CIPFA The Chartered Institute of Public Finance & Accountancy

more medicine needed

the health of health finances revisited

INSIGHTS

for public financial management

Contents

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At CIPFA he supports the work of the Health and Integration Faculty, taking forward our involvement in current developments such as integration between health and social care, and the Future-Focused Finance initiative in the NHS.

summary

The conclusion in CIPFA's briefing *The Health of Health Finances*[1] was that additional upfront funding and new approaches would be needed if the NHS is to deliver the NHS *Five Year Forward View*.[2] The Government recognised the issues but gave only limited additional financial support in the November 2015 Comprehensive Spending Review (CSR). Policy developments, notably around integration and devolution, are promising but their benefits are likely to impact only in the medium to long term, leaving worrying gaps in the short to medium term. In *More Medicine Needed* CIPFA examines the position now, and asks: what more needs to be done?

CIPFA believes there will be a shortfall in the NHS budget of at least £5bn, quite likely £10bn, and in the worst case as much as £16bn by 2020. In the light of further analysis and events since the election, we estimate that the pressures on health services are now in the range £35-40bn and the savings achieved will be in the range £16-22bn. The Government's assessment is of £30bn pressures against a £22bn target for savings, with £8bn promised in the 2015 CSR to fill the gap. CIPFA believes there will be an additional gap of £5-16bn.

The front-loading of promised financial support in 2016/17 and the £1.5bn planned increases in the Better Care Fund are welcome, but too modest. The effect of the Government's actions will be to maintain the short-term year-on-year mentality evident in the Department of Health's responses to the projected NHS overspends of 2015/16. Against that background, CIPFA believes that there is a leadership challenge as much as a financial challenge, and concludes that:

- New methods of prioritisation will be needed if the necessary savings are to be made without affecting services unacceptably. The Government has acknowledged that fewer older people are now receiving social care services despite the increasing number of older people: can an equivalent approach be applied in health? That might, for example, include the acceptance of rationing the NHS offer in some areas, or moving spend between parts of the system.
- The *Five Year Forward View* is based on predicted pressures of £30bn. CIPFA feels more analysis and honest assessment is needed to update and address this figure. We would also like to see an assessment of the comparative phasing of pressures and planned savings. CIPFA believes both that the £30bn assessment is understated, and that the NHS will be unable to react fast enough in the early years to achieve the productivity gains which will be required to hit even the £22bn target.[3]
- The Government should increase public health budgets and set aside more funds to encourage long-term investments which will generate savings in the future without undermining the short term position. As this spending would add future value, it would make sense to allow this investment to be funded by borrowing or a bespoke tax.
- The frontloading of NHS support in the 2015 CSR has not changed the underlying position: it will be necessary either to add further to the NHS budget, charge users more, or reduce services. To choose none of those is not a realistic option.
- Perhaps the most fundamental question of all should be: what should the Government be providing in terms of public services, and should it prioritise health above others?

1 *The Health of Health Finances*, August 2015, www.cipfa.org/cipfa-thinks/briefings
2 NHS *Five Year Forward View*, www.England.nhs.uk/ourwork/futurenhs
3 Details of the NHS's savings plans were presented to the House of Commons Select Committee on 9 May 2016 – see NHS Five Year Forward View Recap briefing for the Health Select Committee on technical modelling and scenarios, www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf. That paper provided substantial new information but did not change CIPFA's overall assessment – see page 16-17.

Setting up a commission

It is vital that the coming financial shortfall is addressed in the right way as part of the realistic long-term planning which should form the core of the Government's thinking. Accordingly CIPFA calls on the Government to set up an independent commission[4] which starts from the consensus that fundamental questions need to be asked of how the NHS can be adequately funded in the long term, and seriously examines the alternative options. CIPFA suggests the commission would have two key tasks:

- To recommend a 'golden ratio' for health and social care spending, for example setting it at 10% of gross domestic product (GDP)[5], so that its national importance is recognised in long-term planning by giving it the same status as already afforded to foreign aid. A figure of 10% (compared with the EU average of 10% for health only) would recognise the added value already obtained from what is a comparatively efficient system. It may be that a subsidiary ratio could also be set for the proportion of spend to be invested for long-term benefit.
- To recommend the best means, however radical, of ensuring that the spending implied by such a 'golden ratio' is adequately funded. Examples of matters to consider would be the role of charging or co-payment (for revenue raising and incentive aspects), opportunities for bespoke taxes (along the lines of the 'Sugar Tax', announced in March 2016), freedom for providers to seek services in the market, and possible means of raising additional investment funds (eg a more liberal approach to use of capital receipts, bonds or prudential borrowing for health purposes).

4 This would in large measure constitute a government follow-on from the work of the Commission on the Future of Health and Social Care in England. Its findings, known as the Barker Report, published in 2014, came to conclusions which remain highly relevant. See www.kingsfund.org.uk/publications/new-settlement-health-and-social-care

5 The Barker Report recommended that 'the Government should plan on the basis that public spending on heath and social care will reach between 11 and 12% of GDP by 2025' without recommending 'golden ratio' as such. A figure of 10% reflects the new reality that health and social care spending is set to fall to 8% of GDP under current government plans.

