Health and Social Care

DELIVERING A SECURE FUNDING FUTURE

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Contents

1. Summary of recommendations
2. Foreword
3. Introduction: The scale of the crisis
4. Our vision: What kind of health and care system do we want to see?
5. The economic case: Why is more investment needed?

Consideration of options:

6. Uses of additional revenue
7. Delivering service improvements
8. A sustainable footing for social care
9. Transparency in budget setting
10. Conclusion

Summary of recommendations

1. We believe it is necessary for the Government to provide a rise in real-terms funding for the NHS in England, of at least £4bn in 2018-19. This is in line with the recommendations made by the NHS England Chief Executive and leading think tanks ahead of the November 2017 budget. This should be matched by equivalent increases in funding for the devolved nations under the Barnett Formula. We further recommend that this should be followed by an annual rise of at least £2.5bn a year in real terms, uprated in line with inflation at approximately 2 percent per annum, for two further years. This should be matched by equivalent increases in funding for the devolved nations under the Barnett Formula.
2. We do not believe that further increases in council tax are a progressive, or sustainable, way to set health and social care services on a sustainable financial footing in the long term.
3. We recommend bringing together health and care funding in a single, ring-fenced tax which would replace National Insurance. This should be combined with social care funding which is currently raised through council tax, to raise the amount needed to sustain good quality services.
4. We recommend that additional funding for the NHS and social care should, for at least the next three years, be ring-fenced as an investment in out of hospital care.
5. We recommend that, in the medium term, the NHS should move away from the tariff for the pricing of healthcare services, which has greatly increased hospital and A&E activity.
6. We recommend that dedicated innovation funding should be made available in local areas to enable them to invest in innovative new ways of joining up local health and care.
7. We recommend that additional revenue be made available for local Government to invest in public health improvements.
8. We recommend that the Government look to introduce incentives to encourage people to save more towards the costs of their adult social care.
9. We recommend that the Government reinstate its commitment to introduce a cap on the costs of adult social care in order to give further clarity to individuals about the amount they should aim to save towards these costs, during their working life.
10. We recommend that an independent 'OBR for Health' is established, to make recommendations to Government about the funding required for a five-year cycle. Their considerations should take into account the costs of meeting projected demand for services and the cost of meeting any commitments to extend services which the Government has proposed.

Foreword

There are few who would deny that financial and capacity pressures on our health and social care services have become more severe in recent years.

Reports of services being cut back and treatment targets being missed are an almost daily occurrence; and the body of evidence suggesting that the current funding settlement is unsustainable has become hard to deny.

We know that in 2014 the NHS itself projected a funding gap of £30bn across health services by 2020[1], and that the Government claims to have committed £10bn of extra funding[2]. Yet the Health Select Committee has concluded that the Government's spending plans will only amount to a real-terms increase of £4.5bn[3] – a drop in the ocean of the total that is needed. In fact, in real terms, the Government's plans equate to a falling percentage of national income being spent on health and care[4], at a time when demand continues to rise[5].

We cannot underestimate the human cost of this crisis. Longer waiting times - with particularly poor access for many with mental ill health - cancelled operations, restrictions in treatment and more and more people unable to leave hospital following treatment because there is no follow-up care available for them. Ultimately, each of these factors leads to poorer outcomes and premature death.

We believe that, regardless of one's political persuasion, this does not make sense. Given the increasing pressures, we cannot continue to expect a service to deliver high standards of care without more resources. We also know that our health and care services are the most crucial safety nets the Government provides, so it is absolutely vital that policy makers of all views, should be prepared to think boldly and ambitiously about how we can protect them.

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[1] NHS, *Five Year Forward View*, October 2014. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2]Gov.UK, '*Spending Review and Autumn Statement 2015: key announcements*', November 2015. Available at: https://www.gov.uk/government/news/spending-review-and-autumn-statement-2015-key-announcements

[3] Health Select Committee correspondence to the Chancellor of the Exchequer, October 2016. Available at: http://www.parliament.uk/documents/commons-committees/Health/Correspondence/2016-17/chair-to-chancellor-NHS-funding-26-10-2016.pdf

[4]The Kings Fund, *How does the NHS Spending Compare With Health Spending Internationally?* January 2016. Available at: https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally

[5] The Kings Fund, '*How hospital activity in the NHS in England has changed over time'*, December 2016. Available at: https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes

That is why this panel has come together to make recommendations on how to deliver a new funding settlement for the long-term sustainability of our health and care system. We have discussed issues including:

- How much additional funding is needed for health and care services, both in terms of closing the projected funding gap, but also in terms of delivering any innovations which are needed to increase sustainability in the longer term?
- What are the specific areas of health and care services where additional revenue should be targeted?
- What are the options for raising additional tax revenue to fund health and care services? Thinking about how to reach the necessary amount, but also about how to ensure this is done in a way which is progressive and takes account of intergenerational fairness. This has included the case for introducing a hypothecated health and care tax.

