

IS NHS FUNDING IN CRISIS?

NIESR General Election 2017 - Briefing No. 5

Prof Peter Dolton

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NHS Funding

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Key points

- More money is being spent on the NHS in real terms than ever in its history. We now spend an average of £2,160 per person, per year on health care. We also now commit a higher fraction of our GDP to Government Health Spending than at any time in the past – it has risen from under 4.7% of GDP in 1997 to 7.6% in 2015. However, we spend less of our GDP on health than many major industrialized nations. For example, the figure in France is 8.7% and in Germany it is 9.4%.
- The NHS is variously predicted to have an aggregate funding shortfall of £20-30 billion by 2020/21. The major political parties either do not acknowledge the severity of this financial position or do not seriously address how the revenue would be raised to solve the problem.
- Currently, NHS Trusts in England are in combined deficit to the tune of over £750 million. At the same time, there has been: a 60% rise in hospital referrals and a 65% rise in A&E attendances in the last 13 years with a halving of available hospital beds in the last 25 years. Many A&E departments in hospitals now routinely miss their 4-hour maximum wait target and there are record numbers of GP vacancies and many GP practices closing. The main driver of these problems is that we have an ageing population who require extra spending as they get older.
- If we wish to see spending on the NHS rise we will need to: increase taxes, or spend a higher fraction of public spending on health (at the expense of some other public service). Alternatively, if we wish to see the NHS remain the same in terms of service delivery, we either need to make substantial efficiency gains, or consent to being charged for certain services. The main political parties are not realistically discussing all these alternatives.
- The evidence that there is suggests that patient satisfaction with the NHS is higher than it has ever been. The biggest problems patients have with the NHS are that it takes too long to get a GP appointment and that there are not enough staff or resources in the NHS.
- Is the electorate willing to have Income Tax rise to pay for more NHS funding? Recent research evidence suggests 72% of the public do not think more Income Tax should be raised to fund the NHS.

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Introduction

In the run up to this 2017 election many politicians talk as if there was only a single important issue - namely - Brexit. Most politicians, and the majority of the electorate, are agreed that Britain is leaving the EU. What will become of our trading relations with other countries in the future is largely a matter of negotiation which will take place over the next few years. Therefore – as far as the electorate is concerned - the central, most important, real issue, now affecting ordinary people is Health and Social Care, and its funding into the future. This is because, we are all patients, and we all care about the NHS and it's funding.

The Conservatives report that funding in the NHS has never been higher. But the opposition parties suggest that we are in the middle of the biggest funding crisis ever faced in the NHS, and talk of funding cuts, marketization, privatisation by the back door, lengthening waiting lists and staff morale being at an all-time low. What is the truth of the position – are we in the middle of a crisis? This Briefing Paper will set out the facts of the current NHS funding position, and provide a context on the bewildering array of reforms and policies which have hit the NHS in the last 20 years. We will let the data speak for itself by presenting it objectively.

This will provide the backdrop to understanding what the major political parties are proposing to do about with the NHS in the future. We will recap their main policy views on health care provision and, where appropriate, provide neutral commentary on the feasibility of their proposals. In the penultimate section, we will present some evidence of what voters think of the NHS and the extent to which they are ready and willing to pay extra to fund health care. In the final section, we will provide a perspective on the NHS funding debate and overview the policies, which the major parties have proposed.

The UK Context

The UK's Financial Position.

The country's capacity to spend public money on the NHS must depend, for the most part, on its: fiscal position, public deficit, growth in GDP and its capacity to raise revenue through taxation. It must also depend on the hard choices it faces about spending public money on the NHS rather than, Education, Defence, or the other public services. Following the 2008 financial crisis, the UK has had a hard time recovering. In 2016, out of 35 advanced countries, the UK had the fifth largest deficit. In order to eliminate this deficit before 2022, the UK would need an extra £15bn more in net tax rises (and/or spending cuts) than what has currently been planned. Even so, after seven years of austerity measures, overall public spending, only now in 2017, is close to pre-crisis levels as a fraction of GDP. Notwithstanding this gloomy picture it is important to note - as we shall describe - that whilst public spending has fallen, spending on healthcare has increased in real terms, as well as, as a fraction of national income ¹

¹ Emmerson, C (2017)

In addition to the impact of the deficit on spending habits, the UK will face challenges in increasing its revenues. As it currently stands, nearly two thirds of revenues come from three sources. These are income tax, national insurance contributions and VAT.² Given, that despite the growth in employment rates, average earnings have been declining³, UK tax revenues will also decline if adjustments for this are not made. With a declining tax base these factors considerably limit the capacity of the government to propose spending.

The current NHS climate

Health Care Spending

Government spending on health in the UK has been rising in real terms for the last 50 years. The clearest graph to show this is from the IFS and is reproduced in Figure 1. Here we see that by 2016/17 aggregate UK spending in real terms has risen to over £140bn. On the same graph the real spending, as a percentage of national Income, is also plotted. The IFS has been careful to calibrate only public state expenditure on health. So, it specifically excludes private health expenditure and health insurance spending. We can see that this fraction has been steadily rising to its 2016/17 level of around 7.4%.⁴ Figure 2 charts the rise of per capita spending that underlies the aggregate spending pattern in Figure 1. Here we see that per person spending has risen from under £500 per person per year in 1970/71, to £2160 per person per year in 2016/17 real prices. So the claims of the current government, and recent past governments is true – namely – that there has been a considerable extra investment in the NHS. However, if we look more closely at the levels of changes in NHS spending in recent years, in Figure 3, we see that since 2010 this rate of increase has slowed considerably to around 1% growth. Prior to this, over the years 1997-2010, under the Labour Government, NHS spending had grown between 2% and 10.5%, per year, averaging 6% per year over this 13-year period. There was a huge increase in extra resources for the NHS, which has slowed under the Coalition Government and the Conservatives from 2015.

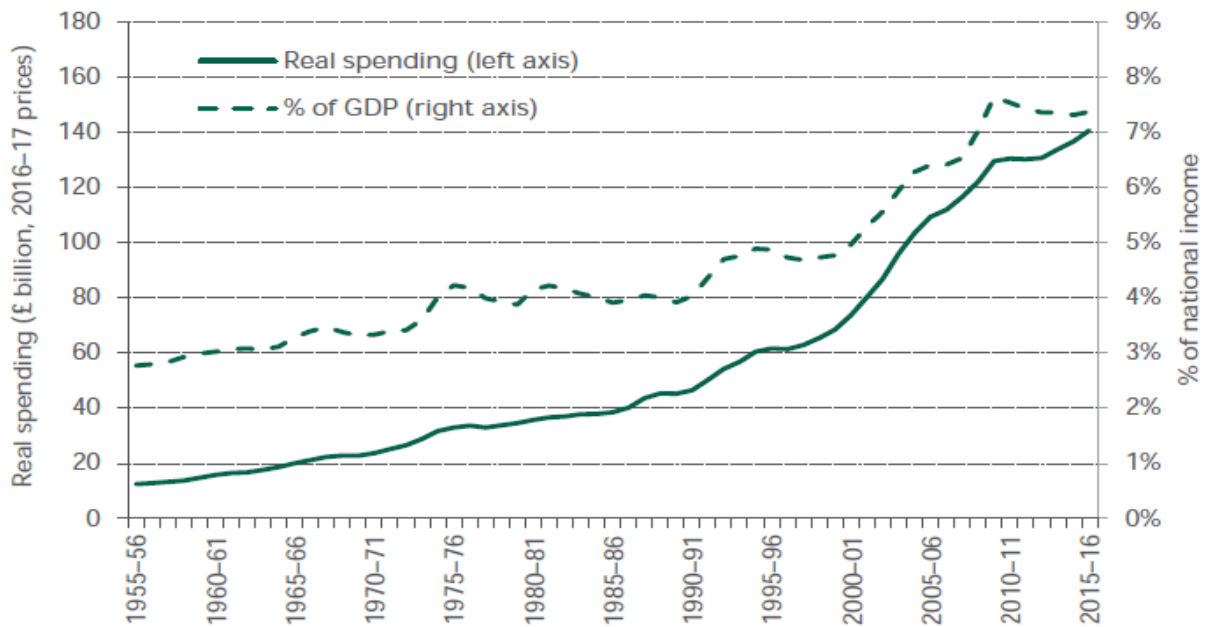
Another important component of the current position is that this increase in spending has not been mirrored in other areas of public services. Figure 4 shows how spending on the NHS has been rising as a fraction of total public spending and total public service spending. This means that there has been some considerable displacement going on with NHS spending rising at the expense of other public services which have been cut back.

² Miller and B, Roantree (2017)

³ Cribb., R, Joyce and A.N,Kieller (2017)

⁴ This figure is slightly at odds with that reported by the OECD which we consider later in Figure 6.

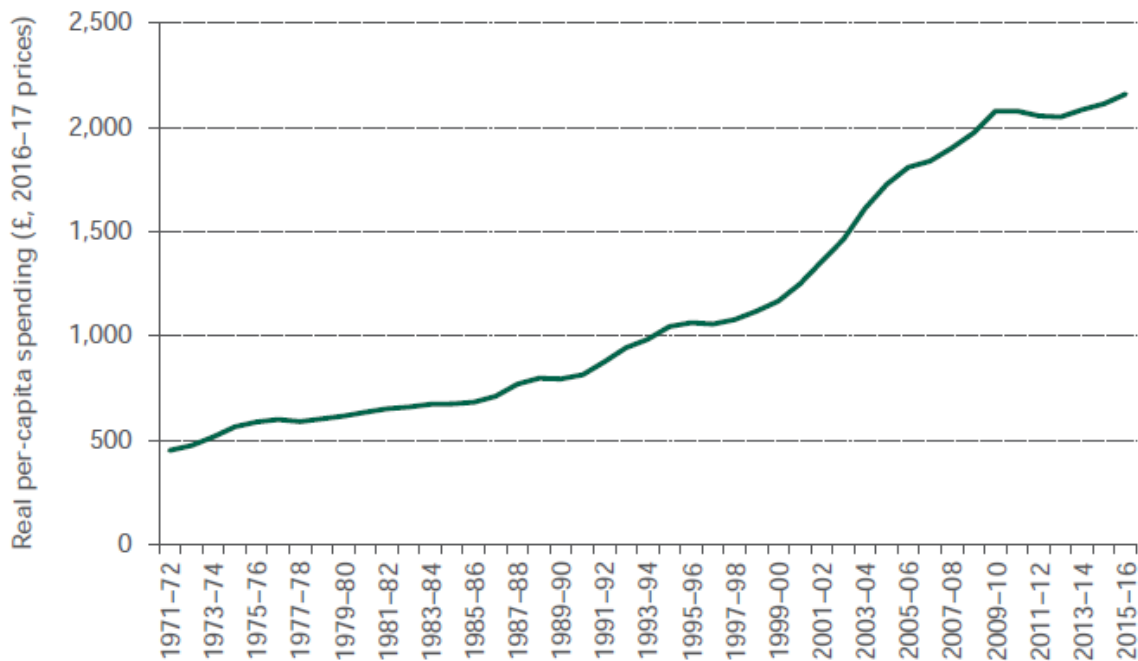
Figure 1: Annual UK public spending on health in real terms (2016–17 prices) and as a percentage of national income, 1955–56 to 2015–16



Source Luchinskaya et al (2017) Figure 5.3.

Note: Nominal health spending data from Office of Health Economics (1955–56 to 1990–91) and HM Treasury *Public Expenditure Statistical Analyses* (1991–92 to 2015–16). Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016.

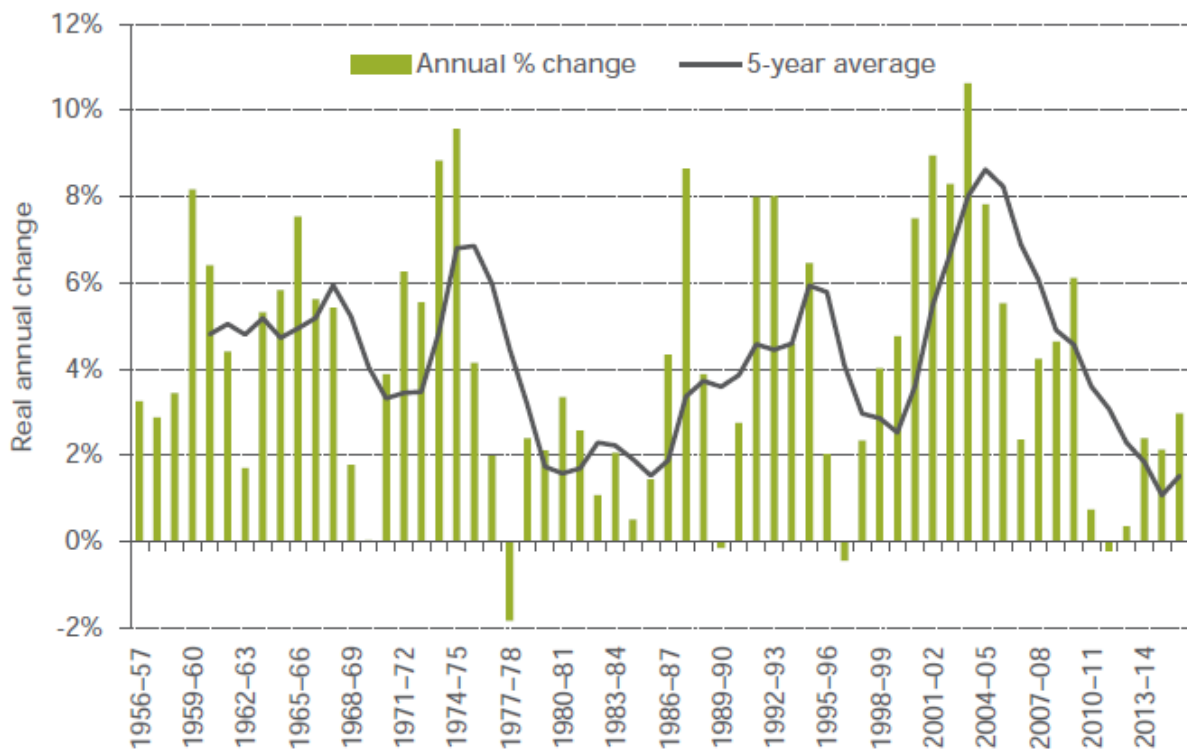
Figure 2: Real per-capita public spending on health (2016–17 prices), 1971–72 to 2015–16



Source Luchinskaya et al (2017) Figure 5.4.

