

Written submission

Health and social care funding: the short, medium and long-term outlook

Overview

The period covered by this Spending Review will be the most challenging in the recent history of the health and social care system. Both services must simultaneously respond to growing pressures on services and put in place large-scale changes to ensure their future sustainability. Failure to do so will mean patients having to wait longer for diagnosis and treatment, the quality of health and social care declining, and fewer people receiving publicly funded social care.

The challenge for the Spending Review is to provide adequate resources to maintain high-quality care and to enable change to happen. The health and social care system must also re-double efforts to improve productivity. As we have argued, it takes time to realise the productivity opportunities that exist, and time is short (Appleby *et al* 2014). Extra funding is urgently needed to deal with growing deficits in the NHS and the prospect of even deeper cuts in social care.

Changes in spending plans between the budgets in March and July showed that there are choices to be made about the pace and scale of deficit reduction. These choices are not easy but they demonstrate that it is not inevitable for health and social to be put under even greater pressures as a result of five more years of austerity. If the government is serious in its commitment to health and social care, it must ensure that adequate funds are available both in this parliament and longer term.

In this context, these are our key messages for the Spending Review.

- With all parts of the NHS under growing financial pressure, and even the most prestigious and well-run hospitals now forecasting deficits, the NHS is on course to overspend its budget in the current financial year. Emergency deficit funding is likely to be required this year, perhaps amounting to £1 billion.
- The government's commitment to increase the NHS budget in real terms by £8 billion by 2020 is welcome but this is the absolute minimum requirement to maintain standards of care. It will not pay for new commitments such as seven day services. It is essential that this money is front-loaded from 2016/17 to avoid an accelerating decline in performance and quality.
- A dedicated transformation fund is essential to unlock productivity improvements and support the development of new care models across health and social care. Our work with The Health Foundation estimates that £1.5 – £2.1 billion a year is required from 2016/17 to 2020/21. Some of this funding could be found from existing sources, although additional funding will also be needed.
- The previous government protected all health spending. This approach must be maintained. Further cuts to the public health budget would be a false economy and undermine government commitments on prevention. There are also risks in cutting spending on training the future workforce when staff shortages and the costs of agency staff are major concerns.
- While achieving £22 billion in efficiency savings by 2020 is hugely ambitious, there are significant opportunities to improve productivity, and the NHS must engage staff at all levels in a new mission to deliver better value at lower cost by changing the way that clinical care is delivered (Alderwick *et al* 2015). The 1.4 million staff who work in the NHS must be supported to achieve this.
- The social care system must be protected from further cuts in local government budgets and the £6 billion in funding previously earmarked to implement the Dilnot reforms must be invested over the Spending Review period to tackle the growing pressures on social care. If this does not happen, publicly funded social care will become a safety net for only the poorest and most vulnerable members of society.
- The temptation to support social care by transferring funds from the NHS must be avoided. Instead, as the Barker Commission set out, there is a compelling case for a new settlement that brings the two systems together and moves to a single ring-fenced budget and a single local commissioner of services. This is best done by a staged transition over the next decade as outlined by the Commission (Commission on the Future of Health and Social Care in England 2014).

- To ensure adequate funding, the long term aim should be to increase public spending on health and social care to 11–12 per cent of GDP, the proportion currently spent by countries such as France, Canada and the Netherlands on health care alone. On current plans, GDP on health care in 2020/21 will fall back to levels last seen in 2005/6, underlining the seriousness of the situation facing the health and care system

In our view it is not credible to maintain that current standards of care can be sustained (let alone improved) without the funding needed to deliver this. The government should therefore spell out the consequences for patients and users of publicly funded social care of not providing the additional funding we argue for. This means being honest about the fact that access to care will deteriorate further and quality of care will be compromised because of the choices made about public spending and taxation during this parliament.

Introduction

Following five years of real cuts in social care spending and limited growth in health funding, this year's Spending Review will be critical.

The legacy of the past five years means there are short term funding issues that must be addressed this year and next. Over the medium term – the period covered by the Spending Review – there are serious questions about whether the NHS can meet its new productivity challenge and whether local authorities can maintain their services. Looking beyond 2020/21, there are longer term policy options for funding and for the integration of health and social care budgets.

This briefing considers the short, medium and long-term funding issues for health and social care in England.

1: The short term: 2015/16–2016/17

The 2010 Spending Round afforded the NHS in England some relative protection from the coalition's reductions in public spending. While this reflected the public's broad priorities for government spending, demand pressures exceeded the growth in funding, leaving the NHS with the need to make unprecedented productivity savings. There are now clear signs of widespread financial stress and failures on headline measures of quality.

For social care the past five years have been particularly difficult. Spending on adult social care has fallen by 9 per cent in real terms between 2009/10 and 2013/14; without more than £2 billion support from the NHS budget this would have been 14 per cent. This has meant a fall of more than 25 per cent in the number of people aged over 65 receiving community-based, residential and nursing care services and much stricter eligibility criteria. These reductions have occurred even as the aging population has increased the need for care.

All parts of the NHS are under significant and growing financial pressure. For NHS trusts, 2014/15 was the worst year financially this decade: 117 organisations (46 per cent) ended the year with a gross overspend of £1.25 billion (equivalent to a net deficit of £818 million, see Figure 1). As the NHS Trust Development Authority noted in May this year, '2014/15 has been a challenging year for all those that work in the NHS Trust sector' (NHS Trust Development Authority 2015). Monitor also confirm 2014/15 was an '...exceptionally challenging year for the NHS foundation trust sector.' (Monitor 2015). While the NHS as a whole ended the last year of the 2010 spending round in surplus (by just £64 million), this was only after additional funding of £250 million from HM Treasury and overspends on revenue bailed out by a £640 million transfer from the capital budget, among other measures.

