National Health Service Finances

Briefing Paper

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Introduction

The National Health Service is one of Britain's most popular institutions. It is also a very large institution, spending over £100billion a year and employing over a million people. However, the organisation of the National Health Service is often seen to be complex, its financial management arrangements difficult to understand and the financial challenges that it faces numerous. It is often said that the National Health Service is in 'crisis'. The purpose of this briefing paper is to provide an overview of the finances of the National Health Service in England and of the financial challenges that are faced and to provide some commentary.

While it is usual to refer to the 'National Health Service' there are, in fact, four different National Health Services in the United Kingdom; with the United Kingdom government managing National Health Service England and the devolved administrations in Northern Ireland, Scotland and Wales managing the National Health Service in those countries. There are therefore differences between the four jurisdictions. Funding is linked in that the expenditure on National Health Service England by the United Kingdom government feeds into the 'Barnett formula' that determines funding for the devolved administrations that they can use to fund the National Health Service in those areas.

Health Service Structures in England

National Health Service England

National Health Service England took on full statutory responsibilities in April 2013. Prior to this, all National Health Service planning and delivery was done by the Department of Health, strategic health authorities and primary care trusts.

National Health Service England is an independent body, at arm's length to the government. Its main role is to set the priorities and direction of the National Health Service and to improve health and care outcomes for people in England. National Health Service England is the commissioner for primary care services such as General Practitioners, pharmacists and dentists, including military health services and some specialised services.

As part of the National Health Service Five Year Forward View, primary care co-commissioning was introduced. An example of this is National Health Service England inviting Clinical Commissioning Groups to take on an increased role in the commissioning of General Practitioner services.

National Health Service England manages around £100billion of the overall National Health Service budget and ensures that organisations are spending the allocated funds effectively. Resources are allocated to Clinical Commissioning Groups.

Clinical Commissioning Groups

Clinical Commissioning Groups replaced Primary Care Trusts in April 2013. Clinical Commissioning Groups are clinically led statutory National Health Service bodies responsible for the planning and commissioning of healthcare services for their local area. Clinical Commissioning Group members include General Practitioners and other clinicians, such as nurses and consultants. They are responsible for about 60% of the National Health Service budget, commission most secondary care services, and play a part in the commissioning of General Practitioner services. The secondary care services commissioned by Clinical Commissioning Groups are:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours and National Health Service 111
- Most community health services
- Mental health services and learning disability services

Clinical Commissioning Groups can commission any service provider that meets National Health Service standards and costs. These can be National Health Service hospitals, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, considering both National Institute for Health and Care Excellence guidelines and the Care Quality Commission's data about service providers.

Both National Health Service England and Clinical Commissioning Groups have a duty to involve their patients, carers and the public in decisions about the services they commission.

Health and wellbeing boards

Health and wellbeing boards were established by local authorities to act as a forum for local commissioners across the National Health Service, social care, public health and other services. The boards intended to:

- Increase democratic input into strategic decisions about health and wellbeing services
- Strengthen working relationships between health and social care

- Encourage integrated commissioning of health and social care services

Public Health England

Public Health England provides national leadership and expert services to support public health, and works with local government and the National Health Service to respond to emergencies. Public Health England:

- Co-ordinates a national public health service and delivers some elements of this
- Builds an evidence base to support local public health services
- Supports the public to make healthier choices
- Provides leadership to the public health delivery system
- Supports the development of the public health workforce

Vanguards

Vanguards were introduced in 2015 as part of the National Health Service Five Year Forward View. The fifty chosen vanguards are tasked to develop new care models and potentially redesign the health and care system. It is envisaged that this could lead to better patient care, service access and a simpler system.

Regulation – safeguarding people's interests

Responsibility for regulating aspects of care is now shared across a number of different bodies, such as:

- The Care Quality Commission
- National Health Service Improvement – an umbrella organisation that brings together Monitor, National Health Service Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams
- Individual professional regulatory bodies, such as the General Medical Council, Nursing and Midwifery Council, General Dental Council and the Health and Care Professions Council
- Other regulatory, audit and inspection bodies – some of which are related to healthcare and some specific to the National Health Service

Primary and Secondary care

Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including General Practitioners, dentists, pharmacists and optometrists, as well as National Health Service walk-in centres and the National Health Service 111 telephone service.

Secondary care includes most of the hospital and community National Health Service services and are commissioned by Clinical Commissioning Groups.

