Realistic or utopian?

Aiming for Health Success submission to the 2021 Comprehensive Spending Review

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Aiming for Health Success

Aiming for Health Success is a new initiative which will develop the case for new public / private collaboration in health and care to deliver extra services and support. It will combine the insights of its network of NHS and care leaders and leading companies with the latest academic and policy analysis. It will produce frequent publications and online communications and hold events with policymakers and health care leaders.

AFHS is run by Andrew Haldenby and Professor Nick Bosanquet. It is funded by companies who will partner on major events and receive regular policy and market commentaries.

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Executive summary

Our assumption is that the sustainable growth of public spending has to be aligned to economic growth. This is likely to be around 2 per cent.

Some advocate a real terms rise in NHS and care spending of 4 per cent per year. This would give the NHS priority over every other large spending programme including education, childcare and home support for people with disabilities. Such priority does not make sense in terms of social value.

There could be a situation in which the only development path for the NHS would require this priority but this is not the current situation. There is a clear development path to essential improvements which could be funded by a 2 per cent real terms increase per annum, in line with economic growth. We also set out how it would be feasible to raise productivity in the acute sector.

A 4 per cent per year increase would lead to further increases in the future. By 2050 the NHS would be approaching American levels of spending (15-17 per cent of GDP) which would be a burden on future generations.

Ministers have tough decisions to make especially as they have to take account of differential pressure group power. High tech hospital services in London and other large cities have vast pressure behind them. Childcare in Birmingham and primary care in Hull have no such pressure. There is naturally great sympathy for patients who are acutely ill but little for a child with unstable care who becomes addicted and dies in their twenties. It is hardly a surprise that spending on high tech hospital services has doubled in the last 15 years while spending on childcare and on primary care in deprived areas has fallen in real terms.

The 2 per cent per annum development path is the best route to levelling up. Hospital activities are at least 25 per cent higher in deprived areas. The gaps are in primary and social care. The recent IPPR study showed that GP numbers were lower in deprived areas and home care availability much less. The key to reducing inequality is to provide more effective support in the community for all age groups.

This is realism for the patients of today and tomorrow.

Recommendations for CSR 2021

- Set the expectation of long-term growth in the NHS budget of 2 per cent per year in real terms.
- Maintain the Long Term Plan commitment to 3.4 per cent real growth till 2023-24 as an investment. Recognise that this rate of growth is not likely to be sustainable, nor lead to the most effective balance of services.
- Use the investment period until 2023-24 to: develop a new financial system; invest in higher productivity, lower cost services i.e. more home support and reduced admissions; and promote high volume elective centres to tackle the elective care backlog.
- Increase funding levels for local-authority-funded social care.

1

Health funding: the record

This chapter presents evidence on the growth in health spending since the early days of the NHS, its volatility and its cost levels compared to other countries. It also compares the growth in health spending as a share of GDP to that of other public services.

National Health Accounts

The ONS has done good service in producing National Health Accounts for 1997-2018 (see Figure 1). Its work shows:

- total healthcare spending rose from 6.9 per cent of GDP in 1997 to 10 per cent in 2018;
- private spending rose from 1.7 per cent of GDP in 1997 to 2.2 per cent in 2018; and
- public spending rose from 5.2 per cent of GDP in 1997 to 7.8 per cent in 2018.

Figure 1: healthcare spending as a share of GDP, UK 1997 to 2018

Source: Office for National Statistics, 2020; authors' calculations

Year	Private Spending	Public Spending	Total
1997	1.7	5.2	6.9
1998	1.7	5.4	7.1
1999	1.7	5.5	7.2
2000	1.7	5.6	7.3
2001	1.8	5.9	7.7
2002	1.8	6.2	8.0
2003	1.8	6.4	8.2
2004	1.7	6.8	8.5
2005	1.6	6.9	8.5
2006	1.6	7.1	8.7
2007	1.8	7.1	8.9
2008	1.7	7.5	9.2
2009	1.8	8.2	10.0
2010	1.8	8.2	10.0
2011	1.8	8.2	10.0
2012	1.9	8.2	10.1
2013	2.1	7.9	10.0
2014	2.1	7.9	10.0
2015	2.0	7.9	9.9
2016	2.0	7.9	9.9
2017	2.1	7.7	9.8
2018	2.2	7.8	10.0

The ONS also showed that total spending on healthcare doubled in real terms and trebled in real terms over the period (Figure 2).

