Institute for Public Policy Research

IPPR

THE STATE OF HEALTH AND CARE 2022

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ABOUT IPPR

The progressive policy think tank

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ABOUT THIS REPORT

This report supports IPPR's aim of reducing disadvantage caused by disease or disability.

SUMMARY

At the time of writing, England has a number of new health and care leaders. NHS England has a new CEO in Amanda Pritchard, who has been in post since August 2021. Sajid Javid took up post as secretary of state for health and social care in June 2021 – and has new opposites in both Labour and the Liberal Democrats. Outside Westminster, the ongoing introduction of Integrated Care Systems (ICSs) means a new cohort of CEOs, chairs and board members. Such a large leadership shift creates a unique opportunity for new and bold policy-thinking.

These new leaders stand at a defining crossroads. On one hand, they'll need to contend with Covid-19's disruption. On the other, they'll contend with the fact that health and care services were struggling even before the pandemic. They'll also need to prepare for a reality in which health shocks are a perennial risk (whether variants, further pandemics, the health consequences of climate change, anti-microbial resistance, an ageing population, or multiple condition prevalence). The implication is clear – recovery is not nearly enough: we must build back better, and we must do so for the long term.

The pandemic has rapidly accelerated an existing trend of decline in access and outcomes. The NHS was formed to 'universalise the best'. However, a steady decline over the last, austerity-defined decade – rapidly accelerated by the pandemic – threatens to undermine this founding mission. Across clinical priorities, access is poor, outcomes are below international standards and inequalities are widening.

- **On mental health:** Referrals and waiting times are rising. Referrals among children for eating disorders have doubled, and for self-harm they have tripled. NHS England board papers show a 74 per cent increase in referrals to mental health crisis services since the pandemic, and CF analysis of South East data shows sharp rises in routine and urgent referrals.
- **On dementia:** only around four in 10 people with dementia received a proper care plan/care plan review in 2021, compared with around seven in 10 through 2018-19.
- **On long-term conditions:** Analysis by CF shows a 19 to 30 per cent decline in outpatient appointments, which would lead to significantly worse outcomes for people living with chronic conditions
- **On cancer:** CF analysis suggests 369,000 fewer people than expected were referred to a specialist for suspected cancer - and 187,000 fewer episodes of chemotherapy were performed - in the first wave of the pandemic.
- **On primary care:** New polling by IPPR/YouGov showed that one in two British people are finding it harder to speak to a GP than before the pandemic (54 per cent) - with the GP patient survey suggesting this means more avoidable A&E admissions

This is creating the conditions for an 'opt-out' by those who have the means – embedding a two-tier system. As access to, and quality of, care declines, more people are supplementing their entitlement to public health and care with paid-for products – private insurance, health tourism, direct payments and 'waiting list fast passes'. Our analysis shows that:

- The UK is the G7 nation with the fastest rise in healthcare expenditure from out-of-pocket or voluntary insurance sources. As a proportion of GDP, both have approximately quadrupled since 1980.

- IPPR/YouGov polling shows that 31 per cent – extrapolated to the whole population, the equivalent of **16 million adults**[1] – in Britain found it hard to access the care they needed during the pandemic. Of these, 12 per cent said they used some form of paid-for alternative – and 26 per cent actively considered it. These figures rose sharply by social grade[2] (to 16 per cent and one in 31 per cent).

The risk is less a sudden privitisation, and more an emergence of something resembling the English education system - where the very best education is so often conditional on ability to pay (either private school fees, or via increased house prices). If this were to become the new normal after the pandemic (as it has in social care and dentistry), it would worsen overall health and widen inequality.

There is near-universal public support for retaining a universal, free, comprehensive and tax-funded NHS. Our polling shows consensus public support for the basic principles of the NHS as a system that universalises the benefits of the best healthcare and shares the cost across the population.

- 88 per cent of people thought the NHS should be free at the point of delivery.
- 88 per cent thought the NHS should be comprehensive, for everyone.
- 79 per cent of people thought the NHS should be funded through taxes.

This was consistent across voters for all three major UK political parties. It's a clear mandate to leaders: the public wants healthcare services that 'universalise the best'.

We propose policies designed to better live with Covid-19, to help build back better and to help prepare for the future. Our proposals are based on three aims: recovery, building back better and increased sustainability facing an uncertain future. Headline recommendations include the following.

- **On capacity:** Allowing a yearly cycle of huge strain in summer and near collapse in the winter, in health and care, would be sub-optimal – not least given health and care capacity are vital to keeping the economy open. We recommend the government introduce a statutory definition of sustainability in health and care, backed by a legal duty to maintain sustainability and scrutinised by a new independent body. More immediately, workforce retention is the most important priority, for both immediate resilience and build back better. We recommend a bold retention strategy, including a CPI + 5 bonus for staff, but also including action on workforce conditions, flexible working and progression. Last, we recommend government set a hospital occupancy target of 85 per cent – with both new hospital beds and expanded community care capacity used to meet that level.

- **On culture:** We recommend three big paradigm shifts in health and care: towards innovation, integration and prevention. On the first, we recommend new 'innovation adoption and spread mission statements', covering all the missions identified by the life science vision. These should give national purpose, set expectations and empower local adaption and implementation. On the second, we recommend a focus on culture, not just structures. Specifically, we recommend a major programme to develop 'system leadership' locally. We also recommend a new multi-year community health building fund, designed to build thriving health economies across the whole country. On the last, we recommend government target a doubling of the proportion of healthcare spend on prevention by 2030 – combined with bold action on obesity and tobacco outside the NHS.

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1   IPPR extrapolation using official population estimates
2   NRS social grades are a system of demographic classification first developed by the National Readership Survey. It is based on occupation.

- **On resource:** While the Comprehensive Spending Review and Health and Social Care Levy provide a financial boost for health and care, funding remains a challenge. Our analysis suggests the NHS will face a small resource gap in 2022/23, but much larger problems in 2023/4 and 2024/5. In turn, this will threaten social care funding, which is reliant on money being transferred from the NHS. Elsewhere, local public health budgets remain below 2014/15 levels in real-terms – despite the fact we've just experienced a public health crisis. We recommend the following increase in funding across health and care. In all cases, we recommend funding is confirmed for the next three years, now, to ensure much greater planning certainty.

