CENTRE *for* ECONOMIC PERFORMANCE

THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

CEP 2019 ELECTION ANALYSES SERIES

A series of background briefings on the policy issues in the December 2019 UK General Election

Health and Social Care

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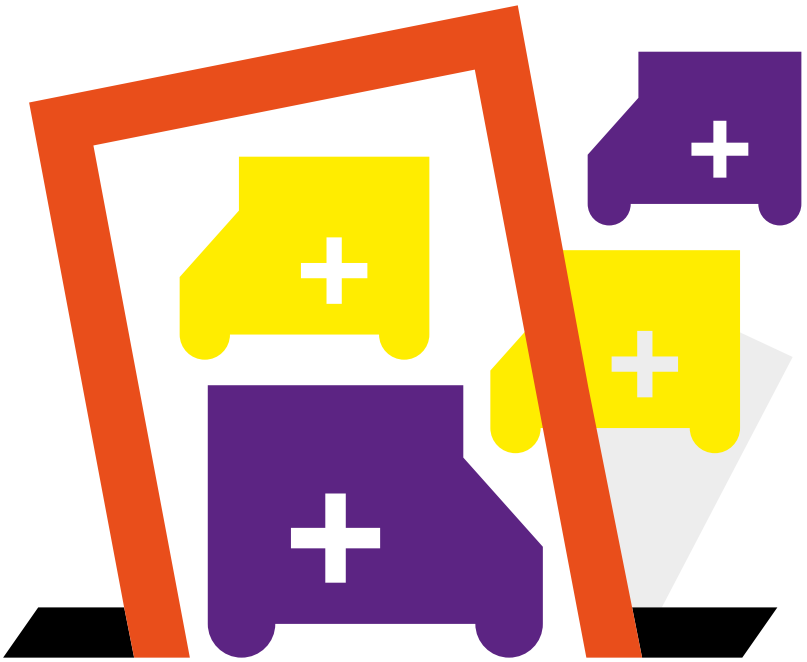
#GE2019Economists



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CEP ELECTION ANALYSIS

Michael Anderson, Elias Mossialos and Alistair McGuire

November 2019

Summary

- The UK National Health Service (NHS) is acknowledged to have suffered from a funding crisis since 2010.
- The UK currently spends 9.6% of GDP on healthcare (2017 figures), but this percentage is slightly lower than in previous years.
- NHS expenditure is 7.6% of GDP, which is approximately the same as it was in 2012 even though population and treatment pressures have been increasing.
- Historically, the average annual increase in NHS expenditure since it was established has been over 4%, but since 2014/5 average annual NHS expenditure growth has been 1.6% and between 2009/10 and 2014/5 it averaged a mere 1.1% per annum.
- For more than five years, hospital trusts in England have been recording financial deficits.
- As just under 70% of NHS expenditure is spent on the workforce, the low growth in funding has been achieved partly through wage freezes.
- Severe workforce shortages have emerged; currently one in 12 posts are vacant within the English NHS Hospital and Community Services sector.
- This has led to a subsequent deterioration in the quality of service provision with a number of service targets being missed; the cancer treatment target has been missed for the fifth year in a row.
- Social care, which is directly linked to NHS treatment provision, is largely provided by local authorities; adult social care funding fell by around 2% per year between 2010/11 and 2014/15, but has since grown, although it has not recovered to its 2010/11 levels.
- The underfunding of social care, at a time of increasing population pressures has led to issues of bed-blocking within the NHS
- The two major political parties are pledging NHS expenditure growth (3.3% per annum for the Conservatives; 4.3% by Labour), but are less explicit over social care reform.

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Introduction

The National Health Service (NHS) is arguably the one national institution that unifies the country in terms of general public support. But there is growing concern about the long-term sustainability of the NHS, with 57% of people surveyed in a recent Ipsos MORI poll expecting deterioration in services (Ipsos Mori, 2017). It is therefore unsurprising that it has been a major source of political debate over the past few elections.