National Health Service Trusts

In 2013 the National Health Service underwent a fundamental restructure. Under the old National Health Service system there were a wide range of National Health Service trusts – such as acute trusts, ambulance trusts, and mental health trusts – that managed National Health Service hospital care in England, including community care and mental health services. Most of these services are now provided through National Health Service foundation trusts and National Health Service trusts providing ambulance services, emergency care services, or mental health services.

Foundation Trusts

Most hospitals in England are now managed by National Health Service foundation trusts. First introduced in April 2004, they differ from other existing National Health Service trusts. They are independent legal entities and have unique governance arrangements. They are also, in theory, accountable to local people, who can become members and governors.

Each National Health Service foundation trust has a duty to consult and involve a board of governors – including patients, staff, members of the public, and partner organisations – in the strategic planning of the organisation.

They are set free from central government control and are no longer performance-managed by health authorities. As self-standing, self-governing organisations, National Health Service foundation trusts are free to determine their own future.

They have financial freedom and can raise capital from both the public and private sectors within borrowing limits, determined by projected cash flows, and are therefore based on affordability. They can retain financial surpluses to invest in the delivery of new National Health Service services.

Acute Trusts

Some hospitals in England are managed by acute trusts, some of which have also gained foundation trust status. Acute trusts ensure that hospitals provide high-quality healthcare and check they spend their money efficiently. They also decide how a hospital will develop so services improve.

Acute trusts employ a large part of the National Health Service workforce, including nurses, doctors, pharmacists, midwives, and health visitors. They also employ people doing jobs related to medicine, such as physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists, psychologists, and healthcare scientists. There are many other non-medical staff employed by acute trusts, including receptionists, porters, cleaners, specialists in information technology, managers, engineers, caterers, and domestic and security staff.

Some acute trusts are regional or national centres for more specialised care, while others are attached to universities and help train health professionals. Acute trusts can also provide services in the community – for example, through health centres, clinics, or in people's homes.

Ambulance Trusts

Ambulance services in England help many people with serious or life-threatening conditions. They also provide a range of other urgent and planned healthcare and transport services. Ambulance services are managed by either an ambulance trust or a foundation trust. The National Health Service is also responsible for providing transport to get many patients to hospital for treatment. In many areas the ambulance trust provides this service.

Mental Health Trusts

Mental health trusts provide health and social care services for people with mental health problems. Many National Health Service trusts have merged over the past couple of years and may now be governed by a foundation trust that provides a mental health service. Mental health services are provided through primary care, such as General Practitioner services, or through more specialist care. This might include counselling and other psychological therapies, community and family support, or general health screening.

More specialist care is normally provided through National Health Service trusts or local authorities. Services range from psychological therapy to very specialist medical and training services for people with severe mental health problems.

Example: Cumbria Partnership National Health Service Foundation Trust Accounts

The Cumbria Partnership National Health Service Foundation Trust operates in East, North and West Cumbria. They have in place major contracts to provide services as follows:

- National Health Service England – Offender Health, and Dental Services
- Cumbria Clinical Commissioning Group – General Community, Mental Health, Learning Disability, and Children's Services
- Cumbria County Council – Sexual Health, Health Visiting Public Health and Wellbeing Nurses

The accounts for 2016/17 and the financial plan for 2017/18 are summarised as follows:

	2016/17 Actual £million	2017/18 Planned £million
Income	180.3 Cr	175.3 Cr
Operating Expenditure	175.5	171.6
Earnings before Interest, Taxes, Depreciation & Amortisation	4.8 Cr	3.7 Cr
Depreciation, Dividend and Interest	6.0	6.2
Net Deficit before Exceptional Items	1.2	2.5
Exceptional Items	3.8	0.7
Net Deficit	5.0	3.2

The Trust also incurred Capital Expenditure of £5.0million in 2016/17 and plans to incur a further £4.3million in 2017/18.

The Consolidated Statement of Comprehensive Income for 2015/16 and 2016/17 is as follows:

	2016/17 £million	2015/16 £million
Group Income from Activities		
NHS contract income for clinical services	156.0 Cr	155.0 Cr
Non-NHS contract income for clinical services	9.2 Cr	5.5 Cr
Other clinical income from commissioner requested services	1.8 Cr	1.5 Cr
Other non-commissioner requested clinical income	3.3 Cr	4.1 Cr
Operating income from patient care activities	170.3 Cr	166.1 Cr
Other operating income	10.2 Cr	6.6 Cr
Total Operating Income	180.5 Cr	172.7 Cr
Operating Expenses		
Staff costs	135.8	131.1
Executive Directors' costs	1.2	1.1