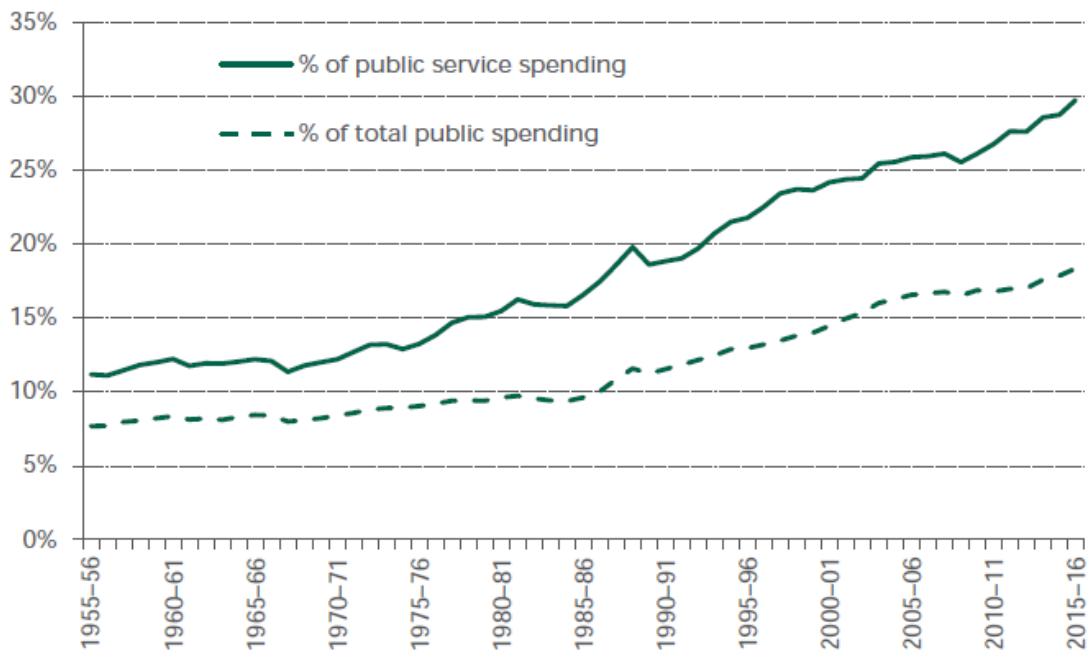
Note: Nominal health spending data from Office of Health Economics (1971–72 to 1990–91) and HM Treasury *Public Expenditure Statistical Analyses* (1991–92 to 2015–16). Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016. UK population data available on an annual basis (but not financial year) from the Office for National Statistics (ONS) mid-year population estimates (June 2016 release)

Figure 3: Annual real growth rate in UK public spending on health, 1956–57 to 2015–16.



Source Luchinskaya et al (2017) Figure 5.2.

Figure 4: Annual UK public spending on health as a percentage of total public and public service spending, 1955–56 to 2015–16.



Source Luchinskaya et al (2017) Figure 5.3.

Note: Public spending is total managed expenditure. Public service spending is defined as total public spending less spending on gross debt interest and less spending on benefits and tax credits.

Historically, the UK on average has spent less on healthcare as a percentage of GDP than comparable countries in Europe. This is total health spending from all sources. In 2000, the then government started to close the gap in expenditure between the UK and the EU 14. UK health spending totaled 8.8% of UK GDP in 2009. Figure 5 shows that the latest OECD estimate of this percentage has risen to 9.8%, which places us just at the EU average. The country comparison position looks somewhat worse if we consider expenditure per head in terms of \$PPP terms in 2016 prices. Measured in this way the UK comes behind: the US, Switzerland, Norway, the Netherlands, Sweden, Germany, Denmark, Austria, Luxembourg, Canada, Belgium, France, Japan, Ireland, Iceland, Finland and New Zealand⁵.

However, we must be very careful with these OECD figures and reconcile them with the IFS figures discussed above. At the outset we should be clear what is being measured when we talk of health spending as a function of GDP. Specifically, in the OECD publications they are careful to spell out a distinction between Government Spending and Voluntary or Private Spending on health. Another consideration is that any percentage figure – like the percentage of GDP spent on health - must crucially depend on the accuracy and comparability of both the numerator and the denominator. In order for cross country comparisons to be reasonable, we need to be confident that that what is being measured in each country is the same. The reality is that we cannot be sure this is the case. Coyle (2014) provides many examples of both the vagaries in measurement of GDP but also of the cross country differences in methods of calculation. Likewise – although the OECD makes the best job possible of making the health spending figures comparable – how confident can we be that the health spending figures cover all the same categories of spending – for example in social care or prescription costs? We should be aware of these measurement discrepancies in making cross country comparisons. Therefore, in statistical terms – with measurement error in both the numerator and denominator of this percentage – can we be sure that the figures reported are different from one another. For example – can we be really sure that the 9.8% figure for the UK and the 11.0% for France (for Total Health Spending) are (statistically) significantly different from one another?

What is perhaps a better way to get to grips with Health Spending it to only consider Public, Government Health spending as a fraction of GDP and look to see how this has moved over time and across countries. This information is presented in Figure 6 which compares key country comparators from 1997 to 2015. Several important trends leap out from this figure. Firstly, UK spending rose markedly under the Blair Labour government from 1997 to 2010 when, starting from a low point we closed the gap on our neighbours. Second, all countries expenditure took a jump upwards in 2008 – this is a good illustration of the point that this percentage figure is a ratio and what was happening was not the Health spending was growing – but rather that GDP of all countries was falling at the start of the Great Recession in 2007/8. Note that in each country the fraction of spending on Health fell back in 2009. The third point to notice is that UK spending on Health fell back in 2013 to 2015 – but some of this could be

⁵ See figure 5.1 in OECD (2016)

due to the disproportionate rise in 2012. The fall in this ratio from 2013 is not surprising given the falling level of growth on Health Spending in these years charted in Figure 3.

The position also looks somewhat worse if we project current spending plans forward over the next few years. As it stands the UK is currently on track, to see Government healthcare spending (i.e. not including private health care spend) fall to 6.6 % of its GDP by 2020/21, compared to the 7.6 % seen in 2015. In real terms. In broad terms it is estimated that this will mean an increase from £135 billion to £142 billion, rather than the £158 billion it would need to be, if spending was to be kept in line with the growth in the economy. When comparing the total expenditure of the UK to OECD countries (excluding the U.S), it is estimated that the UK would need to get it's expenditure up to £163 billion by 2020/21 in order to catch up to France and Germany, by which time numbers may well have moved once again.⁶ It is important however, to take into consideration that the systems in these countries differ a lot and this does have an impact on the methods of expenditure accounting. In addition, there should be some recognition that UK, although behind other OECD countries in terms of total spending, tends to spend a higher proportion of public money on healthcare than some of the other countries within this group.⁷

If we compare the UK to other countries in the G7 we came 6th out of 7 members for total expenditure as a percentage of GDP in 2014. It is important to point out that public spending on healthcare made up a much higher share of its total healthcare spending⁸, and accounted for 79.5% of its total health spending that year.⁹ To consider the health spend in finer detail the three largest categories of healthcare spending in 2014 were; curative/ rehabilitative care (56.6%/ £101.5 billion), long-term care (18%/ £32.2 billion) and medical goods (£26.6 billion).¹⁰ Thus these are areas in which efforts to improve efficiency are most salient. These figures also reflect the technological cost incurred of investing in the latest treatments. So an even more detailed examination of the break down of costs would be appropriate in a more rigorous evaluation of the scope that there is for productivity and innovation.

⁶ Appleby (2016)

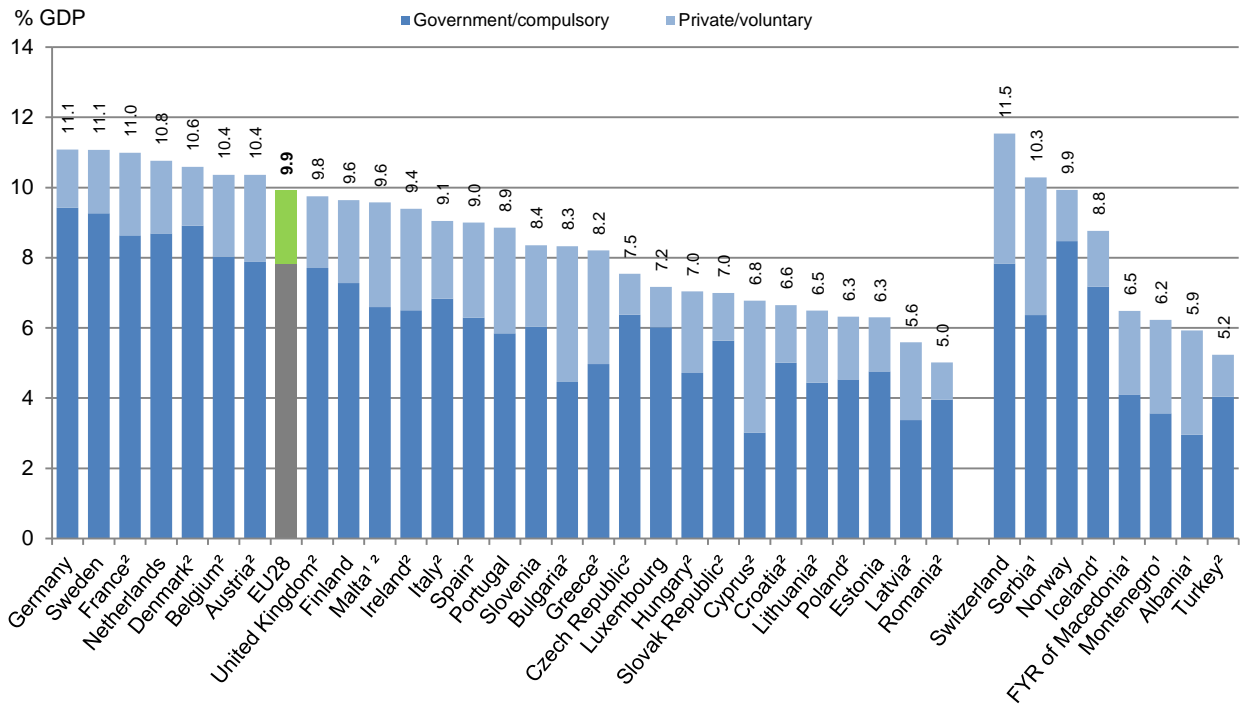
⁷ Kelly et al (2016)

⁸ Office of National Statistics (2016)

⁹ Lewis (2016)