TABLE S.1: OVERALL MULTI-YEAR FUNDING RECOMMENDATION FOR HEALTH AND SOCIAL CARE

	2022/23	2023/24	2024/25
Increase in health and care funding	£12.6 billion	£15.5 billion	£20.2 billion

Source: Authors' analysis

INTRODUCTION

Health and social care services remain under immense pressure in England. National Health Service (NHS) waiting lists stand at almost six million – meaning more than one in 10 people in England are actively waiting to receive care (Thomas 2021). Elsewhere, IPPR research has shown huge disruption to cancer care (Patel and Thomas 2021b); large variation in outcomes between the new Integrated Care Systems (Patel 2021); discrepancies in who gets access to high-quality social care in/around their home or community (Thomas 2021a), and an unprecedented strain on the NHS workforce (Patel and Thomas 2021a).

Simultaneously, there is a major shift in health and care leadership. Most obviously, NHS England and the Department of Health and Social Care have new top bosses – in Amanda Pritchard and Sajid Javid MP. Social care also has a new minister (Gillian Keegan MP), as does public health (Maggie Throup MP), and many departments vital to the health of the nation – notably, Michael Gove's Department for Levelling Up and Nadhim Zahawi's Department for Education – also have new secretaries of state. Opposing them are new leads for health and care in both Labour and the Liberal Democrat parties.

Outside Westminster, there is an important new cohort of local leaders. The new Integrated Care Systems (ICSs) are in the process of appointing chief executives, chairs and two boards each. Moreover, in just a few months, local government will go through a major election – with 146 English authorities and seven mayor roles under contention.

This new national and local leadership cohort find themselves in a uniquely important moment. On one hand, they may be tempted to focus on recovery from the severe and ongoing disruption caused by Covid-19; on the other, they need to contend with the fact that a return to 2019 standards of health and care is nothing like good enough. This edition of IPPR's annual State of Health and Care report demonstrates why there is an onus on each leader – local and national, government and opposition – to have a meaningful plan to build back better, and to do so sustainably, in the face of a hugely uncertain future.

RECOVERY IS NOT ENOUGH

The data suggests that aiming to 'recover' to 2019 levels would not be sufficiently ambitious. Even before the pandemic struck, the UK was experiencing steady decline in health and care access and outcomes. Capacity has been constrained by a combination of funding cuts, misplaced reform and incorrect definitions of 'efficiency'. In turn, health improvements had slowed considerably – and moved into reverse by the end of the decade (figure 1.1).

TABLE 1.1: AN EVALUATION OF HEALTH AND CARE RESILIENCE IN ENGLAND GOING INTO THE COVID-19 PANDEMIC (RED, AMBER, GREEN RATINGS)

Measure	Status	Evaluation
Beds	On the eve of the pandemic, England had just 600 critical care beds free – and an average of 2.5 general hospital beds per 1,000 people.	On beds per capita, we were well below average (around four per 1,000). By contrast, Germany had around eight per capita, and South Korea and Japan over 10.
Occupancy	At the end of 2019, only one in five hospitals had an occupancy under 85 per cent.	The best evidence suggests 85 per cent is the safe occupancy level of hospitals.
Workforce (health)	The UK had below average numbers of nurses and doctors at the end of 2019.	Meeting *just* the OECD average for nursing and doctors would require 20,000 more doctors and 30,000 more nurses.
Workforce (care)	The UK had a small social care workforce, relative to the size of its over 65 population, compared to other similar countries.	Social care work has well-established problems with pay, retention, progression and vacancies in England.
Finances	In 2019, UK spend on healthcare was just over 10 per cent of GDP. This was the second lowest of the G7.	While the impact of Covid-19 on finances is not yet known, the UK would need to invest significantly more into healthcare to meet the standard of comparable countries.
Capital	England has a nearly £10 billion maintenance backlog on the NHS estate – and recognised problems investing in the best technology and equipment.	UK capital was around 25 per cent below the OECD average, as a per cent of GDP, in 2019. Recent funding announcements may improve this, but do not grapple with more fundamental problems with the capital regime.
Tech/equipment	The UK has average amounts of radiotherapy equipment (RTE), and below average amounts of MRI and CT scanners.	Community Diagnostic Centre investment will improve diagnosis – but there remains clear evidence that the UK needs more, and more modern diagnostic capacity.
Medicines	Despite a proud history of medical discovery and innovation, the NHS has difficulty adopting and spreading new treatments.	Compared to similar countries, the UK adopts just 20 per cent of NICE approved medicines within 12 months of approval.
Years of poor health	Gains in longevity have outpaced gains in healthy life expectancy in the UK.	At the outbreak of the pandemic, men could expect to live 16 years in poor health – and women 19 years in poor health.
Population health	A major slowdown in the UK's progress on preventing avoidable ill health was noted between 2010 and 2020.	At the outbreak of the pandemic, England had a higher prevalence of adult excess weight (63.3 per cent of population, compared to 59 per cent OECD average); greater alcohol consumption per capita (9.8 to 8.8 litres); but a lower rate of smokers (16.6 per cent, compared to 18 per cent).
Inequality	England has wide and long-standing health inequalities.	In 2019, the deprivation life expectancy gap was 10 years for women and nine years for men. Since then, inequalities in life expectancy have widened.

Source: Recreated from Thomas (2020)

