bedpans in the South Wales valleys being monitored in Whitehall, as a guide for governing and public administration, was never practical, and never achieved practically. But over the decade before 2000, waiting lists had emerged as a public issue as did the gaps in performance between the most efficient and the least efficient providers. In political assessment terms, ministers were answerable for every dropped bedpan in the NHS or each individual case on the waiting list: there was a centralization of blame.

The NHS has endured as a cherished British institution despite repeated concerns about its actual performance in delivering healthcare to UK citizens. The chapter investigates how the pattern of political success relative to policy

performance catalysed a reform process and, in the case of NHS waiting times, produced significant programmatic success in improved access to NHS services over the decade from 2000. The waiting times case has been presented a sequenced pattern of policy success; from politics to process to programme. The sequence in the case is highly contingent, with various reform processes only being triggered in the context of an unprecedentedly quick redistribution of national income towards healthcare provision—a fiscal decision itself made apparently off the cuff on a UK television show.

The use of top-down performance targets fell out of fashion long before the electoral defeat of the Labour government in 2010; one Labour Health Secretary, John Reid, introduced the much-ridiculed target for reducing targets. However, the evidence suggests that targets and aggressive performance management did play an important part in the policy mix to reduce waiting times without negative side effects on patient health.

There are several reasons for this programmatic success. First, because long waiting lists were seen as a problem by most of society, and were salient in Westminster politics terms, the targets may have acted as a mission for NHS employees, inducing additional effort at no cost. Second, the fact that the targets were announced in advance and were escalating may have meant that production was reorganized on a long-term basis, so increasing productivity over the long term, rather than simply resulting in short-term fixes to a one-off policy. Finally, the policy was accompanied by extra resources. While we have established that our results are robust to controls for resources, it is probably easier to engage in extensive service reorganization in a time of generous resources.

The case of NHS waiting times indicates programmatic success but also reveals an unexpected capacity for bricolage in the UK leading to process success. Labour strongly opposed the Conservatives' internal market reforms in the 1990s but came to adopt and adapt them after several years of policy inertia after 1997. Whilst Whitehall is littered with policy failures, a number of unsung successes in NHS policy do seem to have been remembered in the reform process that developed the waiting times policy mix.

Thinking about any NHS policy reform as a distinct period with an end, a plaque or ribbon cutting moment is misguided. Health reform is a hardy perennial of British politics. This means new reform initiatives, problem definitions, and options for change all become temporally fused with implementation. In policy cycle terms, whilst there is feedback and possibly lessons to be extracted because the cycle is spinning at a cadence of major reforms per two years, the implementation of a specific reform though a distinct activity is not a distinct period. Indeed, in several implementation programmes, interim evaluations of pilot projects were starting just as the policy under which they had been initiated was being abolished.

The temporal compression of NHS reform processes has meant that folk theorems, anecdotes, and ad hoc hunches have often driven policy, rather than

considered evidence bases. Implementing major healthcare reforms takes a lot of time and consistent direction; whilst obvious points in the abstract, time and consistent political commitment have often been difficult to detect in most NHS reforms of the last twenty-five years or so. This backdrop makes the assessment of policy success in this chapter notable.

Of course, NHS reform is never a one-shot game but rather a repeated political game. The inherent features of NHS politics continue to apply after any policy instrument is introduced or policy mix designed; the gap between policy as designed and policy as executed is always at the centre of academic study of implementation. As new models in the process are implemented, they coexist with the command-and-control structure built up in earlier years. The NHS landscape therefore represents an often confusing mix of different, overlapping policy strata. Healthcare reform never starts from a *tabula rasa*; instead policy is 'layered' to use a term from academic literature on institutions.

To overcome tensions and difficulties of implementation requires consistent prime ministerial attention, and arguably from a prime minister in the ascendant politically, in order overcome the potential for bureaucratic inertia, resistance, transition/switching costs, and transaction costs between old and new elements in the system that all come into play in the implementation. The pre-Iraq War Tony Blair appears in retrospect to have been good at keeping the guiding principles of NHS reform alive. His mantra that 'I have no reverse gear' (*The Guardian*, 1 October 2003) did serve to push the Labour Party in a reform direction which subsequently has been not just abandoned but thoroughly repudiated.

