

SUBMISSION TO THE HEALTH SELECT COMMITTEE INQUIRY INTO PUBLIC EXPENDITURE

1. The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.
2. This submission focuses on the key issues identified in the preamble to the inquiry's terms of reference. In doing so, it draws on three reports recently published by The King's Fund:
 - *How cold will it be? Prospects for NHS funding 2011–17*, which was published with the Institute for Fiscal Studies and considered the implications of the economic crisis for NHS funding.ⁱ
 - *Securing good care for more people: Options for reform*, which updated the review of social care funding carried out for The King's Fund by Sir Derek Wanless in 2006.ⁱⁱ
 - *Improving NHS productivity: More with the same not more of the same* which re-visited the likely funding prospects for the NHS and the productivity improvements it will need to deliver in the next few years.ⁱⁱⁱ

Summary

3. Despite the government's pledge to protect the NHS budget, health and social care services face significant financial challenges over the next few years.
 - The NHS is facing the biggest financial challenge in its history. Although it will receive a small real-terms funding increase in the Spending Review, it will need to deliver annual productivity savings of £14 billion – equivalent to 3–4 per cent of its budget – by 2013/14 (and most probably beyond this date) to maintain quality and avoid cutting services.
 - This does not mean that it needs to slash budgets, cut services for patients or sack staff. There are significant opportunities for the NHS to improve productivity, particularly by reducing clinical variation.
 - There is a significant risk that implementing the reforms set out in the government's health White Paper will distract attention from delivering the productivity improvements needed. This risk must be managed to ensure that work to improve quality and productivity is not sidetracked.
 - Inevitable cuts in social care budgets are likely to result in local authorities increasing charges and restricting services. This will further increase unmet need and is likely to increase costs to the NHS by increasing the number of avoidable hospital admissions and delayed transfers of care.
 - Progress in integrating health and social care services has been patchy, despite emerging evidence that it offers significant opportunities to deliver better outcomes and financial savings. It is essential that the NHS and local authorities do more to pool resources and align services locally.

- In the longer term, there is a compelling case for considering how the combined public expenditure on the NHS and social care of £121 billion could be better planned and allocated.

The prospects for NHS funding

4. The government has pledged to increase health spending in real terms in each year for the rest of the parliament. This means that, after a decade of unprecedented growth, the NHS budget is likely to increase slightly above the rate of inflation for the next few years. Based on current inflation estimates, an increase of around 1 per cent in real terms would provide around £3 billion a year in *cash* funding for the NHS.
5. To put this into context, a 1 per cent real increase compares with average real-terms growth of 4 per cent since the NHS was established and 7 per cent since the turn of the century. With total (public and private) health care spending having increased as a share of national income by nearly three percentage points over the past 10 years to almost 10 per cent by 2010/11 – taking spending close to the European Union (EU) average in 2006 – this will mean that it will decline as a proportion of national income for the first time in many years, as the economy starts to grow more quickly than the increase in NHS funding.
6. Compared to inevitable spending cuts in other Whitehall departments, a real-terms funding increase will seem generous. Nevertheless, a number of factors need to be considered in assessing the true impact of any increase in the NHS budget.
 - The additional costs associated with demographic change are likely to equate to annual real terms increases in the NHS budget of around 1 per cent each year.
 - There is some uncertainty about the baseline for the Spending Review. While the last Comprehensive Spending Review set the NHS budget for 2010/11 at £109.8 billion, the most recent Department of Health annual report stated that planned expenditure is £105.8 billion.
 - There is also uncertainty about the fate of the £1 billion surplus the NHS is planning to carry over into 2011/12, following reports that the Treasury may claw back the £1.5 billion surplus accrued in 2008/09.^{iv}
 - Despite the two-year freeze on public sector pay for anyone earning above £21,000 a year announced in the Emergency Budget, the NHS pay bill is likely to increase by at least £750 million a year due to increments built into most NHS contracts.
 - The increase in VAT to 20 per cent from January 2011 is likely to cost the NHS an additional £250 million a year.
 - There will be costs associated with implementing the proposals put forward in the government's health White Paper; one estimate puts this at £2-£3 billion.^v
7. These factors mean that although the NHS will benefit from a small real-terms increase in funding and a far more generous settlement than most areas of spending, its purchasing power will in fact be eroded.