FIGURE 1.1: STEADY IMPROVEMENTS IN ALL-CAUSE MORTALITY STALLED BETWEEN 2010 AND 2020

Total deaths per 100,000 (all causes), 1990 – latest data, UK
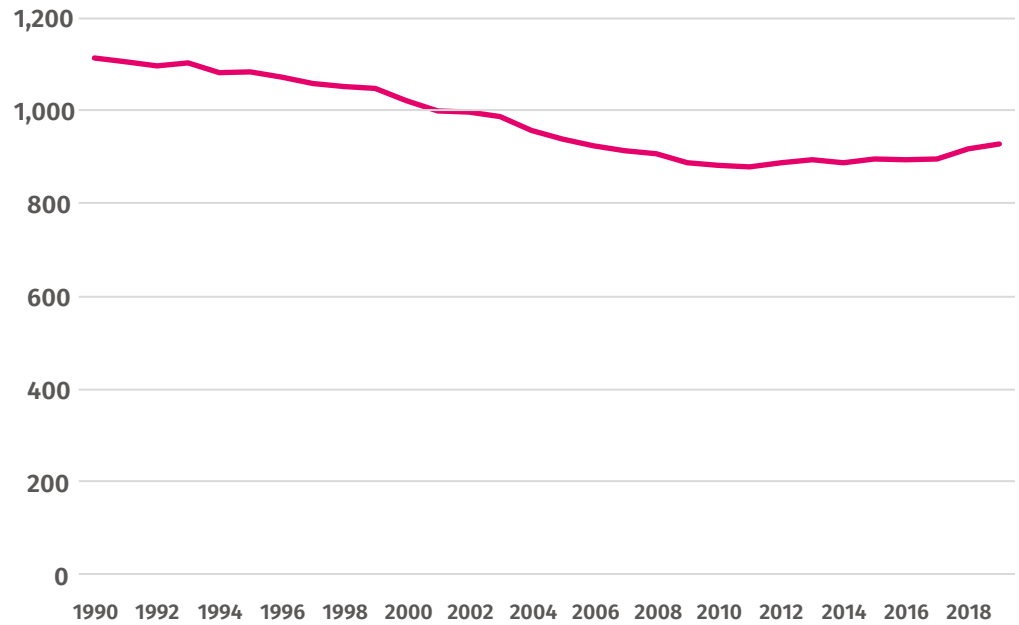
Source: Institute for Health Metrics and Evaluation (2020)

Had all-cause mortality maintained its 1990–2010 trajectory through the last decade, there would have been around 500,000 fewer deaths in England over the period.[3]

'Recovering' from the pandemic to a trend of stagnation is unlikely to be sustainable given that health now presents a source of significant ongoing vulnerability. This can be thought about in terms of national vulnerability.

• An ageing population, combined with stalling healthy life expectancy.
• An increasingly unhealthy and unequal country.
• The shift in health need to multiple long-term conditions and high-morbidity health conditions.

But it also includes supranational vulnerability, such as:

• the health consequences of climate change
• the increasing risk of pandemics or overlapping pandemics
• the challenge of anti-microbial resistance (AMR).

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3   This analysis does not justify an oversimplistic link to an individual cause. All-cause mortality refers to death from any cause.

Between health shocks

Covid-19, decisions during the pandemic and the context leading to the pandemic

Growing **supranational** health vulnerability, driven by growing pandemic risk, AMR, climate change (and the combination of the three)

Growing **national** health vulnerability – driven by ageing populations, rise in chronic and multiple conditions, high morbidity, social inequality

The extent to which we learn from the former will impact our ability to prevent or prepare for the latter

Source: Authors' analysis

The challenge is both a return to improvements in health and care access and outcomes, and making sure that those improvements are sustainable in the face of the growing risk of health disruption. Leaders will need to consider not just undoing the damage of Covid-19, but actively preparing for future health shocks.

MAJOR HEALTH THREATS

Climate change: In the coming decades, it is estimated that we will see an increase in environmental disasters, climate heating and extreme weather events. Pollution, severe weather and natural disasters all have their own direct health consequences.

Pandemics: The probability of experiencing a pandemic in one's lifetime is predicted to double over the coming decades (Marani et al 2021). The majority of this likelihood comes from increased animal-human contact globally, meaning pandemics and climate emergency share many of the same risk factors.

Population ageing: It is currently estimated that we will have an additional 7.5 million people aged 65 years and over in the UK in 50 years' time (ONS 2021a). This is likely to increase demand in health and social care across the UK.

Rise of multiple chronic conditions: An ageing population is linked to a rise in multiple chronic conditions, including mental illnesses such as depression and neurological conditions such as dementia. Two-thirds of adults over the age of 65 are set to be living with multiple conditions by 2035.

Anti-microbial resistance: AMR could change medicine as we know it. As many as 123 countries report extensive multi-drug-resistant tuberculosis, two billion lack access to anti-microbials, and the UK faces an increase in both health and economic impact in the years to come (see Thomas and Nanda 2020).

THE 'OPT-OUT' – THE CONSEQUENCES OF SUSTAINED DECLINE

If leaders fail to return health and care to a trajectory of improvement – and insulate those improvements against an uncertain future – there will be a consequence for the NHS as a project in universal, comprehensive care for all who need it. If healthcare in England falls behind the best a public health system can offer – in terms of either access or quality – we are likely to observe an 'opt-out' from public healthcare by those with the means to do so. That is, people who can and are willing to do so will supplement their entitlement to NHS care with private healthcare products – from insurance to direct payment, waiting list fast passes to out-of-pocket expenditure.

The risk is that this begins to decay the electoral coalition that has historically stood behind a comprehensive NHS.

This would not be a sudden transition (as is sometimes posited) to an American healthcare system. Instead, it would be a shift to something more like the English education system, where the best is attainable only by those who can pay and are willing to do so.[4] Or it might be comparable to dentistry in England, where poor NHS access for some, and superior but expensive access for many, has been gradually implemented and normalised since the 1950s. This would leave many vulnerable in an uncertain decade, for no better reason than their ethnicity, postcode, income or occupation.[5]

The alternative is a reinvigoration of health and care systems that genuinely 'universalise the best'. This is the most often forgotten of the NHS's founding principles, with campaigners and commentators more likely to quote its architect Aneurin 'Nye' Bevan on public ownership or tax funding, but it is integral. Universalise the best helps the NHS to ensure democratic consent, to share the benefits of good health and to evenly distribute the cost of that provision.

THE STATE OF HEALTH AND CARE

This edition of IPPR's annual State of Health and Care report has two aims. In part 1, it warns about the severe consequences faced if health policy is not sufficiently ambitious, well funded and innovation orientated. Our new analysis shows a worrying trend of rapid decline in both access to, and outcomes from, health and care services – observable in the decade before Covid-19, but rapidly accelerated by the onset of the pandemic. Part 2 then looks at the evidence around the 'opt-out'. We show that, while we are not past the point of no return in the journey to a two-tier system, we stand at the precipice of a growing 'opt-out' by those who can.

The report's second purpose trades more strongly in optimism. Our research has focused on what leaders – from Westminster, to ICS, to local government, to communities – can do to support a system of health and care that genuinely universalises the best. In Part 3, our policy recommendations are designed to help leaders balance the three challenges that define the current moment.

