

A series of background briefings on the policy
issues in the May 2015 UK General Election

Health: how will the NHS fare in a cold climate?

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CEP ELECTION ANALYSIS

Health:

How Will the NHS Fare in a Cold Climate?

- The NHS absorbs a fifth of all public spending and constitutes 8% of UK GDP. This percentage is set to fall over the next Parliamentary session.
- Recent NHS spending has been relatively low, growing only at 0.7% per year in real terms between 2010 and 2015, well below the long-run average growth rate of 4% per annum.
- The coalition government have been partly successful in achieving efficiency savings. But growing demands – due to demographics, technology and people’s expectations – have stretched service provision.
- A majority of NHS foundation trust hospitals are in financial deficit, and those in surplus have seen their surpluses fall from previous years. Waiting time targets are being missed.
- Predictions by NHS England show that even with continued efficiency savings, there will be a minimum shortfall of £8 billion in the NHS budget by 2020-21.
- The Cancer Drug Fund, which provides additional money for certain drugs has no clear rationale given the role of NICE in assessing NHS treatments.
- The coalition government’s 2012 Health and Social Care Act caused a large-scale reorganisation of the NHS, but appears to have been largely ineffective in improving services.
- Reforms from the mid-2000s and onwards that increased choice competition between *publicly* run NHS hospitals led to improved quality of care for patients, higher productivity and reduced inequality between rich and poor.
- The private sector plays a very small role in direct service provision in the NHS and no party is planning to increase this substantially.

Introduction

The NHS – and healthcare generally – has already become a central issue of the general election. The parties are debating funding, the form of provision, quality and productivity. All agree that they will not devote substantially more resources to the NHS in real terms.

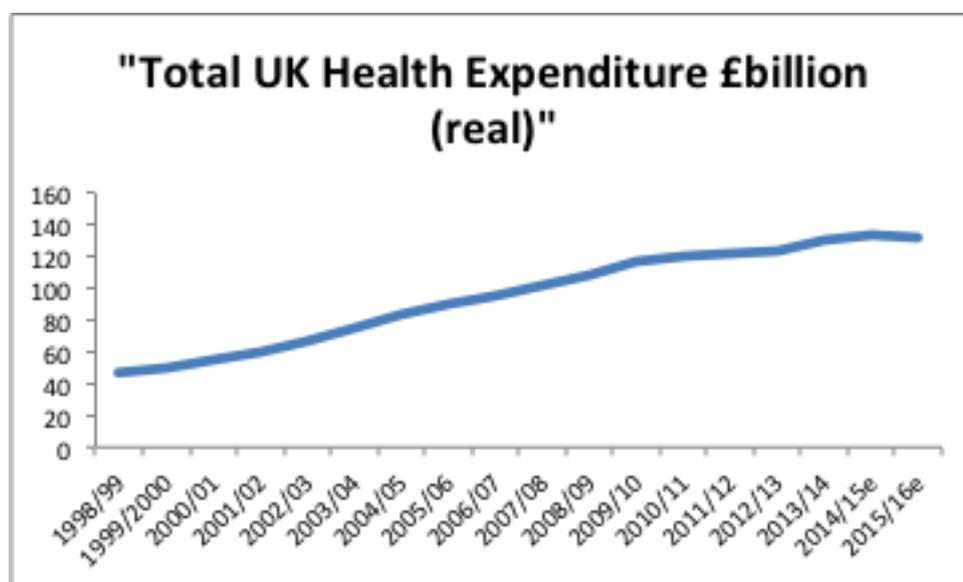
The Conservatives wish to continue to pursue competition among providers, whereas Labour want to ‘abolish’ such competition. Both parties want more integration of care across health and social care providers. The Liberal Democrats’ statements seem similar to Labour’s, although they would base integration around local authority control, a model recently proposed as a pilot in the Manchester area.

Resources spent on health

Healthcare comprises a fifth of all UK public expenditure. Total NHS spending was £129.5 billion in 2013-14 (see Figure 1) and it is planned to be £131.4 billion in 2015-16. This funding is allocated across England (£102 billion), Scotland (£11 billion), Wales (£6 billion) and Northern Ireland (£3.8 billion).¹ Current plans are for increases across England (1.1%), Scotland (0.3%) and Northern Ireland (2%), but a fall (of 1%) in Wales 2014-15. In fact, from 2009-10 to 2015-16, spending on the NHS in England will have risen by around 4% compared with a 1% fall over the same period in Scotland.

Between 2008 and 2012, private healthcare spending has fallen by over 2.5% per annum, to the lowest proportion (17%) of total healthcare expenditure since the mid-1990s.