Although the panel was brought together by the Liberal Democrats, and some members are affiliated with the Liberal Democrat Party, our recommendations have been arrived at independently, and are our own conclusions based on our professional backgrounds in the fields of health, care and economics.

This report sets out our conclusions in relation to the points above, as well as some points for wider discussion on related issues pertaining to the sustainability of the health and care system.

Key among our conclusions is our unanimous view that it will be necessary to raise additional revenue for health and care through taxation and therefore we have considered a number of options for how this should be done. First and foremost, we believe we should have this debate in an open and transparent way, as this crisis grows rapidly more severe.

It is our hope that these recommendations, if implemented, would help to deliver a higher standard of health and care, on a more stable financial footing, than is currently the case. This is something which all political parties in the UK should be fighting for and we hope anyone interested in resolving the crisis in our NHS will find this report a useful contribution to the debate.

Introduction: The scale of the crisis.

The pressures facing health and social care are nothing new. From the outset of the NHS, advances in technology, an aging population and growing expectations, have required more resources year on year. However, it is our view that we have now reached an undeniable crisis point and that while the causes of pressures on the NHS and social care are many and varied, underpinning them all is a serious funding shortfall.

January 2017 and December 2017 jointly saw the worst A&E waiting times since targets were introduced[6]. NHS England admit that staff are under "a level of pressure we haven't seen before[7] and NHS trusts recorded a total deficit of £770 million in the last financial year, despite receiving £1.8bn in bailout funding. At the same time, Government figures show that per capita spending on NHS England is due to fall in real terms in 2018-19 and rise by less than one percent in each of the following two years[8].

In social care, the Local Government Association has repeatedly warned of a £2.3bn funding gap in adult social care services by 2020[9].

Of course, when considering the combined effect of these pressures across both services, the picture is worse still. To take a snapshot of figures from the NHS last year, in November 2017 alone over 5,000 patients had to stay in hospital for a combined total of 155,000 days after being fit to be discharged,[10]. In a significant, and growing, proportion of cases this is because the care and support services they require once they leave hospital are not available. Age UK report that as many as 1.2 million older people do not receive the care and support they need with essential daily living activities[11].

Of course the problem is not just the funding total but the reduction of funding in primary and social care. The last ten years have seen an unprecedented rise in the share of spending going to hospitals, and hospital activity. The pressures on hospitals are the result

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[6] NHS England, A&E Attendances and Emergency Admissions, December 2017 Statistical Commentary. Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/01/Statistical-commentary-December-2017-11Jys.pdf

[7] NHS rejects claims of 'humanitarian crisis' in England's hospitals, BBC, January2017. Available at: http://www.bbc.co.uk/news/health-38538637

[8] HC Deb, 26 January 2017, cW. Available at: https://www.theyworkforyou.com/wrans/?id=2017-01-23.61257.h

[9] Local Government Association, *NHS Continuing Healthcare, House of Commons*, November 2017. Available at: https://www.local.gov.uk/parliament/briefings-and-responses/nhs-continuing-healthcare-house-commons-monday-27-november-2017

[10] NHS England, Delayed Transfers of Care Data 2017-18. Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2017-18/

[11] Age UK, Briefing: Health and Care of Older People in England 2017, February 2017. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/the_health_and_care_of_older_people_in_england_2017.pdf

of financial incentives from the tariff, as well as from changing need. (For example, NHS Digital figures show that the number of outpatient appointments rose from 60.6 m in 2005/6 to £113.3m in 2015/16, a near doubling[12], while in comparison, in Scotland the number has hardly changed) [13].

We are very concerned about the dramatic real-terms spending fall in both social care (down by 17 percent since 2009-10[14]) and primary care. We know these services need a secure basis of funding and we also believe we need a programme which will build stronger out of hospital services, that are closer to home.

When we began this work, former Liberal Democrat health spokesperson, Norman Lamb posed several key questions for our consideration. This is where we began our deliberations:

- Should we introduce a dedicated health and care tax? It is his view that funding the NHS only from existing, general taxation is becoming more and more problematic as demand continues to increase. There is an inevitable risk that there will be deeper and deeper cuts to other areas of public spending, such as education, as we struggle to keep health and care afloat.
- How can we make NHS and care budget setting more independent and transparent?
- What is the role of communities in keeping people healthy? For instance, what responsibility do employers have to take care of the health of their staff?
- If it is necessary to raise additional revenue for health and care through taxation, how can this be achieved in the most progressive way?

We have considered these questions and explored a number of other issues around revenue raising and efficiency in the NHS and care system during our discussions. Set out below is a summary of our conclusions on these points to date and a set of recommendations.

[12] NHS Digital, Hospital Outpatient Activity 2015-16, December 2016. Available at: http://digital.nhs.uk/catalogue/PUB22596

[13] ISD Scotland, Annual Acute Hospital Activity and NHS Beds Information in Scotland, December 2015. Available at: https://www.isdscotland.org/Health-Topics/Hospital-Care/Publications/2015-12-22/2015-12-22-AnnualAcuteActivity-Report.pdf?7416933775

[14] The Kings Fund, Adult Social Care Spending. Available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-social-care-older-people

Our vision: What kind of health and care system do we want to see?