Other areas of the NHS are also facing considerable challenges. General practice is under significant pressure as a result of rising demand from patients at a time when its share of NHS funding is declining: between 2005/6 and 2013/14, total investment in general practice fell by 6 per cent. While fewer mental health trusts are reporting deficits (one-third reported overspends last year), financial pressures are also growing in this sector, with bed shortages resulting in delayed admissions and contributing to the increasing number of inpatients being treated a long way from their home. The government's commitment to 'parity of esteem' between physical and mental health and the announcement in the coalition government's last Budget of an additional £1.25 billion over five years for mental health services are therefore welcome. It is essential that spending on mental health continues to be prioritised.

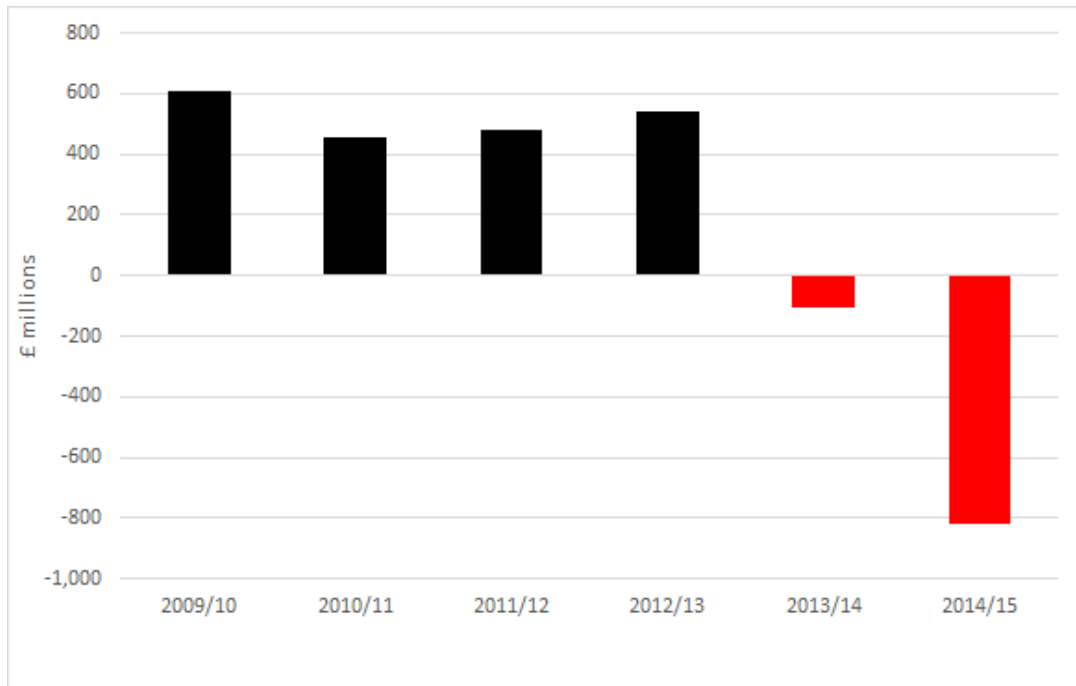
Pressures are not only financial; demand for services is rising (see below) and patients have been directly affected by failures in key performance measures over the past two years.

- The proportion of patients waiting more than four hours in accident and emergency (A&E) is back to 2004 levels, and the number of patients waiting more than four hours to be admitted from A&E into a hospital bed now averages around 5,800 each week compared to 2,100 in 2011.
- The total number of patients on elective waiting lists (3.4 million) is the highest since 2008.
- Though now abandoned, the admitted elective waiting time target was missed in 14 of the past 18 months.
- The target wait for diagnostic services has not been met for 18 months.
- The 62-day cancer waiting time target has not been met for the past five quarters.
- Though performance data in primary care is more limited, the extent of the distress within general practice also points to deterioration, and there are widespread concerns over mental health.

In order to balance their books without additional funding, providers would ultimately need to reduce the number of staff they employ because of the high proportion of their spending on staff. If they were to do so while demand is still rising this would accelerate the decline in performance and compromise patient safety and quality of care, reversing some of the progress made in the second half of the last parliament.

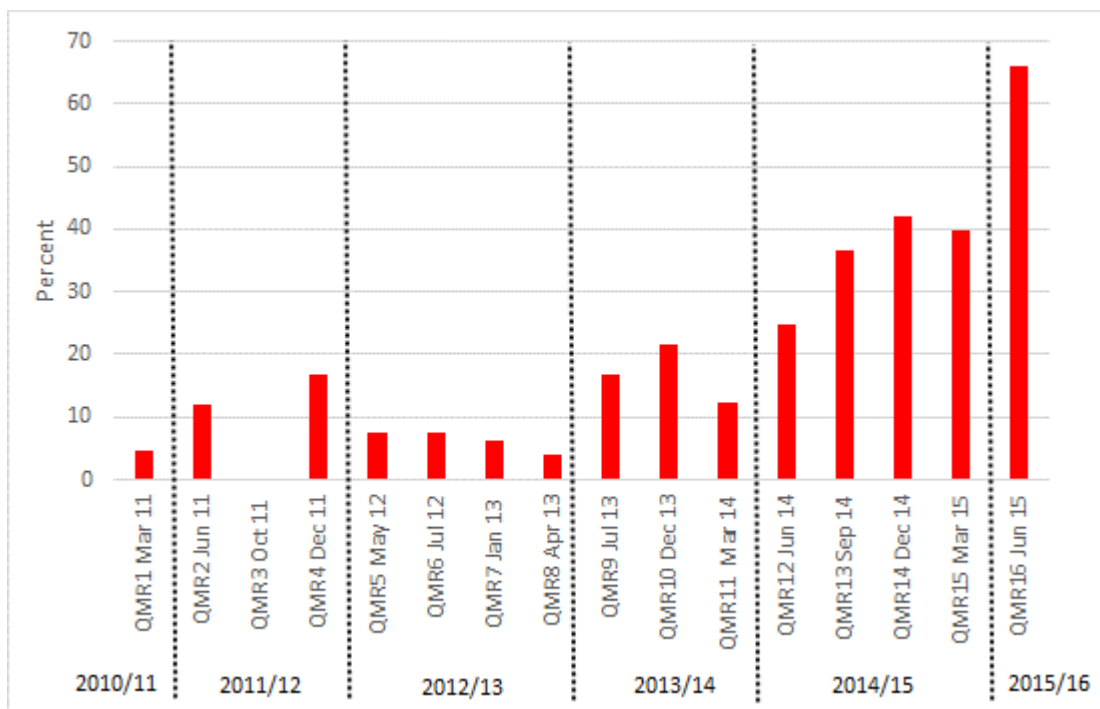
It is perhaps not surprising that forecasts from finance directors suggest that around 66 per cent of all provider organisations could be in deficit – including 89 per cent of all acute trusts – by April 2016 (see Figure 2). The fact that financial problems are now so widespread suggests their causes are systemic rather than resulting from failures of leadership in a small number of organisations.

