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Parliamentary briefing

Spending on health and social care to 2015-16

The first Estimates Day debate in the House of Commons will consider issues of public spending and health care services. This briefing examines the key issues underlying debates on health funding, the decisions about NHS spending in England taken in the recent Spending Round and over the course of this Government, and the closely linked issue of spending on social care.

Key points

- Providers and commissioners in the NHS are under considerable financial pressure despite the ring-fencing of the health budget. This is due to underlying factors such as demographics and technological change, which tend to exert constant upward pressure on costs and demand.
- However, the large proportion of total departmental expenditure accounted for by health means that ring-fencing is reflected in steep cuts for other departments. In the long term further large cuts to these departments or a substantial tax rise will be needed to match rising health cost pressures unless unprecedented productivity gains can be found.
- The need for savings on this scale is reflected in current savings plans up to 2015-16, and the NHS has so far achieved its headline savings targets.
- However, these savings came primarily from pay restraint, administrative cuts and reductions in centrally determined payments for treatments. If further and deeper savings are to be found without compromising care quality, they must come from far-reaching and sustainable changes in the way health is provided.
- The current system of funding social care is unsustainable and unfair. The provisions for a cap on costs and new joint budgets recently set out in the

Care Bill and Spending Round are positive steps, but will not alleviate some of the pressures currently affecting the adult social care system.

- The allocation of joint budgets for work spanning health and social care will need to take into account the importance of culture and long-term evidence if real savings and improvement are to be found.

NHS spending, demand and trade-offs

Decisions around spending on the NHS must be made in the context of powerful internal and external pressures which often push in different directions. There is a general trend in the UK and other developed countries for spending on health to account for a steadily greater proportion of GDP year on year, reflecting increases in demand and costs driven by technology and demographics. Reducing or stopping this increase is likely to create tensions between the supply of health services and the demand for them.

At the same time, given the size of the NHS budget and during a time of austerity, even a level of health spending which is roughly flat in real terms implies either substantial tax increases or deep cuts to other departments, whose budgets have already been disproportionately reduced.

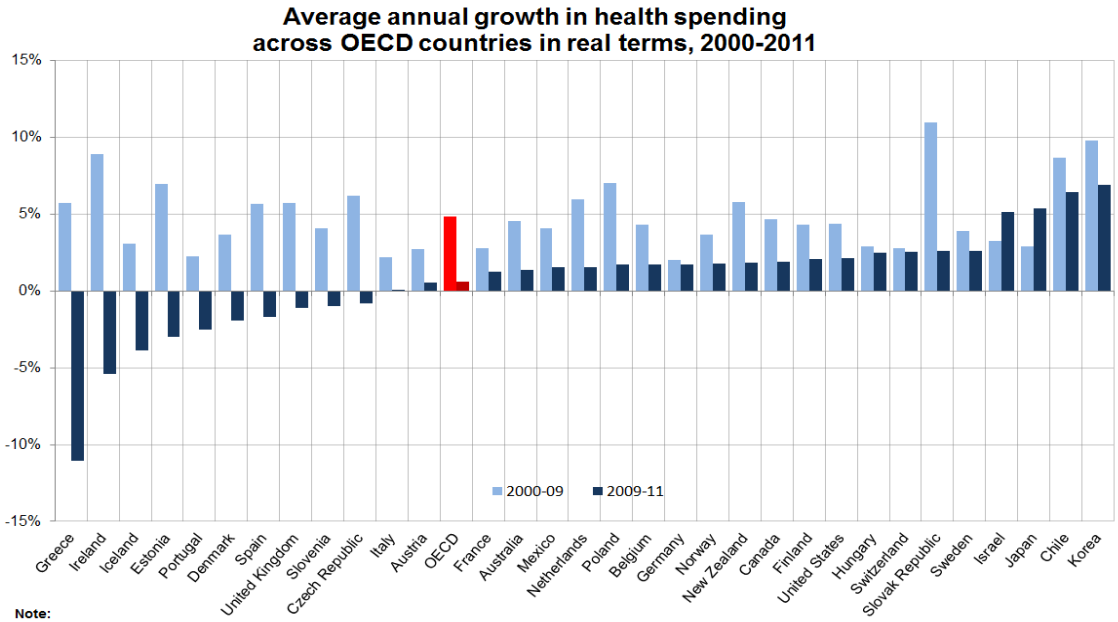
Current and future pressures on health spending