Figure 1: UK healthcare expenditure 1998-99 to 2015-16



Source: HM Treasury Public Expenditure Statistical Analysis (PESA) (Table 4.3)

¹ Public Expenditure: Statistical Analysis (PESA) 2014, Tables 1.13, 9.11 Total Managed Expenditure (real terms) and Table 4.3 Public sector expenditure by function, UK Treasury July 2014, Cm8902.

The majority of health spending is staff costs. The NHS employs over 1.6 million people: 147,000 doctors, 372,000 nurses, 154,000 support staff and 36,000 managers. A further 150,000 provide infrastructure support (central services, catering, hotel-type services), and 289,000 provide support to clinical staff. Although the number of doctors has continued to rise since 2010, the number of nurses has hardly risen. There is also growing concern over the level of GP recruitment.

The NHS record under the coalition government

The coalition government inherited an NHS that had seen dramatic real expenditure growth over the previous decade. The annual growth in the 2000s was about 7%, compared with an historical average of 4%. This resulted in almost a doubling of real expenditure on the NHS between 1999 and 2010, which rose to about 8% of GDP by 2010.

Since 2010, the NHS budget has been almost frozen in real terms. Over 2010-11 to 2014-15, the NHS budget rose by £4.8 billion, representing an increase of only 0.7% in real expenditure per year.

This does not include expenditure allocated to local authorities to promote better integration between the NHS and social services. This expenditure has been under £1 billion per year, but from next year, in line with the recommendations from the Barker Commission (2014), £3.8 billion will be allocated to support better integration. While this is a significant absolute amount, almost £2 billion is a transfer from the NHS budget to the local authorities at a time when social services expenditure on adult services has itself fallen by 12% in real terms since 2010.

Demand and cost pressures have continued to grow during this period of flat-lining expenditure, so consequently there has been increasing reliance on 'efficiency savings' to maintain the provision of NHS services. The 'Quality, Innovation, Productivity and Prevention' initiative began in 2011 and called for £20 billion of savings over the period to 2015 to ensure that the NHS would be able to maintain delivery of services at an acceptable quality. As a result, for most of this Parliament, efficiency savings of 4% per year have been sought, to ensure demand is met and quality of provision is maintained. These are substantial efficiency gains, given that over the 15 years prior to 2010, NHS productivity growth averaged less than 0.5% per year.

The implementation of productivity gains were given a strong boost in the first two years of the coalition government due to the imposed public sector freeze on pay, which helped to keep cost pressures down in the NHS and were estimated to account for 40% of the efficiency savings.

A further 40% of savings were to come from tougher negotiation over contracts. Here it was envisaged that budget-holding 'primary care trusts' (PCTs, which have since morphed into 'clinical commissioning groups') would contract better with hospitals, squeezing hospital tariff prices while maintaining quality. Although some maintain that such hospital tariff cuts are hindering hospitals rather providing them with incentives, the UK Health Committee

reported that just under half of these tariff efficiencies were made through reductions in staff costs.²

The setting of targets on waiting times and access to care, and publicly available information on various metrics of hospital quality were aimed at providing further incentives in the system in a manner that would supplement efficiency savings. But recently an increasing number of hospital trusts have been failing to meet such targets. A further 20% of savings were unattributed, but some have come from a Treasury-led initiative to reduce NHS administration costs.

The efficiency gains have helped to produce increases through constraining inputs rather than through increasing NHS output holding inputs constant.³ It is unlikely that cuts in contract prices and staff costs can be maintained going forward as the private sector of the economy recovers. The combination of little increase in NHS expenditure, the reliance on efficiency gains to generate real resource increases and growing demand pressures has taken a cumulative toll on NHS services, especially in hospitals. One policy institute estimates that NHS productivity fell by almost 1% in 2012-13 and 2013-14, which given a reliance on efficiency savings to release resources to meet demand promises a bleak future (Health Foundation, 2015).

According to the NHS regulator Monitor, over a quarter of NHS foundation hospital providers ended the financial year 2013-14 in deficit (Monitor, 2015). By the end of the calendar year 2014, 60% of hospital foundation trusts were in deficit. Those NHS hospitals in surplus saw their average surplus fall. Indeed, the NHS in aggregate had a projected budget overspend of £625 million in 2014-15 (Health Foundation, 2015).

Various performance indicators signal a system under strain. The A&E waiting time target of servicing 95% of attendees within four hours has been consistently missed recently. Similarly, the target that 90% of inpatient referrals be treated within 18 weeks has also been substantially missed over the past year. The waiting list targets for cancer care have not been met since the end of 2013-14.

Such has been the concern over waiting times generally that in June 2014, £250 million of additional funding was found to treat individuals with exceptionally long waiting times. A further £150 million was then allocated by NHS England to provide further relief of waiting time pressures.

Transfers of care and delayed discharges are causing further concern. Specific areas, such as mental health services, appear to be suffering dramatic staff shortages and a consequent decline in the quality of provision. Given the historic under-provision of such services (Layard and Clark, 2014), this is a major concern.