\ introduction

Much has happened, but has anything really changed since CIPFA published *The Health of Health Finances* in August 2015? In that briefing we concluded that the health system was not sustainable under existing plans, and by the time of the Comprehensive Spending Review in October 2015, CIPFA's assessment had become something of a consensus. There was comparable analysis emerging from the King's Fund, Health Foundation and Nuffield Trust. Our recommendations on what the Government should do (alongside what has happened since) were as follows:

- The Better Care Fund (BCF) must continue in order to prevent the knock-on effects on health services of a failure to invest in social care. *The Government has now committed to continuing with the BCF for the remainder of this Parliament*.
- The Government should set aside invest to save funding in order to make the upfront investments which will save in the future without undermining the short-term position. *The necessity for this continues to be recognised in Government policy documents, and the frontloading of the £8bn announced in the spending review was partly designed to enable this. Yet without additional money, it looks likely that commitment will be diverted almost entirely into solving the current overspending of providers.*
- It will be necessary either to add further to the NHS budget, introduce charges for more services, or reduce services. To choose none of those is not a realistic option. *The Government did commit to frontloading the £8bn addition which had already been identified. There is as yet no evidence of the alternatives of charging users or reducing services being seriously considered.*
- A clear answer is needed to perhaps the most fundamental question of all: what should the Government be providing in terms of public services, and should it prioritise health above others? *There is no sign of any change in thinking, conversely there is an expectation that the healthcare needs of a growing, ageing population can be funded from a diminishing share of GDP – in the context of the Government seeking to reduce the tax burden.*

In our previous report CIPFA recommended that those matters were addressed in the right way as part of the realistic long-term planning and that they should form the core of the Government's Comprehensive Spending Review. *The issues were recognised in the review, but the question remains: did the actions taken amount to short-term fix or a substantive longer term answer?*

Three major recent developments directly affect NHS finances:

- the Comprehensive Spending Review (and the detailed guidance)
- growing pressure on the NHS in 2015/16, with a £2.8bn overspend across providers
- the publication of Lord Carter's review of NHS cost savings in February 2016.[6] The report gave recommendations on how a model hospital should operate, and set out how £5bn of savings could be made by 2021 if the service worked together.

There's no doubt about the mounting pressures on the NHS, due to demographic, medical and economic factors. Against that background this report summarises and refreshes the underlying issues, and then asks three key questions:

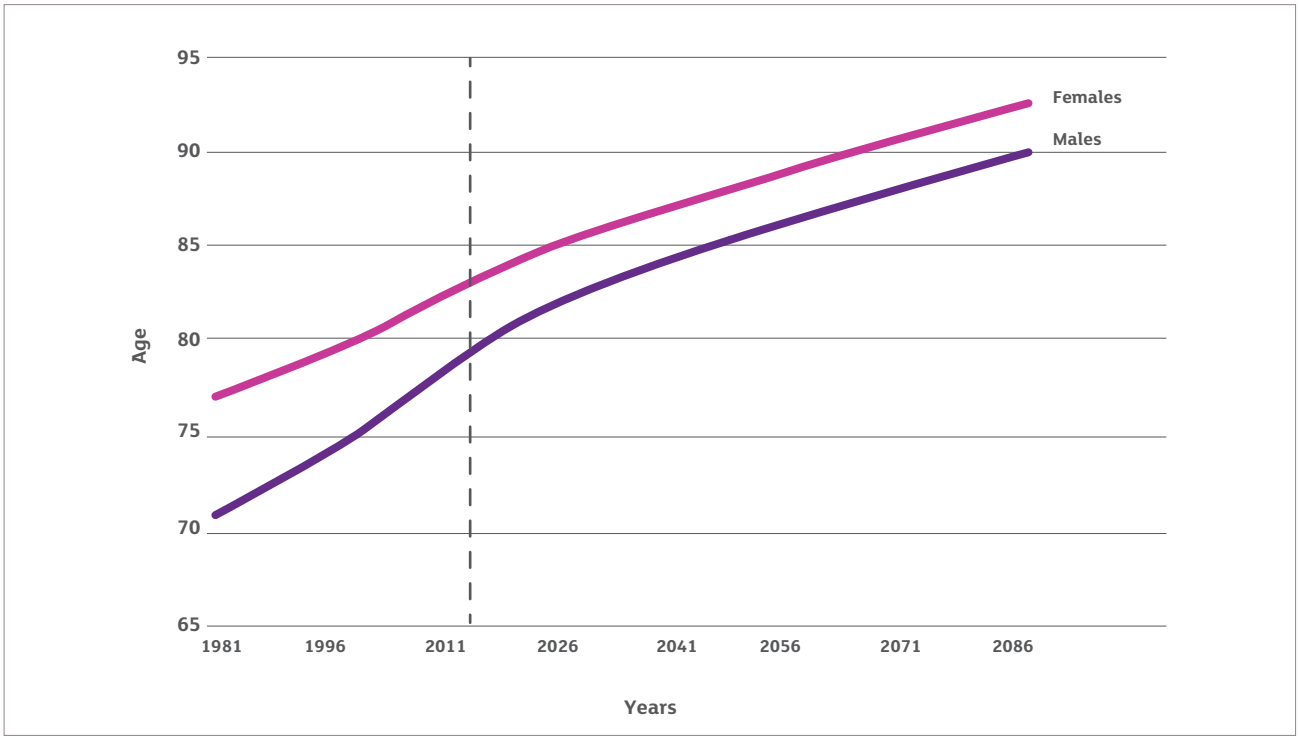
- Are the current savings targets sufficient?
- How realistic are the chances of delivering the necessary savings?
- If they are not realistic, what are the alternatives?

6 *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* at www.gov.uk/government/news/review-shows-how-nhs-hospitals-can-save-money-and-improve-care

refreshing the issues

Public spending will be cut by 10% between 2010 and 2020. The pressure on public spending is obvious enough and there is widespread acknowledgement across political parties, media and professions that the health service faces unprecedented financial challenges, despite its relative protection from cuts in previous spending reviews.

Changes in average life expectancy



The key demographic trend: source Office for National Statistics

Health spending has grown steadily in real terms and as a proportion of GDP since the war, but as the NHS *Five Year Forward View* puts it:

'Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century'.

NHS spending was comparatively protected in the previous parliament, so that it rose on average 0.9% per year over the five years. On one hand this contrasted with the 40% reduction in central government support for local government[7], but on the other it does represent a much tougher position than the NHS has previously faced, especially given the backdrop of a growing and ageing population.

