

CEP ELECTION ANALYSIS

The NHS and Social Care: Prospects for Funding, Staffing and Performance into the 2020s

Alistair McGuire

- The UK currently spends 9.8% of GDP on healthcare but this percentage is due to fall as GDP rises. It is a slightly lower share than in other northern European countries.
- The NHS absorbs the overwhelming proportion of total spending on healthcare, currently standing at £138 billion per year and accounting for approximately a fifth of all the UK's public spending.
- While the organisational structure and delivery varies across the four constituent nations of the UK, there is no evidence that the purchaser-provider split that dominates NHS England is any worse in delivering health outcomes than the more centralised health systems in Scotland, Wales and Northern Ireland.
- The 2012 Health and Social Care Act led to a large-scale reorganisation of the NHS in England, but it appears to have been largely ineffective in improving services.
- The recent growth of NHS spending has been relatively low, increasing at 1% per year in real terms between 2010 and 2015, well below the long-run average growth rate of 4% per annum.
- There is increasing criticism that the NHS is underfunded, and will continue to be into the 2020s with increasing demands from an ageing population. Estimates of the shortfall are put at £30 billion.
- In response, the government has allocated £10 billion additional funding to the NHS from 2015/16 through to 2020/21. With additional productivity savings of 2-3% per annum, the government argues that the shortfall in NHS expenditure will be met.
- But the size of the additional allocated funds is disputed. Some have corrected the figure to £4.2 billion.
- Moreover, many doubt that the accompanying 2-3% productivity gains, which are necessary to meet the predicted expenditure shortfall, can be achieved.
- The integration of health and social care is increasingly seen as a major means of alleviating pressure on the NHS. But social care faces its own funding crisis.
- While there is no 'correct' level of NHS funding, as this depends on social preferences as much as needs, determining NHS funding will remain a challenge regardless of which party is in government.

Introduction

Health featured prominently in the 2016 referendum on the UK's membership of the European Union (EU), with the Leave campaign's claim that Brexit would mean that £350 million extra money per week could be transferred from the UK's EU budget contributions to the NHS. Although the current Conservative government has ruled this out, arguing that any change in UK public expenditure plans is conditional on the Brexit negotiations with the EU, the NHS remains a central focus of all the main parties' election manifestos.

The fundamental issue is whether the NHS is adequately funded. Related to arguments over the level of funding are questions about the delivery of healthcare: in essence, what role efficiency savings and internal competition for NHS resources should play in giving appropriate incentives in the delivery of healthcare; and whether service provision is deteriorating.

Funding for the delivery of social care for the elderly faces its own crisis – and it has become a controversial issue in the election debate.

The structure of the NHS in the UK

While the NHS is national, the organisational structure differs across England, Scotland, Northern Ireland and Wales. The Health and Social Care Act (2012) introduced major changes to the delivery of healthcare in England, building on earlier reforms that had introduced an allocation of resources where GPs held resources and allocated funding to secondary (hospitals) and tertiary (specialist) healthcare providers – the so-called 'internal market', where money followed the patient.

The 2012 Act gave greater management power to NHS England to control day-to-day operations of the NHS, introduced as a separate entity from the Department of Health, which remains in control of national expenditure and strategy. NHS England allocates funding to over 200 clinical commissioning groups (CCGs) to purchase care from hospitals and specialist providers on behalf of the population they cover. Healthcare may be purchased from any willing provider, including those operating in the private sector. A small number of CCGs fund only specialist care.

The Act also created local health and wellbeing boards, the members of which represent the NHS, public health interests and local authorities. Local authorities are also providers of the social care that is integrated with healthcare provision.

The NHS in England retains an internal purchasing-provider split, with money following the patient as approved through CCG purchasing plans. Regulation of NHS England is performed by a number of organisations, including NHS Improvement (formerly Monitor) covering resource and funding issues, and the Care Quality Commission (CQC) covering the quality and safety of provision. The National Institute for Health and Care Excellence (NICE) provides advice on treatment aimed at increasing the quality of healthcare through providing evidence to CCGs on the effectiveness and cost-effectiveness of healthcare interventions.

The Scottish government provides funding through its devolved Scottish parliament and provision of care through 14 regional and seven special health boards within an integrated

system, where money is allocated centrally. Regional health and social care partnerships organise and provide integration across health provision and social care provision.

The Welsh government also retains central control over funding and provision through seven health boards. Similarly, the NHS in Northern Ireland is centrally funded through its devolved parliament and provision controlled through five regional health and social care trusts.