When starting this process, we thought it was valuable to first set out the key principles of our health and care service that we think it is essential to safeguard, and certain improvements we think will help to build a more sustainable health and care service in the future.

- **A tax-funded NHS, available to all and free at the point of use**

It is our clear view that any new financial settlement for health and care must protect the best of what current services offer: an NHS where access is based on need and free at the point of use. This was a non-negotiable starting point for our discussions.

In accordance with this, we further believe that an NHS funded by national taxation continues to be the best option for delivering our healthcare system, and so we decided early in our discussions that we would not explore options for an insurance based health system as a means of raising additional revenue.

- **A health and care system which provides better care and is more efficient because it is integrated around the needs of patients**

We note that a shared concern about the way health and care services work currently, is that they often do not feel like they link up with each other in a way that ensures patients experience the smoothest transition between stages of their treatment and care. The well-publicised issue of delayed discharges for patients moving from hospital into social care, is a key example of this. Other every-day examples include delayed referrals between primary and secondary care, patients having to repeat their symptoms to numerous different care providers because we do not have a single medical records system, and the disconnect between mental and physical health services - to name just a few.

- **A health and care system which embraces improvements and innovation**

We believe there must be an acceptance and acknowledgement that costs for health and care will inevitably continue to rise in light of the growing, ageing, and more complex needs of the population and the availability of increasingly advanced treatments. We want a health and care system which embraces the best standards of care for all who need it, not a system which strips back entitlements to better treatments, or care for those with "less severe" needs, further and further.

As such, while some efficiencies should be possible, ultimately more money must be raised for health and care if we want them to remain the treasured national resources we value so much.

- **A health and care system which educates and empowers people**

We think it is essential that people are informed and empowered to take responsibility for their own health and wellbeing as far as possible. If we want a health system which is able to deliver for generations to come, then fundamental shifts in the way we take care of ourselves as a country are essential. However, we recognise that trying to change habits around food, drink and exercise (to name just a few examples) is not easy to achieve and the benefits can take decades to materialise.
Therefore, we believe it is self-evident that savings accrued from long-term public health changes are not a substitute for immediate investment in our health service - both will be needed.

- **A health and care system which combines strong local leadership with strong national standards**

We believe that allowing health and care to be delivered in closer collaboration offers many benefits for both efficiency and patient experience; and that this will require strong local leadership and commitment. Local authorities have proven highly effective at driving financial efficiencies during the last six years of budgetary constraints; for which they should be commended. We think that the capacity for local government to deliver more services, in closer collaboration with local health services, should be fully explored.

The initiative currently underway in Greater Manchester – where ten councils are coming together to deliver health and care services locally – has potential (although we appreciate that there is no evidence of outcomes yet). We look forward to more information emerging on the impact of this in coming years.

However, where any services are devolved, we are also clear that comprehensive national standards need to remain in place, for local partners to be held accountable.

We recognise that the challenge posed by increased localisation of services is the risk of a worsening 'postcode lottery' in availability and standards. In terms of funding, those areas with most demand for services are likely to be those least able to raise revenue needed to deliver them. As such, we are clear that the vast majority of revenue to fund health and social care should be raised from national taxation and distributed according to comprehensive needs assessments. We explore this in more detail in the section on council tax below. We are also clear that devolution, or better integration of services, cannot be used as a replacement for real financial investment.

The economic case: why is more investment needed?

We realise that many individuals and households have struggled to make ends meet; just as public services have in recent years. Asking people to contribute a larger amount of their income in taxes to fund our health and care system is not a request to be made lightly.

However, we believe the need for better investment in health and care is not just a moral and ethical one, there is an economic case to be made too. Investing in better healthcare and prevention can save both the health service, and the wider economy, billions of pounds in the long term.

Furthermore, the potential to deliver the most significant savings can only be realised if enough funding is made available, not only to keep services afloat, but to innovate too. Whether this is through better technology, trialling public health initiatives or improving the infrastructure in community care.

Currently, budgets are simply absorbed by trying to keep services afloat day-to-day, and there is very little left over for any of the improvements which could deliver savings in the long run. If we want our health and care service to be more efficient, we have to be prepared to invest more upfront.

As referred to above, we are also realistic that if we want to keep benefiting from the increasingly specialised services available to our NHS, there will be a cost associated with that. As such we are not basing our recommendations on any further projected savings to be delivered in the health and care budget.

How much is needed?
The Office of Budget Responsibility and the Organisation for Economic Co-operation and Development have both produced estimates of future trends in health spending in the UK, using age and income effect variables. The OBR looks at the effect of productivity, which produces a range of possible growth by 2060 from 12-18 percent of GDP. While the OECD projections cover relative prices, technology and innovations, and policies; and project a spending share of 14 percent by 2060.