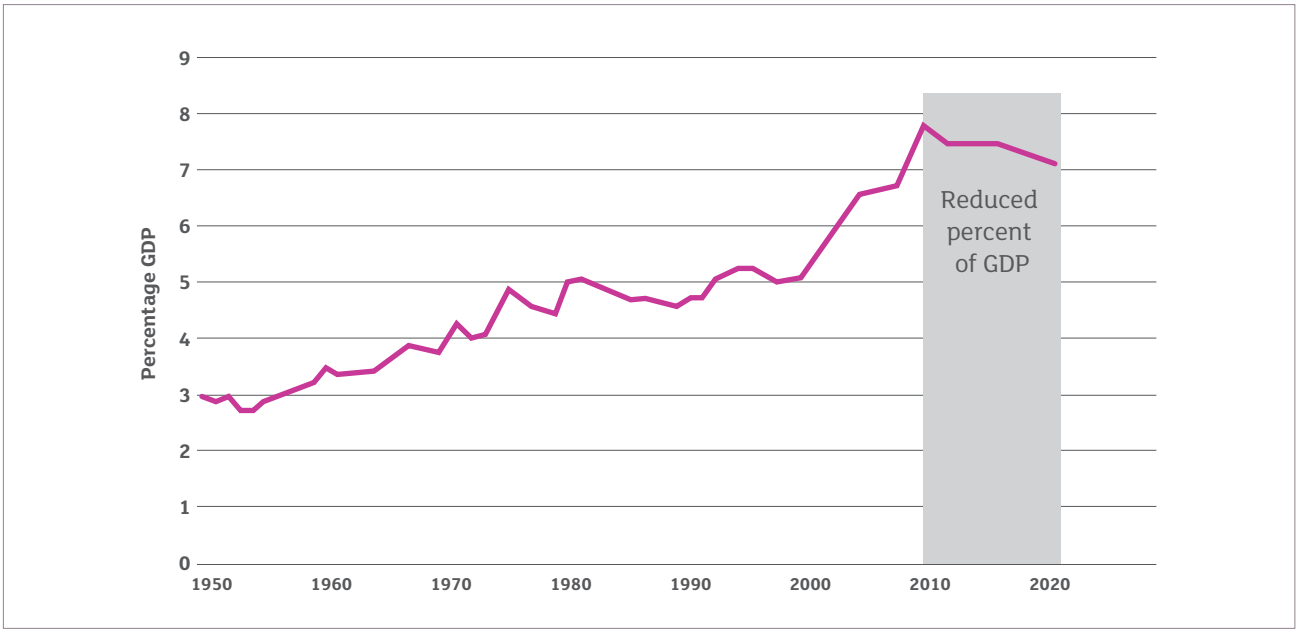
7 See for example the Independent Commission on Local Government, Feb 2015 at www.cipfa.org/iclgf-home

The 2015 Comprehensive Spending Review maintained protection for the NHS, but fell short of previous growth levels, and with much tougher deals for local government, and a reduction in some of the wider expenditure, notably on public health, which helps the NHS.

The real terms £8.4m increase for the NHS is equivalent to 1.3% per year on average compared with a long-run average of 3.7% since 1950. That doesn't, of course, indicate that demand is expected to increase more slowly than has been the case historically, but that offsetting savings will be more than the historic average: 3.4% rather than 1%.[8] Health Foundation analysis issued in March 2016 shows that while the NHS did improve its productivity in the early years of the last parliament, 'performance has now tailed off sharply and the crude productivity of hospitals has gone backwards over the last two years'.[9]

Analysis from the King's Fund, illustrated in the graph below, shows how the decade from 2010 to 2020 will see the largest sustained fall in NHS spending as a share of GDP since the service was formed:[10]

UK NHS spending as a percentage of GDP, 1951–2021



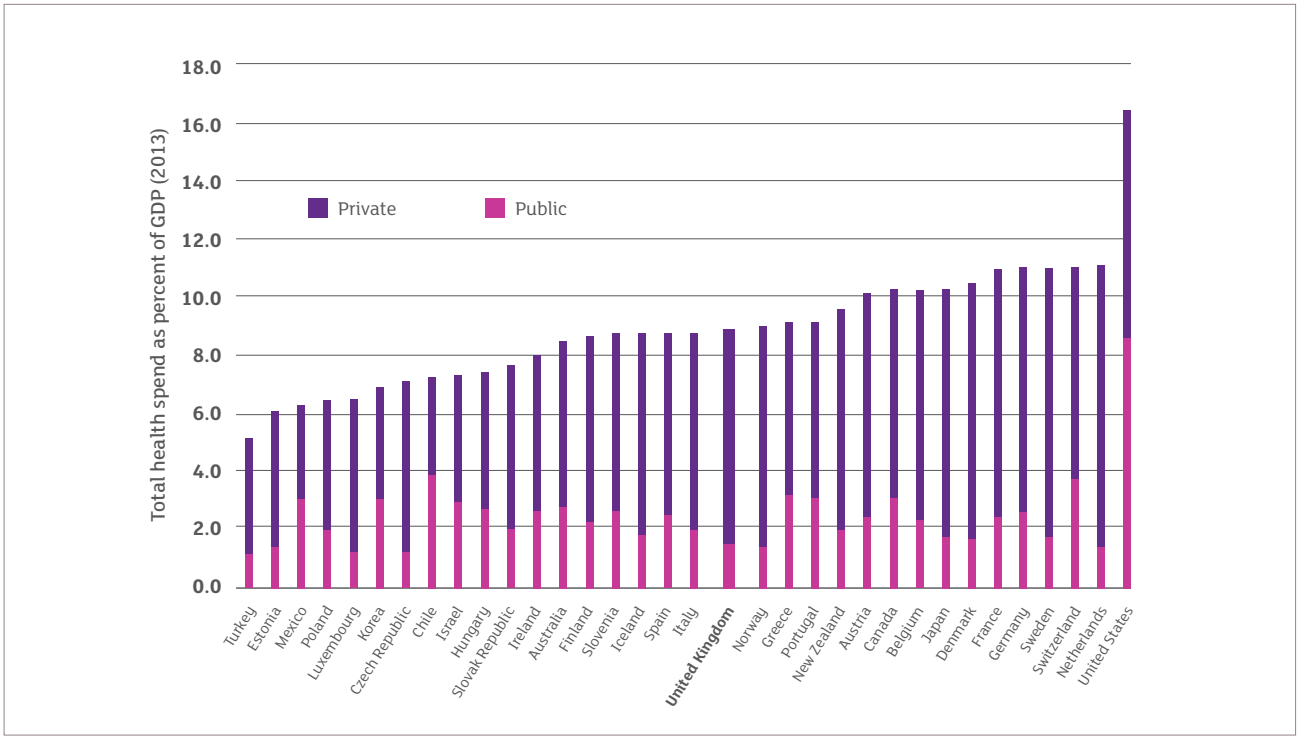
Health spending in the UK accounts for a lower proportion of the GDP than in most countries of comparable wealth. The Barker Report[11], in setting an ambition for 11% of GDP to be spent on health and social care by 2025, puts that in the context of 'the 18% of GDP that the United States spends on health alone. It also compares to 11.2% spent by Canada, the 11.6% spent by France or the 11.9% spent by the Netherlands.