In crude terms, the difference in the funding and provision of healthcare across the UK is that England continues to operate a purchaser-provider split through a devolved management structure with funding following individual patients' requirements. Scotland, Wales and Northern Ireland operate centralised, integrated systems of healthcare funding and provision organised by their separate governments.

There has been little assessment of the efficiency of these separate healthcare systems, partly due to the lack of comparable data. The analysis that has been undertaken finds little consistent evidence that one structure is better than the other (Bevan and May, 2014).

Resources spent on UK healthcare

There are increasing suggestions that the NHS is 'underfunded' (House of Commons Health Committee, 2016; House of Commons Committee of Public Accounts, 2017). This is reflected in the Department of Health falling into deficit in 2015/16 (Department of Health, 2016), and the increasing number of NHS hospital trusts running financial deficits. From a position of surplus in 2012/13, trusts reported a deficit of £91 million in 2013/14; and by 2015/16, the deficits had grown to a total of £2.5 billion.

The deficit would have been higher had the Department of Health not moved £950 million out of its £4.5 billion capital budget to help fund operational activities. It is estimated that over two thirds of NHS hospital trusts are now running a deficit. In 2016/17, this deficit is set to fall, partly as a result of targeted public money of £1.8 billion, but it will not be eliminated.

It is argued by many, including the House of Commons Health Committee (2016), that this financial position reflects NHS expenditure not keeping up with increasing demand for services as the UK population ages, as well as difficulties in integrating health and social care packages, leading to bed blockages and continued cost pressures associated with the rising cost of healthcare delivery.

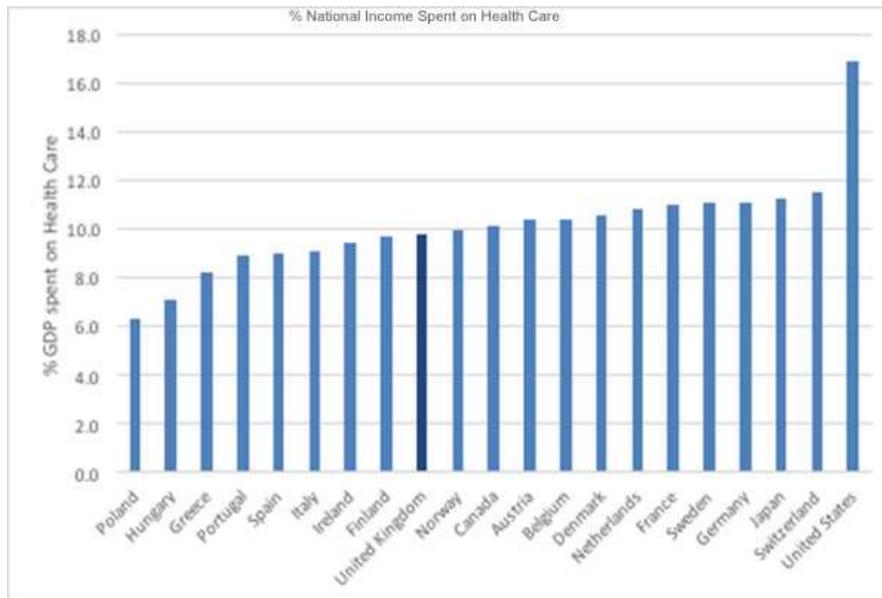
Such pressures are of course universal. To put some perspective on this in terms of total healthcare expenditure, NHS and private expenditure, the UK in 2015 (the latest year for international comparisons) spent 9.8% of GDP on healthcare (see Figure 1). This is lower than in many other EU-15 and G7 countries – such as Denmark, France, Germany, the Netherlands, Norway and Sweden, which all spend over 10% of their GDP on health – but not entirely out of line with these countries. But the percentage spent on health in the UK is predicted to fall over the course of the next four years, according to the Office for Budget Responsibility (2016), as expenditure flat-lines and GDP is predicted to grow, assuming no change in government.

UK healthcare expenditure is dominated by the NHS, which accounts for just over 80% of total healthcare expenditure, with the remainder coming from private healthcare expenditure (including private healthcare insurance). The NHS itself accounts for approximately 19% of

total public expenditure (about 30% of public service expenditure – essential welfare protection, health and education).