The first Fiscal Risks Report published in July 2017 is highly negative about the longer term fiscal outlook[15]. Risks on the horizon could include recession, a rise in interest rates on public debt which now has a larger short-term component and a fall in tax revenues which are now being levied from a much narrower base than in the past. Bearing these risks in mind, we are recommending a steady but modest increase in funding, where the level of funding increase is linked to economic growth. We recognise that in the case of recession

[15] OBR, *Fiscal Risks Report*, July 2017. Available at: http://cdn.budgetresponsibility.org.uk/July_2017_Fiscal_risks.pdf

there would have to be greater restraint in health funding, as with other public spending programmes, but the new rule on steady growth would give confidence as the economy recovers.

We believe that given pressures on funding it is essential to allow a realistic link between health spending and GDP growth.

We believe it is necessary for the Government to provide a rise in real-terms funding for the NHS in England, of at least £4bn in 2018-19. This is in line with the recommendations made by the NHS England Chief Executive and leading think tanks ahead of the November 2017 budget. Formula. We further recommend that this should be followed by an annual rise of at least £2.5bn a year in real terms, uprated in line with inflation at approximately 2 percent per annum, for two further years. This should be matched by equivalent increases in funding for the devolved nations under the Barnett Formula.

Consideration of options for tax increases

As we have stated earlier in this report, we believe it is a misnomer for the Government to continue to claim that our health and care services can meet this funding gap through further efficiencies. It is well documented that our NHS is already one of (if not, the most) efficient health services in the world[1].

We are clear that protecting health and care services as we currently know them, will require additional revenue to be raised to meet the funding gap, through increases in taxation.

We have considered the following options for raising this revenue. In particular, we have taken into account two key principles which we identified at the outset of our discussions: how any tax increase can be delivered in the most progressive way possible and how best to take into account intergenerational fairness.

We believe some of the options below present considerable problems and have discounted them. However, others have the potential to play a key role in putting the NHS and care services on the sustainable financial footing we believe is essential.

Council tax

The Government have attempted to mitigate the social care crisis in the last two years by allowing local authorities to raise additional revenue through a 'social care precept' - essentially a ring-fenced council tax increase. It is our opinion that raising additional revenue for health and care through council tax poses several significant problems.

Firstly, council tax is widely criticised as being un-progressive, as it is not a direct tax on wealth. It is calculated based on house size, and is based on out-dated valuations from the 1990s. Variations are blunt, with the very smallest house paying a third the value of the largest mansion although the difference in values will be far larger. Ultimately it takes no account of ability to pay (with the exception of council tax benefit).

Council tax is also a very poor way of addressing the post-code lottery in the funding of services. As a general rule, areas with wealthier populations will be able to raise much more than those with less well-off populations. Whereas in many cases the wider social determinants of health mean that need can reasonably be assumed to be higher in poorer areas and vice versa.

Thirdly, the amount raised by the last two years of social care precept have been woefully inadequate in terms of meeting the needs of social care services. The three percent rise due to be implemented in this financial year (in those councils who have chosen to take this

[1] The Commonwealth Fund, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, June 2014. Available at: http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

option) will raise an estimated £900m[2] over two years. This is in the face of what we know is a funding gap of at least £2b per year.

While more could be generated by a further council tax rise, it is our view that this would be an unsatisfactory option for families who are financially struggling.

For these reasons, we do not believe that further increases in council tax are a progressive, or sustainable, way to set the health and care service on a sustainable financial footing in the long term.

Income tax increases

We have similarly considered the idea of raising additional revenue, ring-fenced for health and social care services, through an income tax rise. This has the benefit of being easily understood and transparent. Income tax is also the most progressive form of taxation as it is currently modelled, in the sense that it does not hit the unemployed or lowest paid workers at all.

As an example, a one percent increase on all income tax rates would raise just over £4.6bn in 2017-18[3]. This could of course be adjusted to shift a higher burden onto higher and/or additional rate tax payers to maximise how progressive, and workable, this solution would be. We think various iterations of an income tax increase are worthy of consideration by policy makers.

A further benefit of this option is that it appears to have support from the general public. Most recently, a poll commissioned by Sky found that 68 percent would support a one percent rise in income tax if the Government guaranteed to spend it on healthcare[4].

While this would raise a valuable cash injection for health and care services in the short term, it would not, in and of itself, solve the fundamental problems with the current health and care settlement – including siloed health and care budgets and the need for resource to keep pace with need in the longer term.

National Insurance: Changes to the upper earnings limit

We believe that there are some anomalies in the way National Insurance Contributions (NICs) are charged at present, if reformed, this may present a progressive means of raising additional revenue to fund health and care services.