8 The Health Foundation summarises the various assessments made of NHS productivity gains on page 23 of Filling the gap: tax and fiscal options for a sustainable UK health and social care system, 2015, www.health.org.uk/publication/filling-gap#sthash.nX2ppJdQ.dpuf

9 The Health Foundation: *A perfect storm: an impossible climate for NHS providers' finances?* assesses average hospital productivity gains at 0.4% annually in recent years - www.health.org.uk/publication/perfect-storm-impossible-climate-nhs-providers%E2%80%99-finances?dm_i=4Y2,42IVF,LX1YJE,EQQP6,1#sthash.Dm6y7Vkh.dpuf

10 John Appleby: 'NHS spending: squeezed as never before' at www.kingsfund.org.uk/blog/2015/10/nhs-spending-squeezed-never

11 A new settlement for health and social care, King's Fund, 2014 - see www.kingsfund.org.uk/publications/new-settlement-health-and-social-care



Source: King's Fund analysis of OECD Health Data 2015[12]

This downward trend is set to continue under current plans, as the rate of GDP growth is forecast to be greater than the rate of growth in health spending[13], resulting in health spend below 7% of GDP by 2021. It isn't surprising that the current plan looks so challenging, given the ambition to reverse the post-war experience that demographic trends, medical advances and citizens' expectations have driven a remorseless increase in the percentage of GDP spend on health. Whether or not that is a desirable ambition, it is unlikely to be achieved without action far more radical than anything currently envisaged by the Government and planned by the NHS leadership.

Evidence of pressure

One would expect such trends to generate financial pressure in the system and the position has worsened steadily in recent years.[14]

Figures announced for the period to the end of December 2015 showed that NHS providers incurred deficits totalling £2.3m in the first three quarters of the year 2015/16 making it likely that the year-end position would be an overspend in the order of £3bn.[15] This represented the worst quarterly performance since 2013, particularly when combined with deteriorating clinical performance such as 9% of patients waiting longer than four hours in A&E. The main clinical target that fewer than 8% of patients should still be waiting to be seen after 18 weeks was breached in quarter three for the first time since its introduction.

12 www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-care-spending-compared

13 The Health Foundation suggests that fully funding its estimate of cost pressures on the NHS through to 2030/31 estimated at £9bn, would still mean that 'in 2030/31, the UK would be spending a smaller share of its GDP on publicly funded health care than countries such as Germany, France, Denmark, Sweden and the Netherlands were spending in 2012', www.health.org.uk/publication/filling-gap#sthash.nX2ppJdQ.dpuf

14 See *The Health of Health Finances* for more details at www.cipfa.org/cipfa-thinks/health

15 Chris Hopson argued in the *Health Service Journal* in March 2016, that 'the real provider sector deficit, after central financial support, capital/revenue transfers and balance sheet adjustments, is nearer £4bn than £3bn'.

Unsurprisingly, the February 2016 quarterly survey of finance directors by the King's Fund showed considerable concern and was the first such to indicate that a majority (53%) of trust finance directors felt that quality of care had worsened over the past year – the financial pressure is starting to tell on the front line.[16]

Commissioning bodies have historically found it easier to balance their budgets, but the clinical commissioning Groups (CCG) are relatively new bodies and they face some difficult challenges:

- The tariff system, which pays providers according to the volume and type of medical procedures they carry out, naturally encourages increases in provider activity. Unless capacity is reduced, action to reduce spend in one area is likely to lead to additional demand being met in another.
- CCGs are typically small, with less ability to spread risk than their predecessor, primary care trusts.
- The BCF is principally funded from CCGs, which have effectively invested £1.9bn from national 2015/16 allocations with no guarantee of comparable savings in their own budgets, even if savings are achieved in the indicated timescales across the system as a whole. There will be £1.5bn of additional funding for the BCF which is not from CCGs, but this will be phased in slowly. There will be nothing in 2016/17 and only £0.1bn in 2017/18.

The difficult long-term position for providers can be attributed to three main factors:

- Increased staff costs in response to safety concerns – both for permanent and temporary staff. There was a 1% increase in nurses in 2013/14 and spending on temporary staff grew sharply from £3.6bn in 2012/13 to £4.6bn in 2013/14. In the provider sector alone, £3.3bn was spent in 2014/15, more than double the planned total. Between 2011/12 and 2014/15, the number of permanent full time equivalent staff employed rose by 0.8%, but the total staff costs rose by 1.3%.[17]
- Reductions in the value of the tariff compared with the cost of delivering services. Tariff prices were not inflated between 2009/10 and 2015/16, leaving provider efficiencies to cover inflation, which has not proved fully possible. The 1.1% tariff increase in 2016/17 (which represents 3.1% cost pressures less a 2% efficiency requirement) is much closer to the levels which the NHS has been able to deliver, though this may simply transfer pressure to commissioners.
- A focus on short-term cost savings and a lack of progress on more transformational change. Providers are finding it increasingly difficult to realise planned savings and managing cuts in budgets has seen an over-reliance on pay restraint, administrative cost savings and reductions in the tariff payments to hospitals while 'progress on more fundamental change has been slower than planned – and required'.[18]

Paul Baumann, NHS England CFO, has given assurance that the provider sector was committed to ensuring its deficit will not exceed £1.8bn but the underlying position confirms the increasing pressure on the NHS. This leads in turn to three concerns:

1. A return to centralised control. In a bid to resolve the immediate funding crisis, NHS regulators have stepped in to limit the freedoms enjoyed by organisations such as foundation trusts. Organisational control totals have been issued with CFOs and boards being put under significant pressure to achieve their share of the overall NHS position. Whilst this may well be the only tenable response in the short term, it is many miles from the *Five Year Forward View*'s vision of a devolved NHS. Centralised control harks back to a system which will struggle to generate the local ownership of investment for the future which is required for the long term.