Public spending more than doubled in real terms (up by 125 per cent) and more than trebled in cash terms (up by 235 per cent) over the period.

Figure 2: healthcare spending, £bn, cash and real terms, UK 1997 to 2018

Source: Office for National Statistics, 2020; authors' calculations

Year	Total spending, cash terms	Total spending, real terms	Public spending, cash terms	Public spending, real terms
1997	66	98	49.7	73.8
1998	70	103	53.0	77.9
1999	75	109	57.5	83.5
2000	80	114	61.2	87.2
2001	87	123	66.3	93.7
2002	96	132	74.0	101.8
2003	103	140	80.5	109.5
2004	112	148	89.4	118.1
2005	119	154	96.3	124.7
2006	128	161	104.6	131.5
2007	138	168	110.6	134.6
2008	146	173	118.7	140.6
2009	155	181	127.8	149.2
2010	160	184	131.0	150.6
2011	166	187	135.3	152.4
2012	172	191	138.9	154.3
2013	178	193	141.1	153.0
2014	185	198	147.0	157.3
2015	190	202	151.1	160.6
2016	197	205	156.9	163.3
2017	204	208	160.5	163.7
2018	214	214	166.5	166.5

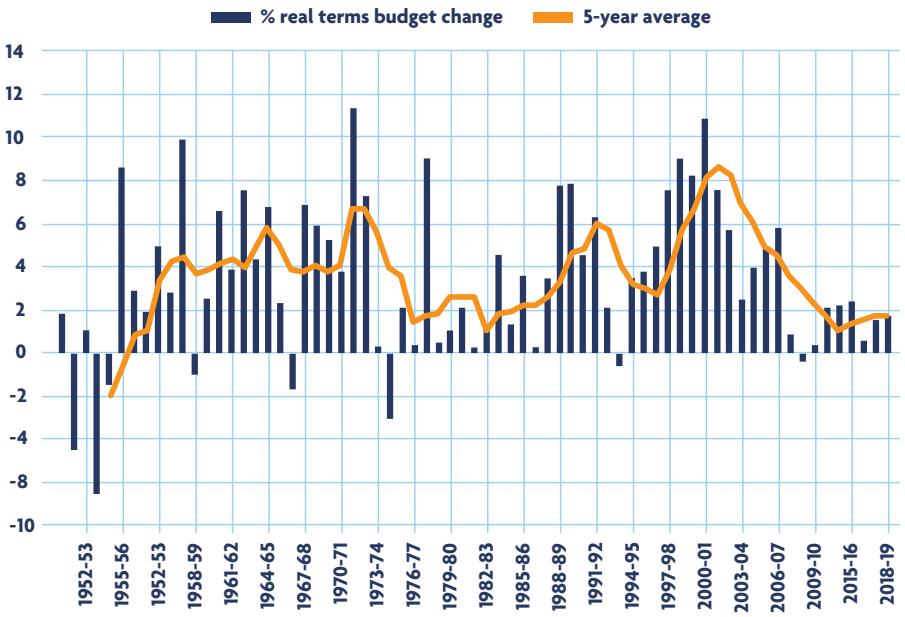
Separately, the ONS has shown that the UK has one of the highest shares of publicly funded healthcare in the OECD. In 2017, out of 25 OECD countries, only six had larger publicly funded shares than the UK (Office for National Statistics, 2019).

Volatility in NHS spending increases

In Figure 3 we set out the record since the early days of the NHS. The lesson usually (and erroneously) drawn from this is that the NHS needs a real terms growth rate of around 4 per cent a year.

Figure 3: Volatility in NHS spending

Source: Harker, 2020



Less often noted is the variability of health spending. From 1950-51 to 2018-19 there were 20 years in which spending rose in real terms by 5 per cent or more and 15 years in which real terms spending rose by less than 1 per cent. This fluctuation is not found in any other major budget across the whole economy, public and private.