	2016/17 £million	2015/16 £million
Premises	10.9	14.4
Supplies & Services (clinical)	7.0	7.3
Supplies & Services (general)	5.8	5.3
Drugs	5.2	4.7
Transport	3.2	3.3
Establishment	2.2	2.5
Depreciation & Amortisation	3.9	3.2
Net Impairments of property, plant & equipment	3.2	0.7
Other Expenditure	5.8	5.1
Total Operating Expenses	184.2	178.7
Operating Deficit	3.7	6.0
Finance income	0.1 Cr	0.1 Cr
Financial liabilities	0.6	0.6
PDC dividends payable	1.5	1.7
Net Finance Costs	2.0	2.2
Movement in fair value of investments	0.3 Cr	0.1
Gains / losses on disposals of assets	0.2 Cr	0.8
Deficit for the Year	5.2	9.1
Impairments on property, plant & equipment	2.4	0.2 Cr
Revaluation gains on property, plant & equipment	0.1 Cr	0.0
Total Comprehensive Expense for the Year	7.5	8.9

Group income from activities can also be analysed as follows:

	2016/17 £million	2015/16 £million
NHS England and Clinical Commissioning Groups	157.9 Cr	157.3 Cr
National Health Service Trusts	2.0 Cr	1.8 Cr
National Health Service Foundation Trusts	0.9 Cr	0.7 Cr
Other National Health Service	0.1 Cr	0.1 Cr
Local Authorities	9.1 Cr	6.0 Cr
Other non-National Health Service	0.3 Cr	0.3 Cr
Operating income from patient care activities	170.3 Cr	166.1 Cr

There are differences between the two pieces of financial information because the annual accounts include the performance of the Charitable Trust Funds whereas the summary does not.

It will be noted that:

- The Trust operated at a deficit in 2015/16 and 2016/17 and plans to do so in 2017/18. Clearly this is not sustainable in the long-term. Many Trusts are in this position.
- Most operating income is derived from NHS contract income for clinical services. This comprised 86% of the total in 2016/17.

- Most operating income from patient care activities is derived from NHS England and clinical commissioning groups. This comprised 93% of the total in 2016/17.
- Most operating expenses consist of staff costs. These comprised 74% of the total in 2016/17. The largest element of staff costs are the salaries of nursing staff.

The accounts also provide a segmental analysis as follows:

	2016/17 £million	2015/16 £million
Non-segment operating income	167.4 Cr	159.9 Cr
Net Segment Expenditure:		
Community care group	50.9	52.0
Mental health care group	38.8	37.7
Specialist services care group	22.1	18.9
Children's services care group	17.6	17.5
Director of Quality & Nursing	2.8	2.7
Operations & clinical management	1.0	0.8
Other non-segmental expenditure	30.6	32.3
Sub-Total	3.4 Cr	2.1
Finance income	0.1 Cr	0.1 Cr
Financial liabilities	0.6	0.6
PDC dividends payable	1.5	1.7
Movement in fair value of investments	0.3 Cr	0.1
Net impairments on revaluation of property, plant & equipment	3.2	0.7
Gain / Loss on disposal of fixed assets	0.2 Cr	0.8
Depreciation & amortisation	3.9	3.2
Net Deficit for the Year	5.2	9.1

This analysis shows that the community care and mental health care groups have the largest net expenditure.

In a recent consultation document, the Trust explained the context of demographic change and the funding of the National Health Service both nationally and locally in which it operates as follows:

"By 2020 the total working age population of… Cumbria may fall and almost a quarter of all people… are likely to be over 65 years old. The health and care needs of this group will grow rapidly over the coming years leading to higher demand for health services and increasing pressure on social care.

"The National Health Service will not see a return to the 6-7% real annual increases in budget that it saw in the early 2000s. If we make no further efficiency savings in the coming years… the increasing demand for health care would lead to a financial shortfall of £30billion a year by 2020/21.

"Local National Health Service organisations are currently spending well beyond their means. In… 2015/16 they had a combined over-spend of around £70million. This is projected to rise to £163million a year by 2020.

"The local health community will need to make efficiency savings of around 6.5% a year over the next five years. This compares with an average national efficiency saving requirement of around 3-4%. By 2020… we will be able to make efficiency savings of £85million a year… We also anticipate we can save £42million a year by 2020 with new ways of working… The direct savings from the preferred option service changes discussed in this consultation document (closing beds in smaller hospitals) would be approximately £2.1million a year. This still leaves a potential financial gap of over £30million a year… There may need to be further service changes."