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[2]The Guardian, Council tax can rise by 3% a year to help fund social care – Javid, December 2016. Available at: https://www.theguardian.com/money/2016/dec/15/council-tax-bills-can-rise-by-3-for-two-years-to-help-fund-social-care-says-javid

[3]HM Revenue and Customs, Direct effects of illustrative tax changes, April 2017. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571367/Nov16_Direct_effects_illustrative_tax_changes_bulletin_final.pdf

[4] Sky News, NHS crisis: Public back tax rises to boost healthcare – poll, February 2017. Available at: http://news.sky.com/story/nhs-crisis-public-back-tax-rises-to-boost-healthcare-poll-10760783

Currently, NICs are charged at 12 percent up to the 'upper earnings limit' of £850 a week (approximately £44,000 a year). Earnings above this limit are charged NICs at a rate of two percent.

Government estimates suggest that increasing the upper earnings limit on Class 1 NI threshold by £10 a week would raise an extra £170m a year[5].

This could, in theory, be raised by further increments, but we recognise the impact which a more rapid increase could have on the budgets of households which, while they might be comfortably off compared to many others, are also not wealthy.

We are keen that we balance the need for those who can afford it, to pay a little more, with the need to spread the cost of additional taxation as fairly as possible, rather than impose a particularly high burden on one group of workers.

National insurance: Payments by over-65s

Currently people who continue working after they reach the state pension age no longer pay NICs, regardless of how much they earn. We believe that in light of concerns about intergenerational fairness, this is increasingly difficult to justify.

The Intergenerational Foundation sets out that 1.4m people now work beyond the state pension age and that this number is rapidly increasing. It nearly doubled between 1993 and 2011, meaning that the revenue lost by the Treasury due to this exemption is also increasingly more significant. The Intergenerational Foundation go on to cite estimates that the additional revenue which could be raised by levying NICs on over-65s would raise around £2 billion[6].

We think this poses a particular problem given that while economic and welfare systems tend to be built on the premise that the next generation will be wealthier than the last, it is now widely accepted that this is no longer the case.

A report from the House of Commons Work and Pensions Committee in November 2016 noted that reductions in incomes associated with the 2008–09 recession have been felt particularly acutely by 'millennials' who constitute the youngest segment of the workforce, while for those aged 60 and over incomes are now 11 percent higher in real-terms than at their pre-recession peak in 2007-08[7].

Furthermore, the Institute for Fiscal Studies has found that "average incomes of those born in the early 1980s are slightly lower than those of the 1970s cohort at the same age - the first time for at least 50 years that a cohort has begun their working-age lives with average

[5] HM Revenue and Customs, Direct effects of illustrative tax changes, April 2017. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571367/Nov16_Direct_effects_illustrative_tax_changes_bulletin_final.pdf

[6] Intergenerational Foundation, All in This Together? Why over-65s Should Pay National Insurance, February 2013. Available at: http://www.if.org.uk/wp-content/uploads/2014/02/All-in-this-together-Why-over-65s-should-pay-National-Insurance.pdf

[7] House of Commons Work and Pensions Committee, Intergenerational Fairness, November 2016. Available at: https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/59/59.pdf

incomes no higher than those of their predecessors". The Resolution Foundation claims millennials are "the first generation that has so far earned less than the one before at every age" and that if productivity growth remains low, "millennials are at risk of becoming the first ever generation to record lower lifetime earnings than their predecessors"[8].

Furthermore, thanks to great strides made in tackling pensioner poverty, after housing costs pensioner households are far less likely to be in poverty than households of working age, particularly those with children[9].

For this reason, we suggest policy makers consider ending the exemption from paying NICs for people who continue working past the state pension age. NICs could either be equalised with the rates paid by the rest of the workforce, or introduced at a lower rate.

We appreciate that there may be concerns about placing this additional tax burden on people who are coming towards the end of their careers. However, this is the age group who are the biggest users of health and care services and, as described in the section on income tax above, on many measures this group of workers are proportionately better off than younger generations.

A dedicated health and care tax

We have also discussed hypothecation of taxation to pay for health and social care – raising all resource from a single tax. In our view, this option has some clear benefits, including that it would improve understanding of what health and care cost, and increase transparency around how our taxes are used.

We acknowledge that there are some challenges around hypothecation. Chief among these is that the revenue raised will fluctuate with the macro-economic situation, and so there needs to be a mechanism to ensure rates can also fluctuate to reflect need.

However, we think these concerns could be mitigated if certain additional safeguards were built in. One option, for instance, is to raise additional revenue as a form of 'stabilisation fund'. This could be raised during periods of national prosperity to supplement shortfalls in periods of economic downturn.

This option could be combined with the introduction of an independent means of setting budgets for health and care (discussed further in the section on 'transparency in budget setting' below). In brief, this could mean that an independent body would forecast the amount of revenue needed for health and care over a given period (for instance, a five-year Parliament), allowing the Government to make adjustments to projected spend, or taxation rates, as they are needed.

[8] House of Commons Work and Pensions Committee, Intergenerational Fairness, November 2016. Available at: https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/59/59.pdf
[9] House of Commons Work and Pensions Committee, Intergenerational Fairness, November 2016. Available at: https://www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/59/59.pdf

If this option were taken forward, we think the natural basis for this tax would be current National Insurance.