Figure 4: categories of government healthcare spending increases, 1950-51 - 2018-19

Source: Harker, 2020; authors' calculations

Annual real terms spending increase, %	Number of years
< 1	15
1.0 - 2.9	18
3.0 - 4.9	11
5.0 - 6.9	7
7.0 - 8.9	8
9.0 +	5

The "magic" 4 per cent figure averages out these disparate annual figures. The focus on the annual spending round has meant this variability has had far less attention than should have been the case. By any common-sense standard this would seem to be a poor way to "run a railroad".

OECD: high UK relative price for healthcare

England is now around the OECD average for volume of activity in healthcare but it is well above the OECD average for the price of healthcare. On OECD data for 2017, the UK's price level was 83 per cent of the US level while the average for the OECD was 72 per cent of the US price level. Australia and New Zealand were also at 72 per cent while Germany was at 68 per cent and France 66 per cent (OECD, 2019).

Figure 5: Comparative price levels for health, 2017, US=100

Source: OECD, 2019

Switzerland	139	New Zealand	72
Iceland	138	Japan	71
Norway	120	Germany	68
Sweden	111	France	66
Israel	110	Chile	59
Ireland	106	Greece	57
Luxembourg	102	Portugal	55
United States	100	Slovenia	54
Canada	92	Korea	48
Finland	90	Mexico	47
Denmark	88	Estonia	42
Netherlands	86	Slovak Republic	34
United Kingdom	83	Hungary	32
Austria	82	Latvia	31
Italy	82	Lithuania	30
Spain	76	Poland	29
Belgium	75	Czech Republic	28
Australia	72	Russian Federation	18
OECB36	72	Turkey	17

In 1997 the UK was a low-cost country for healthcare. What happened to change the situation, so that the UK is placed in the top 15 of the 36 OECD members?

In part the cause has been the variations in spending described above. Such variations have made it very difficult to use extra spending effectively. Prices would rise in the boom years as Trusts bid for resources. With budgeting on an annual basis it was impossible to carry over funds even when resources could have been better used as a result.

Looking at cost rises in different NHS services, the increased cost was mainly in specialised services in hospitals. Spending on NHS Special Commissioning rose from £13 billion in 2013-14 to £19 billion in 2020-21. Some of this was from increased activity

but much more must have been from increased costs reflecting rising prices for high tech equipment.

The change was certainly not because of rising costs in care outside the hospital. Very modest pay gains and extensive use of generic drugs have in fact contained spending outside hospitals.

What does this mean for the new Integrated Care Systems? It means that any sum of money can buy more services in the community than it could in a hospital setting. There is a rising opportunity cost to spending on acute services. Even the United States has now begun to contain spending by developing more prevention and out-of-hospital services.

The new era of Integrated Care Systems starts with differentials in relative prices of a kind which the UK is not accustomed. The differentials have arisen in part because of actions for containing spending in primary and community care, with a mixture of price restraint and false economy. The challenge for the next ten years is to improve access to high tech medicine while also containing spending.

Successful budgetary control 2010-18

The years 2010-18 showed some successes in managing budgets much more actively. This was clearest for prescribing and for new hospital-based drugs.

Greater use of generics (now 90 per cent of prescriptions) allowed doubling in the number of prescriptions for the same total budget. Through the Cancer Drugs Fund there have been successful negotiations, "commercial in confidence", to reduce the price of new drugs. This has allowed better access as well as lower costs. From these successes there are lessons for the future.

Health spending has grown while spending on other public services has been constant or fallen

The steady rise in health spending as a share of GDP has not been mirrored for other public services. Comparing the years 1978-79 to 2016-17, health had the largest increase of any public services in terms of spending share of GDP (see Figure 6). Social security and overseas aid also increased. Services such as public order and transport remained constant. Services such as defence and housing fell sharply.

As the next chapter shows, if the health budget continues to grow as a share of GDP, it will inevitably create significant pressure on the funding available for other public services.

Figure 6: Total spending and spending by function as a percentage of national income

Source: Charlesworth & Johnson, 2018

	1978 - 1979	1996 - 1997	2007 - 2008	2016 - 2017
Total managed expenditure	41.5	35.4	39.0	38.9
Health	3.9	4.7	6.5	7.3
Education	4.9	4.1	5.1	4.4
Defence	4.0	2.4	2.2	1.9
Social security (pensioners)	5.0	5.2	5.5	6.1
Social security (working age with children)	3.1	4.4	4.5	4.8
Public order and safety	1.4	1.8	2.0	1.5
Transport	1.5	1.0	1.3	1.5
Housing and community amenities	2.6	0.6	0.8	0.5
Overseas aid	0.4	0.2	0.3	0.7
Net debt interest	3.5	2.6	1.6	1.7
Long term care	-	0.8	1.2	1.0

2

The medium-term and long-term outlook

This chapter considers the future development of health spending. It asks whether the recent trend of rapid increases in spending can be continued given likely trends of economic growth and the pressure on resources available for other public services.