The Cumbria Partnership National Health Service Foundation Trust is not alone in being in deficit. About two-thirds of National Health Service trusts operate at a deficit (see below).

Funding National Health Service England

The National Health Service in England is funded mainly from general taxation and National Insurance contributions. In 2001, an increase in National Insurance rates intended to boost National Health Service funding increased the proportion paid for by National Insurance, although general taxation still accounts for around 80% of National Health Service funding.

Some funding is generated by user charges. Charges for prescriptions, dental treatment and spectacles were first introduced in the early 1950s. These charges account for only a small proportion of National Health Service income – for example, income from patient fees and charges for prescriptions and dental care was £1.3billion in 2015/16 that was 1.1% of the Department of Health budget. The National Health Service also generates some income, for example, through parking charges and land sales.

The level of National Health Service funding is set by central government through the Spending Review process. This process estimates how much income the National Health Service will receive from sources such as user charges, National Insurance and general taxation. If National Insurance or patient charges raise less funding for the National Health Service than originally estimated, funds from general taxation are used to ensure the National Health Service receives the level of funding it was originally allocated.

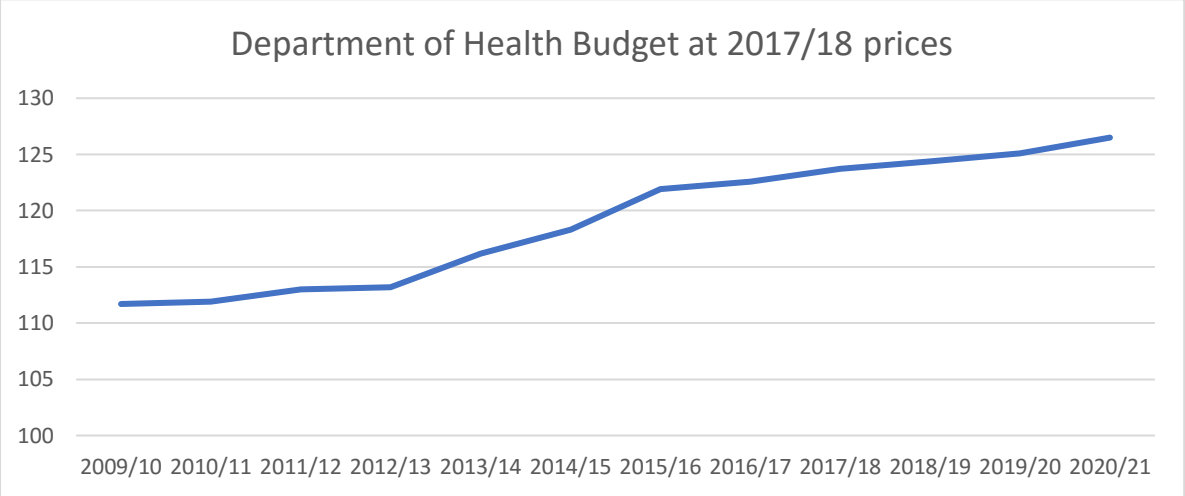
Planned spending for the Department of Health in England is £123.7billion in 2017/18 (at 2017/18 prices).

In the 2015 Spending Review the government announced that funding for the Department of Health would increase to £133.1billion (or £126.5billion at 2017/18 prices after adjusting for inflation) by 2020/21. The increase in health spending between 2015/16 and 2020/21 is less than the government has claimed, mainly because ministers have chosen to highlight the funding provided to National Health Service England only, rather than the Department of Health's total budget that includes provision for other services, especially public health.

Though National Health Service funding is continuing to grow, the rate of growth is slowing considerably compared to historical trends. The Department of Health budget will grow by 1.1% in real terms between 2009/10 and 2020/21. This is far below the long-term average increases in health spending of approximately 4% a year (in real terms) since the National Health Service was established and the increases of 6% to 7% a year that were seen between 1997 and 2007.

Looking ahead, between 2017/18 and 2019/20 the Department of Health budget will increase by just 0.6% on average each year in real terms. This will place increasing pressure on the National Health Service, as demand for services is continuing to grow (see below for a discussion of the increases in expenditure that are required to maintain services).

Movement in the Department of Health's budget during recent years is summarised below:



There are approximately 240 National Health Service trusts and foundation trusts providing National Health Service ambulance, hospital, community and mental health services in England. In 2010/11, just 5% of these providers overspent their annual budgets. As recently as 2012/13 National Health Service providers recorded a surplus of nearly £600million in aggregate. Since then provider finances have deteriorated sharply.