1. Learning to live with Covid-19: How can services continue to contend with the ongoing disruption of the pandemic (and its variants), the backlog of elective care and the otherwise natural increases in population health need?

2. Ensuring better health and care for all: How can we ensure a world-class health system going forward – one that discourages people who can from 'opting out', and one that doesn't fail those who can't?

3. Preparing for the future: How can we ensure that we build back better in a way that prepares for an uncertain future – and learns the lessons of the pandemic, and the decisions taken in the decade(s) before it?

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4   And their payment can come through private school fees, tuition or house price premiums incurred in the catchment area of the best state schools.

5   This system is already the norm, to an extreme degree, in adult social care.

Despite headline trends of poor access, declining quality and resource shortage, our analysis – both quantitative and qualitative – shows the NHS does identify instances of world-leading health and care. The vital task ahead is making sure that those do not remain isolated instances, but rather the rule for all.

PART 1:
STEADY DECLINE, RAPIDLY ACCELERATED

To help understand the current moment in health and care, around two years after the UK's initial public health response to Covid-19 began, we carried out in-depth analysis across five key clinical areas. Our aim was to understand trends in access and outcomes before the pandemic, as well as the consequences of the pandemic itself.

Each topic was selected based on its vital importance to national population health outcomes in the future – making them key determinants of whether our health and care system genuinely universalises the best, or not.

- **Elective care:** A key government priority and an area where there has been significant disruption over the last two years.
- **Mental health:** A major driver of poor quality of life, and a near universal experience across age groups.
- **Cancer:** The biggest driver of UK mortality (when considered as a whole).
- **Social care:** The area most hit by the pandemic, with long-standing concerns around access and quality.
- **Multiple long-term conditions:** The fastest growing challenge for both health and care services, and a key test of both integration and the shift to community-led health and social care.

Our analysis uncovers a pattern of slow decline during the austerity decade, rapidly accelerated by the pandemic.

CASE 1: MENTAL ILLNESS

The prevalence of mental illness has been rising in England for a long time – most acutely in women and young people (Adult Psychiatric Morbidity Survey 2016). Mental health problems are now the leading cause of disability in working-age adults (Vos et al 2020). Policy has failed to prevent the rising tide of mental illness in the population, and mental health services and treatment options have not been expanded to meet rising need.

The pandemic has amplified this mismatch. The Centre for Mental Health estimates that 8.5 million adults and 1.5 million children and young people will require mental health support over the next three to five years because of the Covid-19 pandemic (Centre for Mental Health 2021). This makes what once looked ambitious NHS Long Term Plan targets – to expand access to mental health services to an additional two million people – seem inadequate.

Children and young people's mental health has declined sharply during the pandemic, with large rises observed in both common and severe mental illnesses. A July 2020 survey commissioned by NHS Digital found a 50 per cent increase in the prevalence of clinically significant mental health conditions in children compared to 2017 – a rise far outstripping the background rate of increase (NHS Digital 2020).

Early reports of a rise in suicidal thoughts among children and young people has transpired into increased rates of severe mental health problems. In the third

quarter of 2020, our analysis shows hospital admissions for self-harm and assault in five- to 14-year-olds was 25 per cent higher than expected for that period (figure 2.1). An even steeper rise is seen in referral rates for urgent treatment of eating disorders, which have doubled since the onset of the pandemic (figure 2.2).

FIGURE 2.1: RISE IN HOSPITAL ADMISSIONS FOR SELF-HARM AND ASSAULT IN CHILDREN AND YOUNG TEENAGERS

Per cent change in hospital admissions for self-harm and assault compared to combined monthly average from 2018 and 2019
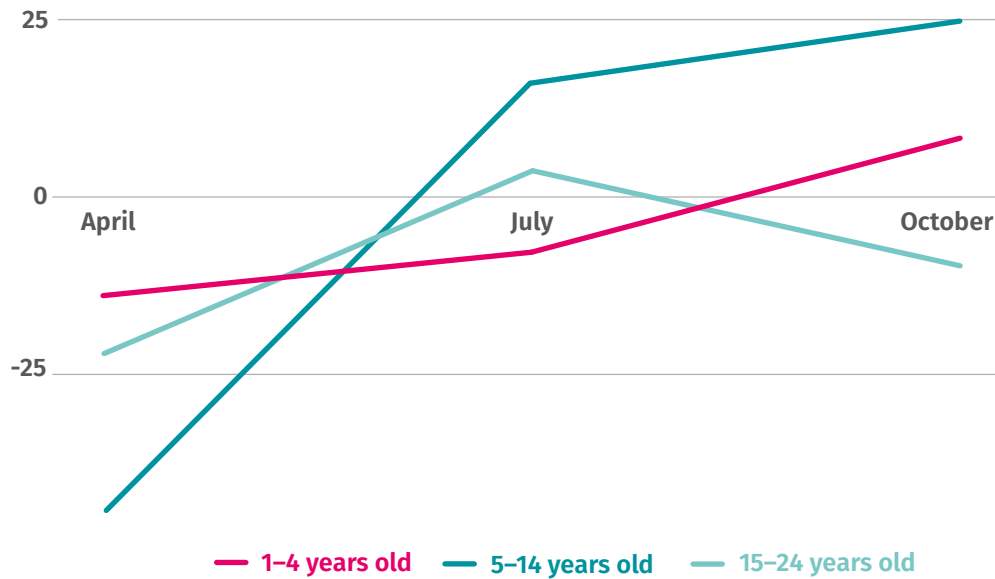
Source: IPPR analysis of Hospital Episode Statistics (2021), NHS Digital (2021)