Figure 1: Net financial outturn, NHS trusts and foundation trusts: 2009/10-2014/15



Source: Department of Health 2015

Figure 2: Percentage of provider organisations forecasting a deficit at year end



Source: Appleby *et al* 2015

Note: QMRs 1-4 based on a panel of 50 finance directors

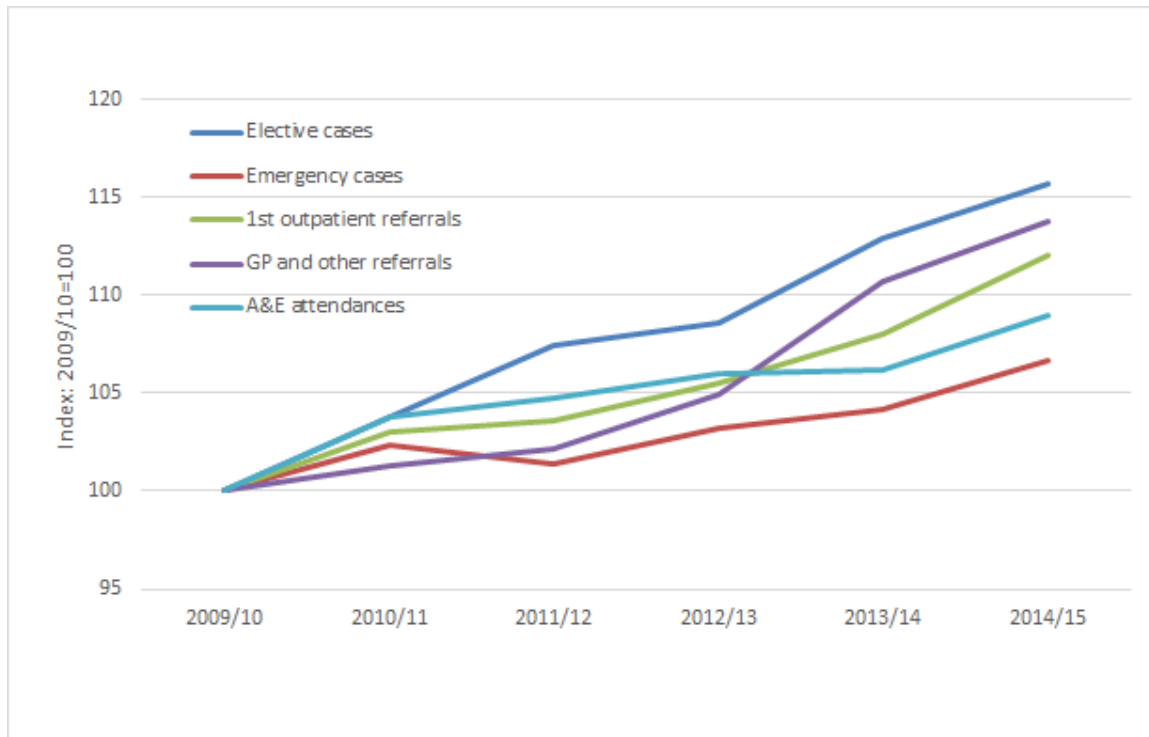
It remains to be seen whether or not the forecast overspending is realised, and the impact of the many measures already taken to rein in deficits in the current financial year is unknown. Our most recent survey of NHS finance directors suggested that the new controls on agency costs are unlikely to have much impact and it is notable that Monitor estimates that the £500 million these controls are expected to save will not be delivered until 2018/19.

A number of factors that explain the deteriorating financial position of providers in the NHS.

- The cash increase for the whole of the NHS of £3.4 billion (a 1.6 per cent real rise) this year will be wholly absorbed by the NHS contribution to the Better Care Fund. While the BCF will hopefully produce benefits for patients, it carries an opportunity cost for providers as money is diverted to other services
- Demand for NHS care continues to rise, (see Figure 3).
- Costs have risen and continue to rise with pressures to spend more on, for example, nurses (and related higher spending on agency staff given the shortage of nurses for permanent posts).
- Continuing real cuts in tariff prices for secondary care services have increased provider deficits but have not improved the financial situation for commissioners.
- Increasing difficulties in the short term in finding sustainable recurring savings to close the gap between rising demands and costs have accentuated these problems.