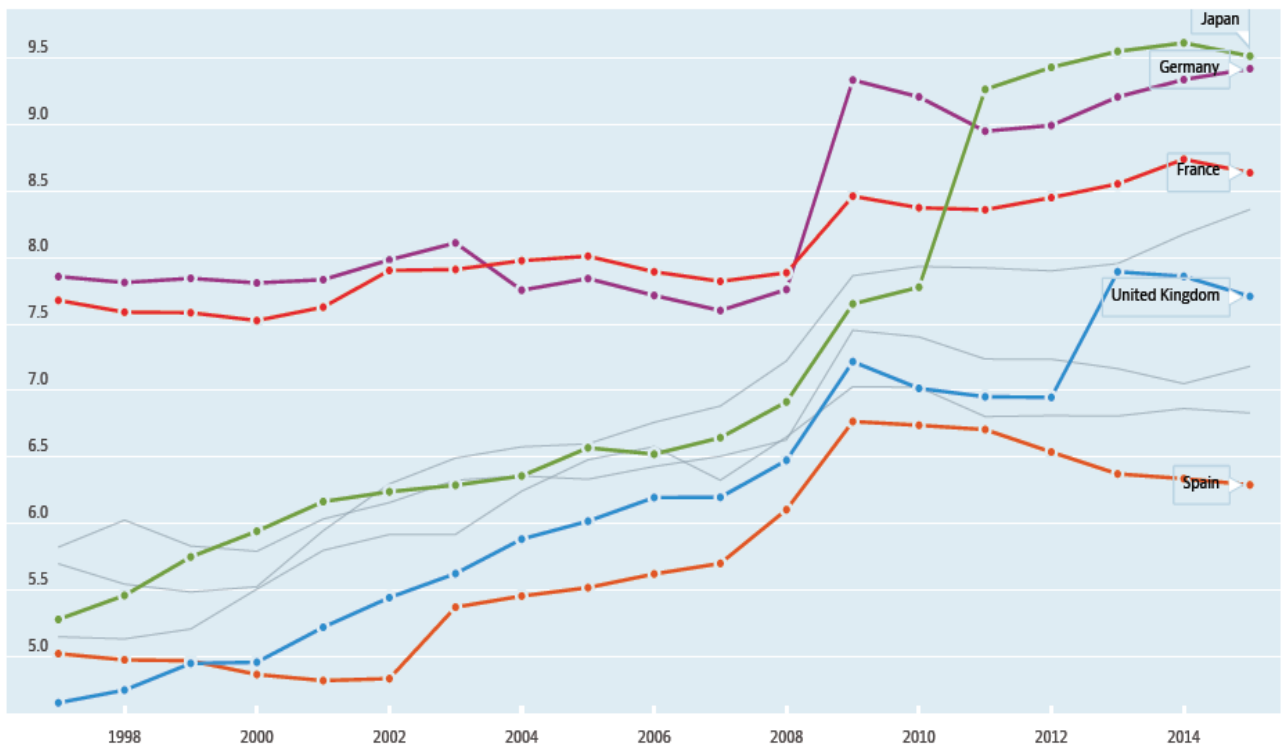
¹⁰ Lewis (2016)

Figure 5: Health expenditure as a share of GDP, by Country 2015 (or nearest year)



Source: OECD Health at a Glance 2006 Figure 5.3

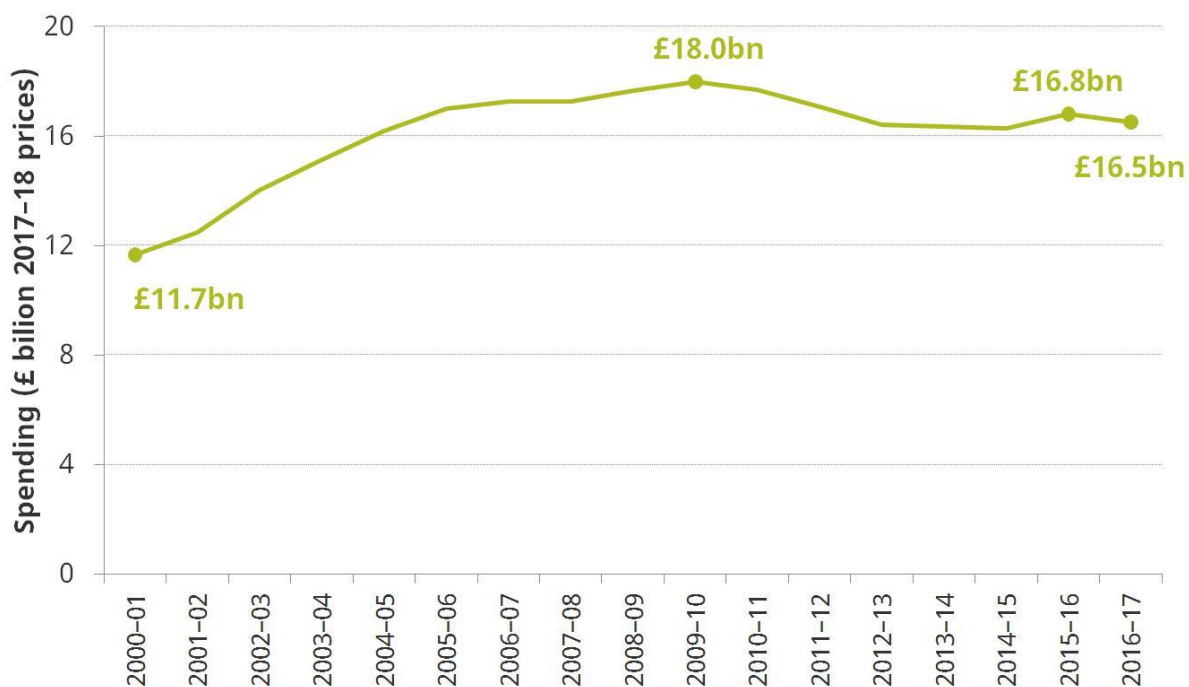
Figure 6: Government Health Expenditure as % of GDP for selected Countries 1997-2015



Source: data.oecd.org source data plotted by author

Although spending, in real 2017 prices on Social Care rose from £11.7bn in 2000 to £18bn by 2010, it has fallen back subsequently to £16.5bn by 2017. (See Simpson 2017). The trend is plotted in Figure 7. This is a fall of over 13% or £59 per adult, from £439 in 2009–10 to £379 in 2016–17. The real position is worse than portrayed in this figure as the number of people who these payments cover has risen by 18% due to the fact that the population is ageing as we now have 1.5 million more pensioners with a rise in those over 85 of around 17% - up by 200,000. These shrinking budgets, operating in the face of increasing demand, have put huge pressures on adult social care services.

Figure 7: Spending on local authority-organised adult social care, 2000–01 to 2016–17.



Source: Simpson (2017).

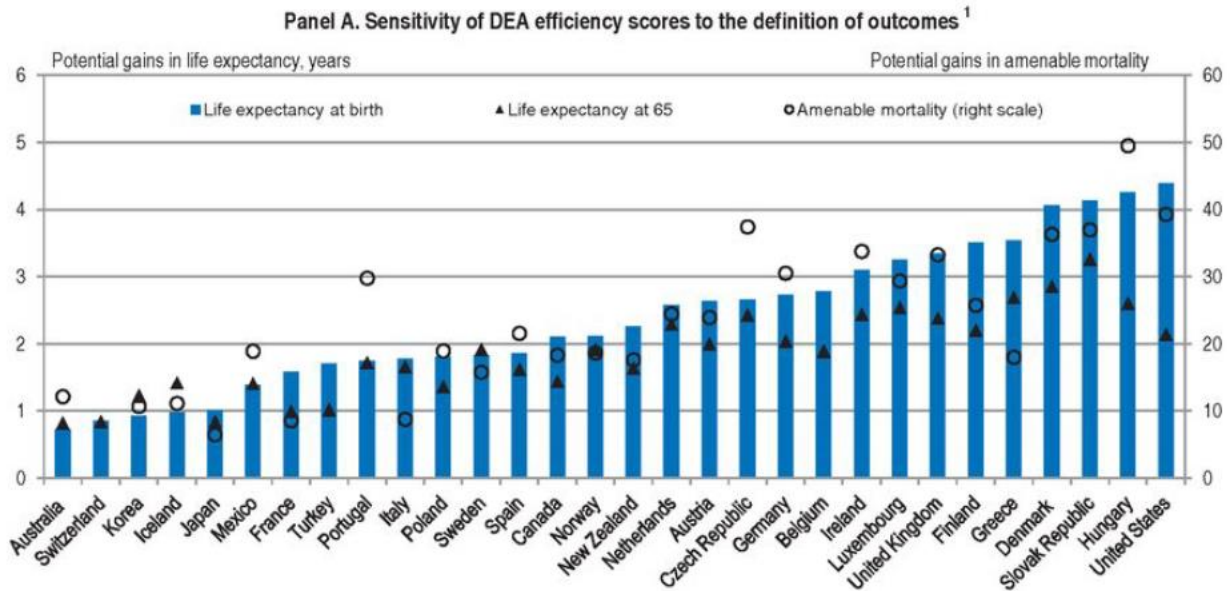
In some respects it could be argued that the debate about health care spending and league tables of who spends the most are rather academic. In a very real sense, each country in the long run, in a democratic system, will get the spending they deserve. The logic is that this will happen over the long run by the process of electing a new government, who spend more or less on health, as the electorate wishes (otherwise, in due course, they will be voted out). So, to some extent, what we see in these league tables is, in effect, the country's preference for health spending as opposed to education spending, defence spending or a lot less public spending altogether. Therefore, it could be argued, that what is more interesting is the efficiency with which each country spends its allocated health budget on service delivery. There is now a whole branch of applied econometric research work¹¹, which seeks to examine this question rigorously. So the question becomes, not which country spends the most, or which

¹¹ OECD (2010) and Jacobs et al (2006)

country spends the most per head, but rather, given the level of spending, which country does best to produce the most acceptable level of output or performance.

Efficiency analysis is predicated on being able to define and measure the performance of most concern to a health system. The OECD uses: life expectancy at birth, life expectancy at 65 and an (amenable) mortality rate. All slightly different, but most countries would agree that they wish their health system to perform well on these measures. Although they may disagree to what extent they would wish to judge their system only on these measures. Notwithstanding this, as long as we can agree to an output performance measure, we can, given the input levels in terms of money, staff and resources, measure the efficiency performance of each system. So, crudely, what is the value for money that each system provides. The OECD has performed this analysis using a technique known as Data Envelopment Analysis. The results are tabulated in Figure 8. They show that, although the UK falls behind in spend per capita, we perform substantially better in terms of efficiency. Specifically, depending on the output measure used, we perform in the top few OECD countries and better than many who spend much more than we do. This should reassure us, that although we do not spend as much as many would like, what we do spend, we spend very efficiently. This means that many could argue, and do, that the health care system we have is a good one, and one we should not modify, or tinker with, too much, as it delivers good value for money.

Figure 8: Data Envelopment Analysis Efficiency Scores Across Country 2009.



Source: OECD (2010) Fig 2.7, Panel A.

The Current NHS Health Care Landscape – A Short Tour

Before discussing the current 2017 Election debate and the funding issues around NHS, a brief overview of how we got to where we are, is necessary. Here we summarise the main events leading to the current debate. This is not a complete history, but merely a short overview of the present landscape, focusing on the main policy issues relevant to the 2017 Election.

1948: In the Beginning

The NHS was born in 1948. From the outset, it was to be funded out of general taxation with:

- Services provided free at the point of use;
- Everyone being eligible for care (even people temporarily resident or visiting the country).

The original structure of the NHS in England and Wales had three components, known as the *tripartite system*:

- Hospital Services: 14 Regional Hospital Boards were created in England and Wales to administer the majority of hospital services. Beneath these were 400 Hospital Management Committees which administered hospitals.
- Primary Care: GPs were independent contractors (that is they were not salaried employees) and would be paid for each patient on their list.
- Community Services: Maternity and Child Welfare clinics, health visitors, midwives, health education, vaccination & immunisation and ambulance services together with environmental health services were the responsibility of local authorities.

The Purchaser-Provider Split

In 1985, Enthoven (1985) and others, including Maynard¹², suggested that efficiency in health care provision could be improved by the use of an 'internal market' inside the NHS. The central idea was that monopoly provision of services (by hospitals) makes for the protection of vested interests and inefficient service provision. It was suggested that competition amongst providers would increase efficiency. It was proposed that the introduction of incentives – to GPs and hospitals – would result in improved value for money and better services to patients. In 1990, under Prime Minister Margaret Thatcher, the National Health Service & Community Care Act (in England) the internal market in health care was implemented, whereby Health Authorities ceased to run hospitals but "purchased" care from their own or other authorities' hospitals. Certain GPs became "fund holders" and were provided with a full budget for each patient from which they were to purchase medical services from hospitals on behalf of their patients. Specifically, patient hospital referrals were paid for by their GPs – the rationale being that, as 'gatekeepers', they would have an incentive to minimize unnecessary costly referrals. The "providers" or hospitals became NHS trusts, which encouraged competition but also increased local differences. The economic evidence was that GP fund holding did change incentives and

¹² Maynard (1991)

led to important differences in referral behavior¹³. GP fundholding was abolished in 1997 when Tony Blair came to power.

2012 Health and Social Care Act (HSCA)

This Act provided for the most extensive reorganisation of the structure of the National Health Service in England to date. It removed responsibility for the health of citizens from the Secretary of State for Health, which the post had carried since the inception of the NHS in 1948. It abolished NHS primary care trusts (PCTs) and Strategic Health Authorities (SHAs) (with redundancy costs of £1 billion for around 21,000 staff) and transferred between £60 billion and £80 billion of "commissioning", or health care funds, from the abolished PCTs to several hundred "clinical commissioning groups" (CCGs), partly run by the general practitioners (GPs). Facilities owned by PCTs and SHAs were transferred to NHS Property Services, a limited company owned by the Department of Health. The then Minister for Health, Andrew Lansley, said the Act had three key principles: patients were to be at the centre of the NHS; a change in the emphasis of measurement to clinical outcomes; the empowering health professionals, in particular GPs.

