

**Submission to the House of Lords
Select Committee on the long-term sustainability
of the NHS**

September 2016

Summary

The Centre for Health and the Public Interest is an independent think tank promoting evidence-based policy in line with the founding principles of the NHS. We publish reports and analyses on key issues affecting the NHS, social care and public health. These reports are produced by respected academics and health and social care practitioners. We welcome the opportunity to respond to this inquiry.

1. This submission focuses on:
 - the meaning of sustainability when applied to a public service;
 - rising healthcare costs as an international trend;
 - why an ageing population may not bring greatly increased costs;
 - the burden of payment through changes in the dependency ratio;
 - how cost effective the NHS is; and
 - the lessons to be learned from the current hospital deficit.
2. We make recommendations on containing costs and reducing future need by appraising:
 - the costs of the current marketised structure;
 - PFI schemes;
 - changes needed in the provision of adult social care;
 - the value of general medicine for the management of long-term conditions;
 - mental health, especially in relation to physical health;
 - socio-economic inequality and its impact on health;
 - the need for a stronger commitment to investment in prevention; and
 - models of service delivery and integration.
3. We would welcome the opportunity to discuss the issues raised in our submission or to provide further information.

The long-term sustainability of the NHS

The meaning of sustainability in relation to a public service

1. ‘Sustainability’ in relation to a public service has two aspects: first, whether there is a willingness to provide the resources needed to sustain it at a given level of quality and coverage, and second, whether the resources made available are being allocated and used as efficiently as possible. The first question has been consistently answered in the affirmative by all mainstream political parties. As a society we have chosen to have a health service free at the point of access offering a high quality comprehensive service to all. The practical questions about sustainability have to do with how well the resources made available are used, assuming that they are adequate for the purpose.

2. The trend for all developed OECD economies is for increasing health care expenditure over the coming years, which will partly be due to increased costs but partly also to measures that improve the health and quality of life of their populations. In the UK the public has consistently made it clear that it wants a free-at-point-of-use NHS to be sustained, with three quarters consistently opposed to its scope being reduced.¹ Yet for considerable periods of the NHS’s existence it has been underfunded relative to other leading economies. Resources are not unlimited; choices have to be made in how they are allocated. But both the scale of the resources made available for health care and how they are allocated are political choices.

3. A comparison with other major advanced economies suggests that we could afford to spend substantially more:

Country	Spending (% GDP)	\$ Per capita spending
Austria	10.3	4,896
Belgium	10.4	4,522
France	11.1	4,367
Germany	11.0	5,119
The Netherlands	10.9	5,277
Norway	9.3	6,081
Sweden	11.2	5,065
Switzerland	11.4	6,787
United Kingdom	9.9	3,971
Average (excl. UK)	10.7	5,264

Source: OECD (Spending - 2014); (2014 Current prices and PPPs);

NB Comparison with advanced EU economies who follow the latest international accounting standards for health

4. The UK’s spending on health care ranks in the middle of the range of OECD countries at 9.9% of GDP and \$3,971 per capita (2014 at current prices), but significantly below the average of the

¹ British Attitudes Survey 2015. NHS. http://www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf (accessed 5th September 2016)

major economies of Europe at 10.7%.² If the UK were to increase its spend to 10.7% this would equate to an extra £15bn of health funding.

The drivers of rising health care costs

5. OECD projections suggest that the UK will not face a greater ‘sustainability’ challenge than most developed countries over the next 20 years. In a ‘cost pressure’ scenario the UK is expected to spend 14.2% of GDP on public health and long term care spending by 2060 compared with the EU 15 average of 14.5%.³ The rising cost of healthcare spending is an international trend.

6. The gradual increase in the share of GDP spent on health care internationally is not surprising. As the American economist William Baumol pointed out, there are limits to productivity improvement in any activity in which skilled labour is irreducibly involved.⁴ Productivity in health care can rise through the use of technology and better organisation – major improvements have been achieved in the NHS by both means. But its dependence on highly skilled labour and the complexity of individual cases mean that the share of resources devoted to activities like health care tends to rise relative to other sectors in which productivity is raised through the substitution of capital for labour. However, the resources released by growth in these other sectors make it possible to spend more on health care while also increasing consumption.