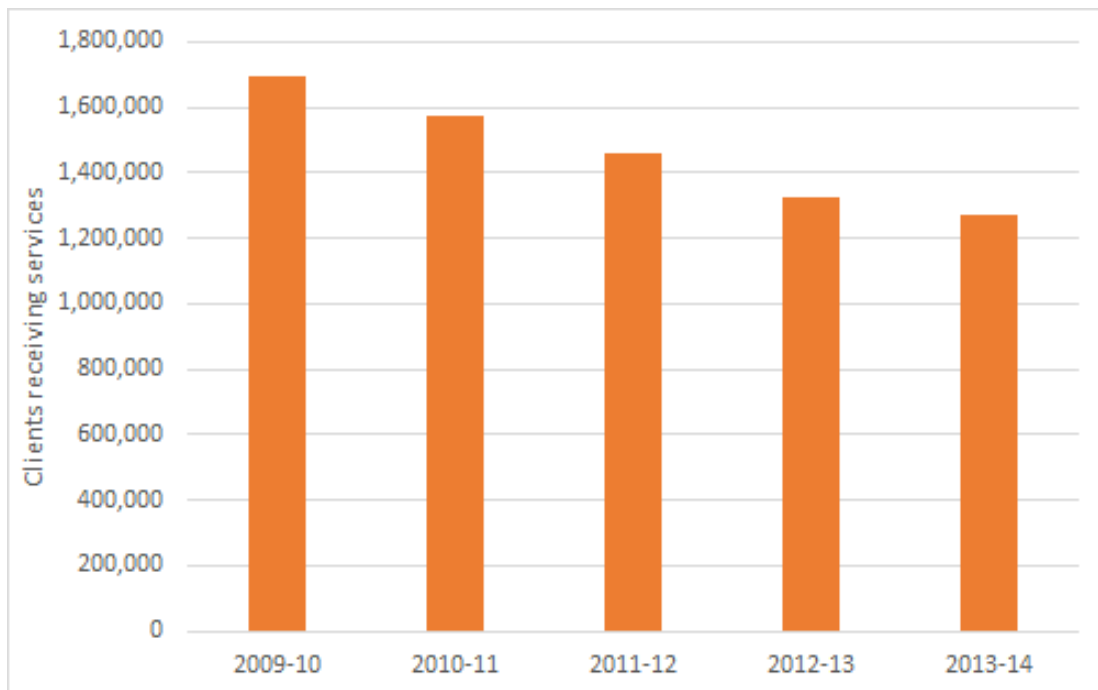
While NHS activity has grown since 2009/10 (Figure 3), the number of people receiving adult social care services has reduced by more than 400,000 since 2009/10 – and, as the 2015 Association of Directors of Adult Social Services survey notes, a significant number of those who do get support are receiving less care (Association of Directors of Adult Social Services 2015).

Figure 3: Growth in referrals, outpatient, elective, emergency and A&E activity: 2009/10 – 2014/15



Source: NHS England 2015a,b

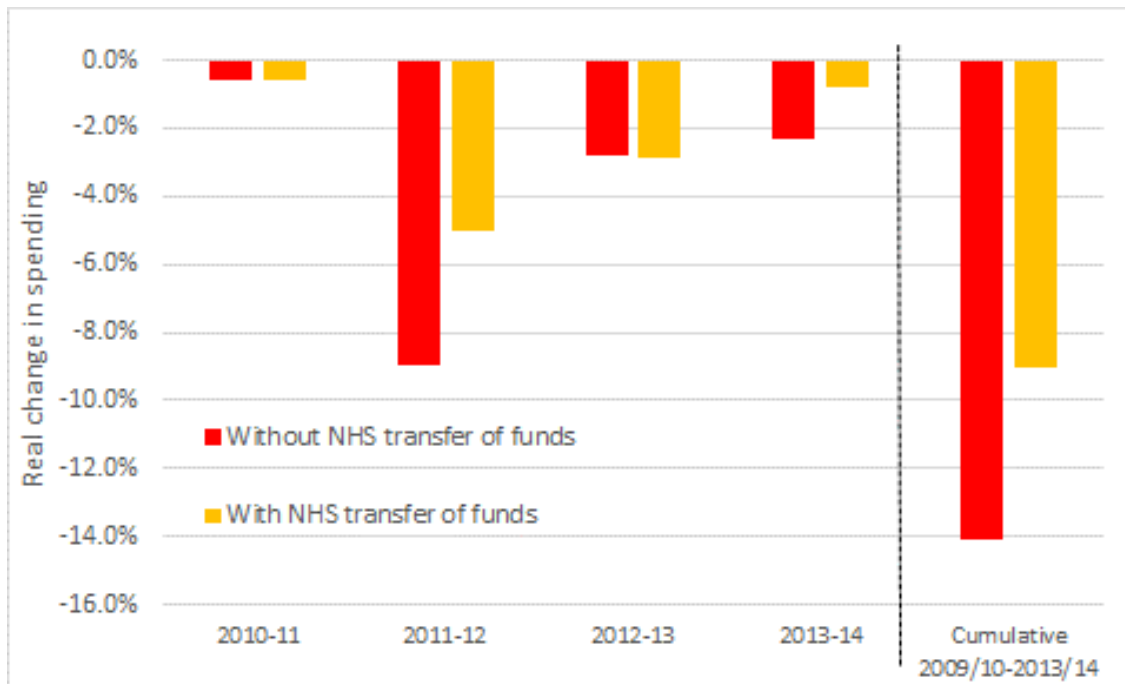
Figure 4: Number of clients receiving adult social care services: 2009/10 – 2013/14



Source: Health and Social Care Information Centre 2014a

This reflects a cumulative real cut in adult social care spending of 9 per cent between 2009/10 and 2013/14 – including additional funds transferred from the NHS and extra funding for winter pressures (see Figure 5).

Figure 5: Real change in adult social care spending: 2010/11 to 2013/14



Source: Health and Social Care Information Centre 2014b, King’s Fund analysis

As the 2015 survey of directors of adult social services makes clear, the cumulative effect of reduced funding is now acute, with savings increasingly hard to generate without further reductions in services. As a result councils will make reductions of £420 million in services to people needing that care and support. Spending on prevention continues to fall, accounting for less than 7 per cent of all spending this year (Association of Directors of Adult Social Services 2015).