The Act also established: the independent NHS Commissioning Board; new local authority health and well-being boards; and developed Monitor¹⁴ as an economic regulator. The HSCA foresaw all NHS trusts becoming, or being amalgamated into, foundation trusts. It also abolished the existing cap on trusts' income from non-NHS sources, which in most cases was previously set at a relatively low single-digit percentage.

Opponents of the HSCA have seen it as a further attempt to introduce more 'marketization of healthcare' with a progressive disinvestment in the NHS. Many commentators have suggested that this has meant aspirations centred on clinical and service user leading commissioning have not been realized. In the developments that have followed in the Better Care Fund and Strategy and Transformation Plans we have seen a backing away from commissioning. Recent NHS initiatives are moving away from competition and the commissioner (purchaser)/provider split and towards localised 'place based' collaboration between social and health care providers, NHS commissioners, Local Authorities, service users and other local people. This collaborative agenda has been taken further in some areas – for example - in 2016 in Manchester, which took control of a £6bn budget to provide health and social care for its 2.7 million population.

2013 The Better Care Fund (BCF)

Partly as a result of the crisis in social care provision the Better Care Fund (BCF) was launched as a collaborative partnership between local government and the NHS. The partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Five Year Forward View. The

¹³ Dusheiko et al (2006).

¹⁴ Which subsequently became NHSImprovement.

BCF encourages integration by requiring CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan. In 2016/17, £5.9 billion was pooled in the BCF. The intention was to shift resources into social care and community services from the NHS budget in England and so save £1 billion a year by keeping patients out of hospital. In 2017/2018 the budget was set at £5.128 billion through pooled funding arrangements between local authorities and Clinical Commissioning Groups. This new figure reflects current policy in its costings, such as the 7 day NHS requirement and managing the smooth transfers of care for patients. In addition, the mandated budget will rise to £5.617 billion in 2018/2019 to keep in line with inflation. This may indicate in a reduction in total funding as the budget in 2015/2016 was £5.3 billion through pooled resources and £5.8 billion in 2016/2017.¹⁵ It is therefore unclear as to how this funding has been arranged to meet the new requirements set out and whether some areas have larger budgets than others, resulting in an asymmetric care system in which some vulnerable people could be left behind.

The 'Better Care Fund' was meant to begin to align health and social care budgets by sharing money across the divide of Local Government and the NHS but the reality is that with shrinking budgets there was not enough money in either pot to achieve significant change to benefit communities. Local Authorities might prefer people to be in hospital where they do not use scarce LA resources. Equally, hospitals prefer to get the same people out into social care and when both are stressed financially then innovative, creative solutions do not emerge.

Local Authorities have had their budgets cut and now often recruit social care workers to support frail people in their own homes from private agencies on zero hours contracts. The care workers time is allocated into 15 minute slots which is not enough, in many cases, to make a proper therapeutic/supportive impact. Overall, an extensive 'privatization' of social care provision has happened below the public radar.

In February 2017, the National Audit Office¹⁶ produced a report suggesting that the £5.3 billion spent in 2015/16 had not delivered value for money. Emergency hospital admissions had increased by 87,000 between 2014/15 and 2015/16, rather than the planned reduction of 106,000, which had cost an additional £311 million. Delayed transfers of care increased hospital admissions by 185,000 days, rather than the planned reduction of 293,000, which cost £146 million more.

2014 The Five Year Forward View

In 2014, the NHS published its Five Year Forward View (5YFV), which was a wide-ranging review of NHS activity, and planned changes in the future. Its optimistic tone of innovation and productivity reassured many commentators that the NHS was on course. However, the detail revealed the disturbing financial situation that the NHS is in. Overall, to continue to deliver to the needs of the growing UK population, it was suggested that there was a £30bn shortfall of funding. The 5YFP suggested that the NHS could deliver £22bn of annual productivity savings in

¹⁵ The Department of Health (2017)

¹⁶ National Audit Office (2016)

the next 5 years. This is the latest of a long line of reports to assert that there is scope for the NHS to make major savings. But the report does make it clear that more resources, an extra £8bn in Government funding by 2020, are needed.

NHS efficiency savings of 2% to 3% a year from 2015 to 2021 were supposed to save £22bn a year but this is thought to be unrealistic in many quarters. Between 2004 and 2014 NHS output increased considerably. Hospital admissions increased by 32%, outpatient attendances by 17%, primary care consultations by 25% and community care activity by 14%. As a whole NHS output increased by 47% and inputs by 31%, an increase in productivity of 12.86% during the period, or 1.37% per year, but this is considerably less than envisaged in the 5YFV – and specifically much less than the 2-3% efficiency needed, year on year to 2021, to ensure the financial viability of the NHS.

The 5YFV claimed that there would be a "radical upgrade in prevention and public health", but as Dr Sarah Wollaston (MP) pointed out in October 2016 there were reductions in other areas of health spending outside NHS England's budget, in particular public health. Without improvements in social care she said the NHS could not be expected to deliver the Five Year Forward View.¹⁷

2016 - Strategy and Transformation Plans

The operational response by NHS England in March 2016 to the 5YFV was to¹⁸ organise the geographical division of England into 44 Sustainability and Transformation Plan areas (or footprints). The idea is that the implement the 5YFV was to be locally heterogeneous and specific to the needs of each local area. These areas were locally agreed between NHS Trusts, local authorities and Clinical Commissioning Groups. A leader was appointed for each area, who is to be responsible for the implementation of the plans which are to be agreed by the component organisations. They will be "working across organisational boundaries to help build a consensus for transformation and the practical steps to deliver it"

The 44 Sustainability and Transformation plans (STP) have aspirations to better integrate of health and social care with innovation led by local clinicians, social care experts, Local Authorities and service users. But many frontline staff and Local Authorities criticise STPs as they were not involved in devising them. The BMJ recently reported that many of these STPs that don't even mention General Practice. Confusingly, these Strategy and Transformation Plans of 2016 were renamed Strategy and Transformation Programs in 2017.

The overarching aim of the STPs is to implement 30% less activity in NHS by 2020 to generate savings. The idea is that these are to be brought about by increased spending on 'prevention' and 'encouraging self-help and independence ' of service users. At the same time Local Authorities are cutting spending on Public Health (experts in 'prevention' with local bias now working for LAs) and other 'health' services commissioned by LAs e.g. Smoking cessation services are being cut.

¹⁷ "MPs slam government's 'misleading' £10bn NHS cash pledge". Public Finance. 31 October 2016. Retrieved 20 May 2017.

¹⁸ Guardian, August 26, 2016. [The NHS secret is out. And local communities won't like it.](https://www.theguardian.com/politics/2016/aug/26/the-nhs-secret-is-out-local-communities-wont-like-it) Available at: <https://www.theguardian.com/politics/2016/aug/26/the-nhs-secret-is-out-local-communities-wont-like-it>

To some extent these STPs allow local areas to move away from the principles of earlier NHS directions. For example, Simon Stevens himself is of the view that several STP areas are moving to “accountable care” structures which “will for the first time since 1990 effectively end the purchaser provider split”.

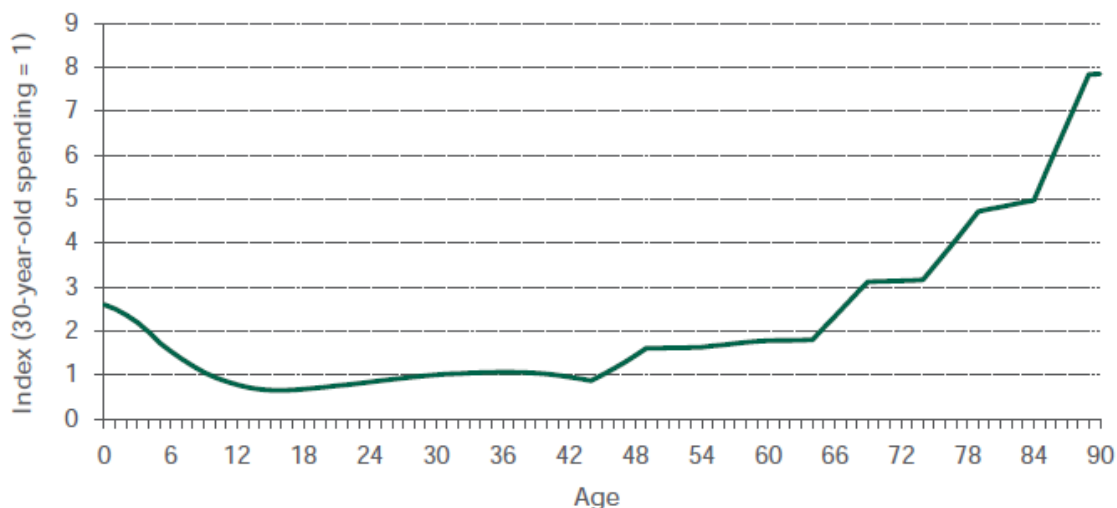
The Demand for and Provision of Health Care

So why is the NHS struggling to maintain standards of care despite funding having increased? A key reason for this is that demand for services is rising. Here we explore demand for hospital services by looking at the data for different aspects of activity over the past 13 years. A major driver of demand is that the patient population is growing and a higher fraction of them are old people or the very young, who demand and need more health care services. Figure 9, from the Office of Budget Responsibility shows us that, relative to a 30 year old, the average new born requires 250% more medical attention and an average 90 year old requires nearly 800% more health spending. This basic demographic fact is at the root of the escalating demand for health care in the UK.

Evidence of what is happening to demand can be seen in A&E attendances, secondary care referrals and elective hospital admissions. Figure 10 shows us that between 2003 and 2016 there has been a 65% rise in A&E attendances. Over the same period of time, Figure 11 shows the total number of Secondary Care referrals has risen by 2 million from 3.5 million to 5.5 million (in round figures). This has caused the number of elective admissions to hospital to rise by 650,00 in the same time period. By any standards, this is a massive increase in demand. To make matters more difficult we have seen a fall in the number of hospital beds available on any day by around 40,000. Overall, Figure 13, shows a halving of the number so hospital beds in the last 25 years. This is the crux of our NHS problem – namely hugely increasing demand from an ageing population with co-morbidities. It is these factors which are driving up the need to spend more of our GDP on the system if we wish to keep the level of service delivery the same.

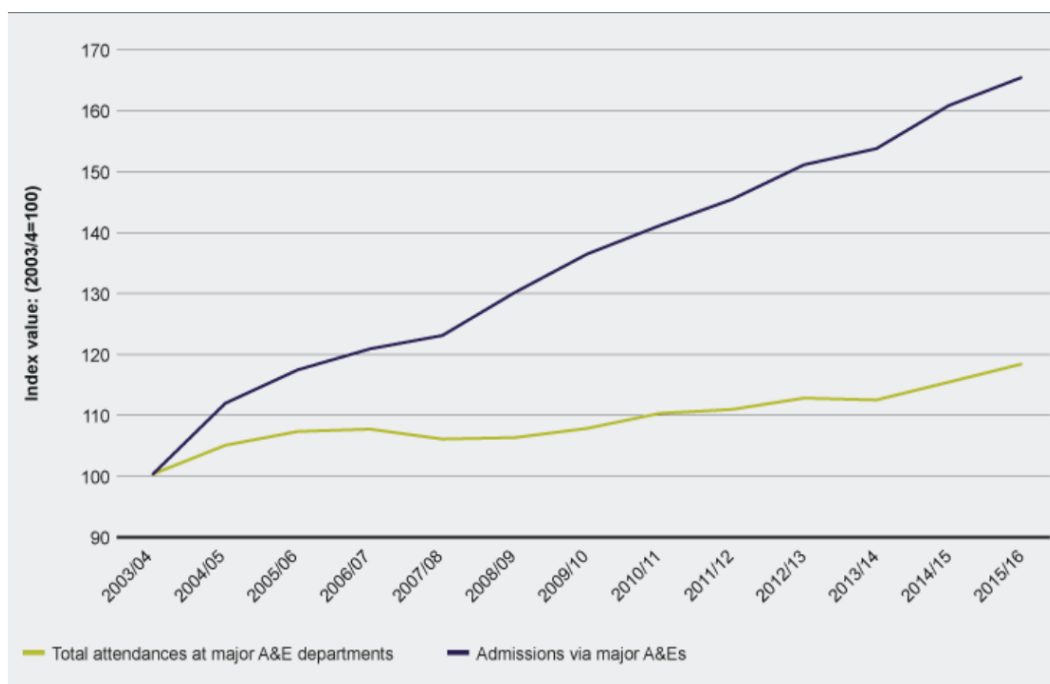
Clearly, if we don't put more resources into the system then the only way the system can respond it to have longer waiting lists for treatment and falling response times. An example of the effect is seen by examining what has happened to A&E waiting times in recent years. Figure 14 shows the the 95% target on less than 4 hour waiting times at A&E has been missed ever since 2013.