Since its founding in 1948, NHS expenditure has grown by an average of 4% per year in real terms. Spending on the health service now accounts for twice as much of our total national income as it did 65 years ago. Work by the Nuffield Trust has demonstrated that the factors underlying this rise will continue to exert similar pressures over the rest of this decade, implying that continued rises of 4% a year would be necessary to maintain quality of care in the absence of substantial increases in productivity (Roberts et al, 2012).

These factors include:

- Demographics: the population of England is growing, and the proportion who are in older age groups associated with greater demand for healthcare is rising.
- A greater prevalence of long-term conditions such as diabetes and dementia.
- Technological progress. Across many countries, the availability of expensive new technologies and more intense use of them tends to increase the cost of health care provision, both because they improve life expectancy for people with the highest healthcare needs and because new capabilities quickly become seen as part of the minimum acceptable care package by patients and professionals (OECD, 2012).
- The tendency of wages for healthcare professionals to rise, even in the absence of substantial labour productivity growth. This is also an international trend, which may be driven in part by the need to compete for workers with other sectors which are becoming more productive.

This historic trend has now ended for the foreseeable future. Since the beginning of austerity in 2010 NHS spending has fallen across the United Kingdom as a whole. The chart below shows that the UK is somewhat unusual in cutting health spending during the economically difficult 2009-11 period, but that the cuts remain smaller than several other countries where deficit reduction has been a priority, such as Ireland and Spain (OECD, 2013).



Note:
Growth rates for Australia, Denmark, Japan, Mexico and Slovak Republic refer to 2009-10 instead of 2009-11
Growth rates for 2009-11 are not available for Luxembourg, and Turkey.
Growth rates for Chile calculated using the Consumer Price Index (CPI).

Source: *OECD Health Data 2013.*

In England, the health service has seen small real term increases in its departmental spending allocation over the past two years. However, the recent Spending Round confirms that the Government intends to effectively freeze the funds allocated to the NHS in real terms up to 2015-16 (HM Treasury, 2012) (HM Treasury, 2013b).

Health spending in the broader fiscal context

This is in fact one of the most generous funding settlements for any government department over the period covered by the 2010 and 2013 Spending Rounds. Over the full period 2010/11 to 2017-18, the Government has committed to reducing total managed expenditure by an average of 0.4% each year in real terms (HM Treasury, 2013a). Because Annually Managed Expenditure, the non-departmental component of spending which includes welfare transfers and debt interest payments, is rising, the Government is set to introduce total cuts to departmental spending allocations of 10.3% over the 2010/2013 Spending Round period, with further substantial reductions likely after this.

The ring-fencing of the NHS, along with spending on schools and international aid, means that these cuts fall heavily on other departments. The Foreign and Commonwealth Office, Home Office and Ministry for Justice are among eight which will see their budgets reduced by more than a fifth (Tetlow, 2013) at the end of this period. As a result the proportion of total departmental spending taken up by health is set to rise steadily to well over a third in 2015-16 (SMF, 2013).

This impact on other budgets from even maintaining health spending as a rough constant throws into sharp relief how large the trade-offs required for a return to the historic rate of spending increases would be. For the seven years beyond 2015-16, IFS calculations on behalf of the Nuffield Trust suggest that all other departmental spending would have to be frozen in real terms for a return to 4% increases in the health budget, even assuming that Britain returns to historic levels of economic growth.

A settlement where the NHS budget grew in line with national income while other departments saw funding rises of just 1 per cent in real terms would require £10 billion from borrowing, or from tax rises equivalent to a 2 per cent rise in VAT (Crawford & Emmerson, 2012).

Bridging the gap

The Government and NHS England have committed to meeting the gap between funding and cost pressures discussed above through increased savings from efficiency and service reform. The "Nicholson Challenge", first set out by the NHS Chief Executive in 2009, estimated that the NHS would have to find up to £20 billion in efficiency savings from 2011-12 to 2014-15, a figure broadly adopted as the target of the Government's 2010 Quality, Innovation, Productivity and Prevention initiative (QIPP). The health budget allocation set out in the 2013 Spending Round suggests an implicit commitment to continuing to find savings of around four per cent per year beyond this date.