Collectively in 2015/16 National Health Service trusts reported a deficit of about £2.5billion despite measures taken by National Health Service England and the Department of Health (costing £2.4billion) to reduce them. At the same time, central government and National Health Service England came in under budget, meaning that the 'net deficit' of National Health Service bodies was £1.85billion overall in 2015/16. The size of the deficit has been increasing — in 2014/15 the overall deficit was £574million.

In December 2016, National Health Service Improvement forecast that National Health Service trusts would end 2016/17 with a potential deficit of £750–£850million. This position includes £1.8billion of additional financial support provided through the National Health Service Sustainability and Transformation Fund. National Health Service bodies and provider trusts have made significant efforts over recent months to further reduce the number and size of trust financial deficits in 2016/17. However, 51% of all trusts ended the year in deficit. Nearly three-quarters of these trusts are acute hospitals.

Comparative Spending

In 2000, current spending on health care in the United Kingdom was 6.3% of Gross Domestic Product, and the then Prime Minister Tony Blair committed his government to matching the average for health spending as a percentage of Gross Domestic Product in the fourteen other countries of the European Union in 2000 (8.5%) through increases in National Health Service spending.

Over the next few years spending on the National Health Service increased substantially, pushing total (public plus private) spending to 8.8% of Gross Domestic Product by 2009. By then, however, the European Union-14 spend (weighted for size of Gross Domestic Product and health spend, and minus the United Kingdom) had moved on to 10.1% of Gross Domestic Product. Still, the gap between the United Kingdom and its European neighbours was closing.

Data from the Organisation for Economic Co-operation & Development shows that in 2013 the United Kingdom spent 8.5% of its Gross Domestic Product on public and private health care. This placed the United Kingdom 13th out of the original fifteen countries of the European Union and lower than the European Union fourteen's level of 10.1% of total Gross Domestic Product. Spending in Europe had been maintained since 2009 but spending in the United Kingdom had fallen in relation to Gross Domestic Product.

Since then, however, the Kings Fund has calculated that the gap has started to widen again (particularly against countries that weathered the global financial crisis better than the United Kingdom) and looks set to grow further. United Kingdom Gross Domestic Product is forecast to grow in real terms by around 15.2% between 2014/15 and 2020/21. But on current plans, United Kingdom public spending on the National Health Service will grow by much less: 5.2%. This is equivalent to around £7billion in real terms – increasing from £135billion in 2014/15 to £142billion in 2020/21. As a proportion of Gross Domestic Product, it will fall to 6.6% compared to 7.3% in 2014/15. But, if spending kept pace with growth in the economy, by 2020/21 the United Kingdom National Health Service would be spending around £158billion at today's prices – £16billion more than planned.

The Kings Fund calculates that, if the United Kingdom was to close this gap solely by increasing National Health Service spending (and assuming that health spending in other United Kingdom countries was in line with the 2015 Spending Review plans for England), by 2020/21 it would take an increase of 30% – £43billion – in real terms to match the European Union-15 weighted average spend in 2013, taking total National Health Service spending to £185 billion. They also note that by 2020/21 the European Union average may have moved on, leaving the United Kingdom lagging its neighbours once more.

Compared to Organisation for Economic Co-operation & Development countries there is also a gap. Omitting the United States of America, the Organisation for Economic Co-operation & Development spend is 9.1%. For the United Kingdom to match this would require total spending to reach £163billion – an additional 15% or £21billion – by 2020/21 over current spending plans.

The Kings Fund concludes that:

"Whatever the flaws of international comparisons, it's clear the United Kingdom is currently a relatively low spender on health care – as the Barker Commission pointed out – with a prospect of sinking further down the international league tables.

"The question is increasingly not so much whether it is sustainable to spend more – after all, many countries already manage that and have done for decades. Rather, it is whether it is sustainable for our spending to remain so comparatively low, given the improvements in the quality of care and outcomes we want and expect from our health services."

Demand for Health Care and the Need to Spend

It is generally recognised that the demand for health care and the need to spend is increasing and will continue to increase principally due to increased longevity and new treatments becoming available. In his report of 2002, Sir Derek Wanless reviewed the need for expenditure on health and concluded that real increases in expenditure of 4.4% a year would be required for the service to 'stand still'. While such increases in budgets were made until 2007, the rate of real increase was reduced to 4% in the Comprehensive Spending Review of 2007 and in the Comprehensive Spending Review of 2010 this was reduced to a commitment to maintain expenditure on the National Health Service in real terms. In relation to need, therefore, the budget of the National Health Service has been reduced since 2007.