The amount spent per capita on NHS healthcare was £2,009 per head across the UK in 2014/15; varying from £1,992 per head in England, to £1,998 per head in Wales, £2,150 per head in Scotland and £2,115 per head in Northern Ireland. NHS expenditure on private sector services has grown, but is levelling off; in England, just over 10% of the total NHS budget in 2015/16 (about £9 billion) was spent on independent sector providers.

Figure 1: International comparison of percentages of national income spent on healthcare



Source: OECD Health Statistics, 2016.

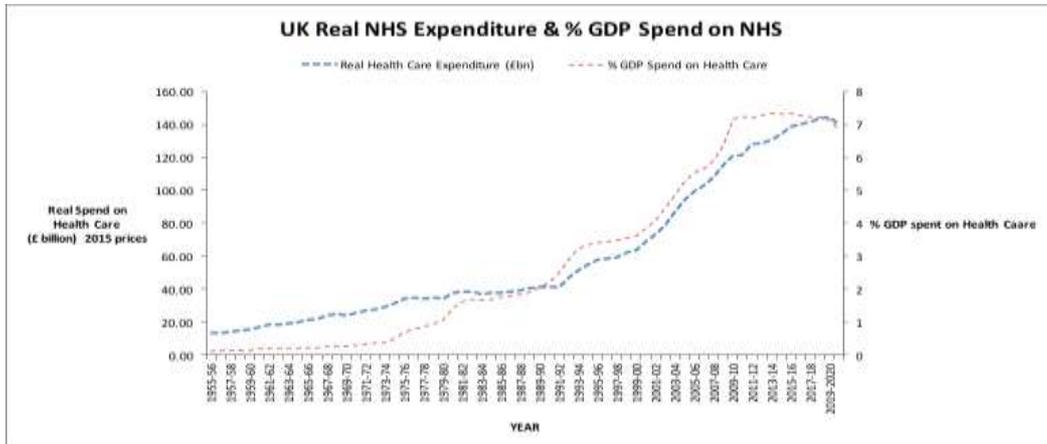
Figure 2 shows the trend for real (inflation adjusted) NHS expenditure to date, plus Treasury projections of NHS expenditure to 2019/20. Figure 2 also plots (right-hand axis) the percentage of GDP spent on the NHS. Under the Blair government, from 1997 to 2007, there was a substantial rise in NHS expenditure, almost a doubling. This also accounts for the large increase in the proportion of GDP spent on the NHS. But between 2009/10 and 2015/16, NHS expenditure levelled off and the percentage of GDP spent on the NHS is forecast to fall, essentially as the economy is projected to grow faster than health spending, to 6.9% in 2019/20 (Office for Budget Responsibility, 2016).

Indeed, as Figure 3 shows, under the coalition government between 2010 and 2015, the average percentage growth in NHS expenditure was at an all-time low. The average annual increase in NHS expenditure was approximately 1%, well below the historical trend of 4% expenditure growth in the NHS per annum (although note that this overall average is partly reflecting the high growth in NHS expenditure initiated by the Blair government).

While the first year of the current Conservative government returned NHS expenditure growth to approximately 3%, a level of approximately £139 billion (see Figure 3), this has to be seen in the context of growing pressures on NHS demands. The low rate of NHS expenditure growth between 2010 and 2015 reflected a general governmental desire to reduce public sector debt essentially through a reduction in public expenditure. NHS expenditure was to be ring-fenced