ONS: national population projections, 2018-based

Population change affects the size of the economy as well as demand for NHS services and staff availability. The ONS usefully provides data on population change including ageing and migration (Office for National Statistics, 2019).

Over the longer period to 2043, numbers of people over 85 will double from 1.6 million to 3.0 million and numbers of pensionable age will rise by 30 per cent. The ONS expects the fall in fertility to continue and a reduced number of young people in the population.

Most recent ONS projections were for a small rise in population at 0.4 per cent a year ("The total projected increase in the UK population is less than that over the last 25 years.")

Nearly all the population growth was expected from net migration. These projections were based on migration rates before 2018. They are likely to be revised to take in the Brexit and Covid effects which will pull net migration down to zero.

As the ONS makes clear, "over the 25 years between mid-2018 and mid-2043, the projected population would fall slightly if there were no migration".
The ONS emphasises that because migrants are concentrated at young adult ages, the impact of migration on the projected number of women of childbearing age is "especially important".

Because of the reduction in net migration, it is possible that there will be no increase in the UK population in the next 25 years. England would join Scotland and Wales in expecting static and rapidly aging populations over the next twenty years.

These changes have three key impacts on the NHS and social care:

- demand for services will rise by at least 30 per cent over the next ten years and by more after that;
- the number of working age taxpayers will be static; and
- the recruitment of staff will be from a reduced number of young people in the labour market.

OBR economic growth projections

Projections for economic growth are more speculative. OBR forecasts to 2025 show a growth rate of below 2 per cent after a post-pandemic bounce.

Figure 7: OBR growth predictions 2019-25

Source: Office for Budget Responsibility, 2021

	2019	2020	2021	2022	2023	2024	2025
GDP	1.4	-9.9	4.0	7.3	1.7	1.6	1.7

Beyond that it would be prudent to expect a growth rate of around 2 per cent per annum. The last period of growth at 3 per cent was from 1992 to 2008 when the labour force expanded by 3 million through immigration. Consumer spending rose by 5 per cent or more a year.

Without an expanding labour force, growth depends on higher productivity much more so than over the last twenty years. Even a growth miracle by Global Britain is not going to change the growth rate very much, especially if the savings rate rises with anxiety about post retirement income and consumer spending is static.

OBR: long-term health spending increases

In its most recent Fiscal Sustainability Report (July 2020), the OBR predicted that health spending will continue to increase as a share of GDP. It predicted a rise of around 1 per cent of GDP per decade, resulting in a level of 14.8 per cent of GDP in 2069-70.

Figure 8: Long-term fiscal projections, per cent of GDP

Source: Office for Budget Responsibility, 2020

	Upside scenario	Central scenario	Downside scenario
Health	14.4	14.8	15.3

Further, it noted that the Government is facing increasing pressure "to grasp the nettle of adult social care funding reform". It noted that the House of Lords Economic Affairs Committee wrote to the Chancellor in May 2020, advocating a funding model that could cost £7 billion per year or around [0.5 per of GDP].

Others have suggested a full nationalisation of the cost of social care, which would cost 1 per cent of GDP at a minimum.

Taking health and additional social care costs together, the OBR prediction points to costs of between 15 per cent and 16 per cent of GDP by 2069-70.

OBR: public finances already unsustainable, requiring tax increases or spending reductions

The OBR noted that health spending is the "largest – and most likely – source of long-term risk to fiscal sustainability". It also noted that "adult social care represents a similar source of fiscal risk, with demographic and other cost pressures raising demands for spending and governments announcing periodic top-ups to strained budgets."

With rising health budgets playing a major role, the OBR found that the public finances are unsustainable in each of its three scenarios: "In all cases the public finances would clearly be on an unsustainable path, with net interest spending taking up an ever-larger share of GDP – a conclusion that has been common to all our FSRs to date."