In 2013, National Health Service England calculated that it faced a funding gap of £30billion by the end of the decade, even if government spending kept up in line with inflation. So, it needed that much more to deliver care to a growing and ageing population, assuming it made no savings itself.

In 2014, National Health Service England laid out plans for how it might handle this gap. One ambitious option was that the National Health Service itself would find £22billion in savings, leaving the other £8billion to be filled by the government. In 2015 the government committed itself to finding the additional £8billion of funding. In practice, they have increased the health budget by £8billion and have reduced the public health budget by £2billion thus enabling them to increase the budget for the National Health Service by £10billion.

Some commentators were sceptical about whether the £8billion would be sufficient. The Nuffield Trust, for example, commented that:

"£8billion is the bare minimum to maintain existing standards of care for a growing and ageing population … improving productivity on this scale (£22billion) would be unprecedented"

The Head of National Health Service England, Simon Stevens, told the Public Accounts Committee of MPs recently that:

"It's right that by 2020 National Health Service England will be getting an extra £10billion over the course of six years. I don't think that's the same as saying we're getting more than we asked for over five years because it was a five year forward view… not a six year forward view. And over and above that we've obviously had a spending review negotiation in the meantime and that has set the National Health Service budget for the next three years. It's a matter of fact ... that like probably every part of the public service, we got less that we asked for in that process. And so I think it would be stretching it to say that the National Health Service has got more than it asked for."

However, some people argue that this analysis based on increasing demand and constrained resources is too simplistic. For example, Professor John Seddon of Buckingham University Business School told the twelfth annual health conference in Dublin in February 2016 that:

"When we established the health service, back in the 1940s, a lot of the demands that it was designed to service were things like acute infections, accidents, people who needed surgery. Let's call this 'fix me' demand.

"When you study demand today, you find as much as 85% of demand into the health service also includes what we might call 'help me' demand. 85% of the demand is both help me and fix me. By 'help me' I mean psycho-social, contextual, issues; things like obesity, drugs, family breakdown, and so on.

"When you take a big picture approach to understanding what is happening to demand, you learn that in hospitals 5% of the patients consume as much as 54% of the unscheduled beds. In General Practitioners' surgeries, 8% of the patients consume as much as 40% of the General Practitioner's resource. Now commissioners sit above this and they're excited about the fact they're reducing unit costs, but worried about the fact that the volume of activity is always rising – they can't see what's going on. Managers… they're looking at their targets and they're meeting their ambulance targets, their Accident & Emergency targets, their waiting times; they see unit costs going down, they see length of stay going down and in their world; if they're using the RAG status, everything is Green.

"But when you study these systems at the level of individuals going through them, which you must, you learn that the truth is the world isn't Green, its Red… So, for example, you find one person over 63 days, had eight visits to Accident & Emergency, six days in hospital consuming 44 nights, had thirteen tests, 32 assessments, including nine disciplines. Managers can't see that.

"They can't see the big picture. The Accident & Emergency target drives more demand into hospitals. It's interesting when you study it that 52% of people being sent through to hospitals from Accident & Emergency occur in the last ten minutes of the Accident & Emergency four hour target and most of these people stay for fewer than three days.

"In the National Health Service managers are obsessed with improvement. We've had more improvement activities in the National Health Service in the last 35 years than you can shake a stick at. Managers spend their time reviewing their processes and pathways; trying to reduce their activity, because they think activity is all about cost. It's a mistake. You know, if your processes and your pathways are full of failure demand this is not going to improve anything. They worry about standardising activity. Well that will stop the system absorbing variety, so that'll create more failure demand. They employ strategies and tactics for getting rid of 'bed blockers' as they call them. It is absolutely the wrong thing to do; it will ensure people are sent away for the wrong reason.

"Let me tell you of an example of how to dissolve this so-called problem. Working in stroke care, leaders studied demand to understand peoples' need and context, understand the things that I talked about before. If you design the right service for every individual that comes into stroke care the consequences are that the service improves and the costs of stroke care fall – they were halved in this case – and the number of beds utilised dropped by 30%. There's the story you see: effectiveness means managing value; doing the right thing for the patient; not managing cost.

"Another example of managing cost is that managers are obsessed with passing doctors work to nurses and nurses work to technicians."

For some commentators therefore, the management model in the National Health Service exacerbates the problems by taking a top-down approach and focusing on commissioning and targets rather than on patients and outcomes.