2. Trouble is being stored up. Not only might unsustainable rates of spend be carried forward to 2016/17, but all the available one-off measures to help manage the expenditure position will be called into play during 2015/16 and so be unavailable in future. An increasing number of providers have taken out loans for day-to-day expenditure such as salaries. This will be their last roll of the dice, because if the loans cannot be repaid this will lead to further problems.

16 King's Fund Quarterly Monitoring Report: http://qmr.kingsfund.org.uk/2016/18/

17 *A perfect storm: an impossible climate for NHS providers' finances?* Health Foundation, March 2016 at www.health.org.uk/publication/perfect-storm-impossible-climate-nhs-providers%E2%80%99-finances

18 Health Foundation – *NHS Finances – The challenge all political parties need to face* at www.health.org.uk/publication/nhs-finances-challenge-all-political-parties-need-face

3. Thinking short term. In effect, the extra resources frontloaded in 2016/17 are already being spent and the NHS risks slipping back into the short term mentality which the *Five Year Forward View* sought to move beyond. This will leave nothing for the preventative and transformative investments which are needed to secure services in the long run.

In February 2016 Monitor stated, correctly, that 'the solutions to today's problems lie in a radical upgrade of prevention and new models of service delivery'. Unfortunately this is at odds with the current reality of central control, short-term borrowing and money already committed elsewhere. It all points to the need to take radical action to ensure that invest to save planning can occur.

The 2015 Comprehensive Spending Review

Ahead of the October 2015 Comprehensive Spending Review NHS Chief Executive Simon Stevens flagged five key requests of future health funding settlements:

- Front-loaded investment in transformation
- new requirements from the NHS to be consistent with phasing of the new investment
- continuing political support for the set of efficiencies required
- investment and funding protection for social care services
- make good on the public health opportunity.

The first three requests were broadly delivered in the comprehensive spending review although doubts remain about the protection to social care services and the ongoing effects to public health services.[19] [20]

The Nuffield Trust summarised the position as follows:[21]

- The underlying NHS provider deficit (in excess of £2bn) is structural and will take at least five years to clear at the rate of change currently projected.
- Balancing provider deficits in the meantime will cost in the region of £6bn over those five years. These are funds which will not be available for 'service change'.
- As a result of the need to balance provider deficits, additional funds for 'transformation' will not be front-loaded but will instead be back-loaded, reducing scope for significant investment and change by the end of the spending review period.
- The last NHS efficiency drive to save £20bn a year by 2015 relied heavily on extracting efficiencies from the provider sector and pay restraint. The opportunities to extract further efficiencies in these ways are now limited.
- There are now signs that financial restraints may be undermining care quality and access.

19 Funding for public provision for adult social care fell in real terms by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly funded social care. Following the CSR in 2015, public funding for adult social care is planned to rise by an average of 0.6% per year in real terms between 2015/16 and 2019/20, as against expected demand pressures of 4% per year.

20 9% reduction over the CSR period.

21 Supplementary written evidence submitted by the Nuffield Trust to the Health Select Committee enquiry on the Impact of Comprehensive Spending Review on health and social care, March 2016.

delivering the savings

In the *Five Year Forward View,* Simon Stevens suggested that we should expect £30bn of pressures by 2020/21, dealt with by £22bn of savings and £8bn of additional funding. In *The Heath of Health Finances* CIPFA suggested that the £30bn looked like a fair assessment of expected pressures as at 2014, but that there was little to show that £22bn could be generated in the timescales required. What does that balance look like now?

Two questions are relevant here:

Will £22bn of savings be enough, or have pressures increased beyond £30bn?

Can savings of £22bn (or more) be made?

What needs to be saved?

The figure for the additional pressures was based on demographic factors and the potential need to fund medical advances, but did not include the additional pressures which have built up since 2014. CIPFA estimates those additional pressures to be up to £10bn:

Updating the balance (eventual annual position by 2020/21)

Pressures on spending	£bn
b/f pressures already allowed for in *Five Year Forward View*	30
Seven day working and support to doctors	1
Additional commitment to mental health	1
Pension contributions	1
Effect of current deficits in system	3
Knock-on effects from non-NHS cuts	2
Extra invest to save	2
Maximum total pressures if *Five Year Forward View* to be delivered in full	**40**

Funding position	£bn
Currently declared savings targets	22
Current additional resources in CSR	8
Source to be identified	10
Total	**40**

Some of the pressures remain unclear and so overall a range of £35-40bn makes sense. CIPFA suggests it would be prudent to plan on the basis that pressures will be at least £35m and could rise to £40bn.

The *NHS Five Year Forward View Recap briefing* states that the £30bn estimate of pressures doesn't factor in additional costs 'not known about as of October 2014'. In the absence of any update, the effect is that current NHS plans make no allowance for the following factors:

Seven day working and support to doctors: the shift to seven day working was announced in July 2015. This could be very expensive to implement, depending on how full the coverage is, and the level of additional payments are needed to deliver ongoing shift patterns in the wake of the junior doctor dispute. The Comprehensive Spending Review suggested that the manifesto commitment would be delivered slowly, not across all parts of the system, and mostly within current resources. In April 2016, Simon Stevens announced allocation of an additional £2.4bn to doctors, but that was from within existing NHS resources and came with the expectation of service improvements requiring extra spend. Overall, an extra £1bn of unfunded pressures appears a modest assessment. This is broadly consistent with HFMA's analysis of eight providers which concluded that net costs of the seven day week are likely to be in the range 1-2% of total provider income (which would equate to £0.75–1.5bn).[22]

Additional commitment to mental health: following on from the report of its mental health taskforce, the Government announced in February 2016 that an additional £1bn would be spent on mental health by 2020/21, but there was no additional money available to enable the NHS to meet the pledge. The extent to which this commitment will increase the pressure therefore remains unclear.