FIGURE 2.2: RISE IN CHILDREN AND YOUNG PEOPLE EATING DISORDER REFERRALS

**Total number of children referred to eating disorder services since 2016**
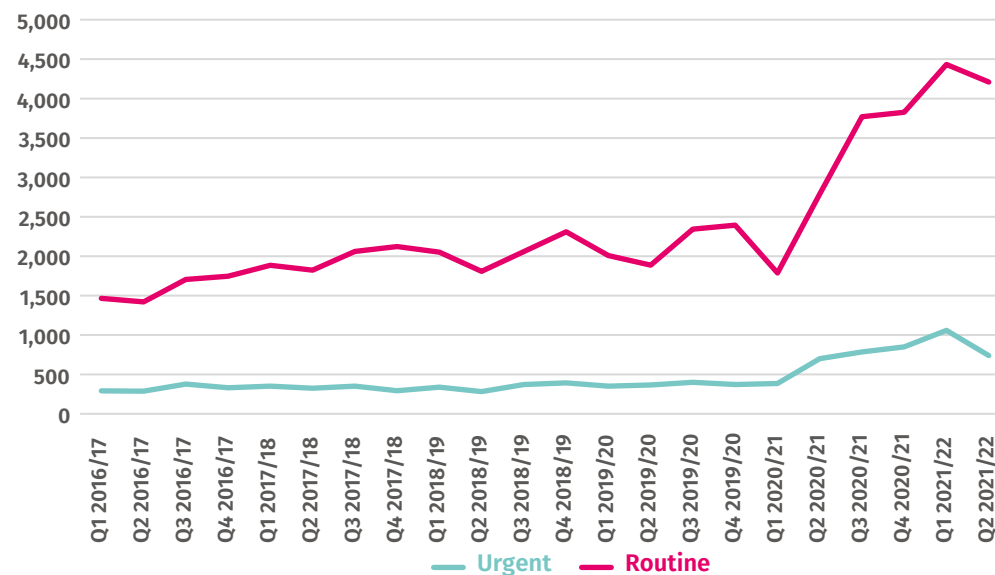
Source: IPPR analysis of Hospital Episode Statistics (2021), NHS Digital (2021)

Mental health problems in childhood and adolescence are especially damaging because of the life-course effect. New research from the London School of Economics, shared with IPPR, has analysed data from the longitudinal 1958 National Child Development Study to estimate the impact of adolescent mental health problems on future earnings (figure 2.3).

FIGURE 2.3: ADOLESCENTS WITH CONDUCT MENTAL HEALTH DISORDERS EXPERIENCE SIGNIFICANTLY LOWER LIFETIME EARNINGS

Cumulative earnings loss attributable to adolescent mental health problem
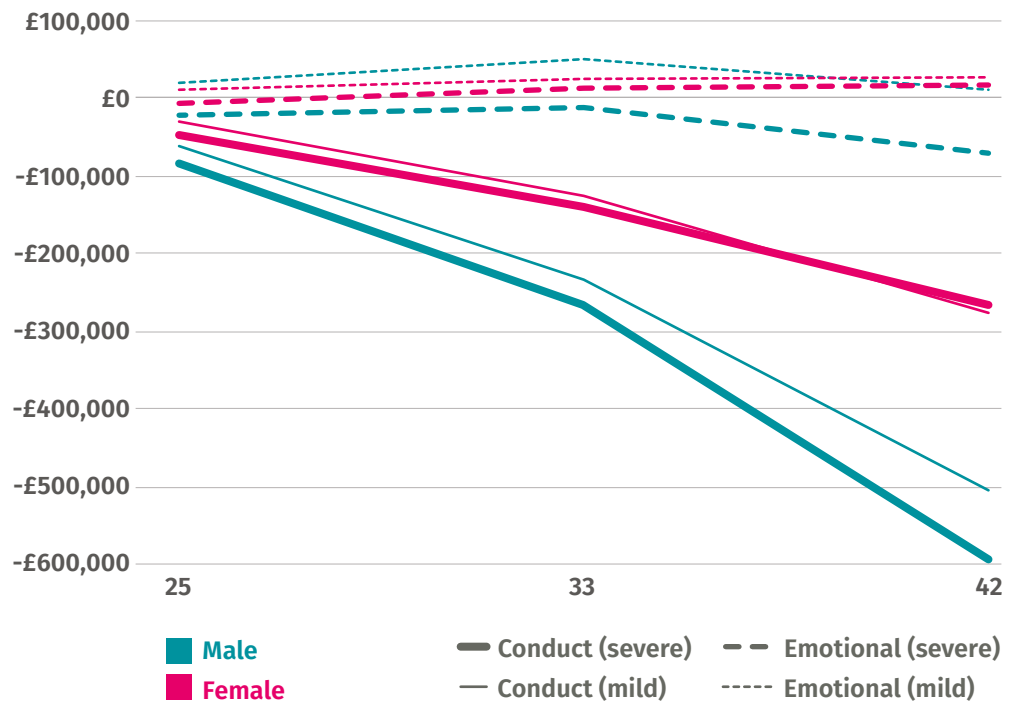
Source: Evans-Lacko et al (2021)[6]

The cost on lifetime earnings of a conduct mental health problem in adolescence is £600,000 for a man and almost £250,000 for a woman. This accelerates in a person's thirties, indicating that interventions among adults are not too late to have both a health and an economic benefit. This also reiterates 2020 IPPR research, which showed that, without intervention, mental ill health among the current cohort of children will cost the NHS and economy £155 billion per year by 2040 (Hochlaf and Thomas 2020).

Our new analysis also indicates an acceleration of mental health need among adults. The Office for National Statistics' (ONS) opinions and lifestyle survey finds depression rates increased from 10 per cent pre-pandemic to a height of 21 per cent at the beginning of 2021, falling slightly to 17 per cent in summer 2021 (ONS 2021b).

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6   Unpublished analysis of National Child Development Study cohort shared with IPPR.