The OBR concluded that "in almost any conceivable world there would be a need at some point to raise tax revenues and/or reduce spending (as a share of national income) to put the public finances on a sustainable path".

LSE / Lancet Commission

The recent LSE / Lancet Commission put forward a specific set of taxation proposals that would finance annual NHS and public health spending increases of 4 per cent of real terms until 2030 (Anderson et al., 2021). The Commission also proposed increases in social care spending and the introduction of a "Dilnot" style reform to social care funding.

The Commission estimated that its proposals would cost an additional £65 billion in 2030-31, once economic growth is taken into account.

The authors recommend that around two-thirds of this "funding gap" could be filled by a two pence increase in the basic, higher and additional rates of income tax; a two pence increase in national insurance contributions, and a one pence increase in the main rate of VAT.

Further tax increases are envisaged. The Commission notes that, "our tax options presented only fund around 63 per cent of the funding gap". To finance the remaining portion, the Commission recommends: "Reforms to other taxes, for example wealth taxes, would also be required."

The authors also note that tax increases on this scale may provoke a "behavioural response" i.e. a reduction in economic activity due to the increase in marginal rates. They recommend that, "to minimise distortions", the increases could be phased in over time.

3

A new commitment to real terms spending increases at 2 per cent per year

The NHS Long Term Plan sets a very clear direction for a shift towards integrated care with more services across the community. This would involve a reduction of one third in outpatient activity and reductions in emergency admissions through earlier diagnosis and care programmes for people with long term conditions.

Figure 9: NHS and social care in deprived areas

Sources: NHS Digital, 2020; Nussbaum, et al., 2021; Yurday, 2020; Thomas, 2021

Service	Measure	Comparison
A&E	Attendance by decile of population	3.1 million attendances for the 10% living in most deprived areas 1.6 million for the 10% living in least deprived areas
Acute hospitals	Beds per 10,000 population	London: 13.9 North East: 23.0
GPs	GPs per 10,000 population	1.4 GP fewer in most deprived decile compared to least deprived
Home care	Proportion of social care provided at home	46 per cent in Barnsley 84 per cent in Hammersmith and Fulham.

The Long Term Plan and the recent LSE / Lancet Commission both stress the urgent need for improving outcomes for people in deprived areas. These areas have seen a recent reduction in life expectancy. Their rates of long-term conditions and hospital activity are both higher. For example A&E attendances in 2017-19 were 3 million for the population in the 10 per cent of most deprived areas and 1.5 million for the population in the least deprived.

How should these improvements be funded? The LSE / Lancet Commission recommends 4 per cent annual growth in real terms spending (in effect 6 per cent in cash terms after allowing for a 2 per cent rise in prices). We recommend 2 per cent in real terms (or 4 per cent a year in cash terms).

Key arguments for a 2 per cent annual real growth in spending

The rate of increase in funding should be related to the health strategy and represent the level which can best deliver on this strategy. Integrated services in the community, including new hubs, cost less than expansions in the hospital service but are more difficult to organize.

A very high rate of growth within the annual budgeting system will lead to more spending on those existing areas of the service which can most easily absorb large amounts of spending and which command most political and media attention i.e. the hospital services. Between 1997 and 2009 NHS spending trebled in cash terms, most of it devoted to the hospital services, but inequalities in health got wider. Instead, new funding needs to bring about a difficult change of direction. A steadier growth of funding is more likely to make this possible.

A 2 per cent growth in funding is more likely to be sustainable. 4 per cent real annual growth would be likely to squeeze public spending in other areas including childcare, education and action on climate change. It could repeat the pattern seen from 2010 when the NHS was given priority and other programmes were severely reduced. It also affects generational equity; giving the main priority to a programme where, as the LSE Commission points out, 5 per cent of (mainly older) users account for 50 per cent of health service costs.

Finally there would be effects on prices. A high rate of growth would lead to bidding for scarce resources. The NHS has already become a higher cost programme, again mainly through the hospital spend. Health specific inflation would be likely to rise. An expansion in spending on the lower cost programmes in primary and integrated care would be more achievable using resources which are lower cost and more "place" available.