NHS savings since 2010

So far, the NHS has successfully in met the headline figures for savings set out under QIPP. The National Audit Office has found that the key factors driving this were a series of contractual and budgeting changes driven from the centre – primarily pay restraint, reductions in the tariff rate which hospitals are paid for providing healthcare services, and cuts to "back office" administration budgets in NHS and central bodies (NAO, 2012).

The 2013 Spending Round implies a similar approach to savings in 2015-16, laying out plans for a further 10% reduction in administrative costs, a continued 1% nominal cap on pay increases and the gradual replacement of progression-based pay systems. The Government argues that these measures are only fair at a time when pay in the private sector has been falling at an unprecedented rate (Treasury, 2013b).

The road ahead

However, reports on planned and achieved from both the National Audit Office and the Health Select Committee have concluded that, as the NAO put it, "understandably, the NHS has started by making the easiest savings first" (NAO, 2012). There is a consensus that continuing to find savings at a similar level over the years ahead is likely to require much deeper reforms to the way in which healthcare is delivered, with either an increase in underlying productivity or better management of demand.

Although administrative reductions have made a substantial contribution to savings and would continue to do so under plans up to 2015-16, staff within Clinical Commissioning Groups (CCGs) and quality regulators are a vital part of the system ensuring quality of continuity of care in the NHS. Groups representing CCGs have already warned that they are struggling with current budget allowances (NHSCC, 2013). The Government will need to lay out where further cuts will fall and explain how they will ensure that management in the NHS remains able to carry out core functions following the 10% cut laid out in this year's Spending Round.

Evidence from health systems historically in the UK and internationally suggest that the rate of technical efficiency savings may be near their limits: in 2012-13, plans for almost one in three health care providers in England require savings of more than 5%, yet work carried out for the Department of Health suggests that this rate would be almost unprecedented for any provider of care (NAO, 2012).

Meanwhile, recent work by the Nuffield Trust has shown that although increasing pay costs have been limited by the wage freeze, labour productivity has generally continued to stagnate in the NHS since 2010 (Jones & Charlesworth, 2013), implying an overall reduction in output reflecting the reduction in spending on labour. Gains in productivity and efficiency which are fast enough to meet the cost pressures described above will require a shift to long-term, strategic transformation of services, creating savings by providing care differently rather than simply cutting down certain costs in a fundamentally unchanged system.

Social care and integration

Funding, fairness and the 2013 Care Bill

The way in which help to people paying for adult social care is provided is based on individuals meeting two thresholds before they receive assistance: firstly, their needs must reach an eligibility threshold set by local authorities, and secondly they must fall below a means-test threshold set centrally. This threshold is currently set at £23,250, with individuals continuing to make contributions down to a level of £14,250.

This system has been widely agreed to be unfair and unsustainable since before the 2010 General Election (Charlesworth & Thorlby, 2012). The burden of costs fall overwhelmingly on the small minority of people requiring residential care for several years, with little pooling of risk (Commission on Funding of Care and Support, 2011). The eligibility standard is inconsistent across different areas, and the reduction in grants from central to local government since 2010 has resulted in many local governments raising this standard. Meanwhile, reductions in payments to care providers have been associated with reports from social services directors that the quality of care they commission is falling (The King's Fund, 2013).

In response to this, the Government has introduced provisions in the Care Bill currently before the House of Lords for a cap on social care costs, along the lines suggested by the 2011 Commission on Funding of Care and Support ("the Dilnot Commission"). This will mean that from 2016/17 individuals whose needs are eligible for help will have their care funded by the state after paying £72,000 - roughly equivalent to £60,000 today. The upper means-test threshold will also be raised to around £100,000 in today's prices, and eligibility according to needs will be standardised rather than varying at council level. The Government has committed to fund these reforms fully through spending increases (DH, 2013a).