Pensions: changes in the arrangements for employer National Insurance contributions and the 2016 budget announcement reducing the discount rate for public sector pensions will cost the NHS at least an additional £1bn annually.

Current deficits in the system: the Government has explicitly earmarked £1.8bn of the £3.8bn growth in 2016/17 to deal with ongoing provider deficits – but the total pressure (effectively reducing the net savings available in the system) is £2.8bn.

Knock-on effects from non-NHS cuts: The main areas of indirect or preventative support to the NHS – public health (see above), social care, housing, and the benefits system – are faced by reductions in funding:

- The specific grant for public health reduces by 9% between 2016 and 2021 which will add to the longer term pressures on the NHS.
- Given that Lord Carter claimed that £1bn could be saved by unblocking inappropriately occupied hospital beds, the most immediate problems are likely to arise from reduced support of social care services. Core support for local government through government grants and business rates will be reduced by 24% between 2016 and 2021. With social care accounting for 30% of local government spend, an impact is inevitable. Even if all councils take up the option of increasing council tax by 2% specifically to support social care that would probably fund only the additional costs of the Living Wage.
- Housing budgets – another contributor to health issues – will also be constrained.
- There also continues to be a strong emphasis on welfare reform savings, which may well have knock-on impacts for health and social care if it makes individuals worse off financially. Welfare savings are due to contribute £12bn of the £17bn additional consolidation announced in summer 2015.

The assessment of the £30bn pressures did not allow for upfront investment in transformation and prevention. Only £200m of the frontloaded support will be available to help with transformational change in 2016/17. CIPFA, the Health Foundation and the King's Fund have called for a £2bn per year Transformation Fund for the NHS in England.[23] That is also consistent with the Future Focused Finance agenda of ensuring that investments concentrate on value.

22 *Costing Seven Day Services*, HFMA 2013 at www.hfma.org.uk/publications/details/costing-seven-day-services-report
23 Making change possible: a Transformation Fund for the NHS - See: www.health.org.uk/publication/making-change-possible-transformation-fund-nhs#sthash.wh9siBZO.dpuf

How much can be saved?

The *Five Year Forward View* states that 'The NHS's long run performance has been an efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance – compared with the NHS's own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period – provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements'.

According to the HFMA, however, 88% of finance directors believe they cannot realise the 2-3% annual improvements in productivity envisaged in the plan, suggesting that the viability of the ambition needs to be checked.[24]

Pay restraint is a clear, though not necessarily straightforward, source of savings. This would mean paying staff increases at less than the overall 1.75% average annual inflation assumed in the settlement. If pay rises can be held to the intended 1% per year that will save nearly £400m in each year, amounting to £2bn by 2020/21. Any more than that would seem too ambitious and so likely to fuel the current trend towards the use of agency staff. £20bn (plus up to £10bn extra) would then be left to find by other means.

The £22bn challenge assumes no extra income, so it must be about taking actions which lead to less being spent than would otherwise have been the case. At the most strategic level, there are three ways of saving money in the NHS:

- Do what you are doing more economically, efficiently and effectively.
- Do different things which meet the same demands, with less expensive treatments, including by coordinating the whole system better to increase use of the most cost-effective options.
- Reduce the volume provided, either by rationing/meeting a lower proportion of demands or by preventing demands arising in the first place (eg through public health programmes).

To give those labels: **efficiency**, **transformation** and **prevention**.

The efficiency agenda is the easiest to tackle, as by and large it doesn't require upfront investment, and can be dealt with mostly within existing budget boundaries. It deals with technical rather than allocative efficiency (ie how best to spend the budgets as they are, rather than how the total funds available should be split between budgets).

Transformation and prevention are more complex, as both have aspects of allocative efficiency, requiring work across traditional budget boundaries:

- across organisations – in order to ensure that money is allocated to the most appropriate part of the system to maximise whole system benefit
- across time periods – if money is to be invested up front to generate longer term value.

Such work across organisations and time in order to improve allocative efficiency faces political and practical obstacles. The health and social care system is not currently set up in a way which incentivises the right allocative decisions across organisations and between time periods. Integration, devolution, and the Vanguard programme, that's piloting new models of care, plus the *Five Year Forward View* all aim to change those dynamics, but the Government's funding priorities have not always backed up the agenda.

24 HFMA November 2015 financial temperature check results at www.hfma.org.uk/nhstemperaturecheck

Taking the potential savings areas in turn, what are the maximum gains currently identified?

Efficiency

The Carter Report published an all-inclusive assessment of the scope to make efficiency savings in general hospitals. It identifies the potential to save £5bn in the following areas:

	£bn
Optimise use of clinical workforce	2.0
Hospital pharmacy and medicines optimisation	0.8
Diagnostics – pathology and radiology	0.2
Improved procurement	0.7
Estates and facilities management	1.0
Back office costs	0.3
	5.0

The £5bn estimate is based on the £55bn expenditure of general hospitals. Assuming that the issues can be extended to specialist, community and ambulance facilities, the base becomes nearly £80bn. Similar levels of savings through related measures might therefore save a further £2bn pro rata to their scale of budgets, taking provider savings/cost avoidance through efficiency improvement to £7bn. There may also be opportunities to make efficiency improvements in the CCG and central budget areas, but Carter's biggest savings are in medical supplies and staffing, and it is probably prudent to assume that non-medical savings are sufficiently captured in the transformation stream. £7bn may, then, be a fair practical estimate of the total scope for efficiency savings.