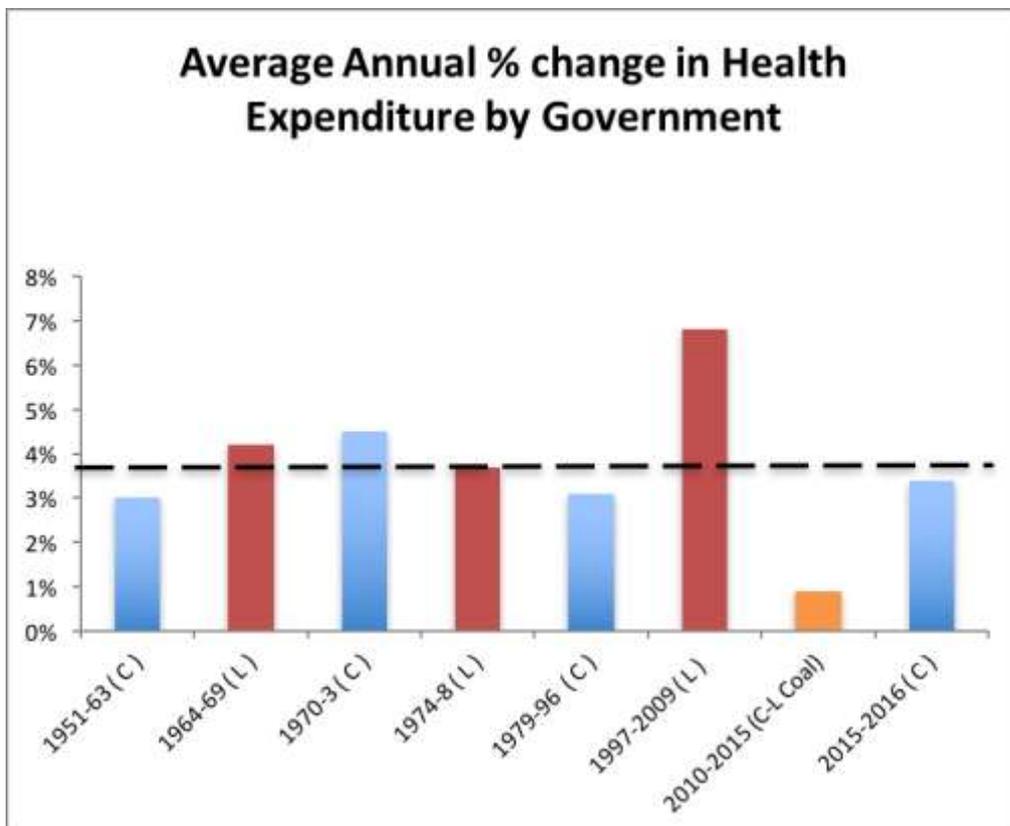
to maintain real levels of expenditure; there were to be no real cuts in NHS expenditure. But to maintain this level of NHS expenditure, substantial productivity (or efficiency) savings were to be made.

Figure 2: NHS expenditure



Notes: The Figure 1 data comes from the OECD, (which allows international comparisons to be made) and with the NHS spend as a percentage of GDP given as 7.9% and UK private health care spend given as 2%, with data relating to 2014. The data for Figure 2 comes from the UK Treasury PESA up-dated data (released 2016) which estimates NHS spend as 7.3% of GDP for 2014/15. *Source:* Various PESA estimates.

Figure 3: Percentage change in NHS expenditure by government



Source: House of Commons Library.

A Five Year Forward View (NHS England, 2014) of the NHS published in 2014 forecast that the NHS would have a funding gap of £30 billion by 2020/21 if current demand and cost pressures continued, if the NHS received no real increases in expenditure and no further productivity gains were achieved.

The Forward View considered three scenarios to address this funding gap with different productivity gains. In the first, the £30 billion funding gap was reduced to £21 billion on the back of 0.8% productivity growth per annum up to 2020/21. In the second scenario, the funding gap was reduced to £16 billion on the basis of productivity gains of 1.5% per year. In the third, productivity gains of 2-3% per year would allow the funding gap to close if matched with staged real increases in funding of £8 billion.

The government responded to this Five Year View with financial plans for the NHS that would see funding rise by £10 billion by 2020. Coupled with productivity savings of £22 billion by 2020/21 (based on 2-3% annual productivity savings in the NHS), this was predicted to cover the £30 billion funding shortfall.

In fact, the House of Commons Health Committee's analysis, 'Impact of the Spending Review on health and social care', challenges the increased sum of £10 billion additional NHS funding (House of Commons Health Committee, 2016). They point out that the £10 billion actually included approximately £2 billion already allocated and the actual increase to match the Five Year Review was £8.4 billion. The figure of £8.4 billion announced in 2015 was expressed in 2020/21 prices and if estimated in 2015 prices (that is, those in force at the time of the announcement) the extra government spending would in fact be £7.6 billion.

This is important as a large proportion of the funding increase occurs in the earlier years, with £3.8 billion in 2016/17, an additional £1.5 billion in 2017/18, £0.5 billion in 2018/19, £0.9 billion in 2019/20 and £1.7 billion in 2020/21. Moreover, part of the £8.4 billion would be funded by transfers from local authority public health and health education grants, amounting to £3.5 billion, and it is therefore not new public money. The overall impact, the Committee argues, is to reduce the new additional NHS funding to £6 billion in 2015 prices.

Furthermore, some of this funding was drawn from the 2014/15 budget, so if restricted to the five-year spending review period of 2015/16 to 2020/21 and expressed in 2015 prices, the net increase to the NHS would be £4.5 billion, a figure far from the announced £10 billion. Noting that a per annum productivity increase of 2% would also have to be attained to meet the estimated shortfall of £30 billion by 2020/21, the Committee argues that this does not meet the necessary commitment to fund the NHS to match demand and cost pressures by 2020/21.