FIGURE 2.4: A LARGE AND UNEQUAL RISE IN POPULATION DEPRESSION RATES

Percentage of people reporting symptoms of moderate or severe depression, grouped by age and disability
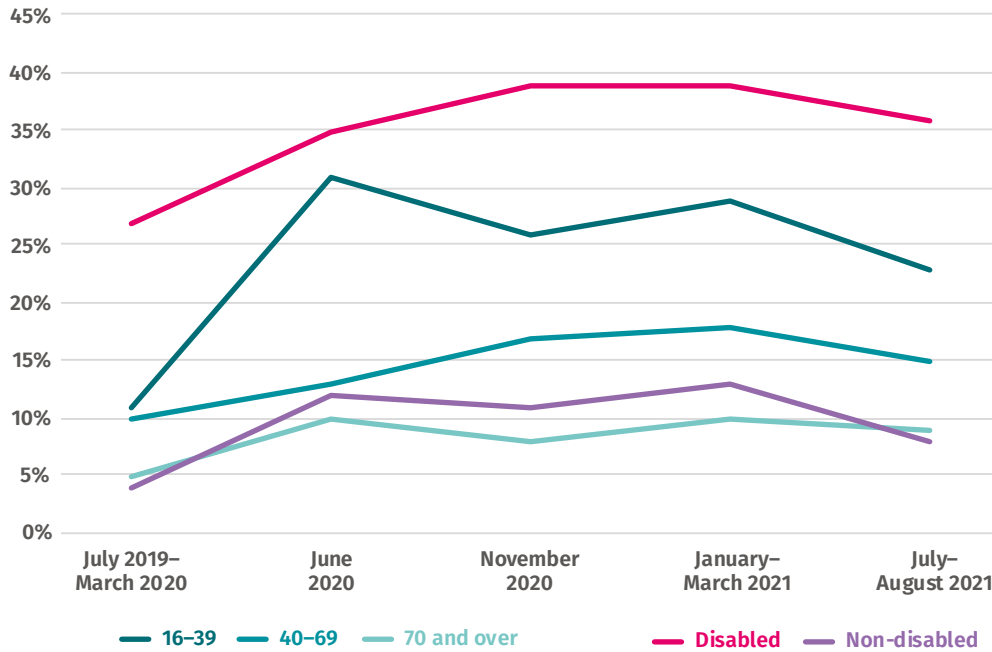
Source: Authors' analysis of ONS (2021b)

Figure 2.4 shows that this is unequally distributed by age and disability. This line graph demonstrates a clear peak for all groups during the first lockdown period in March 2020. Whilst this peak began to level out towards the beginning of the Autumn period, there was another increase towards the end of December 2020 and January 2021 where a second lockdown period occurred across the UK. This supports our overall understanding that the pandemic has further widened pre-existing inequalities, and social-economic concerns such as the closing of educational institutions and low-paid hospitality workers likely to have impacted young people.

Despite the greater burden of mental health problems among the most deprived communities, the number of outpatient appointments does not vary across deprivation levels (figure 2.5).

FIGURE 2.5: OUTPATIENT MENTAL HEALTH APPOINTMENTS DO NOT VARY BY DEPRIVATION LEVEL DESPITE THE UNEQUAL BURDEN OF MENTAL HEALTH PROBLEMS

Outpatient mental health attendances by deprivation quintile, as a percentage of all attendances

(least deprived)   (most deprived)
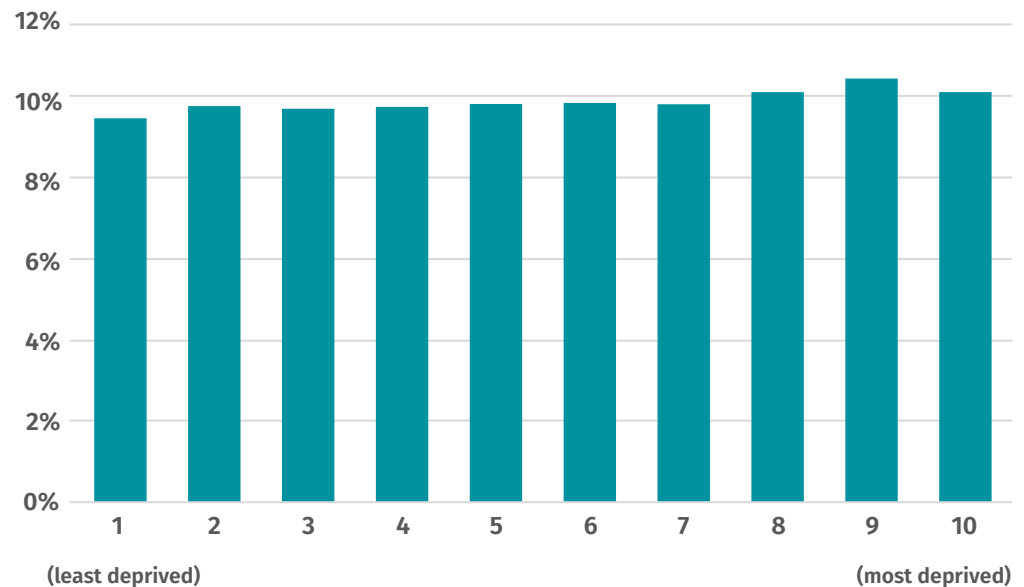
Source: CF analysis of Hospital Episode Statistics (2021), NHS Digital (2021)

The implication is that the greatest burden of unmet mental health need is in the most deprived groups.

CASE 2: DISRUPTION THROUGHOUT THE 'MULTIPLE CONDITION PATHWAY'

More than a quarter of adults in England have two or more long-term health conditions (Cassell et al 2018), and one in three people admitted to hospital have over five underlying health conditions (Stafford et al 2018). The distribution is very unequal; those in the most deprived regions are more likely to have multiple conditions – and do so 10 to 15 years earlier than their less deprived counterparts and with more functional limitations (Dugravot et al 2020).

By 2035, it is estimated that one in six people will be living with over four long-term conditions (Kingston et al 2018). Our health and care systems are not set up to handle this epidemiological shift, which means many people with chronic long-term health conditions end up in the place of last resort – hospitals – for care they could not access in the community. That is why shifting care out of hospitals has been a decades-long strategic priority for NHS England. Most recently, it was a central aim within the NHS Long Term Plan for England.[7]

The disruption to primary, community and outpatient care services over the past two years has derailed existing ambitions. Our analysis explores how the pandemic has accentuated challenges in settings central to supporting people with multiple conditions (primary, community and outpatient) – leaving us further from an NHS able to contend with this epidemiological reality of co-morbidities, and the demographic reality of an ageing population.

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7   For example, through the National Outpatients Transformation Programme.

Primary care

The almost five million people in England with over four health conditions usually see their GP once a month (Stafford et al 2018). They have suffered disproportionately from longer GP waiting times and much reduced planned GP appointments (booked 15 days or more in advance) that occurred between March 2020 and September 2021, compared to the monthly average for 2018 and 2019 (figure 2.6).

IPPR/YouGov polling of 3,466 adults in Great Britain in November 2021 found that as many as 54 per cent of people believe it is harder to speak to a GP – whether by phone or in person – compared to before the pandemic. The heightened demand pressures on GPs mean that planned appointments have still not recovered to their pre-pandemic levels (figure 2.6). As a consequence, and as shown by the GP Patient Survey, many will either wait until their symptoms worsen, or find themselves in emergency settings (where the cost is higher and outcomes far worse).