However, we recognise that this would have to be combined with changes in National Insurance rates or Income Tax, in order to ensure enough additional revenue is being raised to increase investment in the health and care system in the short term. We believe policy makers should consider the following options in order to do this:

- A small increase to all rates of Income Tax
- A small increase to the upper earnings threshold for NICs
- Ending the total exemption from NICs for workers who continue working past the age of 65
- An increase on NICs Class 1 employee main rate

To effectively bring together health and care funding, we believe a new funding formula would have to be designed to bring local authority funding which is currently allocated to social care into the central funding pot – this would then be distributed to areas on the basis of need.

We recommend bringing together health and care funding in a single, ring-fenced tax which would replace National Insurance.

This should be combined with social care funding which is currently raised through council tax to raise the amount needed to sustain good quality services.

Uses of additional revenue

We are acutely conscious that in asking people to pay more towards health and care services, policy makers have an obligation to ensure that money is used in the most efficient way, and that people have confidence about where their money is being spent.

We wholly accept that hospital care is facing a capacity crisis, and that public perception may be that this is where the health and care crisis is most acute. However, we think this is in large part due to long-term under investment in primary care, social care and community mental health services which leads people to seek out treatment in hospital when this is not the best, or most efficient place, to deal with their health complaint.

It is therefore our view that investing additional money in out of hospital care (chiefly, primary care and public health) to ensure we have strong services in those settings which people routinely use as their first point of call (as opposed to hospital/A&E, as is common-place now) would alleviate the pressures we've seen throughout the system – including in secondary care – in the most efficient way, as well as doing so in a way which is best for patients.

A single visit to the GP is estimated to cost £45[16] whereas a single visit to A&E can cost £124 just to be seen[17]. Of people attending A&E, around 11 percent of people are discharged without requiring treatment, and a further 38 percent receive guidance or advice only. The Kings Fund point out that this does not mean all of those attendances were inappropriate[18] but it does imply that a large number of costly and unnecessary A&E appointments are happening across the country.

While this is by no means entirely attributable to people being unable to access GP appointments, the same analysis from the Kings Fund suggests that four percent of people who could not get a GP appointment, or were offered an inconvenient appointment, went to A&E instead – a significant number, when considering the costs involved with each visit.

Of course, it is not just the cost - there are also significant benefits to patient care where it happens at a GP or other community-based service.

Equally, the positive impact of funding social care will be felt throughout the rest of the health system. Kings Fund research found that cuts in social care budgets were adversely affecting health services, according to nearly 9 out of 10 NHS trust finance directors and 8 out of 10 clinical commissioning group finance leads[19].

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[16] ITV News, GPs to vote on charging patients for appointments, May 2014. Available at: http://www.itv.com/news/update/2014-05-22/one-visit-to-gp-costs-45/

[17] ChoosewellManchester.org, *What it Costs*. Available at: http://www.choosewellmanchester.org.uk/at-hospital/what-it-costs/

[18] The Kings Fund, *What's going on with A&E Waiting Times*? Available at: https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters

[19] Kings Fund, *Social care budget cuts damaging the NHS, latest quarterly monitoring report finds*, October 2015. Available at: https://www.kingsfund.org.uk/press/press-releases/social-care-budget-cuts-damaging-nhs-latest-quarterly-monitoring-report-finds

We are certain that prioritising investment in these areas would not only deliver the best value for money but also the best quality of care, for patients, and their families, who are relying on these essential services.

We recommend that additional funding should, for at least the next three years, be ring-fenced as an investment in out of hospital care.

We further recommend that, in the medium term, the NHS should move away from the tariff for the pricing of healthcare services, which has greatly increased hospital and A&E activity.

Delivering service improvements

While we fully recognise that our NHS is renowned for both the quality of care it offers and its financial efficiency, we also recognise that some improvements in services will always be possible.

As set out above, we do not believe that efficiency savings can be used to plug the financial blackhole in services in the short-medium term, but we are also aware that if policy makers ask people to pay more, the public has a right to expect that they will notice advances in the care on offer.

Often cracks in services are the direct result of the pressure we are seeking to address here – under funding coupled with increasing demand, along with newer technologies and interventions. However, there are also ways in which we should be prepared to think about how we can deliver innovations, both to improve quality of care, and to put the health and care service on a more efficient footing in the longer term.

One way in which we are keen to see innovation is by breaking down the artificial divide between health and social care. We are interested in the potential of the integrated care pioneer sites and new models of care 'vanguard sites' to deliver these much-needed improvements.

Nationally there were 25 pioneer sites for integrated care announced in November 2013 and January 2015. They are focused on improving the delivery of integrated, person-centred, coordinated care. These pioneer sites now sit alongside the new models of care vanguard sites, which are developing and testing new and different ways of joining up health and social care services across England, utilising the expertise of the voluntary and community sector. They aim to provide high quality care that is accessible to everyone when and where they need it, with the individual in control of their care.