Figure 9: Age profile of public health spending in the UK (relative to 30-year-olds).



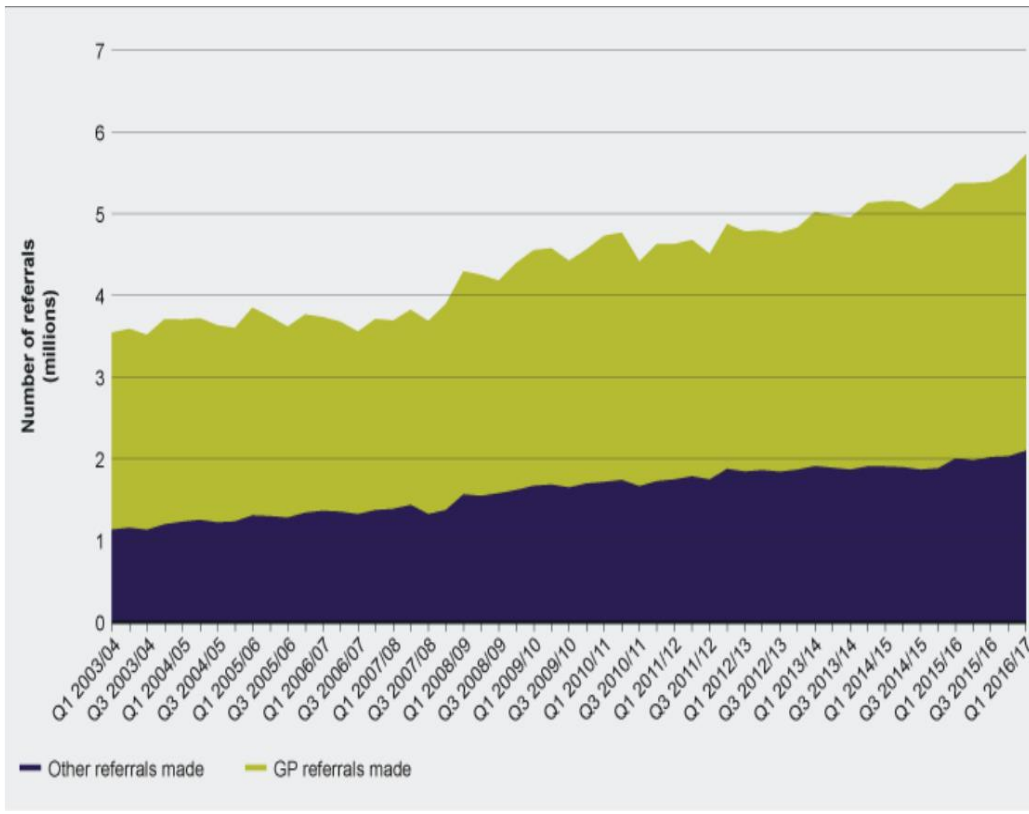
Source Luchinskaya et al (2017) Figure 5.8. previously: Chart 3.7 of Office for Budget Responsibility *Fiscal Sustainability Report 2017*. Costs are reported for individuals of each age between 0 and 90 years, relative to the average cost of treating a 30-year-old in the UK.

Figure 10: Index of attendance at, and emergencies from Major A&E departments, 2003-2016.



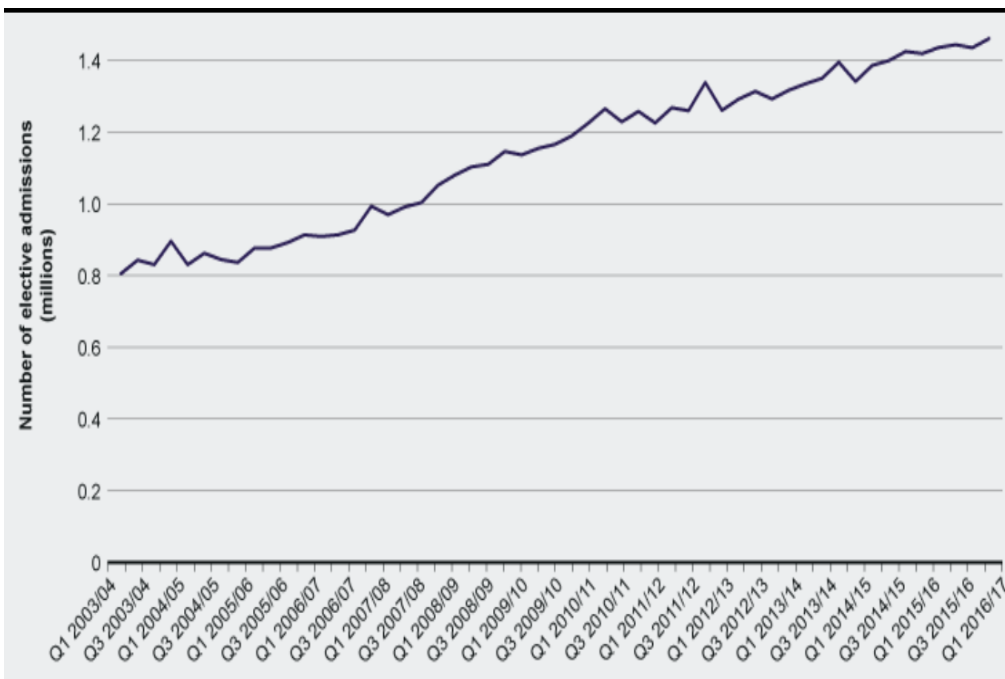
Source Maguire et al (2016).

Figure 11: Number of Referrals in millions 2003-2017.



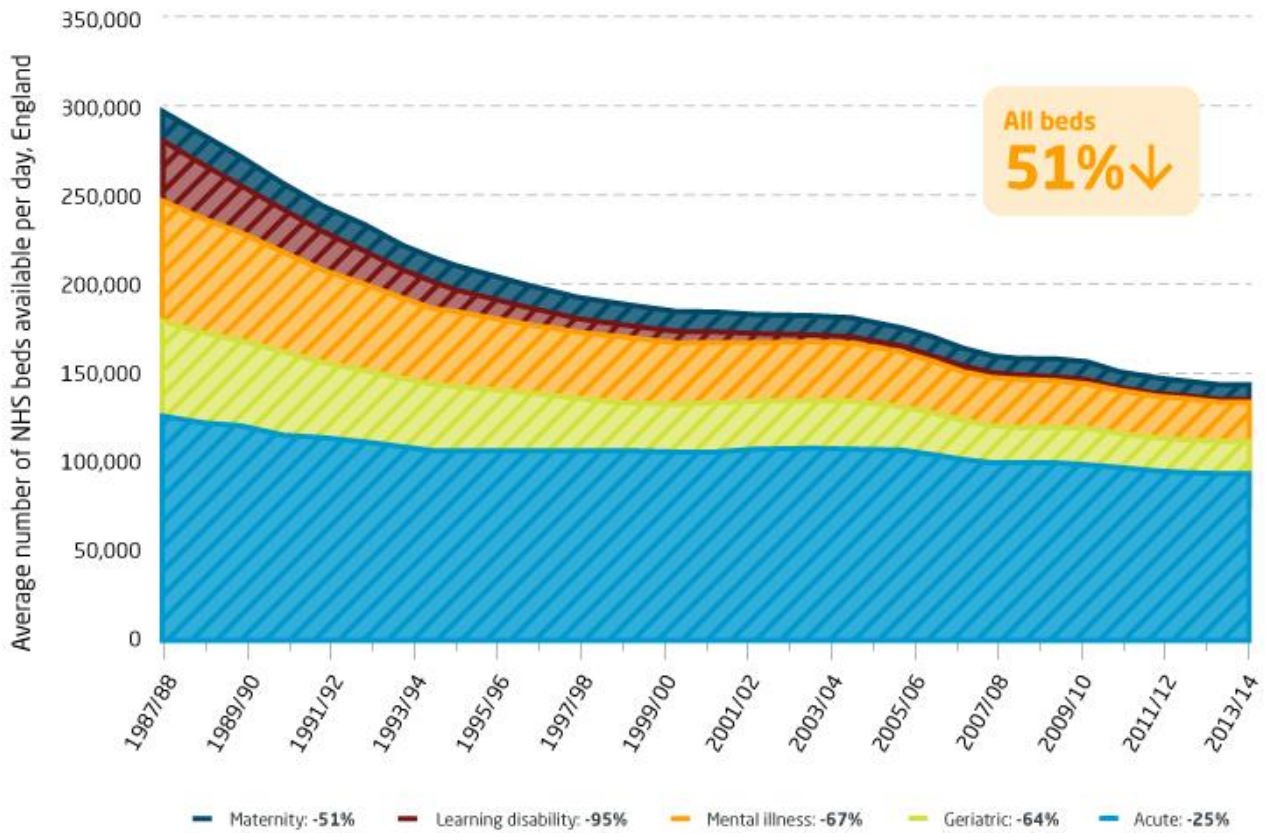
Source Maguire et al (2016).

Figure 12: Number of Elective Admissions in millions from 2003(Q3) to 2016(Q2).



Source Maguire et al (2016).

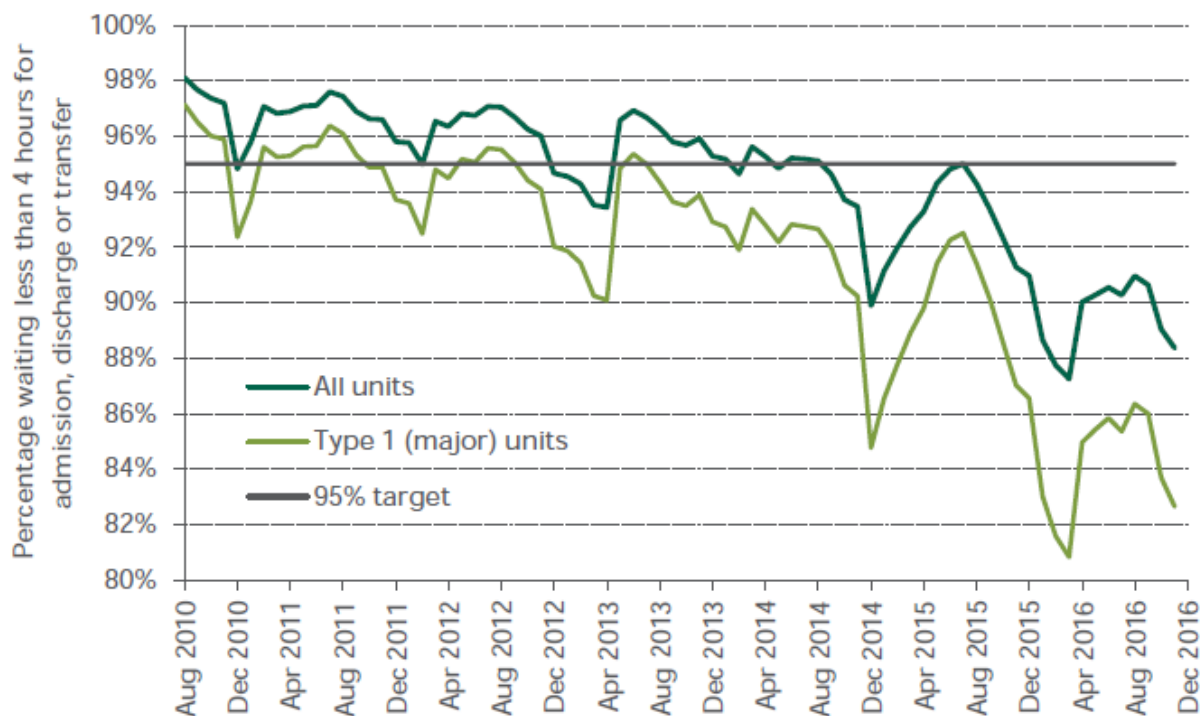
Figure 13: Average Number of Hospital Beds available per day 1987-2014



Source: The Kings Fund – The NHS in a Nutshell.

<https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-beds>

Figure 14: Percentage of patients who are admitted, discharged or transferred within four hours of arrival at an A&E department, by unit type, August 2010 to November 2016.



Source Luchinskaya et al (2017) Figure 5.11.

Note: All NHS hospitals and walk-in centres that provide emergency care are subject to the 95% target. Type 1 units are 24-hour consultant-led emergency departments with full resuscitation facilities and designated accommodation for the receipt of A&E patients.

Source: Data from NHS England, 'A&E attendances and emergency admissions', <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-workareasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/>.

Some Current Debates and Policy Issues.

7 Day Opening

The reality of the NHS service delivery is that 90% of all contacts with the NHS are made with General Practice which remains a highly cost effective method of delivering health care for the general population and performs a 'gatekeeping' function for more expensive treatment in Secondary Care. A major issue in the last 5 years has been the hours that GP surgeries are open and the extent to which this impacts on A&E services. Clearly the logic is that many patients present at A&E out of the hours that GP surgeries are normally closed – simply because then need some medical attention – even though the case may not be a medical emergency. This means the cost to the NHS is enormous. Specifically, the cost of an A&E appointment could be ten or more times that of a regular GP appointment. Therefore, it makes economic sense to open GP surgeries out of normal hours to cater for this demand. This scheme was trialled in Central London CCG and the results rigorously evaluated econometrically. The research by

Dolton and Pathania (2016) showed that 7 day GP opening was shown to be effective in reducing A/E attendances and unplanned admissions when the services offered walk in same day access for patients, which is intuitively correct.