7. As knowledge and techniques improve, many conditions which would have once been fatal, such as extreme prematurity, cancer, and major trauma have changed from being fatal to long-term conditions. This can lead to increased spending on long term care, but represents a welcome advance in life expectations and quality of life.

What is the impact on health costs of an ageing population?

8. Whilst an ageing population does present a challenge to the structure of healthcare provision, ageing in itself does not give rise to heavy additional costs.

As life expectancy has risen, so has the number of years of healthy living. Due mainly to improvements in diet and health awareness many citizens in their 70s and 80s are healthier than in previous generations. Most of the cost of healthcare provision for any individual still relates to the last year of life regardless of age, and this expenditure is incurred by only a small percentage of the population each year.⁵ The OECD estimates that demographic changes will only add 0.3% to UK health and long term care expenditure by 2060.³

² OECD, Health statistics. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed 5th September 2016)

³ Maisonneuve C, Martins J. The future of health and long term care spending. OECD Journal: Economic Studies. Volume 2014. <https://www.oecd.org/eco/growth/The-future-of-health-and-long-term-care-spending-OECD-Journal-Economic-Studies-2014.pdf> (accessed 5th September 2016).

⁴ Baumol W J. Health care, education and the cost disease: a looming crisis for public choice. In Ruth Towse [ed.] Baumol’s cost disease: The Arts and Other Victims. Edward Elgar 1997.

⁵ Aragon M, Chalkley M, Rice N. Medical spending and hospital inpatient care in England: An analysis over time. Centre for Health Economics Research Paper 127. https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP127_medical_spending_hospital_inpatient_England.pdf (accessed 5th September 2016)

9. However, the distribution of healthcare expenditure over lifetimes will change. In 2010 40% of the average OECD healthcare expenditure was on over 65s. By 2060 this proportion is predicted to be 60%.³ Part of this will involve an increase in costs whilst some will mean a re-allocation of existing service provision, discussed in paragraphs 27-32 below.

The burden of payment

10. An ageing population does raise questions about who will pay for the cost of health care and other services. The dependency ratio in the UK is expected to rise from 310 people of retirement age per 1000 of working age in 2014 to 370 of retirement age per 1000 of working age in 2039.⁶ This implies that workers will be paying for the healthcare costs of a larger number of older people.

11. Currently, with a state pension age of 65 (males) and 63 (females) and a life expectancy of 79 years (males) and 83 years (females)⁶ many retired people have an average of 18 years of retirement. During these years they will pay less tax because their incomes will fall.

12. But, a rising state pension age (reaching 67 by 2028) will extend working lives, and recent research suggests that people who are over 45 now will on average face a pension gap of over £2,300 a year between their desired income and their pension income.⁷ This means that more will continue working further into retirement, reducing the dependency ratio.

13. A further offset to the dependency ratio comes from the relative youth of a large proportion of immigrants. On the other hand, most social care is still provided by unpaid, mainly, female relatives, a model which is liable to become less acceptable. Overall a mix of factors looks likely to moderate the impact of ageing on the dependency ratio and the sustainability of health services.

The efficient use of NHS resources

14. Like any public service the NHS needs to ensure that its resources are well used and costs are contained. The evidence from the patient-reported outcome measures regularly surveyed by the Commonwealth Fund is that they are: the UK has consistently outperformed the health systems of comparable countries while also being nearly the cheapest.⁸

15. The principal reason for this, as Sir Derek Wanless concluded following a full investigation in 2002, is the nation-wide pooling of risk, the founding principle of the NHS, and the corresponding method of funding health services from general taxation.⁹

⁶ Office for National Statistics. National Population Projections: 2014-based Statistical Bulletin. <http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10-29> (accessed 5th September 2016).

⁷ Aviva. Over-45s' personal savings will leave them with a retirement shortfall of thousands – and the state pension may fail to bail them out. July 2015. <http://www.aviva.co.uk/media-centre/story/17506/over-45s-personal-savings-will-leave-them-with-a-r/> (accessed 5th September 2016).

⁸ Commonwealth Fund. 2014. International Profiles of Health Care systems. http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf (accessed 5th September 2016).

⁹ Wanless D. Securing our Future Health: Taking a Long Term View. Final Report: April 2002. <http://si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf> (accessed 5th September 2016).