We recommend a 2 per cent rate of growth as more sustainable and more likely to create conditions for the development of new out of hospital services which would be the best option for reducing health inequalities. This would deliver a more consistent and more credible rate of funding increase.

This would be associated with financial management which would create local opportunities for improving value. The NHS is currently the only organization in the country – whether private, public or household – which does not use information on relative costs. As the Carter Report on pathology put it: "There is a lack of usable data about costs, performance and activity within NHS pathology services" (The Review of NHS Pathology Services in England, 2006). This is true more generally.

The LSE/Lancet Commission, like the health establishment, does not make much use of the words "productivity" or "efficiency" for which data on relative costs are indispensable.

Key conditions to deliver better service development within 2 per cent real growth per annum

There is already a commitment to growth in real terms spending at 3.4 per cent from 2018-19 – 2023-24. Within this there is an initial investment of £4 billion in the new services. For the first time in four decades, spending on primary care is planned to rise faster than spending on hospitals.

From 2024-25, fiscal pressures point to the realism of 2 per cent per annum growth. Can the NHS continue to develop better services within this constraint? We would set out four key conditions:

- a consistent growth in funding known in advance;
- a financial system which gives Integrated Care System and place managers the opportunity to achieve value and efficiency;
- strong locally-driven research base on effectiveness and efficiency of services in primary and integrated care; and
- quick progress towards the development of integrated care, which means new integrated services rather than better communication between organisations.

Consistent growth in funding known in advance

As well as variability (most recently with a boom period from 2002-09 followed by a sharp contraction in spending growth), managers have often had only a few weeks' notice of their budget for the next financial year. The budget has also become much more complicated with multiple sources of funding. A guaranteed, single budget over a much longer period would give maximum incentives to find local additions through productivity gains.

New financial system

The Long Term Plan includes some indications about the payment system: "Reforms to the payment system will move funding away from activity based payments and ensure a majority of funding is population based."

The population base makes sense for allocating budgets at the national level but there should also be elements in the system which allow local managers to make decisions on service and achieve better results.

This would have to be based on costing of activities. For the new era the NHS needs a common financial system across Trusts, Primary Care Networks and Integrated Care Systems. Integrated care needs an integrated accounting system.

In the new NHS digital world much of the tariff data can be available online so that costs of services can be quickly assessed. The NHS already has data for hospital procedures and some primary care QOF activities. To these have to be added data for PCN activities and for social care. An average ICS budget will be £3 billion per year.

Locally-driven research base

The research base is vital in order to get most value from the out of hospital programmes, some of which have not been tried before at scale. Some of the research can be shared across ICSs in a region or nationally. The focus should be on the efficiency and effectiveness of actual programmes. It should cover options for better outcomes.

The NHS used to give much more attention to relative costs. The Oxford Regional Hospital, with a great pre-digital pioneer Dr Alex Barr, assisted Martin Feldstein to carry out a study of relative efficiency in hospital and maternity care. This was published in as "Economic Analysis for Health Service Efficiency" (Feldstein, 1967).

The Department of Health report "Priorities for Health and Personal Social services in England" (Department of Health and Social Security, 1976) was a pioneering attempt to cost a programme budget. It urged that the NHS should "use lower cost solutions where this can be done without damage to existing standards of care whether in new developments or by substitution in existing services". There were four pages with 40 references on research into improvements, many to do with day surgery. This document was produced at a time with uncanny similarities to the present: new financial constraints and requirements for integrated services through joint funding across the NHS and local government.

When the heart transplant programme began in the 1980s, it was found that cost differed by 50 per cent between the first two centres, Harefield and Papworth. At Harefield patients for the immunotherapy phase were transferred to a hostel.

The NHS does have some special programmes on productivity such Getting It Right First Time but comparisons of efficiency are less available than they were twenty or even forty years ago. The new ICSs will need data on a comparable basis across the range of services which they will be commissioning.

Cost information for all steps in care along the pathway in and out of hospital should be available in the new digital era and should be accessible to staff across primary and integrated care. There is development potential in creating instant access to data on patient activities and their costs. Such data will allow monitoring of activities and patient responses i.e. progress towards better outcomes.

There can be quicker response when a therapy does not seem to be working and when patients have not been taking medications or carrying out checks. It will be possible for co-management between patient and professional to take place with rapid accessible information. Such information is vital for monitoring and improving quality of care.