Integration with Public Health and Adult Social Care

The need to 'join-up' National Health Service, Public Health and Adult Social Care services has been generally accepted for some time. Public Health and Adult Social Care are both the responsibility of local government.

When I was the Social Services Accountant at Newcastle-on-Tyne City Council in the 1980s this issue was recognised. However, progress has been slow and the issue now needs to be addressed with greater urgency.

In addition, since 2010 there have been significant reductions in local government budgets including those for Public Health and Adult Social Care.

Adult Social Care services faces serious financial challenges. These are well documented. They include demographic change; a lack of funding; and a lack of joined-up thinking and working.

In my work as an Associate Consultant with the Local Government Association I often encounter local authorities that are having to reduce Adult Social Care budgets despite increasing need because of budget pressures; and authorities that struggle to achieve planned savings or to operate within approved budgets.

Following the Autumn Statement in November 2016, the Local Government Association said that:

"Councils, the National Health Service, charities and care providers have been clear about the desperate need for the Chancellor to take action to tackle the funding crisis in adult social care. It is unacceptable that this has not been addressed in the Autumn Statement. The Government must take urgent action to properly fund social care if councils are to stand any chance of protecting the services which care for the elderly and vulnerable.

"Extra council tax raising powers will not bring in enough money to alleviate the pressure on social care and councils will not receive the vast majority of new funding in the Better Care Fund until the end of the decade. Services supporting elderly and vulnerable people are at breaking point now. We cannot ignore this challenge any longer and the Government must inject genuinely new additional funding."

Recent reports have identified that the private and voluntary sectors are also at risk. A recent analysis of the accounts of 6,158 private care home providers (that between them provide 96% of the care homes in the United Kingdom) found that 28% of them had potential problems with financial viability while 12% of them had liabilities that exceeded their assets.

Challenges for the National Health Service

There are some further challenges that the National Health Service is likely to face over the next few years.

Brexit and International Relations

The current position of health services in the European Union was recently summarised in 'The New European' by Martin McKee, Professor of European Public Health at the London School of Hygiene and Tropical Medicine as follows:

"The relationship between national health systems in the European Union has always been complex. In the treaties, European governments have jealously guarded their national sovereignty, reserving the right to organise health care in the way that they chose. Yet. Almost everything that is needed to deliver a modern healthcare system whether it be the health workers, the medicines and equipment, or the research that underpins clinical decisions is subject to European Union law.

"Over the past forty years, enormous progress has been made on developing shared approaches, and in particular, regulatory systems, that will take decades to disentangle. Many of these deal with the incredibly complex issues, requiring scarce, highly skilled expertise, that will be impossible to replicate at a national level."

During the referendum on Britain's future membership of the European Union in June 2016, it was claimed that if Britain left the European Union an additional £350million a week would become available for the National Health Service. The government has since confirmed that this will not be the case.

At the time of the referendum, opinion polls showed that most voters thought that Britain leaving the European Union would benefit the National Health Service, but at the same time, according to the April-May 2016 survey by National Health Service providers, 75% of National Health Service hospital leaders thought that Brexit would be bad for the National Health Service.

The European Medicines Agency is currently based in London but will relocate to one of the countries that will remain in the European Union. There are fears that Britain will become less engaged with medical innovation and research; and that new medicines will not be available in the United Kingdom as promptly as they will be in the European Union. The European Investment Bank has provided more than 3.5billion Euros in low interest funding to the National Health Service during recent years and this source of funding will cease in 2019. At present, medical equipment moves freely around the European Union under the rules of the Single Market that the British government is committed to leaving.

During the referendum campaign, it was claimed that the Transatlantic Trade and Investment Partnership agreement that had been negotiated between the European Union and the United States of America under President Barack Obama was a potential threat to the National Health Service as it would oblige European Union states to open health services up to competition; but in practice it would have been possible for European states to insulate their health services.

However, the election of Donald Trump as President of the United States of America led to the abandonment of the Transatlantic Trade and Investment Partnership and the promise of a bi-lateral deal between the United Kingdom and the United States of America. There are fears that pharmaceutical and healthcare corporations in the United States would wish to use such a deal to gain access to the United Kingdom health care market and that the United Kingdom government may be either unwilling or unable to resist such demands.

The unravelling of current arrangements and their replacement with new arrangements may present opportunities for the National Health Service but they also present serious threats and represent a significant challenge.