Some in the NHS consider the annual productivity savings of 2%, which is also necessary to close the funding gap, to be a 'stretch'. The regulator, NHS Improvement estimates these productivity savings have to total £22 billion to bridge the funding gap, even if the increased funding of £8.4 billion is taken at face value. Obviously, more is required if actual funding received by the NHS lies below £8.4 billion.

While 2% annual productivity savings had been achieved for a year in 2012/13, this was based on cost cuts, rather than increased output in the NHS. Indeed, over the period 2010/11 to 2014/15, payments to hospital trusts for referrals by GP purchasers (and CCGs) have been reduced by over 6% in real terms, while staff pay increases, reflecting the impact of the coalition government's general public sector freeze, averaged only 1% over the same period.

Together with reductions in the number of total NHS staff, these historically low pay increases led to a reduction in the overall NHS wage bill, the largest component of NHS expenditure, for 2010/11 to 2012/13 of £1.5 billion. So any further productivity savings, necessary to address the funding gap, must be made over and above these existing cuts.

Maintaining productivity savings of 2-3% is therefore a big ask. NHS Improvement estimate the hospital sector itself will have to realise productivity gains of approximately 4% each year from 2016/17 through 2018/19 to achieve these overall levels. Historically, average productivity rates have been around 1% per year since the founding of the NHS. Between 1995 and 2010, NHS productivity growth averaged 0.4% per year.

To aid the productivity increases by improving the flow of patients through hospitals, a Better Care Fund was established. The Fund was meant to address directly the issue of bed-blocking. The National Audit Office (2016) estimates that 2.7 million bed days a year are incurred as a direct consequence of delayed discharges. To address this, the fund increased support to local authorities for adult social care by £3.5 billion. But not all of this was new money, as £2 billion was a transfer from the NHS budget.

Local authorities are now also able to increase council tax by 2%, which could raise nationally an additional £2 billion a year, to support social care funding. While this funding to local authorities is meant to aid hospital discharges and the quality of healthcare in the community, it comes at a time when total funding to local authorities has fallen.

The National Audit Office (2016) estimates a fall in local authority funding of 37% in real terms over the period 2010/11 and 2015/16. Indeed, they note the proportion of elderly individuals receiving local authority social care services fell by approximately 40% between 2005/06 and 2013/14. It therefore remains unclear how effective the Better Care Fund has been in addressing delayed hospital discharges.

Impact on NHS staffing and service

Given that around 70% of NHS expenditure goes on staffing, it is no surprise that as expenditure tightens, staffing issues are a growing problem. While the number of NHS consultants rose by over 25% between 2009/10 and 2015/16, 7.5% of clinical posts remain vacant across England; and in parts of London, this vacancy rate rises to 15%. Indeed, vacancy rates for doctors have risen 60% (from 2,907 to 4,669) over the two-year period 2013 to 2015 (Office for National Statistics, 2016). The number of GPs in the NHS declined in 2014/15, after a 20% growth in their number between 2004 and 2014, although NHS England recently announced an aim to increase GP numbers by 1,000 (HCSIC, various years; NHS England, 2016).

For the largest staff group, nurses, there are increasing shortages. Vacancy rates are estimated to be 17%, having increased by 50% over the period from 2013 to 2015 (Metcalf, 2016; Office for National Statistics, 2016). This partly reflects declining numbers being trained (a decline of 20% between 2009/10 and 2012/13) and increasing numbers leaving the profession (estimated to be 24,000 in 2012/13 and a further 17,800 in 2013/14). Some return to nursing, but even this number is falling: between 1999 and 2004, 18,500 individuals completed return to practice courses, while between 2010 and 2014, this fell to 4,800 individuals.

As a response to this shortage, there has been an increasing draw on nurses from abroad. In 2015/16, an estimated one in three newly registered nurses came from outside the UK (Health Foundation, 2016). In addition, agency nurse costs have increased, standing at £3.7 billion in 2015/16, although NHS policy remains one of less reliance on agency staff. While retention is a growing concern, a related issue is pay with median pay for NHS nursing staff currently at around £31,500, which is £7,500 below the median pay in other graduate occupations.