Not only has the NHS been important to politicians in eliciting voter support, related debates on social care provision have also gained in importance over time. Indeed, some would argue that the Leave campaign's claim that Brexit would make £350 million per week available for the NHS was instrumental in the outcome of the referendum, and that the miscalculation in announcing how social care might be financed also led to the eventual downfall of the May premiership, the selection of Boris Johnston as prime minister and the subsequent call for a third UK election since May 2015. Correct or not, health and social care remain central to the political debate in the 2019 election.

The dampening of welfare expenditure since the crash of 2008, with an emphasis on public sector debt reduction has meant that public sector expenditure levels generally, and NHS and social care expenditure specifically, have become a major focus for all the political parties in this election.

At the same time, as various markers of NHS performance, such as A&E and cancer waiting times decline, the election has triggered debate about whether NHS service provision is deteriorating. The House of Lords Select Committee on the Long-term Sustainability of the NHS and Adult Social Care, in reviewing the health and social care sector, began by stating 'the NHS… is in crisis and the adult social care system is on the brink of collapse' (House of Lords, 2017).

The structure of the NHS in the UK

The *National* Health Service in fact provides for the four, individual constituent countries of the UK in different ways. Reforms to the NHS in England in the 1990s had introduced an internal market structured around a purchaser-provider split, where GPs held budgets (based largely on the size of the population they served, weight adjusted for illness and deprivation in the geographical area) to provide primary care services and purchase secondary (hospital) and tertiary (specialist) healthcare.

In England the Health and Social Care Act (2012) built on these reforms, retaining a purchaser-provider split, but now based on approximately 200 clinical commissioning groups (CCGs) purchasing care from hospitals and specialist providers on behalf of the populations they cover. The Act allowed purchase of such care from any willing provider, including the private sector, and included the requirement to put certain contracts out to tender to promote competition. In essence, money follows the patient in terms of their health treatments.

In April 2019, an organisational reform aimed to become more response to regional needs, with the separate bodies of NHS England and (NHS) Improvement merging to manage the NHS in England, based around seven regions. Regulation is maintained through a number of bodies, with the Care Quality Commission (CQC) covering general quality of provision and safety, while the National Institute for Health and Care Excellence (NICE) provides evidence on the clinical effectiveness and cost-effectiveness of individual treatment provision.

Social care provision is provided through local authorities, with some limited cross-sectoral funding. One exception is the current experiment being undertaken in Greater Manchester, where health and social care operates through a strategic board and a combined budget. It is too early to assess the impact of this experiment, although doubts have been raised as to whether it is possible to replicate it across other regions of England (Harker, 2019).

While England still operates a regulated internal market, the general direction of current policy aims to resolve any barriers that are created through these financial flows, with an indication that the promotion of integration across services will be emphasised. Such integration broadly characterises the NHS funding and provision delivery in the other parts of the UK. In Scotland, Wales and Northern Ireland, NHS funding is centrally held and allocated to regional health boards and specialist boards to provide healthcare within a given budget. To a degree, social care provision is also integrated with healthcare provision in these countries.

There has been remarkably little comparison or assessment of the efficiency of these different systems of funding and delivery across the UK. What little analysis has been undertaken finds no consistent evidence that one structure is better in the delivery of healthcare than any other. A common suggested reason for this is that the smaller countries face different health needs, although even here the evidence is not straightforward.