However, disturbingly the 7 day GP opening service commissioned by NHSE specifically excludes walk in patients and is designed for pre-bookable routine apps which will have no impact on A/E attendances but make an easy political point that 'patients can get the service they want 7 days per week'.

Life expectancy in the UK

The NHS, as a result of overall improvements in mortality rates, is facing pressures in part through a demand from a growing and ageing population. The mortality of those in the older age groups has been increasing at a faster rate in recent years. This is due to a combination of societal factors and better chances of survival from various illnesses. These include better provisions for the prevention and treatment of circulatory diseases, better diagnoses of cancers and technological advances in medicines. The life expectancy of males at birth in the UK was averaged at 79 years old during the years 2013-2015, for females this figure stood at 83 years old. For those aged 65 during the years 2013-2015, life expectancy was observed as being 19 years (84 years old) , for women this figure was 21years (86 years old).¹⁹

Hospital Deficits

In 2014, the estimated funding gap between patients' needs and NHS resources stood at £2.2bn. The Department of Health, NHS England and NHS Improvement have a shared plan to close this gap which they intend to do through policies such as: capping public sector pay, renegotiating contracts, reducing running costs and increasing productivity. The National Audit Office has questioned the viability of this plan in closing this resource gap. They found that for the financial year of 2015/16, NHS bodies ended the year with a £1.85bn deficit overall. In particular, NHS Trusts and Foundation Trusts were found to have had a combined deficit of £2,447 million against their income of £75,966 million.²⁰ This most recently reported combined Deficit of NHS Trusts in England stands at £750 million. Despite these financial pressures, the Audit Office suggested that NHS is still offering good quality care. However, waiting times are getting longer and performance has started to decline in the last few years. In addition, the money allocated to the NHS will not be sufficient to meet the targets outlined in the 5YFV at the current rate. This is especially significant where productivity can be improved but due to the pressures the NHS currently faces, this is unlikely to happen at the required rate to meet the target £22bn productivity shortfall²¹.

NHS Pay

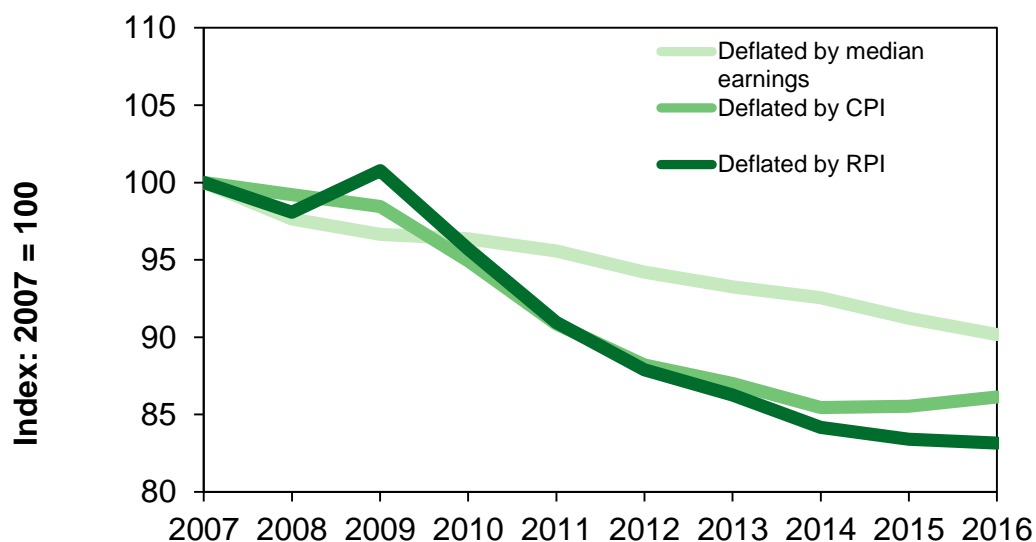
¹⁹ Office of National Statistics (2016) National life tables, UK: 2013–2015

²⁰ National Audit Office (2016)

²¹ The Kings Fund, The Nuffield Trust and The Health Foundation (2016)

The pay of doctors and nurses in the NHS has been falling in real terms over the last 10 years since the recession. The NHS Pay Review Body and the Doctors and Dentists Review make recommendations on the pay and working conditions of nurses and doctors respectively. Over most of the last 10 years these groups of workers have, for the most part, either had no pay rise, or only a 1% rise in line with the Government’s need for fiscal stringency. With inflation (however defined) running at between 2-4% for most of this period, then falling real wages for these groups is inevitable. Figure 15 below shows that, relative to 2007, at the start of the recession, earnings of hospital doctors have fallen by between 10-18 percent over 10 years, depending on what index is used to calibrate inflation. The worst case is if the RPI is used and the most favourable interpretation is if the rise in median earnings is used. If the latter is used then doctor’s pay has fallen by around 10% in real terms. This latter figure can be interpreted as how much doctors have fallen behind the average of all workers in terms of pay rises. The difference is due to the fact that other groups of workers, despite also having falling real earnings, have not fallen so far behind as doctors. There is some evidence that nurses pay has not fared quite so badly as hospital doctors but it is still the case that they have lost somewhere between 10-15 of their value in real terms over the last 10 years. GP pay is less easy to obtain reliable data on²², but the record number of GP practices which are failing is indicative that GP earnings are falling.

Figure 15: Hospital Doctor Real Pay by Year Relative to 2007.



Source: Office of Manpower Economics.

Staff shortages.

²² This is because GPs are self employed and therefore do not appear in the Annual Survey of Hours and Earnings (ASHE) or the Labour Force Survey (LFS). It is only HMRC (Inland Revenue) data on tax returns or NHS Pension data that could tell us the extent of GP pay variability and changes over the last 10 years. This is not easily accessible.

The NHS is currently dealing with staff shortages. Data reported by the OECD suggests we have one of the lowest number of doctors per 1,000 head of population in 2014 – at 2.8. Only Montenegro, Romania, Slovenia, Poland and Turkey have a lower ratio.²³ Recent evidence suggests that there is a sizeable shortage of GPs with GP vacancy rates the highest they have ever been²⁴. In addition, record numbers of GP practices are closing.²⁵ These factors are undoubtedly contributing to patient’s difficulties in getting appointments.

These staff shortages have been created in part by increases in demand and difficulty surrounding succession planning on a governance level i.e. the lack of training bursaries for nurses has led to a skills shortage. This has resulted in the increase use of agency staff in the NHS, and in particular private sector agencies, which is a further financial burden to an already squeezed NHS. One could argue where cost issues far outweigh supply problems. However, even with the introduction of pay caps, this continues to be a significant expenditure for the NHS²⁶. Without discussions into the efficacy of current succession planning methods, this has the potential to be cyclical, given the increase in part time work of doctors and shortages in particular skill sets such as psychiatry.²⁷ It is reasonable to assume that this move to part time work could be as a result of the increased intensity of the workload, given that we know agency staff for instance move into these roles through a desire to escape the increasing pressures and worsening working conditions of a permanent role in the NHS²⁸ In addition, although the UK is reducing its reliance on migrant labour to fill physician roles, significant proportions of the population of doctors across the UK currently show a high reliance on migrant labour.²⁹

The implications of immigration policy post Britain’s exit of the European Union may well increase the staff shortage in the short term and how this is dealt with at a policy level, will affect whether or not this has longer consequences. The NHS is also increasingly relying on older workers, in 2015 the number of doctors aged 50 and above has shown an increase of nearly one and a half more than those aged 30-50.³⁰ This again poses further problems for the current need for staff as if a detailed national succession plan is not put into place, the UK may face a further burden once this cohort retires or moves part time as they age.

Intensity of work

Alongside staff shortages, NHS staff members face an increasing workload³¹. If we take the example of GP’s services, which tends to have relatively high patient satisfaction ratings, there have been mounting pressures in recent years. This is due to a combination of the increase in complex conditions, as a byproduct of an ageing population, and a change in patient

²³ OECD 2016, Fig 7.10.

²⁴ Lind (2015).

²⁵ Kenny et al (2014)

²⁶ H. Rolfe et al (2017)

²⁷ General Medical Council. (2016)

²⁸ H. Rolfe et al (2017)

²⁹ G General Medical Council. (2016)

³⁰ General Medical Council. (2016)

³¹ See Dolton et al (2015)

expectations of their interactions with clinical services. A study by the Kings Fund³² found that over the period of 2010/11 and 2014/15, GP's workloads increased by 15% and the average patient list increased by 10%. Most strikingly, telephone consultations with practitioners increased by 62% over the same period whilst the number of GP's had only increased by 4.8%. Whilst, at first glance, this may seem as though patients are choosing to interact with their GP's differently, this figure seems may be more to do with a difficulty in keeping up with demand as only 6.7% of patients are calling their practices requesting to speak to their GP on the phone. The change in patient expectations of their GP's does however play a role here. Patients increasingly want rapid access to services and more specialized treatment. Of those clinics participating in the study, 40.4% of patients who called their GP service requested an appointment on the same day, 9.9 % requested an appointment for the following day and 23% requested their appointment to take place within the next few days. This change in patients preferences is especially important given that politicians are promoting lower waiting times and faster access to services in their election manifesto's. With the main political parties adopting this policy, the reality is, that this may not be possible under the current conditions. It also poses a cyclical risk - in that the more politicians try to appeal to voters in this way, the more they create expectations of patients of more immediate service delivery.

Waiting Times

At the end of quarter one for the years 2016/2017, there were several targets that were not met. These included waiting times for diagnostics which saw an increase of 6.8% of patients waiting longer than six weeks for a test compared to the previous year and elective waiting times which saw a 15.32% increase from the previous year. The NHS also failed to meet its targets for ambulance response times, cancer treatment/ diagnostic waiting time targets and the A&E target of dealing with 95% of patients within four hours.³³ In light of recent pressures, the NHS have recently reprioritized their targets placing an emphasis on A&E and Cancer. Following the announcement in March this year, hospitals will no longer be required to meet their target of treating 92% of patients in 18 weeks of being referred for non-urgent surgery such as hip and knee surgery. However, this may prove counterproductive in the long run. such For example, where hip and knee surgery is not prioritized for older patients then this means increased reliance on ambulances as a result of decreased mobility which will in turn place a further burden on an NHS already struggling to meet its targets.

Public Perceptions of the NHS.

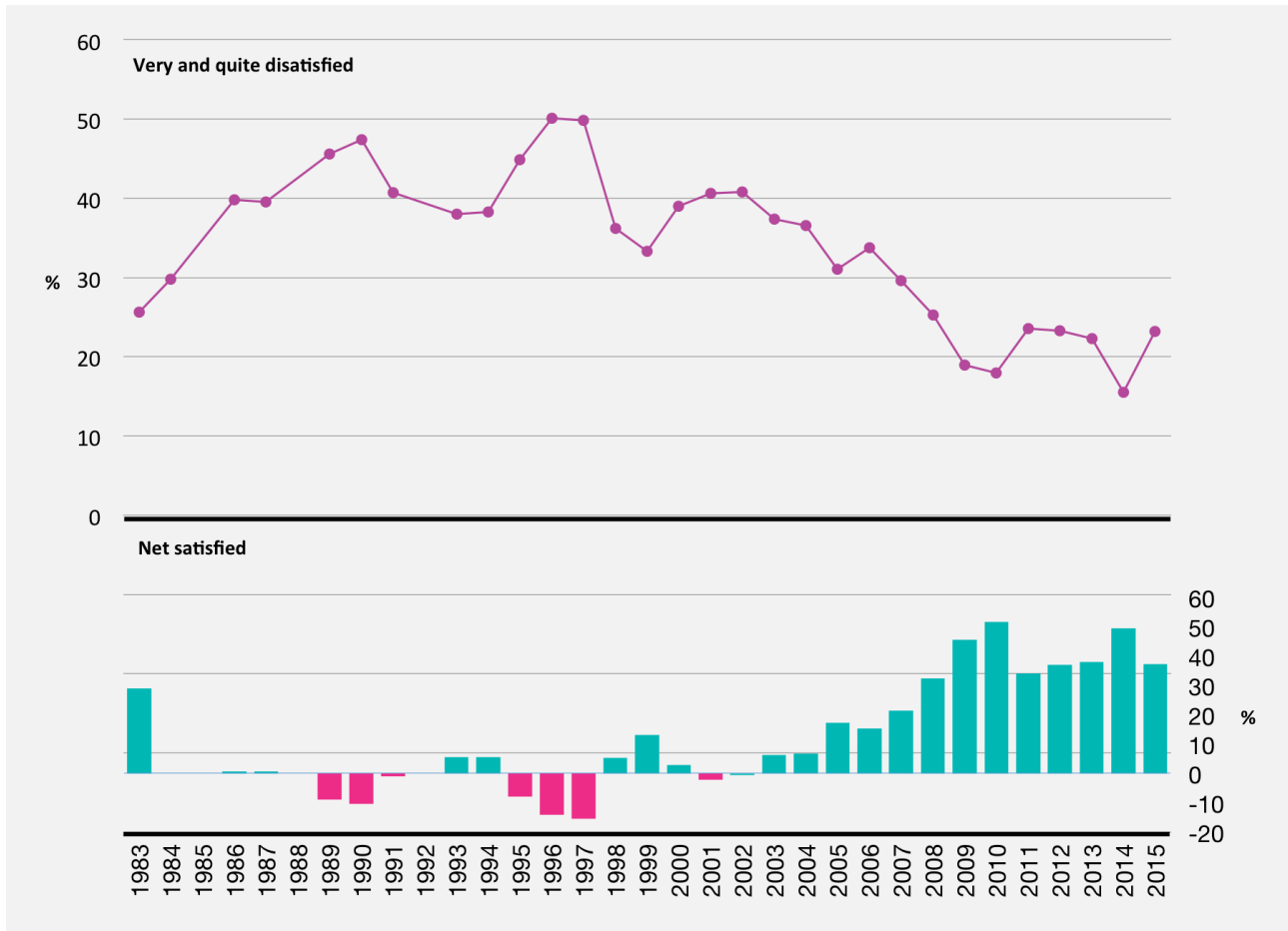
The evidence that there is suggests that patient satisfaction with the NHS is higher than it has ever been. The British Attitudes Survey has examined the attitudes of the British public to the NHS in a consistent way over the last 32 years. Figure 15 below shows the results. It is quite clear that the level of dissatisfaction with the NHS is at around 20% - this is at an all-time low compared to the mid-1990s, when this percentage was around 50%. Corresponding the net fraction who are satisfied with the NHS is at an all-time high in the same figure. When