These reforms introduce risk pooling, improve fairness across regions, and will protect the assets of many people with serious social care needs. The Nuffield Trust and many other health and social care bodies have welcomed them. However, it is clear that the level of standardised eligibility will be set at a point where more councils will raise their thresholds than lower them between now and 2016/17, resulting in a smaller proportion of people with social care needs being eligible for help paying for their care (DH, 2013b).

This risks increasing the number of people with problems carrying out basic personal and social functions who receive no help. Furthermore, these changes will not remove the need to establish certainty that funding levels are not encouraging local authorities to cut costs by reducing the quality of the care they commission. Because there is some evidence that health and social care can act as substitutes, pressure on social care as a result of these factors may increase pressure on the NHS (Georghiou et al, 2012).

Joint budget funding

The 2013 Spending Round includes £3.8 billion in funds earmarked for joint budgets across health and social care (Treasury, 2013b). This, along with recent Government announcements of a wave of path-finding integrated care pilots, demonstrates an ambition to encourage joint work across the sectors. There is some evidence that this could help save money while maintaining or improving quality of care, through early intervention, preventive care and more efficient use of the resources in the system overall.

If these savings are to be achieved it is crucial that the Government focuses these funds on genuinely innovative models of provision, and that they appreciate the importance of culture and leadership in

driving successful joint work across sectors. The Nuffield Trust's evaluations of a number of initiatives designed in part to reduce costly hospital admissions by improving community provision have shown limited evidence of success: results must be measured over a long enough period of time to show the benefits of integrated working moving through the system (Bardsley et al, 2013).

There is also a tension between the aim of using preventive care to help people before they reach the most intensive and expensive parts of the health and social care system, and the idea of a nationally standardised threshold for help paying for care. The Government must ensure that local authorities are able to provide care strategically to promote wellbeing and stop long-term conditions worsening, rather than focusing only on helping with funding for individuals who meet the needs threshold.

References

Bardsley, M, Steventon, A, Smith, J and Dixon, J (2013) *Evaluating integrated and community-based care: how do we know what works?* London: Nuffield Trust

Charlesworth, A and Thorlby, R (2012*) Reforming social care: options for funding* London: Nuffield Trust

Commission on Funding of Care and Support (2011) *Fairer Funding for All – The Commission's Recommendations to Government*

Crawford R and Emmerson C (2012) *NHS and Social Care Funding: The outlook to 2021/22*. London: Nuffield Trust.

Department of Health (2013a) *The Care Bill Explained*. London: HM Stationary Office

Department of Health (2013b) *Social care users will be guaranteed a minimum level of council help under new plans*. Available at https://www.gov.uk/government/news/social-care-users-will-be-guaranteed-a-minimum-level-of-council-help-under-new-plans

Georghiou, T, Davies, S, Davies, A and Bardsley, M (2012) *Understanding patterns of health and social care at the end of life* London: Nuffield Trust

HM Treasury (2012) *Public Expenditure Statistical Analysis 2012*. London: Stationery Office

HM Treasury (2013a) *Budget 2013*. London: Stationary Office

HM Treasury (2013b) *Spending Round 2013*. London: Stationery Office

Jones, N and Charlesworth, A (2013*) The anatomy of health spending 2011/12*. London: Nuffield Trust

National Audit Office (2012) *Progress in making NHS efficiency savings*. London: Stationary Office

NHS Clinical Commissioners (2013) *No new money means CCGs must lead locally* London: NHS Clinical Commissioners

OECD (2012) *A Comparative Analysis of Health Forecasting Methods*. Paris: OECD Directorate for Employment, Labour and Social Affairs.

OECD (2013) *Health Data 2013*. Paris: OECD Directorate for Employment, Labour and Social Affairs

Roberts, A, Marshall, L and Charlesworth, A (2012) *A decade of austerity?* London: Nuffield Trust

Social Market Foundation (2013) *Spending Round 2013 Briefing*. London: Social Market Foundation

Tetlow, G (2013) Post-Spending Round Briefing. Available at www.ifs.org.uk/budgets/sr2013/gemma_tetlow.pdf

The King's Fund (2013) *How is the health and social care system performing? Quarterly monitoring report*. February 2013 London: The King's Fund

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