Additional version of this case

The case study outlined in this chapter is accompanied by a corresponding case study from the Centre for Public Impact's (CPI) Public Impact Observatory—an international repository of public policies assessed for their impact using CPI's Public Impact Fundamentals framework. CPI's framework provides a way for those who work in or with government to assess public policies, to understand why they were successful, so key lessons can be drawn out for future policy work. The case can be easily located in the CPI repository at www.centreforpublicimpact.org/observatory.

References

Alvarez-Rosete, A., G. Bevan, N. Mays, and J. Dixon. 2005. 'Effect of Diverging Policy Across the NHS'. *British Medical Journal* 331(7522), 946–50.

Baines, D., K. Tolley, and D. Whynes. 1997. *Prescribing, Budgets and Fundholding in General Practice* (London: Office of Health Economics).

Barber, M. 2007. *Instruction to Deliver: Tony Blair, Public Services and the Challenge of Achieving Targets* (London: Politico Books).

Baumol, W. J. 2012. *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (New Haven, CT: Yale University Press).

Besley, T., G. Bevan, and K. Burchardi. 2008. 'Accountability and Incentives: The Impacts of Different Regimes on Hospital Waiting Times in England and Wales'. Mimeo. London School of Economics. http://econ.lse.ac.uk/staff/tbesley/papers/nhs.pdf.

Bevan, G. and C. Hood. 2006. 'What's Measured is What Matters: Targets and Gaming in the English Public Health Care System'. *Public Administration* 84(3), 517–38.

Bevan, G. and M. Skellern. 2011. 'Does Competition between Hospitals Improve Clinical Quality? A Review of Evidence from Two Eras of Competition in the English NHS'. *British Medical Journal* 343, d6470.

Brittan, S. 1969. *Steering the Economy: Role of the Treasury* (London: Martin Secker & Warburg).

Campbell, A. 2007. *The Blair Years* (London: Random House).

Coper, Z., S. Gibbons, S. Jones, and A. McGuire. 2011. 'Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms'. *The Economic Journal* 121(554), F228–60.

Department of Health. 2002. *Delivering the NHS Plan* (London: The Stationery Office).

Gaynor, M., M. Laudicella, and C. Propper. 2012. 'Can Governments Do It Better? Merger Mania and Hospital Outcomes in the English NHS'. *Journal of Health Economics* 31(3), 528–43.

Gosden, T. and D. Torgenson. 1997. 'The Effect of Fundholding on Prescribing and Referral Costs: A Review of the Evidence'. *Health Policy* 40, 103–14.

Greener, I., R. Harrington, D. Hunter, R. Mannion, and M. Powell. 2014. *Reforming Healthcare: What's the Evidence?* (Bristol: Policy Press).

Greer, L. S. 2004. 'Four Way Bet: How Devolution Has Led to Four Different Models for the NHS'. Report. University College London, The Constitution Unit.

Ham, C. 1992. *Health Policy in Britain* (Basingstoke: Macmillan).

Ham, C. 1999. 'Improving NHS Performance: Human Behaviour and Health Policy'. *British Medical Journal* 319, 1490–2.

Harrison, A. and J. Appleby. 2005. *The War on Waiting for Hospital Treatment* (London: King's Fund).

Harrison, A. and J. Appleby. 2009. 'Reducing Waiting Times for Hospital Treatment: Lessons from the English NHS'. *Journal of Health Services Research & Policy* 14(3), 168–73.

Hauck, K. and A. Street. 2007. 'Do Targets Matter? A Comparison of English and Welsh National Health Priorities'. *Health Economics* 16(3), 275–90.

Hunter, D. 1998. 'Review of Martin Powell, Evaluating the National Health Service'. *Journal of Social Policy* 27(1), 132–4.