Expenditure on UK health and social care

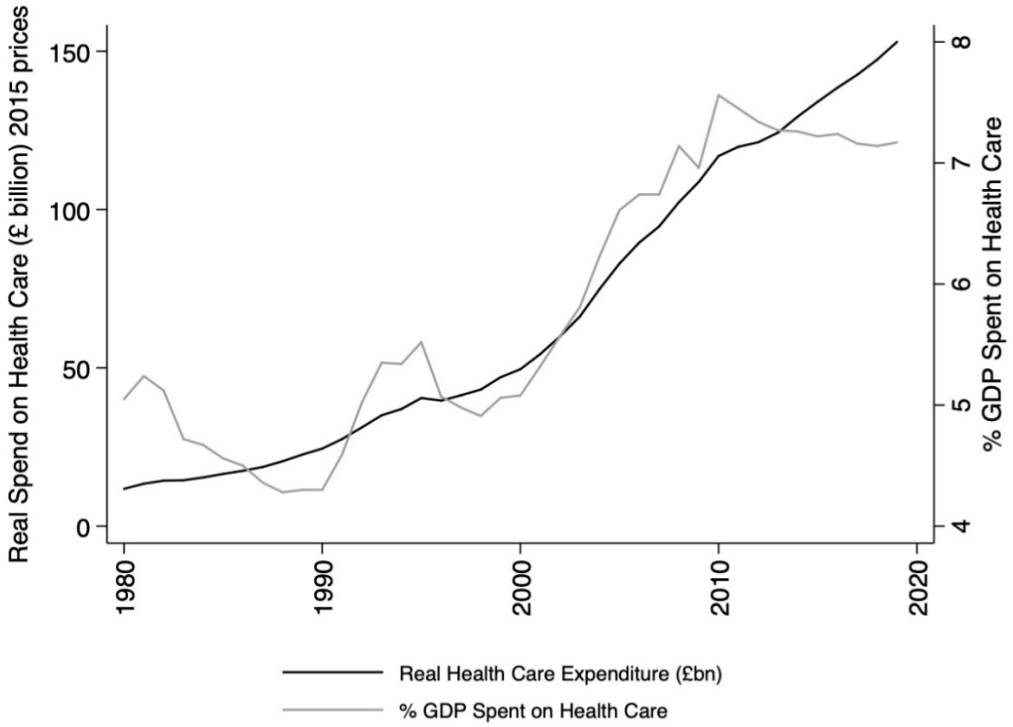
Total (public and private) UK healthcare spending was last calculated for 2017 and estimated to be £197.4 billion (ONS, 2019). At that point, the NHS and local authorities contributed 79% of the total spending, out-of-pocket expenditure was 16% of the total (and given that prescription charges have been abolished in Scotland and Wales, and dental charges are lower in these countries, most of this was incurred within England), private health insurance was around 3% of the total and the rest was essentially charitable spending.

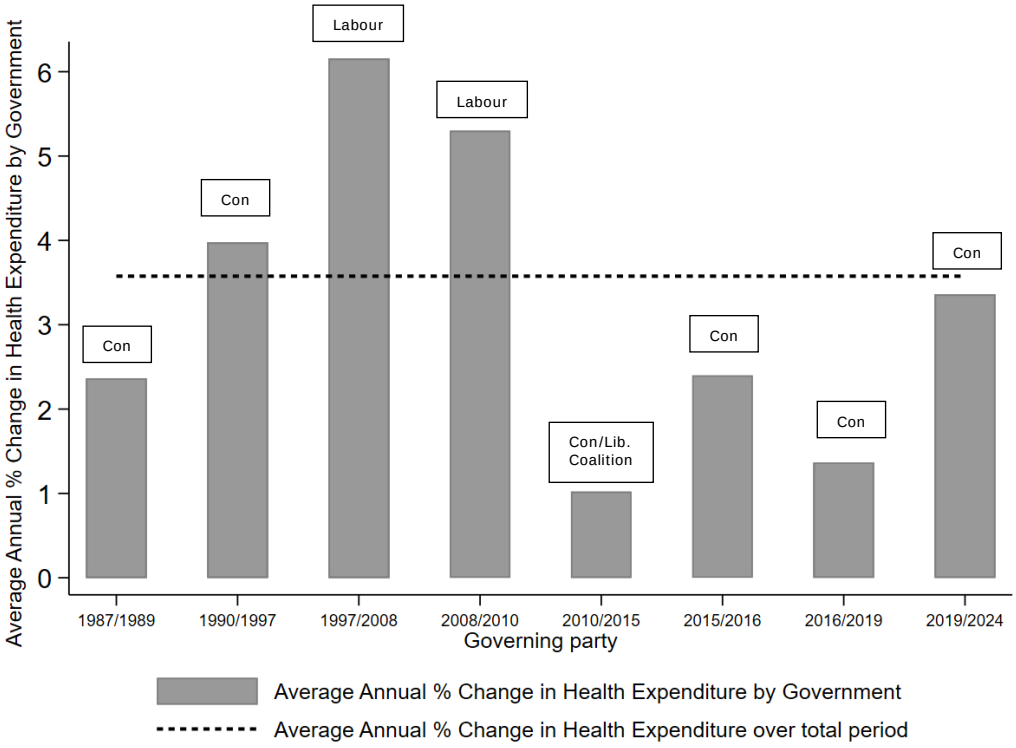
Public expenditure on health was £155.6 billion in 2017, accounting for 7.6% of GDP, which is approximately the same as in 2012 (7.7%) (ONS, 2014). Since that time, the NHS has experienced the lowest expenditure growth since the initial ten years after it was established.