Given all the current circumstances, NHS England has predicted that if real expenditure was not increased, if there were no further efficiency gains and if demand pressures continued to rise as they always have in the recent past, the NHS would face a £30 billion shortfall over the next five years.

² Public Expenditure on Health and Social Care, Health Committee 11th Report of Session 2012-13.

³ There have recently been useful changes made to NHS output definitions to include quality improvements and increasing NHS throughput. See, <http://www.ons.gov.uk/ons/rel/psa/public-sector-productivity-estimates--healthcare/2012/index.html>.

If efficiency gains averaged the long-term norm of 0.5%, there would be a £21 billion shortfall. If efficiency savings remained at recently attained levels of 1.5% per annum, the shortfall would be £16 billion. Even if it were optimistically assumed that efficiency gains were 2-3% per annum, there would still be an £8 billion shortfall by 2020-21.

As a direct result of these calculations, NHS England successfully lobbied the coalition government to increase NHS expenditure in 2014-15 by a further £1.25 billion. Without this, it is likely that the NHS would have ended the financial year in deficit. Moreover, as many have commented, it remains to be established whether this uplift will continue for each of the following years if either member of the coalition government is returned. Unless it is, on present projections, a shortfall of over £5 billion will be the most optimistic future for the NHS over the next Parliament.

Competition

One important policy of the coalition government, adopted from the previous Labour administration, has been the introduction of competition among hospital providers. In particular, hospital trusts were granted more autonomy, money followed the patient, and patients themselves (through their GPs) were given much greater choice over where they could go to hospital. Hospitals could only compete on quality (and not price), so the idea was that hospitals would improve performance or risk losing revenue as patients went elsewhere seeking higher quality. Major investments in improving information, regulation and targets (for example, over waiting times) were designed to support this market between (mainly) public providers.

There is a substantial body of evidence that this competition improved efficiency and patient outcomes. Hospitals facing increased competition improved efficiency (for example, reducing the average length of stay between admission and operations: Cooper et al, 2014) and the quality of care (for example, as measured by mortality rates: Cooper et al, 2011; Gaynor et al, 2012; Gravelle et al, 2014). Some of the improvements generated by competition came from improved management practices (Bloom et al, 2015).

Moreover, equity of access to hospital elective care also improved (Cooper et al, 2009), so inequality fell as quality increased. Hence if Labour do try to abolish competition, this will not only be another unnecessary upheaval, it will be likely to reduce efficiency and equity further.

The coalition government claims to have strengthened competition through the implementation of the 2012 Health and Social Care Bill. The legislation launched a full-scale reform of the NHS (in England), by creating clinical commissioning groups to replace PCT purchasers and a variety of regulators and other bodies (including NHS England itself). These large organisational reforms, coming at a time of limited resources, have been 'distracting and damaging' (King's Fund, 2015). It is unlikely that the reforms have led to increased competition and there is no evidence they have improved services.

'Privatisation'

There was an expectation among some that the Health and Social Care Bill would lead to

much greater private provision of NHS services, given the encouragement to use any willing provider, including private hospitals. It is important here to distinguish between competition and privatisation. Competition for patients is entirely different from privatisation – the positive effects of competition discussed above were among public NHS hospitals.

In any event, the NHS has only awarded a mere 5% of contracts by value to the private sector. So the recent emphasis by Labour on inhibiting private sector involvement by having a profits cap of 5% represents a sideshow to the main debate around the NHS. No major party is proposing any increase in charges for NHS services or a substantial increase in (free) private provision of NHS services.

Cancer Drugs Fund

In 2011, the government established the Cancer Drugs Fund. This Fund was set up to provide extra money for cancer treatments that NICE (the National Institute of Clinical and healthcare Excellence) had deemed too ineffective or too expensive for NHS provision. This was a politically popular and motivated partly to counter the rising cost of new cancer therapies, but as importantly to manage rising treatment expectations.

Expenditure on the Fund has grown continually over the four years of its operation, but even so, by 2013-14, it was £30 million overspent. In response, the government has increased the budget by £80 million in each of the next two years, and the Fund now stands at £340 million. These increases were to be offset by potential savings arising from pharmaceutical price cuts over the next year, and coupled with a de-listing of 16 oncology products associated with 25 treatments. The government has since indicated that future overspending would not be allowed.

The Fund will run at least until April 2016, with Labour now pledging to expand it, but its rationale remains unclear. NICE is an important innovation that makes transparent decisions to fund treatments based on evidence and cost-effectiveness. The Fund is a blatant circumvention of NICE. There is no obvious justification for considering cancer treatments more generously than, say, treatments for strokes, heart attacks or mental health.

What are the main parties promising?