Jordan, A. G. and J. J. Richardson (eds). 1987. *Government and Pressure Groups in Britain* (Oxford: Clarendon Press).

Kavanagh, D. and D. Butler. 2005. *The British General Election of 2005* (Basingstoke: Palgrave Macmillan).

Kay, A. 2001. 'Beyond Policy Community: The Case of the GP Fundholding Scheme'. *Public Administration* 79(4), 561–77.

Klein, R. 1990. 'The State and the Profession: The Politics of the Double Bed'. *British Medical Journal* 301, 700–2.

Klein, R. 2005. *The New Politics of the NHS* (London: Longman).

Klein, R. 2007. 'The New Model NHS: Performance, Perceptions and Expectations'. *British Medical Bulletin* 81–2, 39–50.

Kmietowicz, Z. 2014. 'Cameron Promises to Ringfence NHS Budget in Next Parliament'. *British Medical Journal* 349, g6002.

Louden, I., J. Horder, and C. Webster. 1998. *General Practice under the NHS 1948–1997* (Oxford: Clarendon Press).

Milburn, A. and N. Timmins. 2002. 'A Time for Change in the British NHS: An Interview with Alan Milburn'. *The People-to-People Health Foundation*. HealthAffairs.org.

Miller, R., S. Peckham, K. Checkland, A. Coleman, I. McDermott, S. Harrison, and J. Segar. 2012. *Clinical Engagement in Primary Care-Led Commissioning: A Review of the Evidence*. Technical Report (London: Policy Research Unit in Commissioning and the Healthcare System) (PRUComm).

Petchey, R. 1995. 'GP Fundholding: Weighing the Evidence'. *Lancet* 346, 1139–42.

Propper, C., M. Sutton, C. Whitnall, and F. Windmeijer. 2008. 'Did "Targets and Terror" Reduce Waiting Times in England for Hospital Care?' *The B.E. Journal of Economic Analysis and Policy* 8(2). https://doi.org/10.2202/1935-1682.1863.

Propper, C., M. Sutton, C. Whitnall, and F. Windmeijer. 2010. 'Incentives and Targets in Hospital Care: Evidence from a Natural Experiment'. *Journal of Public Economics* 94, 318–35.

Rawnsley, A. 2010. *The End of the Party* (London: Viking).

Rhodes, R. 1988. *Beyond Westminster and Whitehall* (London: Unwin Hyman).

Sheers, O. 2018. *To Provide All People: A Poem in the Voice of the NHS* (London: Faber & Faber).

Smith, J., M. Bamford, C. Ham, E. Scrivens, and J. Shapiro. 1997. *Beyond Fundholding: A Mosaic of Primary Care-Led Commissioning and Provision in the West Midlands* (Birmingham: Health Services Management Centre).

Smith, M. 1993. *Pressure, Power and Policy* (London: Harvester Wheatsheaf).

Smith, R. D. and P. Wilton. 1998. 'General Practice Fundholding: Progress to Date'. *British Journal of General Practice* 48(430), 1253–57.

Talbot, C. 2008. 'Performance Regimes: The Institutional Context of Performance Policies'. *International Journal of Public Administration* 31(14), 1569–91.

Thatcher, M. 1993. *The Downing Street Years* (London: HarperCollins).

Timmins, N. 2010. 'How New Labour Succeeded with NHS Policy'. *The Financial Times*, 13 March.

Wanless, D. 2002. *Securing Our Future Health: Taking a Long-Term View*. Final Report (London: HM Treasury).

Webster, C. 1988. *The Health Services since the War, Vol. I: Problems of Health Care, the NHS before 1957* (London: HMSO).

Webster, C. 1998. *NHS Reorganisation: Learning from History* (London: Office of Health Economics).

Wistow, G. 1992. 'The Health Service Policy Community: Professionals Pre-eminent or under Challenge?' In D. Marsh and R. A. W. Rhodes (eds), *Policy Networks in British Government* (Oxford: Clarendon Press), pp. 51–74.