16. A second reason is that a centrally managed system makes it possible to minimise the cost of inputs, such as equipment and drugs, and even more important, staff: with 65% of providers' costs consisting of staff pay this is a critically important consideration.¹⁰ As a monopsony employer of medical staff the NHS is in a strong position to negotiate lower wages. Pay freezes can be and have been used to contain NHS costs during a time of low income growth.¹¹ For example, qualified nursing staff median annual earnings since 2011 have been reduced by between 6.3 – 10.5% in real terms.¹²

17. Strong use of this power can only be occasional. Many nurses are choosing agencies to increase their earnings and also to gain flexible working hours, a reason cited by 14% of nurses who left the NHS between October and December 2014, so that the reduced wage bill has been increasingly offset by rising agency fees.¹³ It is clear that there will soon need to be improvements in pay and the flexibility of working conditions. .

18. The fact remains that system-wide management of training, recruitment and pay makes for significant savings over time.

Why are NHS hospitals in deficit?

19. An examination of hospital inpatient spend (25% of the total NHS spend) from 1998 to 2013 showed that most of the cost increases were due to an increased volume and complexity of the cases treated. Little of the growth was due to rising unit costs of treatment.⁵

20. The fact that the NHS provider sector ended 2015/16 with a deficit of £2.5bn is thus not an indication of inefficiency.¹⁰ The overspend was mainly accounted for by the high use of agency staff, delayed transfers of care out of hospital, and a shortfall in 'cost improvement', i.e. efficiency schemes. The need to use agency staff is an index of the limits having been reached to the control of staff pay and numbers and the stresses of working to the limits of hospitals' capacity. Delayed transfers out of hospital were largely due to cuts to local authority budgets for the provision of social care after discharge from hospital. The shortfall in cost improvement was due to the difficulty of making the prescribed annual improvements in productivity without the investment in new technology and other capital assets needed to achieve them.

21. The 'provider deficits' are thus in reality a measure of the shortfall of resources in relation to patient need throughout the system, not of shortcomings on the part of management.

¹⁰ NHS Improvement. Performance of the NHS provider sector: year ended 31 March 2016. https://improvement.nhs.uk/uploads/documents/BM1653_Q4_sector_performance_report.pdf (accessed 5th September 2016)

¹¹ Buchan J, Kumar A, Schoenstein M. Wage-setting in the hospital sector. OECD Health Working Papers, No. 77, OECD Publishing. <http://dx.doi.org/10.1787/5jxx56b8hqhl-en> (accessed 5th September 2016).

¹² Royal College of Nursing. A workforce in crisis? The UK nursing labour market review 2015. October 2015. <https://www.rcn.org.uk/professional-development/publications/pub-005348> (accessed 5th September 2016).

¹³ Nuffield Trust. What will be the real cost of poor NHS staff wellbeing? October 2015. <http://www.nuffieldtrust.org.uk/blog/what-will-be-real-cost-poor-nhs-staff-wellbeing> (accessed 5th September 2016).

The agenda for cost containment and reducing the need for care

22. The public's strong support for the NHS needs to be matched by ensuring that its resources are allocated and used as efficiently as possible. Extensive scope exists for improvement in this respect:

i) *The cost of the now abandoned market model*

23. One of the distinctive cost advantages of the NHS – low administrative costs – has been severely damaged, though not yet entirely neutralised, by the adoption of a market model that has failed to produce the efficiencies claimed for it. The additional annual cost of running the NHS as if it was a market has been conservatively estimated at £4.5bn.¹⁴ The cost-containment case for terminating this experiment is overwhelming.

24. This means further reorganisation, which has costs, not only financial – each of the three main phases of reorganisation of the NHS on market lines since 1990 has been estimated to have cost some £3bn to accomplish – but also opportunity costs – the time and energy devoted to administrative change instead of improving patient care. For this reason no one is keen to advocate further reorganisation. But the Sustainability and Transformation Plans (STPs) which are being drawn up to implement the aims of the Five Year Forward View (FYFV), are in reality a new large-scale reorganisation.