FIGURE 2.6: THE PANDEMIC HAS TRANSFORMED THE COMPOSITION OF GP APPOINTMENTS

Number of appointments as a percentage of pre-pandemic average
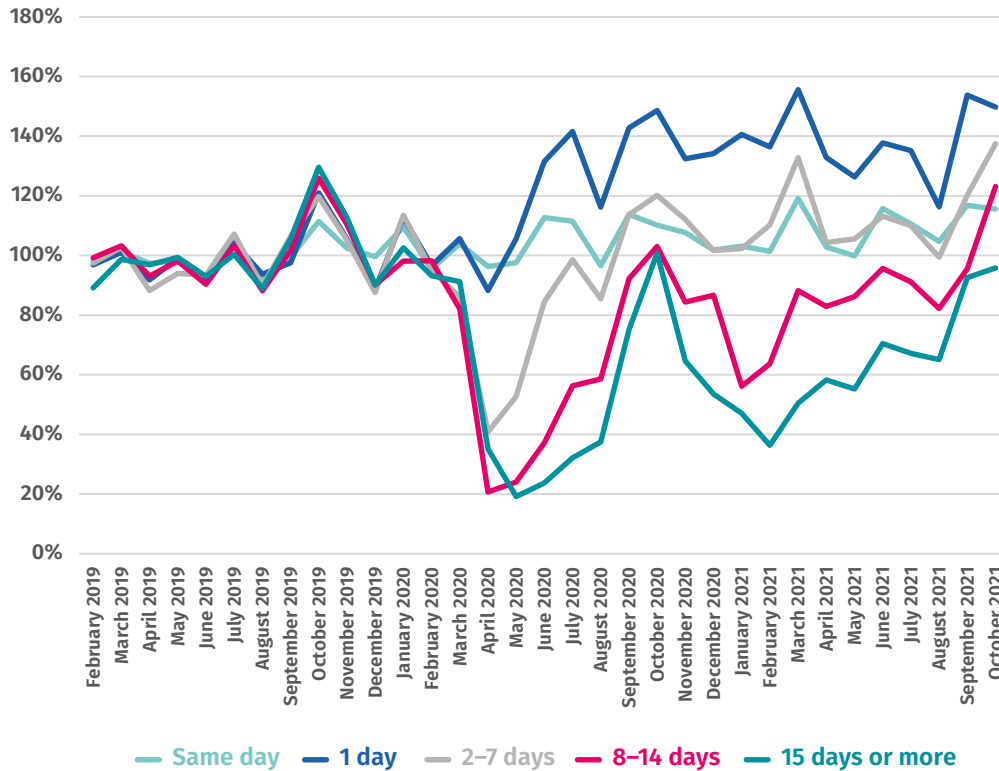
Source: IPPR analysis of Hospital Episode Statistics (2021), NHS Digital (2021a)

Another indicative consequence is a sharp fall in dementia care plan reviews conducted in primary care (figure 2.7). This is cause for concern: routine appointments and care plan reviews are a key part of effective planning for people with long-term conditions and are crucial in preventing avoidable hospital admissions.

FIGURE 2.7: THERE WAS A DRAMATIC FALL IN DEMENTIA CARE PLAN REVIEWS LAST YEAR

Percentage of people with dementia and Alzheimer's disease with care plan or care plan review in the preceding 12 months
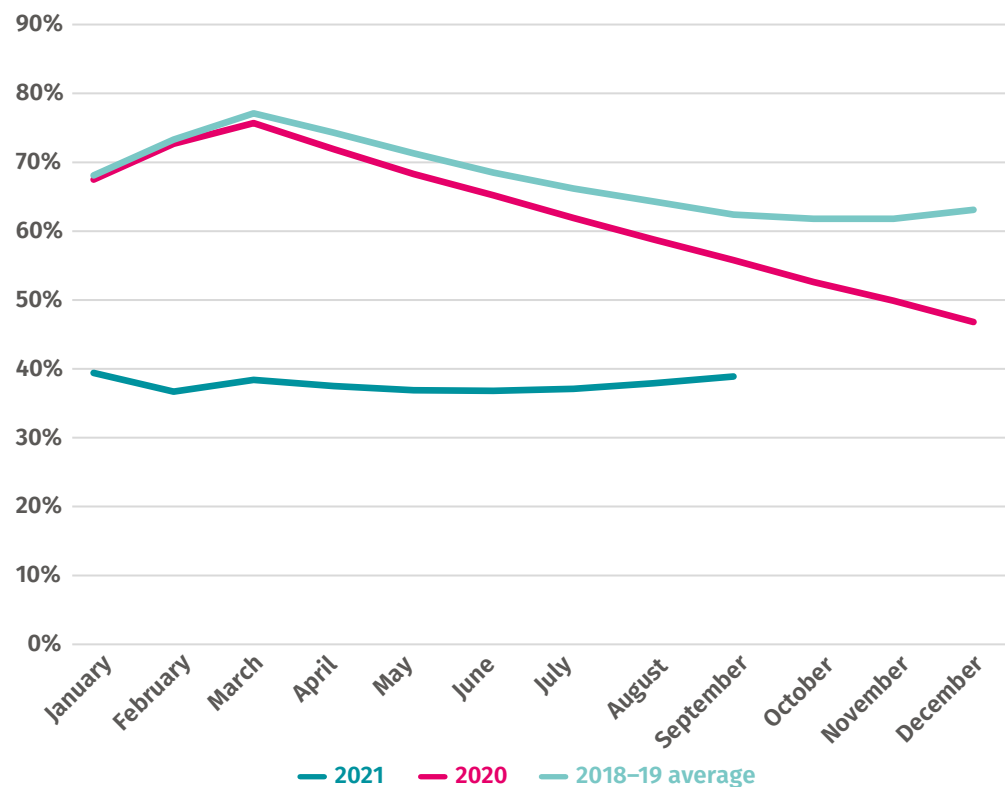
Community care

Expanded community care services – from rehabilitation to crisis – are vital to a 21st-century NHS equipped to deal with the reality of more people living longer with multiple long-term conditions. Primary care and community care services are to be better integrated through primary care networks (PCNs) to deliver more joined-up care for people with long-term conditions. To some extent, the pandemic repurposed community care services and PCNs for functions such as assisting rapid discharge of patients from hospitals and Covid-19 vaccine delivery. The consequence, however, has been a growing backlog of non-Covid-19 care in community care services, which remain far below pre-pandemic activity levels (figure 2.8).