Transformation and integration

While Lord Carter's proposals may help substantially, they will need to be supplemented by more radical transformational changes and this creates different issues. In *Shaping the Future* the Health Foundation looked at the challenges of implementing the *Five Year Forward View* and proposed that five layers of action are needed:[25]

- scientific discovery, technology and skills
- population health
- new ways of delivering care
- process improvement for quality and productivity
- active cost management.

25 *Shaping the Future: A strategic framework for a successful NHS* – Health Foundation, June 2015 at www.health.org.uk/publication/shaping-future

Shaping the Future concludes that these actions are likely to take up to a decade to implement in full, underlining the reality that the pressures between 2016 and 2021 are unlikely to be fundable within the current plans. This also fits with the King's Fund report on better value healthcare which spells out what the changes are likely to be.[26] That report, relevantly, emphasises that such reforms have typically taken a long time, citing the evidence of impressive long-term achievements in the NHS since the 1970's in increasing the use of generic prescriptions, switching inpatient activity to day-case admissions and reducing the average length of stay in hospitals. Consistent with that, the Vanguards programme covers just 10% of the country and won't deliver changes before 2018. And only £300m of the £2.1bn 'Sustainability and Transformation Fund' (from the £3.8bn real terms growth in the NHS budget 2016/17) is earmarked for transformation support in 2016/17. In sum, the projects appear unlikely to generate savings at anything like the speed required in the period to 2021.

Integration is far from proven as a means of saving money. There is no evidence yet that the £1.9bn NHS budgets passed into the BCF will do more than generate benefits equivalent to the contributions, and the additional £1.5bn announced as part of the 2015 Comprehensive Spending Review is too back-loaded to impact on the immediate gaps. More broadly, there is little evidence yet that integration will save cash (as opposed to improving patient experiences)[27], though the recent LGA report *Efficiency Opportunities Through Health and Social Care Integration* does point to ways in which that may become possible over time.[28]

That leaves the Right Care programme as the most developed set of savings proposals likely to impact in 2016 – 2021. The methodology takes a systematic approach to deciding where to look, what to change and how to change. It is the main methodological driver for enabling CCGs to commission services on a more informed and value-driven basis. If all CCGs reach upper quartile performance within their grouping of similar CCGs, this would yield some £2bn. However, the position is complicated. There may be scope to do more (for example if all performers in a group are poor), some of the savings will overlap with actions which are already counted as stemming from the Vanguards or BCF investments, or savings in other areas might be increased by the impacts of the Right Care programme.

26 *Better value in the NHS: The role of changes in clinical practice* www.kingsfund.org.uk/publications/better-value-nhs/summary?gclid=CM3DqIjr4cYCFRQatAod4TgDSQ

27 The issue is explored more fully in *Let's Get Together* (CIPFA, 2015) at www.cipfa.org/cipfa-thinks/health

28 See www.local.gov.uk/documents/10180/11779/Efficiency+Opportunities+through+health+and+social+care+integration/ddec99af-bf5e-4a03-8581-4416861330c8

Prevention

The *Five Year Forward View* provided an excellent summary of why more preventative investment is needed:

'Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and the NHS is on the hook for the consequences. Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool. Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese. And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10bn a year on diabetes.'

In reality, though – for all that the call for a step change expansion of such investment was in a strategy which was accepted by the Government – what has followed since has been steadily reducing resources for public health. Spend on health education has also been reduced – notably by the changes in the funding arrangements for training nurses – which could also have detrimental effects in the longer term. Health Education England would have commissioned 3,000 extra nurse training places for 2016/17 but reduced this to just 331 because of funding cuts to arm's length bodies following the spending review.[29]

This is a cause for concern. However, given the lag likely between investment in public health and the impact on current health costs, the impact is likely to be felt beyond 2020. The current spending review period will be more affected by the pattern of public health investment in 2000-2015, and that was positive, with an increase from £2.7bn to £4.6bn per year. It is reasonable to assume that investment on that level should yield an equivalent future benefit in terms of health spend avoided, so an assumption of £2bn per year benefit has been made below.

Overall savings achievable

CIPFA's prudent assessment of the potential savings is, therefore:

	£bn per year by 2020
Pay restraint	2
Efficiency savings	7
Initial phases of transformation	2
BCF/integration	3
Prevention	2
Prudent total of possible savings	**16**

29 HSJ report on the independent Migration Advisory Committee, March 2016 at www.hsj.co.uk/topics/workforce/desire-to-save-money-caused-nhs-nursing-shortage-says-damning-report/7003565.article

As when assessing the pressures it is hard to be confident and so a range is more appropriate. There may be enough potential opportunities for savings to allow the £22bn target to be delivered, and the NHS has just released details of the means by which it is planned to do so.[30] Compared with CIPFA's analysis, the plans show:

- Nationally delivered savings of £7bn. This is £5bn higher than CIPFA's estimate with renegotiation of the community pharmacy contract, income generation and NHS England central and admin cost savings adding to the effect of pay restraint. It remains unclear whether these actions will reduce the local scope to generate savings and whether NHS England can save substantially more than the reductions already set out in the CSR.
- Provider savings of £9bn. This is £2bn higher than CIPFA's estimate of £7bn, to be achieved by cutting the tariff by 2% in real terms annually and reducing agency spend. Both these actions require the pressures on providers experienced in 2015/16 to be overcome and reversed.
- Commissioning and demand management savings of £6bn. This is a similar assessment to CIPFA's.

The 44 sustainability and transformation plans due to be submitted in June 2016 will provide a more concrete view of the actions to be taken in practice. The £22bn may be achievable but will require a truly exceptional level of performance. CIPFA's view is that a savings range of £16-22bn represents a more feasible planning assumption.

A further note of caution is that £22bn equates to £4.4bn, or a historically impressive 3.3% of the NHS budget, per year, and there are various reasons for doubting that savings on that scale will be achieved in full, including that:

- such an achievement has never occurred before
- one type of saving may render another redundant (eg if service volumes are cut, the benefit from making the service more efficient is reduced)
- there are limits to the capacity for change management, likely to be breached if so many initiatives must be carried forward simultaneously
- delays may occur so that even if savings are achieved, they lag behind the funding demand.