All NHS pay remains subject to the 1% pay increase restrictions placed on the public sector workforce until 2019/20, while it is estimated that pay rates for the rest of the economy will increase by 2.5% to 3.6% annually up to 2020/21 (Office for Budget Responsibility, 2016). This will not aid recruitment and retention of NHS staff.

Brexit will not help this staffing situation. Currently, approximately 50,000 citizens from the European Economic Area are employed in the NHS. While this represents under 5% of total NHS employment, it includes over 9,000 doctors, 18,000 nurses and 2,500 professions allied to medicine (clinical scientists, physiotherapists, etc.). It remains unclear what impact Brexit will have on NHS employees already in employment or those future healthcare professionals seeking employment in the NHS. Nor is it clear what will be the impact of the current government's rescinding of bursaries for those undertaking nursing degrees. While it is difficult to quantify, neither Brexit nor the ending of nursing bursaries are likely to alleviate NHS staffing shortages.

Not surprisingly, as a consequence of the expenditure and staffing constraints, performance appears to be deteriorating. The percentage of patients seen within the four-hour A&E waiting time target fell from 95.9% in 2012/13 to 81% in the first quarter of 2017 (King's Fund, 2017). The A&E standard of 95% of patients spending less than four hours waiting was last achieved in July 2015. The target for GP referral through to hospital for cancer therapy was breached, as was the wait for diagnostic testing, although in both cases only marginally (NHS England, 2017).

Moreover, consultant productivity appears to be falling. Between 2010/11 and 2015/16, NHS hospital consultant productivity, measured as numbers of consultants relative to in-patient and out-patient activity, fell by almost 2.5 %, as output is rising faster than the increase in the number of consultants.

In pursuit of overall NHS productivity gains, the government has called for a 24/7 NHS, with full facilities open seven days a week. The government cannot force GPs to open longer, given current contracts, or even change current working hours for medical doctors without changing their contracts (which led to a protracted labour dispute with NHS junior doctors), but it remains a major policy initiative.

The government's main argument to support this extension in working hours is primarily that in-hospital mortality is higher at the weekend than during the week. But if adjustment is made for the higher weekend admission rate, there is doubt that the weekend mortality rate is in fact any higher (Meacock et al, 2015). If this initiative is pursued, it is estimated a further £1.04 to £1.43 billion funding will be required to extend NHS services.

One specific aspect of NHS provision, mental healthcare delivery, has changed dramatically recently. Between 2010/11 and 2015/16, mental health beds have been cut by 20% and there has been a reduction in mental health staffing over the period of 6,600 nurses and 400 clinicians.

In addition, 57% of CCGs claim that they plan to spend less on mental health in 2016/17 than in 2015/16.

This reduction in capacity comes at a time when mental health service demand is rising with an increased 1,400 people per day being treated compared with 2010. The current government has recently announced an intention to fund 10,000 new posts in this area and initiated a Green Paper to consider more effective delivery of mental health services to children and young adults.

What are the main parties promising?

The Conservatives

The Health and Social Care Act 2012 continues to shape the Conservatives' health policy. This embeds competition among any willing provider, including private providers as well as NHS providers of healthcare, to contract with the NHS to supply hospital care.

Existing expenditure plans are reiterated. There is a recognition that further efficiencies will be required to meet expenditure shortfalls, with the already promised, but contested, figure of £8 billion additional expenditure on the NHS over the next five years being retained by a next Conservative government.

There is also a promise to invest in NHS capital structures, but it is unclear how this commitment will be funded (particularly given the recent raids on NHS capital funds to meet NHS revenue shortfalls). While unclear on detail, the Conservative manifesto also promises a Green Paper on Mental Health, with a view to introducing a new Mental Health Bill to the next parliament, in response to widely accepted failings in the provision of mental health services. An additional £1 billion investment is promised in this area by 2020/21.

On staffing and delivery, there is a pledge to increase the numbers of medical students by 1,500 a year with the ambitious aim that this will train the numbers of doctors the NHS requires. It is also stated that there will be contractual reforms to GP and consultant contracts. There is little detail of how these reforms will be managed, except to state that GP services will be widened and extended to cover routine weekend and evening coverage by GPs to the whole population of England by 2019. There is no detail on the proposed contractual revisions.

Related to these staffing measures, there is a reiteration of certain performance targets (for example, 95% of patients seen within four hours in A&E; maximum 18-week waits for elective care), coupled with a new target to deliver a definitive cancer diagnosis within a 28-day period. Extending the internal market split between purchasers and providers to cover the integration of health and social care is promised for 2018, but again this has little detailed explanation as a promised review of integrated care will follow.