The King's Fund view: the short term

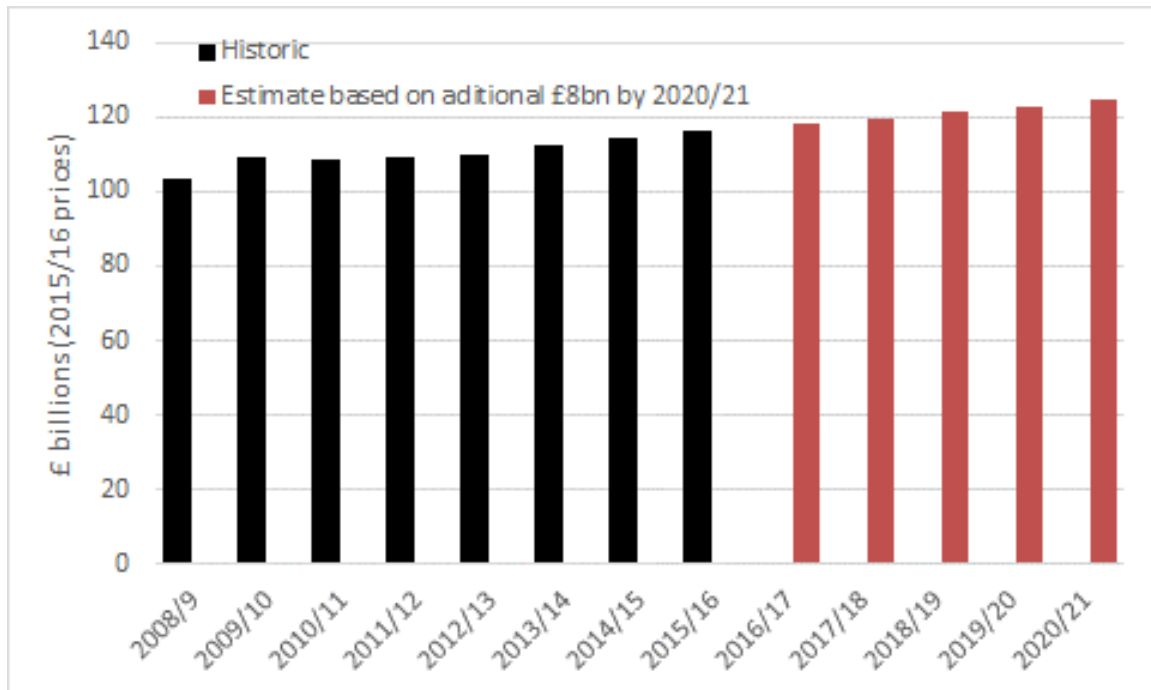
- Although the forecast £2 billion net overspend by providers this year may be reduced by short-term measures such as raiding the capital budget, it is inevitable that the NHS will require more money overall than is currently planned. The alternative is either continued (but unsustainable) overspending or widespread cuts in major areas of spending such as staffing. In either case it is likely that there will be further deteriorations in the quality and volume of services to patients.
- The size of the emergency deficit funding will depend on whether the NHS can overachieve on its planned cost improvement programme, but it is unlikely to be less than £1 billion. This emergency deficit funding needs to be new money over and above the current planned spending this year of £116.8 billion
- With local authorities once again under huge pressure to make cuts, despite rising demand for services, there is also an urgent need to make better provision for social care and protect services from any further reductions in financial support to local government. This could be done in the short term by redirecting some of the resources previously identified to fund phase 2 of the Care Act, whose implementation has now been postponed.

2: The medium term: to 2020/21

Over the period of the this year's Spending Review the government has committed to a real increase in NHS funding of £8 billion over the level of spending in 2014/15 by 2020/21 (HM Treasury 2015c). In addition, the 2014 Autumn Statement increased spending in 2015/16 by £1 billion and set aside an additional £1 billion over the four years to 2018/19 to be spent on GP premises (HM Treasury 2014). Furthermore, around £0.7 billion is to be reprioritised within the NHS budget to frontline services in 2015/16.

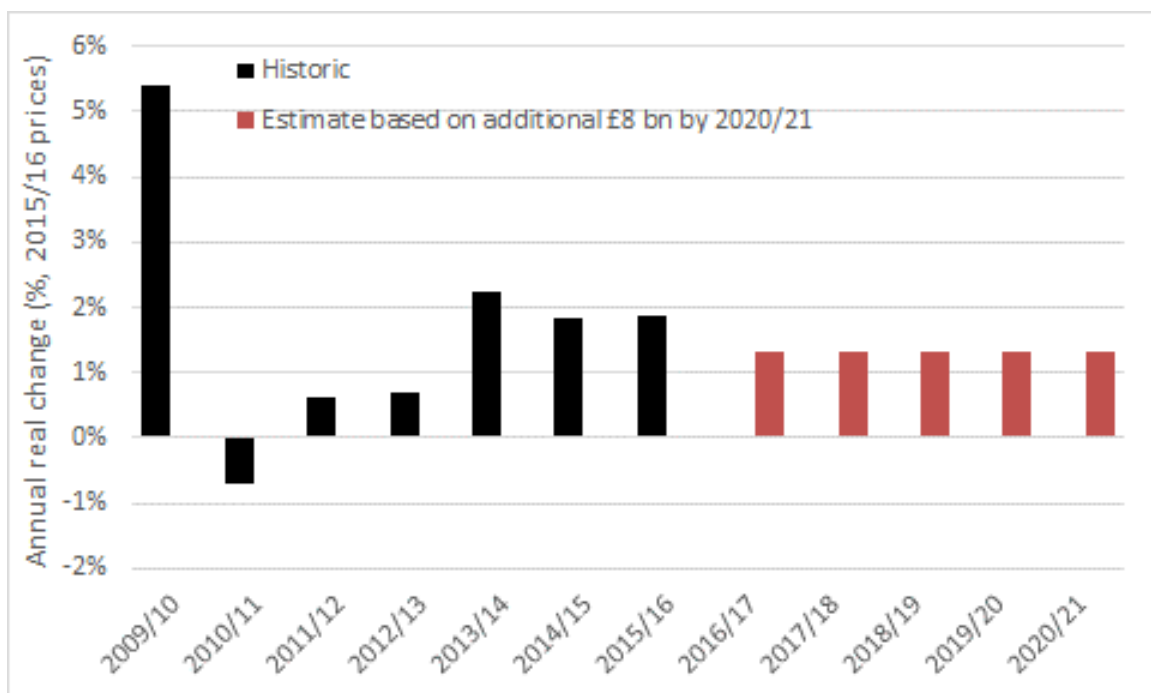
The additional £8 billion (Figure 6) implies an average annual real increase of around 1.33 per cent (Figure 7). Between 2015/16 and 2020/21 the total real increase in funding will be 6.9 per cent – almost exactly the same as the real increase between 2010/11 and 2015/16.