The goal is to put the needs and experiences of people at the heart of the health and care system; to move away from reactive, episodic healthcare and toward a system of preventative, holistic care and support. The hypothesis is that providing better support at home and earlier treatment in the community, will mean fewer people needing emergency reactive care in hospitals and an improvement in people's experience of care.

The Patients Association say they hear regular stories resulting from the negative impact of the lack of joined up patient centred care - particularly for frail older people, people requiring end of life care and people with mental health problems. Access to services in the community or in people's own home often falls down during out of hours periods and at bank holidays and weekends. At worst, the result can be hospital admission, medicalising the problem and loss of independence through prolonged admission.

Barriers to greater integration are largely rooted in the different funding arrangements for health and care, and a further challenge is the historic lack of investment in community

services. As set out in the section above, we believe out of hospital services including community care should be particular targets for additional investment.

The move to integrated care outside hospital would be essential even if there were more funds available. Patients with long term conditions need continuing support close to home. Any long-term illness can have mental and cognitive as well as physical elements and involve a spiral of decline by which greater inactivity leads to loss of functioning and social isolation. This, and other lifestyle changes, can only be improved through a continuing relationship with primary care. We are at a time of great change in patient need and the investment programme we set out is essential for better services to patients.

Integrated care has many merits. It can attract staff which might not be able to work the gruelling shifts now required in hospital. Training courses are shorter and content is under more local control. There is greater flexibility in meeting the new needs. Integrated training fits in better with the themes of devolution and local initiative.

Greater integration would lead to a social model of care which promotes wellness and independence, where medical care can be accessed in a timely way when needed, as opposed to a medical model of care that promotes dependence, as is currently the case. This would be more cost effective in the long run, but there would be a need to invest additional funding in new models of care, and for training and development of the workforce including the development of new roles.

We are keen to ensure that some of the additional funding identified under the proposal we have set out for raising additional revenue from taxation, be directed specifically towards innovation – including the ability to explore and implement new ways of working like those set out in this section.

We have also discussed ways in which other stakeholders within communities can feed into the work of both councils and the local NHS, in driving healthier behaviours within local populations. For instance, we understand that in the West Midlands, local businesses who demonstrate that they are taking steps to support the physical and mental health of staff, will be eligible for a discount in their business rates. We look forward to seeing the evidence of outcomes from this scheme and, if shown to be effective, we would be interested in seeing this rolled out more widely.

Evidence from the pioneer sites to date indicates that the exact model of joined up care can depend on local need and geography. Most models of joined up care use a care hub approach where there is a single point of access to health and care, and professionals work together as a multi-disciplinary team, often co-located. Care hubs may be part of primary care or aligned to primary care. Where individuals do have complex medical needs, there is a need for rapid access to specialist medical assessment. Some areas have developed this through access to community geriatricians or physicians, others have developed GP intensivist roles.

Integrated joined up care does not necessarily require all of the professionals and care staff involved in patient care to be employed in one organisation but it does require combining health and care funding so that services can be commissioned and delivered to meet the segmented needs of the population.

As such, we do not recommend an overhaul of the health and care system to bring the two services together. However, we are keen to see local areas developing processes for integration which best respond to their particular local needs and challenges. We are very clear that funding must be made available to ensure commissioners and providers of care have both the financial room and the capacity to explore and develop these models.

We recommend that dedicated innovation funding should be made available in local areas to enable them to invest in innovative new ways of joining up local health and care.

We recommend that additional revenue be made available for local Government to invest in public health improvements.

A sustainable footing for social care

There is no doubt that adult social care services across the country are in a state of acute crisis, with chronic underfunding and the growth in need for services, pushing councils across the country to breaking point.

Analysis by Age UK shows that 1.2 million older people in England do not get the social care they need[20] and the Local Government Association have warned of a looming £2.3bn gap in social care budgets by 2020[21].

The knock-on impact for NHS services is also clear to see. Of nearly 180,000 delayed transfers of care in NHS hospitals per month (based on statistics from May 2017) almost 40 percent were directly attributable to social care[22] and four out of five GPs say that social care cuts are driving up workloads in their practice[23].

While we welcomed the focus on social care funding in the 2017 general election, we were concerned by the Conservative Government's decision to drop their previous commitment to cap the costs of social care[24], which was developed following a report by Sir Andrew Dilnot, commissioned under the Liberal Democrat-Conservative Coalition Government.

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[20] Age UK, Briefing: Health and Care of Older People in England 2017, February 2017. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/the_health_and_care_of_older_people_in_england_2017.pdf

[21] Local Government Association, *NHS Continuing Healthcare, House of Commons*, November 2017. Available at: https://www.local.gov.uk/parliament/briefings-and-responses/nhs-continuing-healthcare-house-commons-monday-27-november-2017

[22] NHS England, *Statistical Press Notice Monthly Delayed Transfers of Care Data, England*, May 2017. Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/06/May-17-DTOC-SPN.pdf

[23] GPOnline, Exclusive: Four in five GPs say social care cuts are driving up practice workload, April 2017. Available at: http://www.gponline.com/exclusive-four-five-gps-say-social-care-cuts-driving-practice-workload/article/1429750

[24] The Guardian, Tory social care plans will leave people helpless, says former adviser, May 2017. Available at: https://www.theguardian.com/politics/2017/may/18/tory-social-care-plan-example-market-failure-andrew-dilnot

Furthermore, it was extremely disappointing to see no additional money for social care announced in the November 2017 Budget.