The Conservatives' manifesto does discuss delivery of social care for the elderly, (whether at their own home or in a residential or nursing care home), based on means-tested access to such services. Initially, it was announced that individuals would contribute through a combination of their income and assets, including their house (recoverable on death of the individual or their spouse). Under these arrangements, all financial and housing assets minus £100,000 would be considered in the means test regardless of whether service users are in the community or live in an institution. Moreover, the proposed £100,000 retention limit would not take account of markedly differential social care costs and asset levels across the country. In contrast, the current means test disregards the initial £23,500 worth of assets, and only takes account of the

housing assets of individuals if they receive residential or nursing home care, disregarding the costs of care received in their own homes.

Perhaps due to the dramatic change in individual asset contributions towards social care costs, perhaps as the change would have hit a number of home-owning potential Conservative voters hardest or perhaps because of a realisation that differential treatment across disease areas will incur large differences in personal contributions, (with the chronically ill, for example, those with dementia, being hit hardest by the change) the Conservatives announced, after releasing their manifesto, a full review of the social care proposal after the election. This review would consider a cap on the upper limit that an individual would be charged for any social care consumed over their lifetime.

Further promises are made in the manifesto to charge immigrants, including migrant students, for their NHS care, using existing regulations but at a slightly increased rate. The recommendations of the Accelerated Access Review, designed to improve access to medicines and new medical technologies generally are based partly on a similar process recommended by the European Medicines Agency.

In summary, there is little more promised expenditure other than the contested additional £8 billion, plus an additional £1 billion directed to mental health services, an acceptance and extension of existing performance standards and slight increase in staff numbers as well as a review of staff contracts. Without greater detail, promised through a number of reviews, it is unclear how viable such a strategy is given the existing funding and staffing problems faced by the NHS. For social care, generally it is clear that an increased personal contribution will be sought.

Labour

Labour's health policy is based on repealing the Health and Social Care Act (2012) and releasing £30 billion in extra funding over the course of the next parliament. This is the amount outlined as the NHS shortfall by NHS England in 2014, net of any productivity gains. There is a promise to increase funding of GP service provision, but no detail on levels. There is also particular concern for the improvement of mental health services

In terms of service delivery, although short on detail, Labour would make the NHS the preferred provider of healthcare, implying that the purchaser-provider split would be retained. There is also a promise to guarantee existing performance targets: for example, extension of 95% of all patients seen within four hours in A&E to all patients being seen within that period; access to elective treatment within 18 weeks.

In terms of specific proposals, a Cancer Strategy for England is promised to deliver a full upgrade of NHS England cancer services. This upgrade is estimated, when the plan was published, to cost additional NHS funding of £400 million per year. A new Children's Health Fund, costing £250 million, would target inequalities in children's health. This would be accompanied by a specific 'health' tax levied on the soft drinks industry to aid healthier lifestyles.

To oversee these changes, Labour would introduce an independent regulator, the Office for Budget Responsibility for Health, to scrutinise spending objectives and levels, as well as a regulator to monitor quality, safety and excellence. In essence, these new regulators would probably replace existing institutions.

Mental health service delivery is also singled out by Labour. The aim is to increase the priority given to mental health services by ring-fencing mental health budgets and providing increased mental health services to children and adolescents. Noting that 50% of adults with mental health issues present these problems by the age of 14, Labour promises provision of school counselling services in secondary schools. No detail is provided on funding and little on service provision other than a statement of objectives.

In terms of staffing, Labour would abolish the public sector 1% per annum pay cap and re-introduce bursaries for nursing degrees (on top of the abolition of degree tuition fees). It would also pursue guarantees, in terms of rights to work, for the 50,000 EU citizens who work in the NHS.

With social care, Labour promises fuller integration of health and social care provision. Labour also pledges a further £8 billion to local authorities to fund social care delivery, although again there is little detail on exact spending plans or delivery of service. Given that local authorities retain control over their spending plans and how they allocate their aggregate budgets, within which this additional money would accrue, this lack of detail is important.

The Liberal Democrats

The Liberal Democrats' headline policy is that they would introduce an immediate 1p rise in basic, higher and additional rates of income tax to raise an additional £6 billion, over the course of the parliament, to aid funding NHS and social care services. Given the existing NHS expenditure levels they would presumably have to pursue the current efficiency savings to make up any expenditure gaps, although it is not clear what would be the overall NHS and social care spending levels to be pursued.