Figure 6: English NHS funding: 2008/9 to 2020/21 (2015/16 prices): Projections based on additional £8 billion by 2020/21



Source: 2008/9-2015/16 Department of Health (2015); projections: The King’s Fund analysis

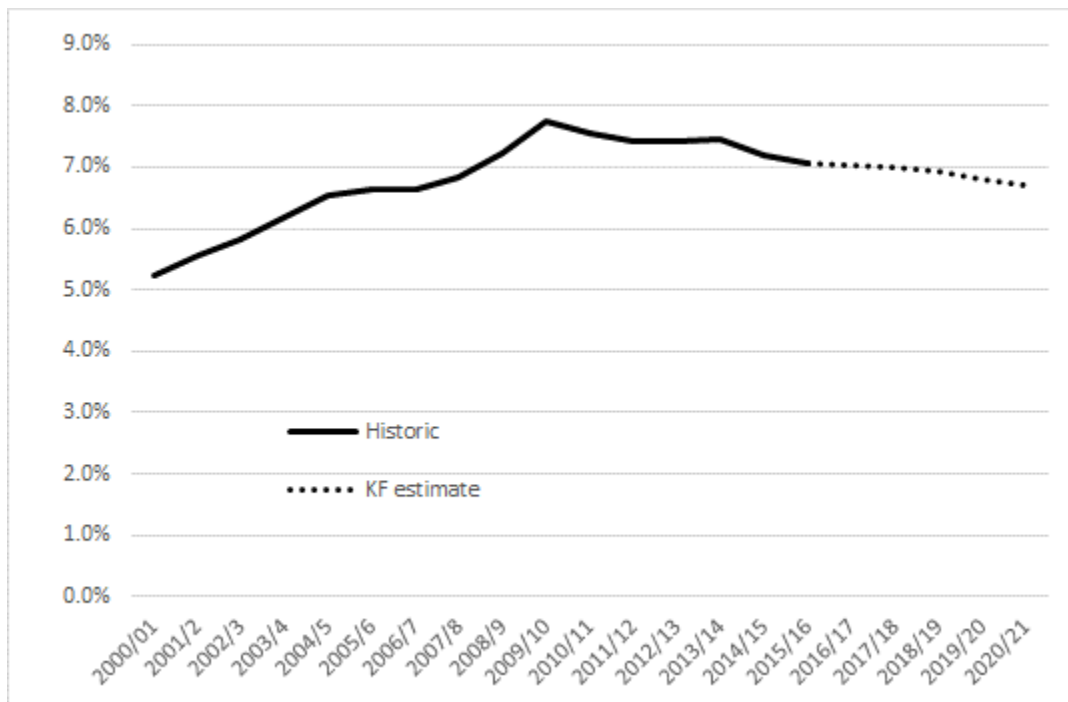
Figure 7: English NHS funding: Percentage annual change: 2008/9 to 2020/21 (2015/16 prices): Projections based on additional £8 billion by 2020/21



Source: 2008/9-2015/16 Department of Health (2015); projections: The King’s Fund analysis

If this increase was reflected across the rest of the UK, NHS spending as a percentage of UK GDP would fall by 0.5 percentage points between 2014/15 and 2020/21 and since 2009/10, by 1 percentage point. This would take the proportion of spending on the NHS back to levels in 2005/6.

Figure 8: UK NHS as a percentage of GDP



Source: King’s Fund analysis

Note: Projection based on pro rata across the UK NHS of additional funding of £8 billion by 2020/21 (equivalent to an additional £9.6 billion across all four countries) and OBR’s central projection for GDP to 2020/21

The additional £8 billion is the absolute minimum the service needs to maintain current standards and does not allow for new policy initiatives or commitments such as seven day working. The Spending Review should therefore not require any new commitments unless they are accompanied by further additional funding over and above the £8 billion already committed.

The additional funding leaves the NHS with another five-year productivity challenge. NHS England estimated the monetary value of the gap between funding and demand to be £22 billion (NHS England *et al* 2014). However, government decisions since the publication of the Forward View will have an impact on this gap. First, continuing the 1 per cent cap on public pay from 2016/7 to 2020/21 could save the NHS up to £900 million per annum – reducing the gap to around £18 to £19 billion by 2020/21 depending on the scale of pay drift. On the other hand, the introduction of the so-called living wage will increase pay costs for the NHS.

With demand continuing to rise and with many providers having exhausted the easier cost savings, the additional £8 billion must be front-loaded from 2016/17 if the NHS is to maintain quality of care and begin to make the changes needed to ensure services are sustainable. Otherwise, the NHS will have to reduce staff and allow performance and quality to decline sharply in the early years of this parliament. It is unlikely that such deterioration could be made good by 2020: experience has shown how difficult it is for the health service to recover once performance has been allowed to slump.

Dedicated funding will be needed to unlock productivity improvements and support the development of new models of care. Transforming services is not easy at the best of times, but to do so while managing the financing, quality and performance of current services will be impossible for many; additional support will be needed to give local leaders capacity and capability to bring about change. We recently made the case for a Transformation Fund to provide this capability and capacity, jointly with the Health Foundation (Health Foundation 2015). This estimated that £1.5 – £2.1 billion a year is required from 2016/17 – 2020/21. Some of this funding could be found from existing sources, although additional funding would also be needed.