Historically, the average annual increase in expenditure since the NHS was introduced is just over 4%, taking account of population growth the increase in per capita expenditure is 3.6% over this period (Gershlick et al, 2019). The highest average annual expenditure growth of 6% per annum was attained over the period 1996/97 until 2009/10 (Gershlick et al, 2019). Since 2014/15 the average annual growth in healthcare expenditure has been a mere 1.6%.

Between 2009/10 and 2014/15 under the coalition government, NHS expenditure averaged 1.1% per annum. Adjustment for population growth would take the average increase in spending across the period 2009/10 to 2018/19 to less than 0.4% per person. In 2017/18, NHS expenditure was £2,168 per head in England, £2,306 in Northern Ireland, £2,310 in Wales and £2,353 per head in Scotland (Harker, 2019).

The Scottish spend per head is over 8% higher than in England. This may reflect a worse population health in Scotland than in England, but it also masks variation in expenditure within England and possibly some differences in public sector prioritisation.





Such historically low levels of spending, in conjunction with increased pressures from an aging population and general cost pressures, have led to a sustained financial crisis within the NHS. For more than five years, English NHS hospital trusts have been recording financial deficits. In 2018/19, NHS trusts overspent by £571 million and CCGs by £264 million, although these deficits were offset by short-term cost savings and emergency funding to achieve an overall NHS financial balance (Harker, 2019).

While attempting to make up for shortfalls in expenditure through efficiency improvements, it is widely recognised that there is limited further productivity gains to be made within the NHS (House of Commons, 2017). There is growing recognition that the lack of growth expenditure has meant that the NHS has failed to keep up with increasing demands arising from an aging population, failures to integrate health and social care packages and the general rising cost of healthcare delivery.

The House of Lords (2017) attributes this failure to an environment of historic low spending on the NHS, with healthcare spending per head historically 'markedly lower than other countries such as France, Germany, Sweden and the Netherlands' (House of Lords, 2017). The latest comparable, healthcare spending for the UK as a whole are produced by the Office of National Statistics (ONS, 2017) for 2017. Total UK spending per person in that year was £2,898, which is among the lowest of the wealthiest countries in the world; it was £3,737 for France and £4,432 per person in Germany.

In response to such criticism, the government announced a £20.5 billion increase in NHS England's budget in June 2018 to be phased in over the five-year period to 2023/24. Given the spread of funding over these five years, this represents an average per annum increase of around 3.3% in expenditure (Gershlick et al, 2019).

While welcoming this increase in expenditure, a number of commentators, as pointed out by the House of Commons Briefing Paper on NHS Funding and Expenditure (Harker, 2019), have stated that this is the minimum required to meet increasing demands and maintain improved delivery of service. The Institute for Fiscal Studies and the Health Foundation (Johnson et al, 2018) have suggested that the top-up of 3.3% per annum, in real terms, increases in NHS to 2023/4 is only enough to 'maintain current standards'. To improve the quality of services, addressing growing waiting lists and improve A&E performance, annual increases of at least 4% per year are needed (Johnson et al, 2018).

Two areas of expenditure are of particular interest in this election. First, a tapering mechanism that reduces tax relief on pensions for people earning over £110,000 per year, has led to over 30% of GPs and over 40% of hospital consultants either taking early retirement, reducing their hours or refusing extra shifts (Bostock, 2019; Salt H et al, 2019) Concern has been great enough for the government to promise to reform pensions taxation in this area. Currently, a deal has been struck with the NHS with £1.25 billion allocated to alleviate pension pressures, which was announced in 2018/19.