³² Baird et al (2016)

³³ NHS Improvement (2016) *Quarterly performance of the provider sector as at 30 June 2016: Further underlying data.*

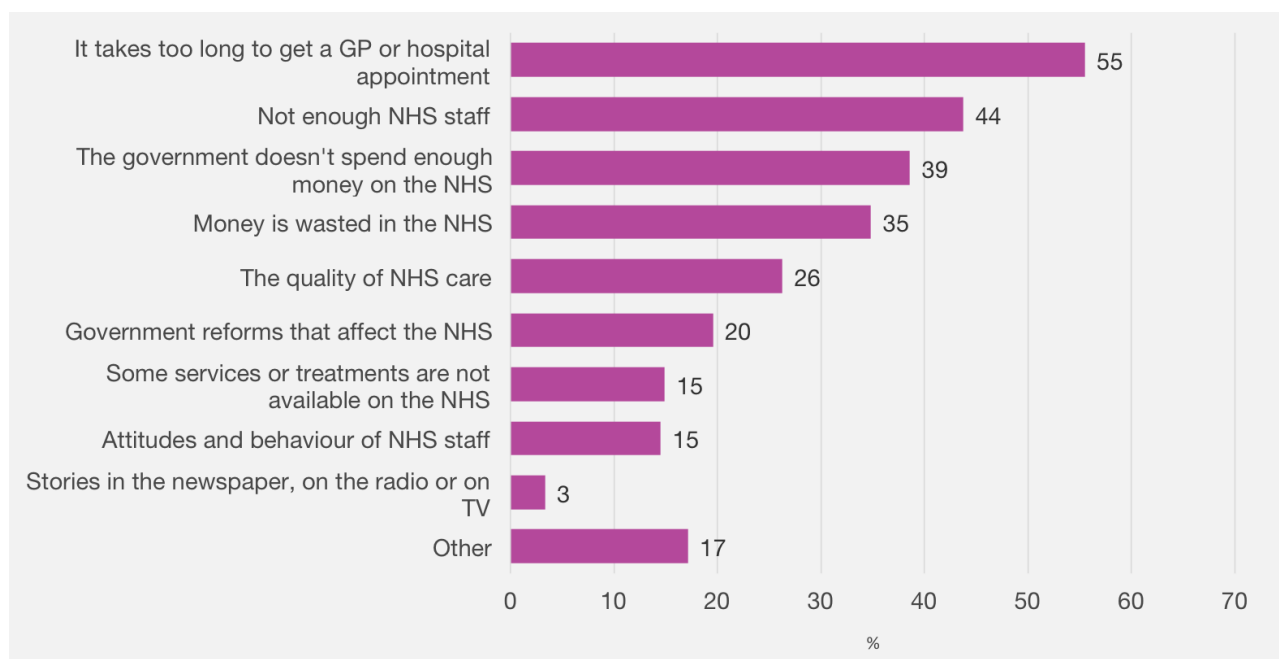
questioned further about their detailed reasons for dis-satisfaction with the NHS the responses suggest that the biggest problems patients have with the NHS are that it takes too long to get a GP appointment and that there are not enough staff or resources in the NHS. This is shown in Figure 17 for 2015.

Figure 16: Dissatisfaction with the NHS, 1983-2015



Source Fig 1 Appleby et al (2016)

Figure 17: Reasons for dissatisfaction with the NHS



Source : Fig 4 Appleby et al (2016)

Willingness to Pay for the NHS.

The British Public love the NHS. But, when push comes to shove, how much extra are they willing to pay for it? This is not an easy question to ask or answer. Recent evidence from a large representative sample of the British public has been gathered which sheds some light on this question. This public policy survey was conducted by Dolton and Tol (2016). As part of the survey, it sampled over 6,000 people to ask them about their views on the NHS, its funding and how much they would be prepared to pay in extra Income Tax to fund the NHS. Questions that are core to this Briefing paper. The results are quite surprising and do not sit easily with the public funding position in the NHS.

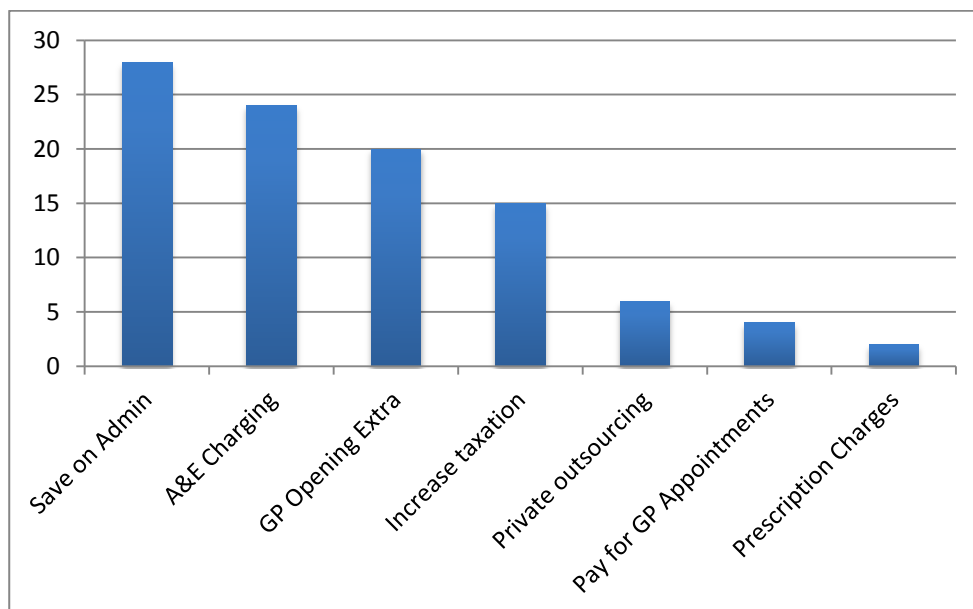
Firstly, the sample was asked : *The demands on the National Health Service are increasing as the population grows and ages. How should this be paid for?* The alternative answers that the respondents could chose were : 1. Save money on administrative costs ; 2. Increasing general taxation ; 3. Outsourcing more services to the private sector ; 4. Patients should pay when they go to see their GP ; 5. Patients should pay for inappropriate use of A&E ; 6. Prescription charges should be raised ; 6. GPs should open more hours to save money on A&E.

Figure 18 shows the fraction of respondents who chose each answer – where they could tick any that apply. We see that : 28% of people were in favour of saving money on administrative costs, 24% thought people should pay for inappropriate use of A&E, 20% thought opening GP surgeries more hours to save on A&E was a good idea, and 15% of people thought that spending more via higher taxes was appropriate. The least popular alternatives were that only 6% thought outsourcing to the private sector was the answer, 4% of people thought that paying for GP appointments was a good idea and only 2% favoured raising prescription charges. These findings are indicative of how the public sees the various policy alternatives.

The survey went on to question the respondents about their willingness to pay for extra NHS spend. It was made clear to respondents that an increase of 1% in the level of Income Tax would raise about £4.5bn in a year. The level of per person spending was also given to the respondents and then they were asked how much they thought should be spent on the NHS per person in a year.

Looking at the responses was instructive. Around 72% of the sample thought no more additional spending on the NHS was appropriate. This is a very high level of resistance to paying extra Income Tax. Of those who thought extra spending was justified, we divided the sample into those who pay tax and those who don't. The distribution of the extra willingness to pay (WPT) is then plotted in Figure 19. The average Willingness to Pay for the non-taxpayers was around £140 per annum and the average WTP for taxpayers is around £500 per annum. Although it is fair to say that each distribution has a long tail. The more formal econometric analysis³⁴ suggests that this WPT was related to Social Value Orientation³⁵. With these figures in mind it is difficult to see that there would be a mandate for the extra tax proposals now being discussed. Some reflection on these figures suggests that since the majority of people (72%) do not want to see Income Tax raised to fund the NHS then this policy would not command enough support. However, if the Liberal Democrat proposal of a 1% increase in Income Tax was imposed it would raise around £4.5bn – but this is not enough to solve the funding problems of the NHS. Paradoxically, a significant minority of people would be prepared to pay much more than this to help out the NHS.

Figure 18 : How Should We Pay for the NHS ? Percentage Respondents

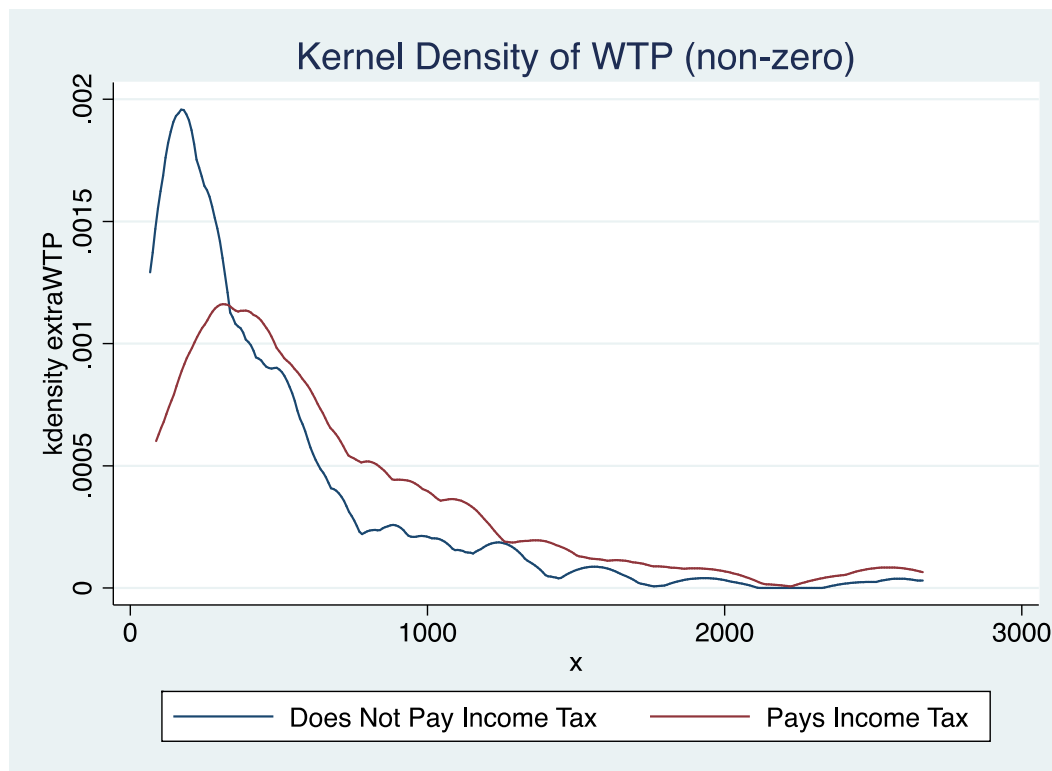


Source : Dolton & Tol (2016)

³⁴ Dolton et al (2017).

³⁵ See Murphy et al (20013)

Figure 19 : The Distribution of Extra Willingness to Pay in £ of UK Taxpayers and Non-Tax Payers



The Political Parties Election Manifestos and their Implications.