25. The FYFV's central aim is better integration of the NHS. But the provisions of the Health and Social Care Act of 2012 are aimed at promoting competition, the opposite of integration. In trying to achieve the aims of the FYFV commissioners and providers have to 'work around' the Act, working against its aims but in conformity with its legal provisions. Planning is thus being undertaken by ad hoc groups of local commissioners and providers working outside any legal framework¹⁵ and doing only what the Act does not explicitly forbid. Informal and unaccountable government of this kind tends to produce bad policies as well as being prone to conflicts of interest and corruption. To achieve the aims set out in the FYFV the Health and Social Care Act needs to be repealed and a rational and accountable area-based structure of management and planning put in its place.

ii) *PFI costs*

26. The annual cost of PFI schemes, which accounts for a large part of the overall deficit of the hospital sector, is £1.9bn.¹⁶ The allocation of this cost to local health systems leads to serious unevenness in the level and quality of care that can be provided at the local level. The cost is also higher than if the hospital assets had been procured with public borrowing. However the PFI debt is dealt with, the excess cost needs to be lifted from individual hospital trusts, and to the extent that the cost cannot be reduced it should be shared nationally.

¹⁴ Paton C. At what cost? Paying the price for the market in the English NHS. Centre for Health and the Public Interest. <https://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf> (accessed 5th September 2016).

¹⁵ Leys C. Living with a zombie. The Commissioning Review. Summer 2016. Pp. 26-28.

¹⁶ Hellowell M. The return of PFI – will the NHS pay a higher price for new hospitals? Centre for Health and the Public Interest. <https://chpi.org.uk/wp-content/uploads/2015/02/CHPI-PFI-Return-Nov14-2.pdf> (accessed 5th September 2016).

iii) *Cuts to social services*

27. Cuts in social care and other forms of social security significantly increase the demand for care from the NHS. Despite the announcement in the spending review that councils can raise council tax by 2% to offset cuts to social care, research by the Kings Fund shows that real terms spending on social care is expected to fall over the next three years.¹⁷

28. The resulting scaling back of services to vulnerable groups, such as the closure of drop-in centres for pensioners and cuts to domiciliary care and other local social and mental health services, drives up attendances at A&E and hospital admissions, while cuts to residential and home care provision all lead to delayed discharges of patients who no longer need hospital care but need continuing care.

29. It is estimated that delayed discharges from hospital cost providers £145m in 2015/16. By July 2016 this equated to 184,188 days in hospital (the highest since records began in July 2010).^{10 18} Even with increased funding from the Better Care Fund, and assuming that all councils raise the additional tax, the proportion of GDP spent on social care is still set to fall from its 2009 level of 1.2% to 0.9% by 2020.¹⁷ Moreover, councils with low property and business tax bases will raise lower levels of additional tax, yet are also those with the greatest need for social care. These policies and the proposed eventual abolition of central government funding of local authorities drive up the cost of the NHS.

30. Against this short-term backdrop, the tension between universal NHS care, free at the point of use, and means-tested social care budgets, will worsen if left unresolved, potentially leading to more unnecessary emergency attendances, admissions and delayed transfers. Besides the need to integrate the health and social care funding streams in such a way as to ensure that the principle of free care is not jeopardised, the deleterious consequences of the privatisation of adult social care also need to be tackled with new forms of regulation and consideration of steps to expand public provision.

iv) *Raising the share of primary care in NHS spending*

31. With more patients living with multiple long-term conditions there is good evidence that a greater investment in generalist medicine and primary care will provide better value for money and limit additional healthcare costs in the future.

32. Around 50% of all GP appointments are with patients living with long-term conditions,¹⁹ and the active management of patients in the USA has been found to reduce the cost and average length of stay for patients. The value of a generalist (whether a GP or in a hospital) is the ability

¹⁷ The King's Fund. Where does the spending review leave social care? December 2015.

<http://www.kingsfund.org.uk/publications/articles/where-spending-review-leave-social-care> (accessed 5th September 2016).

¹⁸ NHS England. Monthly delayed transfers of care data, England. Statistical Press Release. July 2016.

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/July-16-DTOC-SPN.pdf> (accessed 5th September 2016).