Second, there is a debate over the encroachment of the private sector within the NHS. In 2018/19, the English NHS spent £9.2 billion, or 7.3% of its expenditure, purchasing care from private providers. This is slightly less than the record amounts (£9.4 billion or 7.7% of English NHS expenditure) on private healthcare providers in 2015/6 and 2016/7 (Rowland, 2019). Some have argued that this is a significant share of NHS expenditure going to the private sector. Others have argued that, at a time of tight capacity constraints affecting diagnostic services and elective treatments, it is a necessary expenditure. Regardless of the stance it is almost 50% higher than the level seen in 2011/12.

Social care, which is inextricably linked to healthcare, is in an even worse position in terms of expenditure allocation. Inevitably this has an impact on the NHS, as some of the pressure on the healthcare sector comes from deterioration in related social services funding.

In particular, delayed hospital discharges, where hospital beds are blocked as patients are not discharged, remain high. While delayed discharges have fallen since 2017, the 2019 level of

4,478 per day remains 13% higher than that achieved in 2014 (3,3970 per day). One of the main reasons has been the failure to coordinate care across the hospital and social care sectors. For example, the number of elderly individuals awaiting defined care packages in order for them to be discharged has more than doubled over a five-year period.

One of the issues of coordination arises from the fact that social care is substantially provided for by local authorities within the UK. Integrated care is undoubtedly affected by the fact that in England, local authority expenditure fell almost 50% (49.1%) in real terms between 2010/11 and 2017/18 (Comarty, 2019). Between 2010/11 and 2018/19, adult social care expenditure fell by 2% (from £16.5 billion to £16.1 billion), having fallen every year between 2011/12 and 2015/16. Between 2009/10 and 2015/16, spending on adult social care fell 10%. Since 2016/17, adult social care expenditure has begun to rise year on year.

To alleviate the funding pressures, particularly the bed-blocking, the government created a Better Care Fund in 2015, which was meant to increase support to local authorities for adult social care by £3.5 billion, although £2 billion was a direct transfer from the NHS budget. In 2017, a further £2 billion was allocated to the Better Care Fund.

While having some impact, it was clear that progress was slow and the initial aim of achieving financial savings through better integration was not being achieved (NAO, 2018). As a result, in 2019, the government announced an additional £1 billion for local authorities adult and children's social care services.

Even so, to cope with these financial pressures many local authorities have cut services and restricted access through raising eligibility criteria. At the same time, the quality of care delivered is of widely varying quality. It has been estimated that £12.2 billion of additional funding for social care is needed per year by 2023/24 to restore access to 2010/11 levels of service and invest in the social care workforce (The Health Foundation, 2019).

In order to address some of the financial shortfall, the government has allowed local authorities to raise an up to 3% levy on council tax, from 2017/18 to aid funding of social care (Cromarty, 2019). It is not clear how much funding has been raised by local authorities in this way, nor whether if raised it has all gone into social care; although the government is trying to ensure the levy is ringfenced for social care.

Moreover, the potential for raising up to a 3% levy for social care funding also has a direct impact on the amount of access to the Better Care Fund that a local authority has. Essentially up to 90% of the Better Care Fund is open to potential substitution by the potential to levy funds for social care, making the net additional funding less than £2 billion. A further separate £240 million was released to relieve 'winter pressures' in 2018/19 and 2019/20. For reasons yet to be understood, hospital discharge delays attributable to social care inadequacies have fallen by 30% in the year to June 2019 (Cromarty, 2019).

While a substantial amount of adult social care is funded through the public sector, according to Laing Buisson (2018) approximately 45% (176,000) of individuals in independent sector homes, reflecting the highest number in need, paid privately (Laing Buisson, 2018). Reform of the social care funding model is long overdue, and the eligibility criteria (means tested threshold of total assets less than £23, 250) remains unchanged since 2010/11.

The Dilnot Commission (2011) on 'Fairer Care Funding' suggested a lifetime cap of individual contributions of £35,000, and a means-tested threshold of £100,000 (Dilnot, 2011). The Care

Act 2014 included plans to introduce a lifetime cap of individual contributions if £72,000, but these plans have been postponed indefinitely (UK Government, 2015).