Funding plans for the NHS assumed that there will no reduction in access to social care services. However, the reforms to social care funding (phase 2 of the Care Act 2014) have been delayed until 2020. These changes, particularly the introduction of a cap on care costs, are unlikely to be implemented at all in their current form. They were expected to cost £2.4 billion a year by 2025, £6 billion in total over the next five years, which the government had pledged in the 2013 Budget to fund through freezing inheritance tax thresholds and changes to national insurance arrangements. The government has made no commitment to redirect these resources to address the pressures on local authority social care budgets.

The announcement in the 2015 Budget to introduce a national living wage will add approximately £2.1 billion to social care pay costs by 2020 (Gardiner and Hussein 2015). Unless this is fully funded through the local government financial settlement, there will be a significant risk that some private providers will fail or exit the publicly funded market. This in turn will make it even harder for people to get the care and support they need and create further pressures on families and carers and the NHS.

As the Barker Commission has pointed out, the costs of social care will rise as population changes fuel greater demand (Commission on the Future of Health and Social Care in England 2014). The Office for Budget Responsibility (OBR)'s latest projections for spending on long-term care across the UK suggest a real rise averaging just over 5 per cent a year between 2014/15 and 2020/21, with long-term care spending absorbing an increasing share of GDP – from 1.1 to 1.3 per cent by the end of the current Spending Review period (Office for Budget

Responsibility 2015). These 'policy neutral' projections are in contrast to the real cuts in spending seen over the past five years and despite considerable efforts on the part of local councils to protect social care within budgets reduced in real terms overall.

The Local Government Association has estimated that the funding gap for adult social care will rise to £4.3 billion by 2020. (Local Government Association and ADASS 2014) However, the July Budget indicated that non-protected spending areas (such as local government) would need to find around £19 billion of savings by 2019/20 – a real cut of nearly 13 per cent and a total cut since 2010/11 of nearly 33 per cent (Crawford 2015).

At a time of such pressure on frontline services, it can be tempting to look for other budgets to cut. Historically, two common targets were workforce training and public health. Evidence suggests that such cuts were short-sighted, and in the current environment any significant reduction in spending in these areas will prove a false economy. For workforce, this is because many of the existing financial problems in hospitals arise from a fundamental shortage of nursing staff and the reliance on expensive, temporary staff. Difficulties in primary care are also partly due to shortages of GPs. For public health, the funding to local government pays for services such as sexual health, treatment of drug and alcohol misuse, all of which provide an early return on investment. Because of this, the Forward View assumed that such budgets would be maintained, and indeed were intrinsic to the definition of the NHS used by the coalition government when protecting 'health'. In this context, the recent decision to cut £200 million from this year's public health budget sends a worrying signal and undermines the government commitments on prevention (Buck 2015).

There are clearly difficult choices to be made about public financing priorities. However, it is not the case that there is no alternative to planned deficit reduction. The easing of overall public spending cuts from 7.5 per cent to 4 per cent by 2019/20 between the March and July 2015 Budgets indicates, economic and fiscal choices are always available to be made (Crawford 2015).

The King's Fund view: the medium term

- The NHS can only deliver the £22 billion in efficiency savings if the government front-loads the promised additional £8 billion (over and above the additional money promised in last year's Autumn Statement). In addition, social care funding must be protected and support for transformation must be available. Even then it is a hugely ambitious ask of the NHS and social care.
- The previous government's commitment to protect the NHS referred to the totality of health spending. This interpretation must be maintained; short-term cuts to workforce training and public health will be false economies.
- To compensate for abandoning the commitment to cap individual's social care costs and introduce more generous means testing, the government should, as a minimum, use the money the 2013 Budget identified to pay for these reforms (from changes in inheritance tax thresholds and national insurance) – £6 billion over the next five years – to address rising costs and increased demand for care. The full costs of the national living wage should be reflected in the financial settlement for local government.

3: The long term: beyond 2021/22

While the Spending Review will cover the period up to 2020/21, there is a case for thinking further ahead, as the work of Sir Derek Wanless did in 2002 and 2004 (Wanless 2002, Wanless 2004), and reiterated in The King's Fund analysis of those reports with Sir Derek in 2007 (Wanless *et al* 2007). As we noted in our 2007 review:

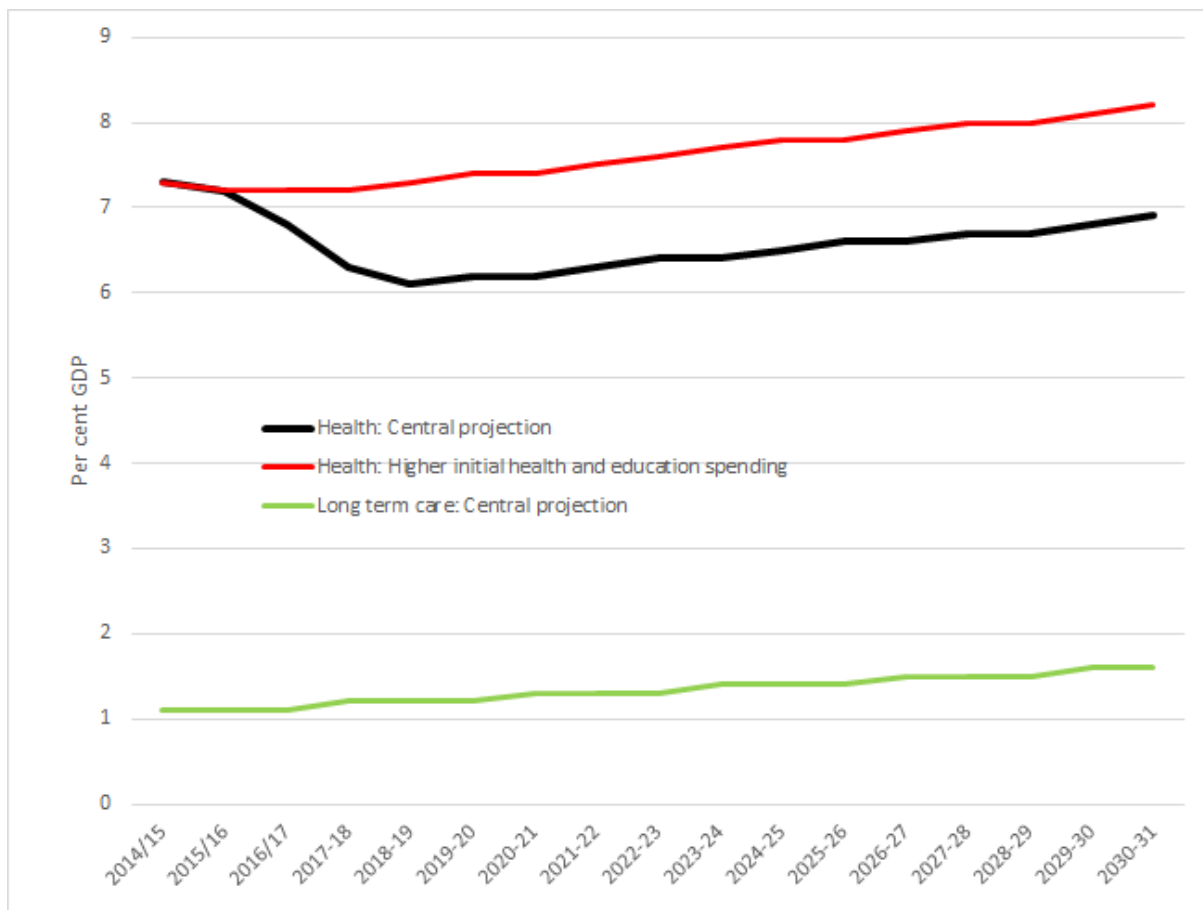
There are good reasons to carry out forecasting on a regular basis given the long-term nature of many of the decisions needing to be taken as well as the need to fix short-term resourcing decisions in the context of longer-term plans. The approach, using scenarios to capture particular uncertainties, based on demographic updates, an assessment of the health status and the future choices and demands of people and the aggregation of forecast costs seems robust. 20 years seems a reasonable period for the forward look and regular updates should have the benefit of developing knowledge and research programmes.

*This work would help inform debates about the effectiveness of spending, the comparability of quality of outcomes domestically and internationally, funding levels and funding sources - debates which will help create conditions for better engagement. (Wanless *et al* 2007)*

Currently, the only regular long-term forward view of health and social care (long-term care) spending are those produced by OBR (Office for Budget Responsibility 2015). Figure 9 shows the OBR's latest projections for health and

long-term care to 2030/31. The central projection for health care suggests a cut in spending from 2014/15 to 2018/19 equivalent to 1.1 percentage points of GDP, then increasing up to 2030/31 – but remaining below the level in 2014/15. The highest projection suggests a rise in health care spending as a proportion of GDP of around 0.9 percentage points (from 7.4 per cent to 8.2 per cent).

Figure 9: Long-term projections to 2030/31 of UK health and long-term care spending as percentage of GDP



Source: Office for Budget Responsibility 2015

While some key uncertainties are modelled (such as future population size and health status, and NHS productivity) the usefulness of these projections are, by definition, restricted by the assumption that there will be no changes to policy.

In part because of the limitations of the OBR’s approach, but particularly to explore and address fundamental policy concerns, The King’s Fund established the Commission on the Future of Health and Social Care in England in 2013. The way in which the NHS and social care support have been delivered and paid for since 1948 has not kept pace with 66 years of social, technological and demographic change, including major shifts in the pattern of disease. Although the NHS remains a universal service, free at the point of use and funded largely through general taxation, social care is being used by fewer people and

increasingly restricted only to those with the highest needs and lowest means. The Barker Commission concluded that a new settlement was needed in which entitlements to, and funding of, health and social care were brought closer together (Commission on the Future of Health and Social Care in England 2014).

Although there is much scope to achieve better value from integration, changing needs and demography would require us to devote a higher share of GDP to the NHS and social care. It argued that this was both affordable and sustainable if a long-term approach was taken and hard choices addressed about how additional spending could be funded. The Commission's projections assumed an annual real terms increase of 3.7 per cent, including substantial improvements in access to social care. This would increase the share of public spending on health and social care to 11.3 per cent by 2025. Much of this would come from health and social care absorbing a larger share of our rising national income produced by economic growth. It should be noted that this level of spending would only broadly match what several other countries, such as Canada, France and the Netherlands, spent on health alone in 2010.

The King's Fund view: the longer term

- Since 1998 there have been at least four independent reviews or commissions, four consultations and five White/Green papers on reforms to improve social care and yet services are now in an increasingly parlous and financially fragile state.
- In addressing questions of entitlement, funding and organisation of social care services, the independent Barker Commission concluded with a vision of a single, ring-fenced budget for health and social care that is singly commissioned. Despite past failures to reform, there are, as the Commission noted, huge benefits to be gained from a more integrated service with simpler paths through it, greater equity for users and a less distressing and confusing experience.
- Such a future care service cannot be simply a merger of an underfunded health service and underfunded social care. It is debatable how much more money will be needed to provide the sort of care service the public expect, but the Barker Commission's estimate of between 11 per cent and 12 per cent of GDP by 2025 seems reasonable.
- As the reviews by Sir Derek Wanless have pointed out, however, longer term funding options need to be informed as far as possible by regular detailed forecasts and projections based on the latest data and modelling approaches. Such work would necessarily go beyond the OBR's current policy-neutral projections to explore future scenarios to inform public and political debate. But, in line with the Ramsden review of the OBR (HM Treasury 2015b), this could be part of the recommendation for the OBR to conduct more in-depth analysis on specific fiscal sustainability issues.

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