19.11.15

1: Something big will have to give by the end of this Parliament. Either the NHS as we know it will cease to exist, or a new funding arrangement will need to be put in place that both provides buoyancy of revenue and becomes an agent of change: change in driving efficiencies; change in constructing a dialogue with voters on what the impact of a rising and rapidly aging population means for services and costs; and a dialogue on the special dynamics of health sector inflation.

2. This paper suggests that it is within the government's mandate both to begin a once in a generational reform of long term health funding and in the process give birth to an 'NHS Mark 2' over which voters feel an even greater sense of pride and ownership.

3. The NHS is already stumbling and, without serious reform, by the end of this Parliament it will be under pressure the like of which has never been witnessed before.

- The deficit on the current budget will be £30 billion (estimate given in the last Parliament).
- £22 billion of this sum will have to be recovered by making "efficiencies" after a decade of such efforts.

- There is uncertainty around how the government is going to drip feed in its promised £8 billion of additional funds.
- Despite ring-fencing the 2010-15 health budget, total health expenditure has grown at the slowest pace ever since the NHS was born in 1948.

To add to this list of woes:

- On an inadequately ring-fenced budget the NHS 'constituency' or patient base will have risen in the decade to 2020 by 4.5 million – a giant 7% increase in the number of people using a service while its real budget, stood against health inflation, is falling.
- Changes in the National Insurance rebate to accompany the new state pension's introduction are resulting in a new additional pension cost to the NHS of £1.1 billion a year
- The Berlin Wall dividing the NHS and social care services becomes ever more costly both in terms of patient care and in cumulative health inefficiencies and costs.
- Not surprisingly, staff morale was already at rock bottom after a decade of pushing through efficiencies. That low morale is being further reduced by

the imposition of new contracts for a seven day working week.

4. The dominance of health at the top of the nation's political agenda will only be challenged during this Parliament by demands to improve further the nation's physical safety and security.

5. This government is the first, in the post-war period, that is committed not to raise greater revenue on the existing basis of taxation. Before the last general election the Conservatives were very clear in promising voters that there would be no increases in personal taxation. The words they used were important. In their manifesto the Conservatives said they 'will not increase the rates of VAT, Income Tax or National Insurance in the next Parliament'.

6. With the £8 billion of additional funds, annual real terms health expenditure will rise in this Parliament by 1.33%, but crucially against a health cost inflation rate of around 3%. This latter rate of inflation constantly outstrips the inflation measurement used for the ring-fencing of health provision. Over the last 20 years, general inflation averaged just over 2% a year; yet, health inflation rose by 3.6% a year.

7. Health service income is also being drawn upon to cover a growing elderly population and an unknown number of new patients among an unprecedented number of new immigrants. Compared with a decade ago there are now 3.7 million more hospital admissions each year and 4.5 million more attendances at Accident and Emergency.

8. The government therefore faces the task in this Parliament of attempting to fit the square peg of health service expenditure into the round hole of health service income.

9. Look carefully though at the Conservatives' manifesto. It did not foreclose on a new contribution or 'tax' to meet one area of expenditure which the voters most support and deem most necessary.

10. There is a political umbilical cord between the electorate and the NHS. This fundamental link, I believe, gives the Chancellor of the Exchequer the opportunity to reshape the political contract between the electorate and the NHS and, in doing so, provide a new independent source of funding which would have widespread public support. The extent of the public's support for specific increases in contributions to finance the NHS surprised Gordon Brown when, as Chancellor, he made

this move after being cornered unexpectedly by a Prime Ministerial promise to raise health expenditure to the European average. A single one penny increase in National Insurance contributions was announced, but the Chancellor did so in a mood of huge trepidation fearing an electoral backlash. However, far from voter disapproval the government found that praise was being heaped on it for its initiative.

11. What we now know, but voters were totally innocent of until recently, was that while a penny increase in National Insurance contributions was presented as making possible a step change in NHS funding, the then Chancellor only allocated a little over half of this new revenue to the NHS. The rest of the purported increase in revenue for NHS expenditure went instead towards some of his other pet initiatives. Voters this time around will be justifiably wary of any similar move that does not guarantee all of the new monies going to the NHS. Indeed any such move would now be made against the background of even more voters being sceptical of politicians keeping their word.

12. Apart from increased public vigilance against government action in general, and specifically on taxes, the Chancellor, this time around, could initiate a major funding move that meets voters' wishes and, in doing so,

begins countering their deep scepticism towards the actions of politicians.

13. This deep public scepticism about politicians meeting their promises can be countered, I believe, by establishing a new National Health and Social Care Mutual into which all new National Insurance contributions would be paid and which an elected group of trustees would control – along the lines of the Office for Budget Responsibility model, but with the trustees elected, at least in part. These trustees would have the duty to:

- Help drive through the reform programme aimed at meeting patients' needs in the 21st century and delivering the efficiency savings targets for this Parliament.
- Oversee the introduction of a National Health and Social Care Service.
- Set out each year the funding requirements of the Service and, with voter approval, the necessary changes in National Insurance contributions to meet these requirements.
- Begin to roll out a National Health and Social Care Entitlement Card for membership of the new Mutual, setting out entitlement to the new Service.

14. The challenge of a £30 billion gap in funding could therefore be met by a new form of governance and revenue raising while at the same time reshaping a health service that reflects the pattern of health needs now, rather than those which the NHS so valiantly met in 1948. Then hospitals were primarily concerned with meeting acute health demands of the population. Now the health needs of a growing number of patients are for care which is now provided independent of the NHS. If the aim of our health service is to protect and promote the best health of each of us, from cradle to grave, it is no longer sensible to have on the one side an NHS meeting a structure of needs that it was set up to cover in 1948, and on the other a radically changing health needs profile which is increasingly covered from outside the NHS system. The proposal here is for refinancing the health and social care system and the changing of its National Insurance base to include, over time, pensioners who wish to opt in to the social care side, free at the point of use, of the new National Health and Social Care Service.

15. If the Chancellor were to seek a renegotiation with voters on a new contract for health and social care funding, he would be opening up the possibility of the most radical reform of this country's health services since 1948. It would enshrine the political necessity of providing health services

free at the point of use, with an independently guarded and buoyant source of income, as well as the revolutionary change of beginning to integrate health and social care.

16. The gains from this move would be considerable:

- A newly buoyant source of funding would be directed by the Mutual's trustees who would be in dialogue with contributors and with the government in setting contribution rates. The trustees' educational duty would necessitate a conversation with its members on the facts of life about rising health costs and any possible limits to the range of treatments that could be financed under a new health contract with voters.
- Health entitlement cards, which should be part of the reform, would help define our borders, combat health tourism and prevent fraud (see separate paper for how social security entitlements could also contribute to this exercise)
- The Mutual, as a democratic body whose trustees are elected by its members, would drive through efficiencies as part of the emergence of a new National Health and Social Care Service with clear funding

arrangements to which voters were committed.