Impact on services and staffing

The NHS is a large employer. The NHS in England employs around 1.5 million individuals (1.1 million full-time equivalent staff) (Rolewicz and Palmer, 2019). Across the social care sector there are a further two million individuals estimated to be employed (Dolton et al, 2018), with a further 6.8 million informal carers (Bucker and Yeandle, 2015). Clearly, in voter terms alone, the NHS is significant, with health and social care accounting for approximately 13% of the UK workforce (ONS, 2019b).

Within the NHS in England, there are approximately 150,000 clinicians and 320,00 nurses (Rolewicz and Palmer, 2019). Together these groups account for approximately one third of the workforce. The second largest staffing grouping is the support to clinical staff group who are around 320,000 individuals, followed by scientific, therapeutic and technical staff, which run to approximately 140,000 individuals (Rolewicz and Palmer, 2019).

The NHS workforce is growing or, in some cases, shrinking at different rates. The section of the NHS workforce with the largest growth rate is hospital medical staff. Between 2004 and 2019, the headcount of hospital medical staff increased by 38%; within that figure the number of hospital consultants rose by 67% (Rolewicz and Palmer, 2019). This contrasts with GPs, where over the last four years the number of full-time equivalents has dropped by 1% (Rolewicz and Palmer, 2019).

Since 2010, there has only been a 1% increase in the number of NHS nurses per 1,000 population employed; between 2010 and 2018, the number of nurses employed in the English NHS per million population fell by 3%, although it has since risen. Again this masks wide variation, as since 2010, employment of acute hospital nurses per 1,000 population has grown by 7%, but employment of mental health nurses has fallen by 13% and community health nurses by 11%, while district nurses have fallen by 47% (House of Commons, 2018).

With just over half of NHS expenditure spent on staff, the budget constraints have had an impact on the NHS workforce. NHS England salaries had an annual 1% cap on pay rises between 2013 and 2017, which was preceded by a freeze on public sector pay between 2011 and 2013 (Pyper et al, 2018).

Currently, around one in 12 posts are vacant within the hospital and community services division of the NHS (Rolewicz and Palmer, 2019). But there are wide regional variations. Generally, shortages are lower in the north, running at just under 5% for hospital and community care staff in the North East of England and at close to 12% in the Thames Valley (Rolewicz and Palmer, 2019).

The greatest number of vacancies is in the nursing profession. The RCN in its response to the governmental pay review estimates a total of 40,000 nursing vacancies exist in England, while Health Education England puts the vacancy number at 36,000. The RCN notes that this is an estimate as centralised figures on vacancy rates were not available for recent years (RCN, 2018). Moreover, turnover is high, running at around 15% for the nursing profession.

There are a number of factors driving these staff shortages: the withdrawal of nursing bursaries in England, a potential Brexit and strict immigration rules are compounding the uncertainty surrounding staffing pressures. The NHS has a long history of reliance on foreign staff. In total,

around 13% of NHS staff are from non-UK countries, and 5.5% are from EU countries (Baker, 2019). This varies within professional groups: around 9% of doctors, 16% of dentists and 5% of nurses are EU nationals (Dolton et al, 2018).

It is clear that the largest potential impact on the NHS workforce will be future migration policy, rather than the impact of Brexit (assuming it occurs) per se. But it should be noted that between 2015/16 and 2017/18, the number of nursing staff joining the NMC register has dropped from around 10,000 to just under 1000 each year (NMC, 2019).

Staffing shortages are also a concern within the social care sector. In England, the overall vacancy rate is high, with vacancy rate in adult social care rising from 6% in 2012-13 to 8% in 2017-18 (Skills for Care, 2019). There is significant variation within England, with vacancy rates in parts of London above 20%. Turnover is particularly high, with a 31% turnover rate across all adult social care jobs in 2017-18, rising to 35% for care workers.