However, we also recognise that placing a cap on lifetime costs of social care only addresses issues in part and that this needs to be delivered in conjunction with incentives to encourage people to save towards the costs of care in later life.

As part of our work we took evidence from a childcare provider called Busy Bees who advocate introducing a salary sacrifice scheme, along the same lines as the one used for childcare vouchers, to encourage people to save towards the cost of adult social care. Their proposal centres on the introduction of:

"A capped non-taxable benefit scheme specifically for Adult Social Care [that] would result in greater funding which has similarly proved successful in funding and expanding childcare provision…

Through voluntarily sacrificing a proportion of a tax payer's salary, dependents can receive care through registered providers… the solution should allow all eligible tax payers to pay into a managed, ring fenced, adult social care fund that can be used to fund part of the care of their dependents and / or their own care. This fund should allow vouchers to be accrued and used when needed…".

While we have not made a judgement on all of the specifics of the proposal put forward by Busy Bees, we do recommend that the Government look to introduce incentives to encourage people to save more towards the costs of their adult social care.

We also recommend that the Government reinstate its commitment to introduce a cap on the costs of adult social care in order to give further clarity to individuals about the amount they should aim to save towards these costs, during their working life.

Transparency in budget setting

We believe that improving transparency and independence in budget setting for health and social care is essential – not only for the stability of services but also for public trust that their taxes are being spent in the most efficient way.

It is deeply concerning that there often appears to be little, or no, link between Government policy priorities in health and care, and funding allocations. A recent and well-publicised example being the ambition for seven-day GP services, which will require significant additional staff hours, but which has not been allocated the additional funding needed to deliver it.

We would like to see an independent body make a health and care budget recommendation to Government, setting out what is needed to deliver health and care services over a given period. We would suggest a five-year projection, to match the length of a Parliament.

This would essentially be a similar function to that carried out by the Office of Budget Responsibility for wider public spending, and the function could be carried out by a division of the same body.

We do, however, understand that it is important for democratically elected leaders to be able to make ultimate decisions about how to fund services; but this model whereby an independent recommendation is made, would still leave ultimate decision-making powers with the Government.

As such, we recommend that an independent 'OBR for Health' is established, to make recommendations to Government about the funding required for a five-year cycle. Their considerations should take into account the costs of meeting projected demand for services and the cost of meeting any commitments to extend services which the Government has proposed.

Conclusions

Given the NHS and care crisis we expect to see this winter, and the media attention and public concern this generates each year, we know it is essential that policy makers act quickly to make additional revenue available to health and care services. We hope our recommendations will be of use to members of all political parties and that the Government will consider them when setting future budgets.

We are unanimously of the opinion that it is necessary to raise additional revenue for health and care through taxation. We are already seeing the fundamental principles which underpin the service - of universal availability and access free at the point of need – being undermined by longer waiting lists and rationing of NICE approved treatments. We remain a long way off from achieving genuine equality of access for those with mental ill health and in social care, we know that thousands of vulnerable older people have seen services withdrawn.

We are also clear that the use of social care precepts added to council tax is neither an adequate way to resolve the funding crisis (in terms of the low amount of revenue raised) nor the fairest (in terms of where the burden of costs fall, and the unequal distribution of revenue raised).

Instead, we think that bringing together health and care budgets to increase transparency of the costs associated with these services; combined with a measured and progressive tax increase to address the blackhole in funding represent the best solution in the immediate term.

Furthermore, it is our firm view that for the long-term sustainability of services, thorough consideration must be given to where additional investment is best targeted. As set out above, it is our view that the priority areas for investment must be out of hospital care – particularly social care, general practice and community services. We know that primary care delivers better outcomes, at lower costs, and with higher levels of patient satisfaction, and that these sectors are key to delivering more sustainable care in the future[25].

There is also a clear need to ensure resources are available to invest in the innovations which will make health and care services increasingly efficient in future, particularly digitalisation.

Lastly, we would like to reiterate that we believe it is inevitable that the cost of these services will continue to grow and that for policy makers to argue we can deliver health and care services in the current model for the same – or less – money is being fundamentally dishonest with the public.

[25] Royal College of General Practitioners, The 2022 GP Compendium of Evidence February 2013.

We think that if we need to ask tax payers to contribute more money to an area of enormous national expenditure, then people deserve to have more information about what these services cost. We strongly recommend that an independent and transparent process for forecasting health and care budgets is introduced alongside any tax increase, to improve public understanding of why these essential services need the extra money that we are asking them to pay.