Inflation and Supplies from outside the United Kingdom

Half the products used in the National Health Service come from outside the United Kingdom. Since June 2016 the value of sterling has fallen by 20% resulting in a 20% increase in the cost of those products. It has been calculated that this will increase the costs to the National Health Service by £900million a year. The National Institute of Economic & Social Research is forecasting that inflation will increase to 4% during 2017. This will also increase the costs of the National Health Service. No additional funding was made available to the National Health Service in the Autumn Statement of November 2016.

Furthermore, some products are specialised and regulated. For example, the United Kingdom imports most of its medical isotopes under the provisions of the Euratom Treaty. If Britain is to withdraw from this treaty, alternative arrangements will be required that may be associated with a higher cost.

Recruitment and Retention

There are many reports of difficulties with recruitment and retention of staff in the National Health Service. It is reported that more nurses are leaving the service than are joining and that the problem is especially acute with nurses of European Union origin who are reported to be leaving in large numbers because of ‘Brexit’.

Commenting on recent statistics, Janet Davies, Chief Executive and General Secretary at the Royal College of Nursing, told 'Public Finance' that:

"These figures are the starkest warning yet that nurses have put up with too much for too long. Our members have had enough, and as a result the profession is shrinking."

She said the average nurse was now £3,000 worse off in real terms compared to 2010 and urged the government to lift the public sector pay cap.

The recent consultation paper by the Cumbria Partnership National Health Service Foundation Trust refers to:

"Difficulty… in recruiting enough hospital consultants, junior doctors, general practitioners, nurses, paramedics and therapists who are willing to live and work in West, North and East Cumbria… We face staff shortages in primary care, community care and in hospital care too. This means we need to use locums and agency staff which is very expensive and leads to a loss of continuity of care… In 2015 the Care Quality Commission judged general medical services at West Cumberland Hospital to be inadequate. This was largely due to the workforce difficulties."

The public sector pay cap was first introduced as a pay freeze by the former coalition government and was then 'relaxed' to a 1% pay cap. As a result, while private sector pay has now recovered to 2008 levels, public sector pay is lagging. Furthermore, with inflation predicted to increase to 4%, the retention of the 1% pay cap this year would represent a real term pay reduction of 3% for all public-sector workers. With the government having just lost its majority partly due to concerns about austerity, with many public services reporting difficulties with recruitment and retention, and with recent terror attacks and the fire at Grenfell Tower focusing public attention on the valuable contribution made by public sector workers, the government may be preparing for a change of direction. It appears that it may accept pay increases in the public sector of more than 1% where this is recommended by pay review bodies. If the government allows a relaxation of the pay cap in the National Health Service it would presumably provide the funding, if it didn't then there would be significant additional pressure on budgets.

It is well documented that the National Health Service relies heavily on staff from outside the United Kingdom. 60,000 non-British European Union citizens currently work in Health and a further 75,000 work in Adult Social Care in the United Kingdom. In view of the government's intention to leave the European Union and to reduce migration the problem of finding sufficient numbers of appropriate staff are likely to increase. It has already been reported that there has been a 92% reduction in the number of European Union citizens registering as nurses in England from July to December 2016. A poll by the General Medical Council found that 60% of European Union doctors in the United Kingdom are considering leaving with 91% saying that Brexit is a factor.

A leaked government report in March 2017 predicted a staff shortage of 26,000 to 42,000 by 2025. Staff shortages would be likely to lead to increased costs and an inability to meet needs.

Conclusions

The following facts appear to me to be relevant:

- The United Kingdom spends a lower proportion of its gross domestic product on health services than most developed countries. The United Kingdom spends about 8%. France, Germany, the Netherlands and Sweden are among those that spend over 10%.

- All major political parties in the United Kingdom claim to be committed supporters of the National Health Service.
- The financial pressures on the National Health Service caused by demographics, increasing costs and financial constraints are well understood, not only by health professionals but also by politicians and the public; although it may be that these pressures are exacerbated by the current approach to management.
- Evidence from opinion polling and actual voting shows that the public favour increased expenditure on the National Health Service.

I find it difficult to reconcile these facts with the fact that successive governments have allowed the financial problems to develop that are described in this briefing paper. And there are a lot of additional challenges ahead because of the decision for the United Kingdom to leave the European Union.

There is some evidence that improvements could be made in the management of the National Health service both generally and by improving joint working with partners such as local authorities and housing associations. There is also evidence that much of the 'demand' that the National Health Service struggles to meet is actually 'failure demand' – that is, demands that are made by patients because their needs were not met at the first point of contact.

However, the level of resources remains the main issue. An effective National Health Service needs to be adequately resourced.

Adrian Waite
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