Data on the social care workforce in the other UK nations are less detailed. But a total vacancy rate across social care of 6% in Scotland (Scottish Social Services Council, 2019) and Wales (Data Cymru, 2019), suggests that workforce shortfalls are not as high as in England. Approximately a third of this staff group are on zero hours contracts, with no guaranteed income.

The average hourly pay for care workers at the beginning of 2019 was low with the median wage being £8.21, the same as the National Living Wage (NLW) set at £8.21 in April 2019. Just prior to the introduction of the 2019 NLW rate, 46% of social care workers received wages lower than this (Skills for Care, 2019b). As the NLW increases over time (as planned), a major challenge will be to reward individuals with greater experience. The pay differential between care workers with less than one year of experience and those with more than 20 years of experience is, on average, just £0.15 per hour, reflecting poor occupational potential progression or training (Ward, 2019).

Not surprisingly, with these tight expenditure constraints, the increasing demand pressures and the staffing shortages, the level of NHS service provision has been affected. The service provision targets for four-hour waits in A&E, the 18-week waiting time target to see a consultant, and the 62-day cancer treatment target were all missed in 2018/19 (Thorlby et al, 2019). The cancer treatment target has been missed for the fifth year in a row.

It is not easy and too early to assess the effect on health outcomes, and certainly attribution of declining health outcomes to declining NHS standards is not straightforward. What can be said is that the gains in life expectancy appear to have flatlined, while inequalities in life expectancy have widened. In reviewing UK outcomes for a range of conditions, Dayan et al (2018) find that the UK has poor outcomes compared with other wealthy countries for a number of cancer treatments, for stroke, heart disease and amenable mortality as well as for birth outcomes (Dayan et al, 2018). For diabetes and kidney disease, they find the UK performing well.

What the main parties are offering

The following offers a brief review of the major commitments for health and social care within each party's manifesto, with a particular focus on funding commitments.

The Conservatives

The Conservative manifesto says that the NHS will receive an additional £34 billion per year by 2023-24 (approximately £20 billion in real terms), in line with the current five-year funding settlement announced in 2018. This increases funding for the NHS on average by 3.3% per year in real terms (The Health Foundation, 2019).

But this funding settlement only covers frontline services, and does not include budgets for Health Education England (HEE), public health and capital. As noted earlier, the Institute for Fiscal Studies and the Health Foundation estimate that annual increases of 3.3% per year are needed to maintain current standards of care and meet growing demand for health (Johnson et al, 2018). To improve the quality of services, addressing growing waiting lists and improve A&E performance, annual increases of at least 4% per year are needed (Johnson et al, 2018).

The Conservatives pledge to begin work on building new hospitals over the next 10 years, and invest in hospital upgrades and new machines to improve cancer diagnosis. But this includes £2.8 billion of funding for six hospitals to upgrade their buildings over the next five years, and £100 million of 'seed funding' for a further 21 hospital trusts to prepare a business case for building work to take place between 2025 and 2030, but not to start building work (UK Government, 2019).

On social care, the Conservatives have confirmed the extra £1 billion for social care announced in the most recent spending review will be regular funding provided every year. The Conservatives don't suggest any reforms to the social care funding model within their manifesto: instead they plan to work towards building cross-party consensus on potential reforms. They do commit to providing improved financial protection, by stating any reforms must include the prerequisite that no one needing care has to sell their home to pay for it.

For the workforce, the Conservatives pledge to recruit 50,000 more nurses, and to reintroduce training bursaries, as well as 50 million extra general practice appointments a year, by recruiting 6,000 more general practitioners and 6,000 more multidisciplinary team teams such as physiotherapists and pharmacists. Given the length of time to train the workforce, this is an ambitious plan.

Labour

Labour promises to outspend the Conservatives by increasing health expenditure by 4.3% on average per year. This equates to around an additional £26 billion, in real terms, for the NHS by 2023-24. This is closer to the 4% on average, per year that the Institute for Fiscal Studies and the Health Foundation estimate the NHS needs to make improvements to the quality of services, addressing growing waiting lists and improve A&E performance (Johnson et al, 2018).

Labour also plans to reduce private provision of NHS services by repealing the Health and Social Care Act, including ending the requirement to promote competition. They further promise to guarantee real terms pay rises every year, starting with an initial 5% increase for all public sector workers.