The scale of the productivity challenge

8. In his report to the Treasury in 2002, Sir Derek Wanless set out three potential funding scenarios based on a number of assumptions about future demand, supply and costs of health care.^{vi} An update to his report published by The King's Fund in 2007 showed the NHS progressing more or less in line with his middle scenario - 'solid progress'.^{vii}
9. Continuing to meet the 'solid progress' scenario would require funding of £126 billion in 2013/14 (at today's prices). Without real-terms increases in the NHS budget and improvements in productivity, this would leave a funding shortfall of up to £21 billion by 2013/14. Closing this gap would require annual productivity gains of up to 6 per cent a year.
10. The Wanless projections still stand as the most sophisticated attempt to estimate future health care funding needs. In our report *Improving NHS productivity: More with the same not more of the same* we returned to his original analysis to assess whether the assumptions behind his estimates still hold. In light of the progress made in improving health outcomes since 2002, the pressure on the public finances and policy statements made by the coalition government, we suggest his assumptions can be revised in three key areas.
 - **Pay and prices:** Wanless assumed year-on-year pay increases for NHS staff of 2.5 per cent above inflation. The government's decision to freeze pay for public sector employees earning more than £21,000 removes much of this cost pressure. In conjunction with restraining prices paid for pharmaceuticals, this could reduce costs by up to £3.5 billion a year.
 - **Waiting times:** given the progress made in cutting waiting times in recent years, the reduction in the number of targets and changes in performance management announced by the government, further reductions in waiting times will not be a priority for the foreseeable future. Not pursuing further reductions in waiting times could reduce costs by around £1.4 billion a year.
 - **Capital investment:** there are strong arguments that making better use of existing facilities should be the priority, rather than further increasing capital investment in new facilities. Reducing this investment and scaling back the drive to provide hospital beds in single en-suite rooms could reduce costs by £1.6 billion a year.
11. Revising Wanless's assumptions in these three areas could reduce costs by around £6.5 billion a year. This reduces the productivity gap from up to £21 billion to around £14 billion by 2013/14, broadly in line with the £15-20 billion in efficiency savings the NHS has been challenged to meet over the same period by Sir David Nicholson. Assuming the outcome of the Spending Review is a small real terms increase in funding, this suggests the NHS will need to deliver productivity gains of 3-4 per cent a year in order to maintain quality and avoid cutting services.

Meeting the productivity challenge

12. The size of the productivity gap leaves the NHS facing the biggest financial challenge in its history. To put it into context, the Office for National Statistics estimates that health care productivity fell by an average of 0.3 per cent a year between 1995 and 2008.^{viii} Delivering the productivity improvements needed will be even more challenging now that, over the same period, the NHS will also be required to implement the reforms set out in the health White Paper and respond

to the structural changes this will entail, including the abolition of primary care trusts (PCTs) and strategic health authorities (SHAs).

13. However, this does not mean that it needs to slash budgets, cut services for patients or sack staff. Numerous studies have highlighted the opportunities to improve productivity in the NHS – the focus must now shift to execution and implementation. The NHS will need to carefully select the strategies that, together, will produce more value from similar resources, not deliver the same for less.
14. The most significant opportunities to improve productivity will come from focusing on reducing variations in clinical practice. For example, the NHS Institute has estimated that £4.5 billion in productivity improvements could be delivered in acute hospitals alone by bringing performance across the board up to the level currently achieved by the top quartile. Other opportunities include:
 - tackling inefficiencies in support services and back-office functions; for example, estimates suggest that more efficient procurement delivered through the use of national framework agreements could release £240 million a year^{ix}
 - commissioners have a vital role to play by reducing spending on low-value interventions and redesigning care pathways (especially for people with long-term conditions) to avoid unnecessary hospital admissions. With around two-thirds of hospital bed days accounted for by emergency admissions, significant gains can be made here^x
 - NHS employers could increase workforce productivity by improving staff performance, tackling sickness absence and adopting more flexible ways of working; for example, savings of up to £400 million could be made by bringing the performance of weak GPs up to standard.^{xi}
15. Delivering productivity improvements on the scale needed will require action at all levels of the system, especially within clinical microsystems – the frontline teams delivering care to patients who have the most important role to play in reducing clinical variation. It will therefore be essential to continue investing in developing leadership and change management capabilities at all levels of the NHS.