NHS and social care spending would be monitored by an independent Office for Budget Responsibility. In the longer term, the Liberal Democrats propose pursuing a form of hypothecation tax dedicated to the funding of the NHS and social care. They also wish to integrate health and social care into a single provider organisation by 2020. The additional £6 billion funding would be prioritised towards the areas of mental health, social care, GP practice and public health.

In terms of staffing, the Liberal Democrats have similar policies to Labour: abolishing the public sector 1% per annum pay cap; re-introducing bursaries for nursing degrees; and guaranteeing the rights to work of the EU citizens who work in the NHS.

Conclusions

The NHS is a prominent area of debate in this election. There is a recognition that the NHS requires increased funding to meet the growing demands of an ageing population. The current government's plans are to expand funding but to raise more real resource input essentially through efficiency savings.

There is general agreement that there is a funding shortfall with additional money required to meet demographic pressures (approximately 1.5% uplift per year), increased expectations and changes in health technology and medical practice (approximately 2-3% uplift per year) and increased prices (approximately 2% per year; although sought to be contained to approximately 1% per year through the public sector pay restraint by the current government). The efficiency

savings required to maintain NHS resources in line with rising demands and costs would have to be three to four times historical norms for these plans to work.

Even then, under the Conservatives' plans, a funding shortfall, and consequently increasing staff shortages, is likely given the difficulties associated with maintaining productivity gains. In the area of social care, their proposals are to shift the balance of costs towards the individual.

Labour promises to meet the shortfall in funding of £30 billion forecast by NHS England, but gives little detail on how this will affect service delivery. Labour also promises additional funding, of £8 billion, for social care, but again there is scant detail of how this money will be allocated.

The Liberal Democrats plan to allocate £6 billion towards addressing the funding gap, but give little detail on how any future shortfall will be made good, emphasising instead their proposal to move to a hypothecated tax to raise funds for health and social care.

The various planned uplifts in expenditure, whether or not coupled with further efficiency savings, may or may not address all the needs of the NHS and need to be maintained against a background of hospital deficits, labour force shortages and failing performance. Coupled with the looming crisis affecting social care, this renders the health and social care area of social policy 'complex' (to borrow the US president's recent description of health policy).

Health (and social care) policy remains a major challenge regardless of which party is elected and much greater attention to detail will be required on the implications for service provision than is contained in any of the manifestos. Even if the funding gap is met, the growing crisis in staffing in the NHS, which accounts for 70% of total NHS expenditure, is recognised by all parties but remains to be fully addressed.

May 2017

For further information, contact:

Alistair McGuire: A.J.Mcguire@lse.ac.uk

Or Romesh Vaitilingam: romesh@vaitilingam.com

Further reading

- Bevan, G and N May (2014) 'The Four Health Systems of the UK: How Do They Compare?', Nuffield Trust.
- Department of Health (2016) 'Annual Report and Accounts, 2015-16, HC332', HMSO, London.
- House of Commons Health Committee (2016) 'Impact of the Spending Review on Health and Social Care, First Report of the Session 2016-17, HC139', HMSO, London.
- House of Commons Committee of Public Accounts (2017) 'Financial Sustainability of the NHS, 43rd Report of Session 2016-17, HC887', HMSO, London.
- King's Fund (2017) 'Quarterly Monitoring Report', March. King's Fund, London.
- Health Foundation (2016) Staffing Matters Funding Counts, Health Foundation, London.
- Meacock, R, T Doran and M Sutton (2015) 'What are the Costs and Benefits of Providing Comprehensive Seven-day Services for Emergency Hospital Admissions?', *Health Economics* 24: 907-12.
- Metcalf, D (2016) 'A Shortage of Nurses?', *CentrePiece*, Volume 21, Issue 1, Summer, CEP, LSE.
- NHS England, (2014) *Five Year Forward View: Recap Briefing for Health Select Committee on Technical Modelling Scenarios*.
- NHS England (2016) *General Practice Forward View*.
- NHS England (2017) 'Monthly Performance Statistics', March.
- National Audit Office (2016) 'Discharging Older Patients from Hospital', HMSO, London.
- OECD Health Statistics (2016) <http://www.oecd.org/els/health-systems/health-data.htm>
- Office for Budget Responsibility (OBR) (2016) 'Economic Fiscal Outlook', March.
- Office for National Statistics (ONS) (2016) *Dataset VACS02: Vacancies by industry*. London: ONS; various years. Available from: www.ons.gov.uk/employmentandlabourmarket.