As well as quality, such data is also vital for efficiency i.e. achieving a given outcome with possible cost savings. At present the NHS cannot do this except by lurches by intuition since it does not have data on costs and activities for patients either as individuals or as speciality groups over time. 46 per cent of health professionals think that Trusts waste money yet at present there is little of the evidence needed to do something about it or any clear standard for assessment. As a first step there can be local initiative to find ways of increasing quality through reductions in cost. There can also be initiative to redesign services so as to increase access and minimize delays. The coming of new diagnostic hubs will raise new opportunities for doing this.

Integrated care needs a financial system which will create new opportunities for local initiative to use funds effectively in the new era in which funds may be scarcer. Responsibility for value for money needs to have a local ownership as well as the central decisions and evaluations by NHS England and NICE.

New integrated care services

The NHS Long Term Plan (2019) received most attention for its spending settlement. In fact it was a strong statement of a new and potentially much more efficient service model.

As Fuchs has set out well, the pattern of services helps to determine the efficiency of health spending. Improving the pattern of services can improve that efficiency. As Fuchs argues, the relative over-investment in high-technology medicine in the United States is one reason for its poor level of efficiency ("macro-inefficiency") compared to other rich nations.

The new service model is based on integrated care. Integrated care is not just about co-operation between agencies. It is a different kind of care which gives better outcomes for patients, starting with earlier diagnosis and moving on to new care

pathways for improving health and increasing opportunities whether in work or retirement. It must include partnership with patients to reduce risk factors through lifestyle change. The proper development of integrated care will see a recognisably different NHS service emerge.

The development of integrated care will have profound consequences for existing NHS services, in particular the acute sector which (as the ONS has shown) accounts for half of all NHS spending.

To take one example, the Long Term Plan sets a good target to reduce outpatient appointments by a third. Using the ONS data on NHS spending, that in itself would save £7 billion a year (Office for National Statistics, 2020).

In our work in 2021 so far, we have set out key steps in the development of integrated care as well as measures to tackle the backlog in elective care before the next General Election. These include:

- the creation of 20 high volume elective centres, on the model of the South West London Elective Orthopaedic Centre (SWLEOC), established as joint ventures between the NHS and private capital;
- a new acute services strategy, in most cases redefining district general hospitals as community hubs. The NHS as a whole should aim to reduce inpatient and A&E attendances by a third, as well as outpatient attendances;
- the redefinition of primary care as "Primary and Integrated Care", with GPs responsible for out-of-hospital care;
- the grant of control over capital spending to Integrated Care Systems; and
- for staffing, priority for primary care recruitment and training for and research in integrated care positions.

On social care, according to the CQC, providers deliver higher quality care than acute hospitals and is providing welcome new options for care in people's homes, even for those with complex needs. The search for a perfect funding solution has defeated successive governments. Rather than publishing a grand plan, simply providing realistic funding for local-authority financed care residents would do much to provide security for providers and end the unsustainable difference between local authority funding rates and self-pay rates.

The worst approach would be to nationalize social care as a free service under the NHS, leading to higher costs and much worse access.

Conclusions and recommendations

On past perspectives the NHS was often presented as a low-cost service, "the dream of Finance Ministers". Now it is on the edge of becoming a higher cost service which will spend more than the OECD average at higher price levels.

Cost containment in prescribing and in primary care have been the key forces retarding total cost up till now. For the future there has to be a drive for cost containment across the NHS if it is to remain affordable.

In cash terms NHS spending trebled between 1997 and 2018. This cannot be repeated.

In the new era the search has to be for care pathways which will deliver quality at lower cost. The NHS Long Term Plan is the route to financial viability as well as to improved quality.

Recommendations for CSR 2021

- Set the expectation of long-term growth in the NHS budget of 2 per cent per year in real terms.
- Maintain the 2019 commitment to 3.4 per cent real growth till 2023-24 as an investment. Recognise that this rate of growth is not likely to be sustainable nor lead to the most effective balance of services.
- Use the investment period until 2023-24 to: develop a new financial system; invest in higher productivity, lower cost services i.e. more home support and reduced admissions; and promote high volume elective centres to tackle the elective care backlog.
- Increase funding levels for local-authority-funded social care.

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