Social care expenditure

16. Public expenditure on adult social care has increased by over 50 per cent in real terms since 1997. However, this has not kept pace with the impact of the ageing population, increasing numbers of people with complex care needs, and rising expectations about the quality of services. As a result, unmet need has increased, with almost three-quarters of English local authorities now restricting services for older people to those with 'substantial' or 'critical' needs.
17. With the number of people over 85 set to double by 2026 to almost 2 million and care needs for all adults with learning disabilities forecasted to rise by 3-8 per cent a year, services will come under even more severe pressure in the years ahead. Keeping up with demographic pressures alone would require increases in the social care budget for older people of around 3.5 per cent a year over the next few years. Looking further ahead, our report, *Securing good care for more people*, estimated that the cost of the current social care system left unreformed will increase from £6.4 billion in 2010 to £12.1 billion in 2026.

18. Unlike the NHS, social care expenditure will not be protected from cuts in the Spending Review. The Institute for Fiscal Studies estimates that some departments are likely to suffer real term reductions of up to 33 per cent in their budgets by 2014/15. It therefore seems likely that grant funding for local authorities will be cut significantly, on top of the £1.165 billion cut announced by the government earlier this year. With an increasing proportion of local authorities' spending on adult social care now funded from Council Tax revenues – 39 per cent on average and as much as 80 per cent in some areas – the government's commitment to freeze Council Tax for at least a year will leave local authorities even less room for manoeuvre.
19. It is also important to consider this in the context of costs met through the benefits system, including £3.8 billion currently spent on Attendance Allowance and £9.8 billion on Disability Living Allowance. Expenditure on these benefits will be accounted for in the Department for Work and Pensions' Spending Review settlement.
20. Informal intelligence suggests that most local authorities are planning reductions in their overall budgets of around 25 per cent over the three years from 2011/12. Many have already achieved significant efficiency gains and will find it difficult to achieve further savings without impacting on frontline services. How far they can cushion the impact of cuts in grant funding on social care budgets will vary widely and depend on local factors.
21. Some authorities are likely to consider increasing user charges, especially for non-residential services, and the relatively small number of councils still providing care for people with 'moderate' needs are likely to tighten their eligibility criteria. This will further increase unmet need and is likely to increase the number of avoidable hospital admissions and delayed transfers of care, working against the efforts of NHS to reduce the use of expensive acute care.

The interface between health and social care

22. Although greater integration between health and social care services has been a policy objective for more than three decades, progress up to now has been limited to a small number of local authority exemplars and examples of good practice. Yet emerging evidence suggests that care services have an important role to play in delivering savings to the NHS by, for example, enabling people to continue to live at home and preventing emergency admissions to hospital.
23. For example, the previous government piloted a number of Partnerships for Older People projects (POPPs), which were based on proactive case management and flexible use of health and social care budgets. The evaluation of the projects showed that, as well as improving quality of life for participants, every £1 spent on POPP services delivered a saving of £1.20 in emergency bed days.^{xii}
24. Torbay's Integrated Care project comprises five integrated health and social care teams, focused on meeting the needs of older people, operating with pooled budgets and organised in localities aligned with general practice boundaries. Recent analysis of the project highlighted low rates of emergency admissions, emergency bed day use and discharges into residential care compared with other areas in the South West. As a result of its work, the average number of daily occupied hospital beds fell from 750 in 1998/9 to 528 in 2008/9.^{xiii}
25. Given the severe pressure on health and social care budgets over the next few years, it will be essential that the NHS and local authorities do more to work together to pool resources and align services. The cost of not doing so would be

significant cuts in social care services, increased costs to the NHS and worse outcomes for patients and service users.

26. In the longer term, there is a compelling case for considering how the combined public spending on the NHS and social care of £121 billion could be better planned and allocated. It is striking to note that the additional expenditure required each year up to 2015 to gradually phase in The King's Fund's 'partnership model' for funding social care – which would be far more generous than the current system and significantly reduce unmet need – would represent less than 1 per cent of the NHS budget.
27. It remains to be seen whether the reforms set out in the government's health White Paper will encourage greater integration between health and social care services. The abolition of PCTs and consequent loss of co-terminosity with local authorities is likely to undermine progress made in building relationships at the local level. Nevertheless, the creation of local health and wellbeing boards – which will require a different approach driven less by top-down direction and more by locally determined solutions – could create an opportunity to improve on the lack of progress up to now.

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