In this section we summarise the main recommendations of the three main political parties which relate to their financial funding plans for the NHS over the coming Parliament. This is not meant to be a comprehensive discussion of all their health care policies but rather a ‘first pass’ commentary on their policies, in the light of the NHS funding and demand position, as set out in this briefing paper.

The Conservative 2017 Election Manifesto.

The main elements of the Conservative Manifesto for the NHS are that, in power they would:

- *Increase spending on the NHS by £8bn in real terms and increase real funding per head over the next five years.*

As we have seen above this is the figure that the 5YFP explained was necessary to continue the NHS is on track to fill the spending shortfall by 2020/21. But this is assuming that the system can generate productivity savings of around 2-3% per year to find the missing £22bn. Interestingly, the Conservative manifesto does not explain how this £8bn will be raised.

- *Commit to retaining 140,000 NHS staff from EU countries can continue to work in the UK.*

This commitment suggests that the Conservatives view the retention of EU NHS staff as a high priority after Brexit and plan to accord these workers the right to work in Britain. It is unfortunate that they have not already put this policy in place to prevent the leaking of the many EU staff in the NHS who are already leaving – disgruntled with the uncertainty of their futures in the NHS in a Brexit world.

- *Expand 7-day access to patient's own GP surgery, or one nearby, to the whole population by 2019.*

This proposal, as demonstrated in the work of Dolton and Pathania (2016), could be a successful, efficient policy (cutting down on expensive A&E treatment) as long as they don't require to people to book such weekend appointments in advance and retain it as a walk-in service – which is not what is happening at the moment.

- *Increase the immigration NHS surcharge from £450 to £600.*
- *Introduce a new GP contract and reform the Consultants contract and legislate to reform the system of professional regulation of the healthcare professions.*

It should be recognized that this is a huge agenda. The recent, protracted, Junior Doctors revised contract dispute, has caused huge unrest and much controversy over the last 2 years. It could be the case that a new GP contract and a reform of the Consultant's contract could be protracted and equally controversial. Likewise, reforming the regulatory environment could be difficult.

- *Maintain the 95% A&E target and the 18-week elective care standard.*

These are the status quo, *de-facto* standards – but in the light of the evidence we have reviewed above on increasing demand – these will challenging targets to achieve within the existing budget.

- *Introduce mental health first aid training for teachers in every school.*

This assumes that enough people can be trained to do this. The assumption is that mental health problems can be 'nipped in the bud' when people are young. It is unclear what evidence there is that this can be effectively done in the context of the school. The other problem is that this may treat those young people with developing conditions but does not offer anything to those young people who have left school and are already suffering.

- *People, subject to a floor of £100k which you will get to keep, should pay for their own social care out of their assets – and the definition of assets will include the value of their house.*

This proposal has been the one to grab the most headlines. Some commentators are already referring to this as a 'dementia tax' to reflect the fact that this measure is

punitive on wealthy house owners who require expensive care into their old age. Strictly speaking, it is not a tax as it will only be paid by people who receive the care. But, it is a direct redistribution away from those younger people, who have parents who suffer from dementia and need care, who would otherwise have received a large inheritance. One may also be concerned about how this will work in practice: will there be regulatory body to ensure that private care homes do not practice price discrimination on those patients who have large assets to cross subsidize those who do not have such assets? At the time of writing, Theresa May also looks likely to be forced to modify the policy to include a maximum cap on what people may be expected to pay.

On the positive side, the revenue raised by this policy could potentially, in time, secure a much needed huge boost to Local Authorities Social Care budgets. The decline of spending on social care – as we saw in Fig 7 above - has caused many problems in the initiatives of the 5YFP and the BCF – in their attempts to secure a share of the NHS budget to cover the costs of integrated care. In many ways this is a potentially progressive intervention proposal which attempts to free up some of the vast asset value locked up in the housing stock of the South of England. Some variant of this policy would undoubtedly help hard pressed Social Care Budgets, the burden of which will be unfairly borne by young taxpayers in our society³⁶. The attempt to implement a policy to redistribute income across the generations is laudible – but it should not be via the random, unlucky lottery instrument, of dementia in old age.

The Labour Party Manifesto 2017.

- *The main policy of the Labour Party is to commit to an increase in spend of £30bn. Increase spending on Social Care to the tune of £8bn during the next parliament - including a £1bn spend in the next year. This increase in expenditure will be funded by raising income tax on the top 5% of earners (which would presently be at around £80k per annum) and increase the tax on private medical insurance. The suggestion is that this would raise £30bn.*

These spending plans are clearly designed to meet the needs set out in the 5YFP. Labour are alone amongst the big parties, in recognizing that the additional £22bn may not be achieved by productivity and efficiency savings. However, there is a large measure of doubt about the expectation that a top earners tax would raise anywhere near this amount. (See and Brewer & Browne, 2009). Details of how they would impose this tax are not spelt out.

- *Halt and review the present STPs and create a new regulator to be called 'NHS Excellence'.*

This proposal is clearly consistent with their intention to put more money in Social Care directly.

- *Reverse the privatization in the NHS and repeal the Health and Social Care Act.*

³⁶ See Willetts (2010).

This is a general theme and goal of the Labour party but there is no clarity about which areas of privatization of the NHS they would seek to repeal. For example, most GPs are self employed businesses. Is it proposed that they would all be converted to NHS poly-clinics?

- *Legislate to ensure the excess private profits are not made out of the NHS.*

It is not clear what constitutes 'excess profit', nor is it clear what measures labour would take to outlaw this.

- *End 15 minute Social Care visits and provide care workers with paid travel time.*

Many commentators, and those working in the field, would support this policy.

- *Give mental health the same priority as physical health.*

This is one area of policy on which there is a measure of cross party agreement.

The Liberal Democrat Party Manifesto 2017.

The Liberal Party manifesto says they:

- *Would raise income tax for all by 1% and spend the proceeds on the NHS. They suggest that this could raise £6bn.*

The novelty here is that this tax revenue would be ring-fenced money for the NHS. They do not specify what mechanisms they would put in place to safeguard that the extra money would be spent on the NHS rather than general spending. The other matter at issue here is exactly what revenue could one expect to raise by this 1% rise in income tax. Other estimates from the IFS (see Brewer & Browne 2009) of this measure suggest that it could raise only £4.5bn – much less than the estimated £6bn – or indeed – not increase tax revenue at all!

- *Would seek additional investment in health and care services as a matter of urgency and have called on the Government to set up an independent, cross-party commission to look at how we can deliver a new, sustainable settlement for health and care in the longer term. Would campaign for equality of mental health care in our NHS. Suggest that the NHS must provide high quality care to all – across both mental and physical health.*

The idea of seeking additional investment in health and care services is understandable but it is not clear if they mean this to come from other sources than general taxation. The manifesto also does not tell us how much extra money needs to be spent on mental health and what it would be spent on. An independent cross-party commission on mental health and long-term care may be welcome but the cynical voter may be excused for asking: at what cost, over what time horizon, and to what effect?

- *Suggest they would like to see health and care services delivered in a more integrated way and to empower people to take more control of their care through personal budgets which allow people to choose services to fit their individual needs.*

Arguably, the initiatives of the HSCA in 2012, the BCF in 2014, and STPs in 2016 (described above) were all about the delivery of health care and social care in a more integrated way. Many would argue that these policies have yet to yield a more integrated service. The proposed introduction of personal health care budgets is not new, but there is little evidence of how this is presently working or their effectiveness.

Conclusion – A Perspective on Alternative Policy Options.

The NHS has been called ‘a national treasure’ and it has been suggested that it is close to a ‘national religion’. Certainly, all political parties wish to put forward the view that the NHS is ‘safe in their hands’. No political party can afford to risk being seen to threaten the present working of the NHS. This means that any policy proposals, which might seek to transform the NHS, are potentially very controversial. All politicians wish to be identified with the electorate’s wish to preserve the NHS. Yet, nearly all political parties cannot, once in office, resist the temptation to try to make major legislative reform of the system. Why is this? It is because the area of health care provision is inextricably political. Its values and policies go to the heart of traditional Conservatism, Socialism and Liberal Democratic values. The extent to which service should be free at the point of delivery to all those who demand and need it – irrespective of income, wealth or position is now an enshrined principle. Notwithstanding this, the degree to which individuals should have to contribute to its cost and the extent to which the market, may or may not, be used to try and achieve the most efficient provision of services is not straightforward. Clearly, literally **all** treatments – no matter what their cost - cannot be free at the point of delivery – there must be some rationing. Yet, how should this rationing work in practice? Up to now, we have let the professionals use their judgment in this referral and rationing process. In the future, are we going to allow private health care provision to exist – over and above the NHS – or are we going to prevent (or tax) an individual taking out extra private health insurance to cover their additional needs – even if it may mean jumping the queue for an operation.

We have known for over 50 years, from the work of Arrow (1963), that health care markets do not operate like ordinary markets. At the same time we also know that: the price mechanism, the forces of competition, incentives, and ‘nudges’ do work in certain situations and can be cost effective. It is also well known that market mechanism may lead to an unequal distribution of resources away from the less advantaged and needy in society. This means that operationally the NHS must continually address the dilemma that resourcing decisions and allocation mechanisms will be a trade-off between efficiency and equity.

The ‘marketization’ of the NHS has long been seen by some as a plot against the NHS, orchestrated by the power elites in the UK in a direct attempt to influence the nature of political reform of the NHS to provide an opportunity for private sector businesses to make a profit from the taxpayers of the UK who fund the NHS. Pollock (2008) and Leys and Player

(2011), amongst others, provide evidence of how the network of the key players are interconnected and collude to this end.³⁷ Notwithstanding, this opposition to the encroaching market in health care, we must appreciate that individual incentives work and aspects of competition and enterprise can be effective. Indeed, the fact that most of our GPs operate as private, self-employed businesses is arguably the key to how our Primary Care system operates so efficiently. But would we regard the high salaries that some GPs earn as making excess profits' out of the NHS? Many experts argue that the market has no place in the NHS but do not recognise how big the role individual business acumen and professionalism of GPs has played in the NHS. As Tudor-Hart (2010) (a prominent anti-market person) himself admits: *"More than any other single factor, the (GP) gatekeeper function made the NHS more cost effective than any other Western Care system."*³⁸

Clearly, the future of the NHS rest with the talents, abilities and professional motivation of our young doctors and nurses. How far can we change their contracts of employment and hours of work and still expect them to be 'on-side'? Last year many young health professionals were unhappy with the new contract for junior doctors and many are still considering leaving the UK to work overseas. Is it wise to embark on new contract for GPs and consultants in the next Parliament?

The evidence reviewed in this Briefing Paper has suggested that – yes - we are spending more on our NHS – but demand for health care continues to outstrip the supply that can be afforded within the existing funding envelope. We are told that the NHS needs an extra £30bn in the next 5 years to maintain its existing commitments. Yet the Conservatives and Liberal Democrats wish to limit their investment to £8bn over the next 5 years, and trust to unrealistic efficiency gain targets, to find the rest of the short fall in funding. The Labour Party recognise the need to spend £30bn more on the NHS but their plans for meeting this extra spending out of tax increases on the 5% highest earners is not spelt out in detail and some experts believe may not raise the revenue they anticipate.

So where does this leave us? If we wish to see spending on the NHS rise we will need to: increase taxes, or spend a higher fraction of public spending on health (at the expense of some other public service), or we can trust that we can make substantial efficiency gains. Alternatively, as a nation, we could decide that we cannot afford to spend more on the NHS at all, or consent to being charged for certain services. The reality is though, that these hard choices need to be faced by both politicians and the electorate.

An important question is then posed. Is the electorate willing to have Income Tax rise to pay for more NHS funding – or would they prefer to see to less spending on other public services to allow the NHS to take a higher share of public funds? Or indeed, are patients willing to pay for some (or more) of these services on an 'as needs' basis – e.g charges for A&E attendance? Recent research evidence suggests they most of the public are not willing to pay substantially more Income Tax for this purpose. This is disturbing news to any policy maker who is willing to

³⁷ See Leys and Player (2011) The Marketizer Network, p104.

³⁸ p96, Tudor-Hart (2010)

recognise that the NHS needs significant additional funding in order to meet its increasing demands.

Is there scope for more efficiency gains in the NHS or can we be smarter, or more selective about how we spend these funds? Should individuals be encouraged to take out more medical insurance and should the government not provide more behavioural nudges to encourage us to take more individual responsibility for our health and look after ourselves better? Many of the policy alternatives that are options in this field, have not been fully explored and it is regrettably that the major political parties seem unwillingly to acknowledge the extent of the NHS funding problem that we have. As voters, we are encouraged to believe the NHS is safe with each of the parties in this upcoming election, but it is an urgent requirement that all concerned honestly embrace the financial challenges facing the NHS in the next 5 years.

But – it is not all doom and gloom. Our NHS has faced severe challenges in the past and come through. By way of a contextual conclusion we should maybe leave the final sentiments to Kenneth Arrow (2016) – the Nobel Prize winner: *'The NHS has stood out as the cost-effective system achieving a good health standard. I am so surprised that a country that has contained its costs and achieved such good health care should be so worried.'*

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