That conclusion will surprise few. The Health Select Committee's findings in March 2016 stated: 'There is not yet a convincing plan for closing the £22bn efficiency gap and avoiding a 'black hole' in NHS finances'.[31]

CIPFA's analysis suggests that the NHS's underlying position remains unrealistic:

CIPFA view of:	Best case	Mid-position	Worst case
Additional cost pressures	35	37.5	40
Savings achievable	(22)	(19)	(16)
Additional funding in system	(8)	(8)	(8)
Gap	**5**	**10.5**	**16**

More work is needed to assess the pressures in full, to plot both their likely split between years, and to align that in turn with the likely speed with which savings will occur. It is reasonable to ask: if the five year position is not sustainable, what more needs to be done?

30 *NHS Five Year Forward View Recap briefing for the Health Select Committee on technical modelling and scenarios* at www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf

31 House of Commons Committee of Public Accounts: *Sustainability and financial performance of acute hospital trusts*. Thirtieth Report of Session 2015–16 at www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/709/709.pdf

what are the alternatives?

There is too little planning for long-term pressures, which affects the ability to make the upfront investments which might help with long-term health prevention, integration and transformation.

In principle, there are three ways of solving the problem:[32]

1. **Spend less through more radical approaches to efficiency or service reduction.** CIPFA concludes that the efficiencies identified to date will not be sufficient, but explicit cuts in services are both undesirable and not politically feasible. It may be that the Government could:
   - set up a statutory requirement for CFO's in the NHS to balance budgets, as is the case in local government
   - give NHS providers more freedom to make local decisions within budget
   - accept the need for rationing in the NHS
   - move spend between parts of the system to make better use of budgets.

   For example, could end of life spend be reduced by making more use of palliative care? If people go to A&E rather than their GP, does that suggest that rebalancing the spend between sectors and areas of care could help to improve the system's overall efficicency?

2. **Bring more income into the system.** This might be by charging patients, which may affect behaviour as well as increase income if it resulted in deterring unnecessary visits to the doctor (this is a system which works in Australia). However this would be complicated to implement, and is not likely to be judged politically feasible during the settlement period. Other options might include giving more freedom to providers to seek services in the open market and exploring possible means of raising additional investment funds (eg with a more liberal approach to the use of capital receipts, bonds or prudential borrowing for health purposes).

3. **Fund the system sufficiently through extra tax or cross-subsidy from other services.** This is the most likely short-term expectation, and would continue the pattern of how successive governments have dealt with the health funding issue by tactical means. To convert this option into a longer term solution will require either taking a more radical view of other spending commitments to increase the proportion spent on health (eg altering the triple lock which drives state pension costs) or increasing taxes specifically to allow for increased health spending. This could be achieved by introducing bespoke taxes (such as the 'sugar tax', introduced in February 2016). That longer-term thinking could be assisted by fixing the proportion of GDP to be spent on health and social care.

These are sufficiently fundamental choices to suggest that the Government would be well advised to set up an independent commission to explore them.

The commission should start from the consensus that fundamental questions need to be asked of how the NHS can be adequately funded in the long term and examine the alternative options.

32 See the report of the Commission on the Future of Health and Social Care in England (known as the Barker Report), 2014, for a fuller discussion of the options which remains highly relevant: www.kingsfund.org.uk/publications/new-settlement-health-and-social-care

conclusion and possible solutions

The Government's recognition of the issues faced by the NHS, and the actions set out in the Comprehensive Spending Review and subsequent guidance, are encouraging. Nonetheless:

- it seems likely that the pressures faced by the NHS over the coming five years will be more than £30bn and possibly as much as £40bn
- if the pressures are more than £30bn, the £22bn of savings planned for by the *Five Year Forward View* will be insufficient
- it seems unlikely that the full £22bn will be achievable at the right speed to match the pressures.

CIPFA concludes that the financial model behind the *Five Year Forward View* is not tenable and creates both financial and leadership challenges for everyone in the NHS.

Given the difficulties associated with reducing levels of service or introducing charges, increased government funding is likely to be required in the medium-term even if the longer term issues are tackled. That raises the problem of the trade-off involved between spending on the health and other services.

CIPFA thinks:[33]

- More analysis is needed to update the £30bn assessment of pressures on which the *Five Year Forward View* is predicated, and an assessment should also be made of the comparative phasing of pressures and planned savings. Moreover, it is unlikely that the NHS can react fast enough in the early years to achieve the productivity gains which will be required.
- The Government should increase public health budgets and set aside more funds to make the upfront investments which will save in the future without undermining the short-term position. Given that this would be 'virtuous spending' to future advantage, it would make sense to allow this investment to be funded by borrowing or a bespoke tax.
- The front-loading of NHS support in the 2015 Comprehensive Spending Review has not changed the underlying position: it will be necessary either to add further to the NHS budget, charge users more, or reduce services. To choose none of those is not a realistic option.
- Perhaps the most fundamental question of all should be: what should the Government be providing in terms of public services, and should it prioritise health above other areas?

It's not simply a case of saying that more money is needed. It may be in the short-term that a more permissive approach to rationing and prioritisation is an alternative, and there are various longer-term options. What is vital is that the position is addressed in the right way both in the short-term and as part of the realistic long-term planning which should form the core of the Government's thinking. Accordingly, CIPFA calls on the Government to:

- reassess the viability of the NHS's financial position during the remainder of this Parliament, and take action and adjust expectations accordingly
- set up an independent commission which starts from the consensus that fundamental questions need to be asked of how the NHS can be adequately funded in the long term, and seriously examines the alternative options
- ask the commission to recommend what fixed percentage of GDP should be allocated to NHS and social care spending, so reducing the short term political factors influencing the budget.

33 This is consistent with the wider context and proposals in CIPFA's Manifesto 2015, see www.cipfa.org/cipfa-thinks/manifesto2015

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