Labour intends to invest funds in specific areas of urgent unmet need. Mental health is highlighted as a key area that is not coping with rising demand, particularly for children and young people. The manifesto includes a specific commitment to increase funding for mental health services, to reintroduce training bursaries for all nurses, midwives and allied healthcare professional courses, and to review current NHS pensions.

Labour is also promising to reverse cuts to the public health budget, and return funding to 2015/16 levels, by providing an additional £1 billion per year (The Health Foundation, 2019). They plan to abolish prescription charges, provide free hospital parking to all patients, staff and visitors, and introduce free dental checks.

On social care, Labour highlight how social care funding has fallen by £8 billion since 2010, and promise to deliver long-overdue reforms. They plan to introduce free personal care for older people, and a lifetime cap of £100,000 for personal contributions to care costs and increase the carer's allowance for unpaid full-time carers. It has been estimated that implementing this model would add around £4.4 billion to spending in 2019/20, rising to £5 billion by 2023/24 (Gershlick et al, 2019).

The Liberal Democrats

The fundamental pledge by the Liberal Democrats is to halt Brexit. They argue that Brexit would have many negative consequences for the NHS and social care, by jeopardising the UK's ability to recruit or train staff from Europe, risking delays to medicines, and less resources due to reduced long-term economic growth.

The Liberal Democrat's would also raise £7 billion per year to alleviate pressures on social care, workforce shortages, mental health services and public health. They also promise to commit some of a wider £10 billion capital fund to invest in equipment, hospitals, community, ambulance and mental health service buildings.

On social care, the Liberal Democrats pledge to introduce a cap on lifetime contributions, but do not specify what level the cap would be set at. To deliver further reforms, they commit to establishing a cross-party convention to reach an agreement on a long-term and sustainable funding model that will promote integration between the NHS and social care.

To oversee the funding of the NHS and social care, the Liberal Democrats plan to introduce a statutory independent budget monitoring body, similar to the Office for Budget Responsibility, to report every three years on funding requirements, based on projections of demand.

Conclusions

It is clear that the health and social care sectors have suffered a prolonged period of expenditure constraint at a time of increasing demands from an aging population. It is also true that the austerity suffered by the NHS has been less severe than that witnessed by other parts of our remaining welfare state. This leads to a number of clear conclusions.

First, there is a clear need for increased funding. The main political parties' proposals all take the UK either closer to or above historical levels of NHS expenditure growth. Whether this is enough to improve services adequately remains an open question.

Second, it is clear that given the expenditure cuts witnessed by other parts of the public sector, including to local authority budgets, government expenditure cannot be reallocated from other sectors into the NHS. To maintain NHS expenditure growth at historical levels, revenue will have to come from either raised taxes, increased borrowing or both.

There will also have to be a clear fix to supporting social care services. All political parties need to be honest with the public that this is what necessary to secure the long-term future of the NHS.

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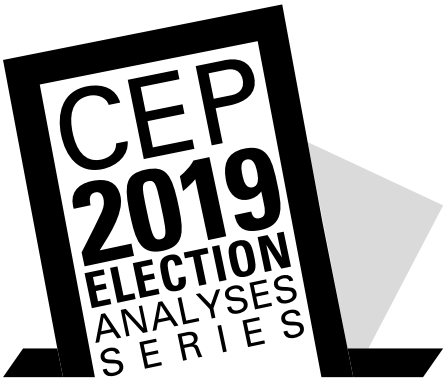
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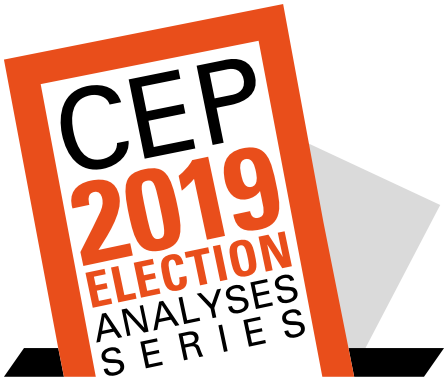
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