¹⁹ Kirkham N. The pathologist in the 21st century: generalist or

specialist? A jack of all trades and master of none? (millennial review editorial). *Journal of Clinical Pathology* 2000; 53: 7–9.

to co-ordinate specialist care and provide holistic care for patients. There is strong evidence that health systems which invest more heavily in generalists (such as the UK and The Netherlands) have better outcomes and lower costs than countries which spend more on specialist physicians (such as Sweden and the USA).²⁰

v) *Raising the share of mental health in NHS spending*

33. Poor mental health is closely linked to poor physical health. About 30% of patients with a long-term physical health condition also suffer from a mental health condition, which can exacerbate physical illness and increase the costs of treating it by 45%. An estimated 12-18% (£8-13bn a year) of all NHS expenditure on long-term health conditions is linked to poor mental health.²¹

34. People who live in areas of high deprivation are disproportionately likely to have a long-term chronic condition coupled with mental illness.²¹ In order to control the costs of long-term conditions more must be invested in the treatment of mental health and in tackling its socioeconomic determinants.

vi) *Reducing economic inequality*

35. The UK has severe levels of socio-economic inequality, raising the burden of illness that falls on the NHS. Not only do those living in the poorest neighbourhoods in England die on average 7 years earlier than those in the richest, but they also spend an average of 17 years more of their lives living with disabilities. With the estimated annual costs of health inequalities (lost taxes, welfare payments, and costs to the NHS) estimated at £36-40bn in 2010 there is a large scope for savings.²²

36. An economic policy directed to reducing inequality through improved levels of secure employment combined with a more progressive tax system would have a profound impact in reducing NHS costs through the reduction of the leading causes of ill health.

vii) *Prevention*

37. Sir Michael Marmot recommended that 0.5% of GDP should be spent on public health prevention and promotion measures.²² In 2014/15 the share of spending on all aspects public health stood at 0.3%. A commitment to meeting Sir Michael's target is needed.

38. A clear example of the impact of public health on NHS costs is the increasing prevalence of obesity. Currently 1 in 4 adults and 1 in 5 children are obese and by 2050 it is predicted that 1 in 2 adults and 1 in 4 children will be obese. Obesity leads to increased health risks such as type 2

²⁰ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *NCBI. Milbank Quarterly*. 2005;83(3):457-502. <https://www.ncbi.nlm.nih.gov/pubmed/16202000> (accessed 5th September 2016).

²¹ Naylor C *et al*. Long term conditions and mental health – the cost of co-morbidities. The King's Fund and Centre for Mental Health. February 2012. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf (accessed 5th September 2016).

²² Marmot M *et al*. Fair Society Healthy Lives. The Marmot Review. 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> (accessed 5th September 2016).

diabetes, cancer, osteoarthritis, and vascular disease. The direct costs of obesity to the NHS are currently estimated to be £6.3bn a year. By 2050 it is predicted that the direct costs will be £9.7bn, and the indirect costs £50bn.²³ A substantially more demanding government intervention to address the obesogenic environment is called for.

New models of care

39. It is possible that new models of care, such as the Multi-specialty Community Providers and Primary and Acute Care systems promoted in the Five Year Forward View, will offer both cost savings and better care, but there are reasons to doubt it. First, there is serious lack of evidence. The Chief Executive of NHS Providers has stated that ‘There is little evidence that moving to new care models will release rapid or sufficient savings’, and observers well placed to judge have expressed doubts whether in circumstances of financial stringency they will improve patient care.²⁴

40. Second, experience with new care models tends to show that they may seem to work when initially tried out, especially when primed with extra funding, but not when rolled out on a wide scale without such support. Yet most of the £8bn Sustainability and Transformation Fund allocated to the NHS is being spent on covering providers’ accumulated deficits, with little left to pay for the capital, training and re-organisation needed to transform service delivery systems.²⁵

41. Third, the focus on new models of care tends to distract attention from the fundamental need to trust and respect the judgement of the professionals concerned, and ensure their commitment.

42. The way forward to greater efficiency and better patient care lies rather in providing sufficient funding to take the NHS out of its current crisis-management mode, endow it with a legal basis for rational and accountable planning, and ensure that new models of care are introduced at scale only on the basis of independently evaluated evidence.

²³ Public Health England. ‘About Obesity’. https://www.noo.org.uk/NOO_about_obesity (accessed 5th September 2016).

²⁴ Chris Hopson, quoted in the Health Service Journal, 12 September 2016, <https://www.hsj.co.uk/topics/finance-and-efficiency/hopson-new-care-models-a-15-year-journey/7010500.article>; and Williams D, McLellan A and West D, ‘A reality check for new care models’, Health Service Journal 19 September, 2016, <https://www.hsj.co.uk/7010620.article>

²⁵ The 2016/17 Sustainability and Transformation Fund: Why is it not enough and what are its implications for the provider sector?, Centre for Health and the Public Interest, June 2016.