All the main parties are focused on public sector cuts to rebalance the economy and the size of the public debt. As in other countries, the UK has historically experienced rates of growth in healthcare higher than the growth rate in GDP. As public expenditure comes under pressure, healthcare as a percentage of GDP will fall, even if the parties pledge to maintain the NHS in real terms.

In 2009-10, UK NHS expenditure was 8.2% of GDP and this fell to 7.9% by 2013-14. The Office for Budget Responsibility (2014) forecasts NHS expenditure to be 6.4% of GDP by 2019-20, the same level as in 2003-04. While this will be a larger level of expenditure in absolute terms, it is likely to provoke a deterioration in service delivery. Even promises to maintain real levels of NHS expenditure are therefore going to prove problematic over the next Parliamentary session.

The Conservatives

The Health and Social Care Act 2012 will continue to shape the Conservatives' health policy. This embeds competition among any willing providers of healthcare in a regulated structure, which promotes patient choice based on increasing public information over aspects of delivery.

There is a recognition that further efficiencies are required given that there will be no rise in expenditure in real terms and a policy of assuring patients of GP access '8 'til 8' and at the weekends is to be guaranteed. At the same time, there is a move to allow GPs to hold patient budgets and commission care directly, and to increase the link between GP pay and performance.

While unclear on priorities, the draft manifesto promised improved focus on cancer, strokes, mental health and a reduction in infections. Various forms of integrated care spanning health and social care are proposed, including 'integrated community commissioning', multi-specialty community providers, and integrated primary acute care specialty provision.

At an individual level, those with complex, chronic conditions can be given a personal budget with which to purchase health and social care. There will also be an offer of an £8,000 insurance premium to protect housing assets being sold to cover social care costs for the elderly.

Most recently, the Conservatives announced a proposed piloting of a scheme where the NHS would transfer £6 billion of the annual health budget to the 10 local authorities defining Greater Manchester, which would take responsibility for some areas of expenditure including staffing, regulation and capital spend. Local clinical commissioning groups would continue to exist and work alongside the Greater Manchester local authorities, aiding priority setting and purchase of care.

The Conservatives have also recently announced that hospital care quality will be improved through guaranteeing that consultant care is extended to weekend coverage. This is partly to re-address higher weekend within hospital mortality rates. There has been no detail forwarded, yet, on how these moves will be incorporated within NHS consultant contracts or paid for.

Indeed details of all proposals are scant. In particular, details of the transfer of healthcare budget to local authorities, which mimics the original organisational structure of the NHS when it was established in the late 1940s, have yet to emerge. Some commentators have applauded the move, suggesting that it supports the general regional transfer of public funds and power to Greater Manchester Combined Authority, the flagship of proposed devolved regional democracy. Others have raised concerns that it represents another ill thought through NHS reorganisation.

Labour

Labour have set out a 10-year plan for the NHS that will abolish the Health and Social Care Act 2012, fostering greater integration across NHS providers through enactment of preferred providers. While this does not rule out private provision of healthcare to NHS patients, it will give priority to NHS and voluntary providers.

Labour have also promised to recruit 20,000 more nurses, 8,000 more GPs, 3,000 more midwives and 5,000 more homecare workers over the timeframe of the next Parliament. This will help with the guarantees to get access to a GP within 48 hours, a single point of contact for complex cases with personalised care plans, cancer diagnosis within one week and increased emphasis given to mental health and prevention generally.

Labour have also pledged to integrate health and social care and for the system to be regulated by Monitor and provided with incentives, for example, through year-of-care tariffs to cover chronic diseases. This would be paid for through further efficiency savings and by an estimated £2.5 billion to be raised from a mansion tax, more penalties for tax avoidance and a new levy on tobacco firms. Pay restraint and assurance of the efficiency of the increased tax base will be the basic issues moving forward. Once again, little detail has emerged with the announcement of these proposals.

The Liberal Democrats

The Liberal Democrats' headline policy is that they will increase NHS funding to provide 6,000 more clinicians, lower waiting times and improve cancer care. They will increase mental health funding by £400 million and will improve access to GP care, in a similar manner to the Conservatives. But like Labour, they will promote the integration of health and social care and a retreat from competition in the delivery of healthcare.

Conclusions

The NHS has become a dominant area of debate for this election. This debate is being played out against a background of recognition that resource constraints are already beginning to bite hard within the NHS. All parties are seeking to portray an NHS protected from major public sector expenditure cuts, with expansion in some areas. This is only viable through further efficiency savings of some kind, and even then it is not clear how resource levels will be maintained.

The threat to the NHS is certainly not going to be creeping privatisation, but rather on extending or adding more ill thought through reforms that target inputs, rather than focusing on improving the value of NHS outcomes. The important matter to concentrate on here is what achieves higher quality service provision, given the expenditure constraints.

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Further reading

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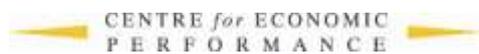
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