People with (multiple) long-term conditions often also rely on outpatient care from specialty consultants. Here, following the initial drop at the onset of the pandemic, the recovery of outpatient appointments has been unequal, with inequalities between deprivation deciles widening.

FIGURE 2.8: UNEQUAL RECOVERY OF OUTPATIENT ACTIVITY FOR OLDER ADULTS (70 YEARS AND OLDER) BY DEPRIVATION DECILE

IMD

− 1 = most deprived −2 −3 −4 −5 −6 −7 −8 −9 −10 = least deprived
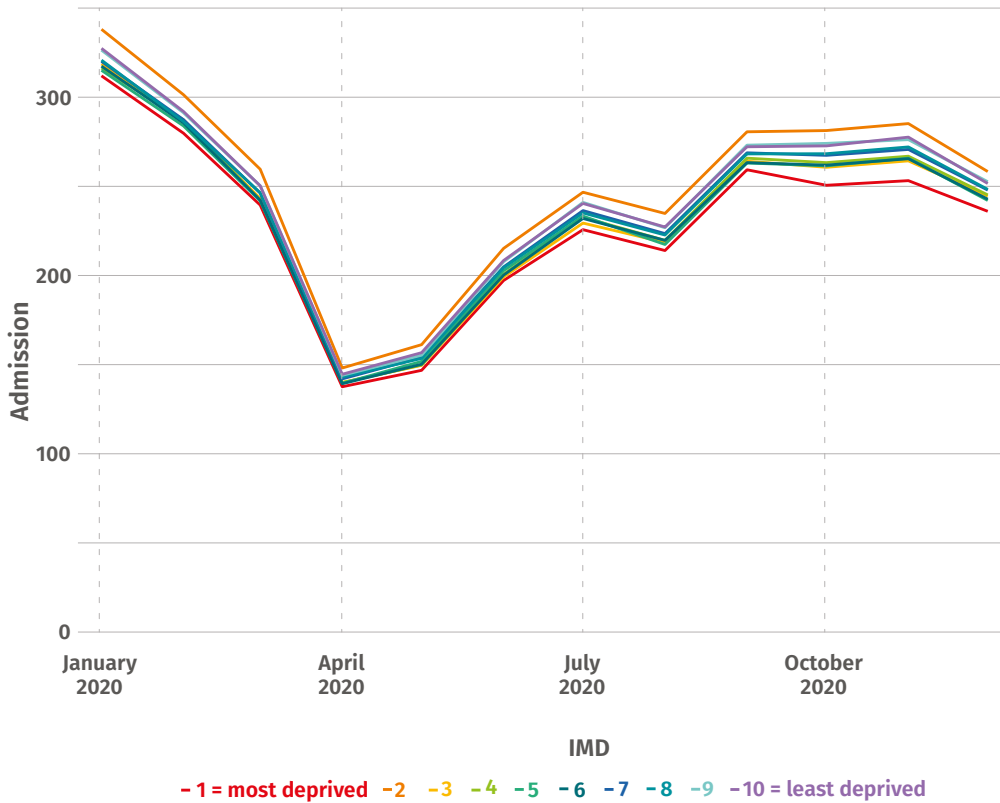
Source: IPPR analysis of Hospital Episode Statistics (2021)

Analysis by CF, a healthcare analytics firm, finds a 19 to 30 per cent decline in first outpatient appointments across a range of specialties between March and December 2020, compared to the same period in 2019 (figure 2.9). They suggest these disruptions will lead to an estimated 2,800-4,400 additional years lived in disability for people with long-term health conditions in the UK.

FIGURE 2.9: OUTPATIENT APPOINTMENTS HAVE DECLINED SHARPLY

Percentage drop in attendances between 2019 and 2020 by treatment specialty
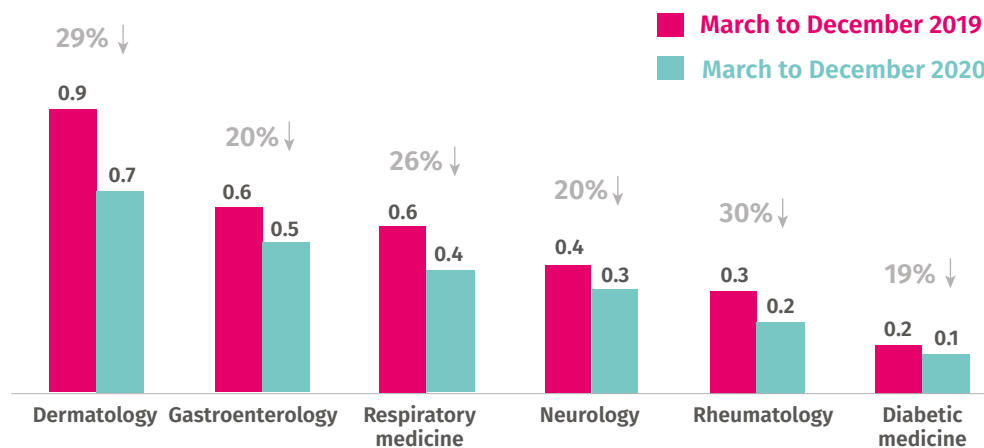
Source: CF (2021)

CASE 3: ACCELERATED DECLINE IN CANCER CARE

Cancer is one of the clearest case studies where a steady decline in the last decade has been rapidly accelerated by the pandemic. Our analysis of key cancer performance targets shows this across almost every key standard. Figure 2.10 shows – on two-week wait, one month to treatment and two-month standards – that this trend can be consistently observed. In each case, the operational standard was being consistently missed by circa 2018 and declined further, rapidly, during the pandemic.

Of course, these targets do not account for everything that matters in cancer care – from prevention to genomic pathways. Instead, they provide a representative indication of the trend and trajectory of cancer care in England. Moreover, it is consistent with analysis that suggests below average cancer performance in England – including gold standard international comparisons by the International Cancer Benchmarking Partnership (Arnold et al 2019).

FIGURE 2.10: A SLOW DECLINE IN CANCER PERFORMANCE WAS ACCELERATED BY THE PANDEMIC

Monthly cancer performance, national data, four indicative performance targets, 2009–latest data (% difference)
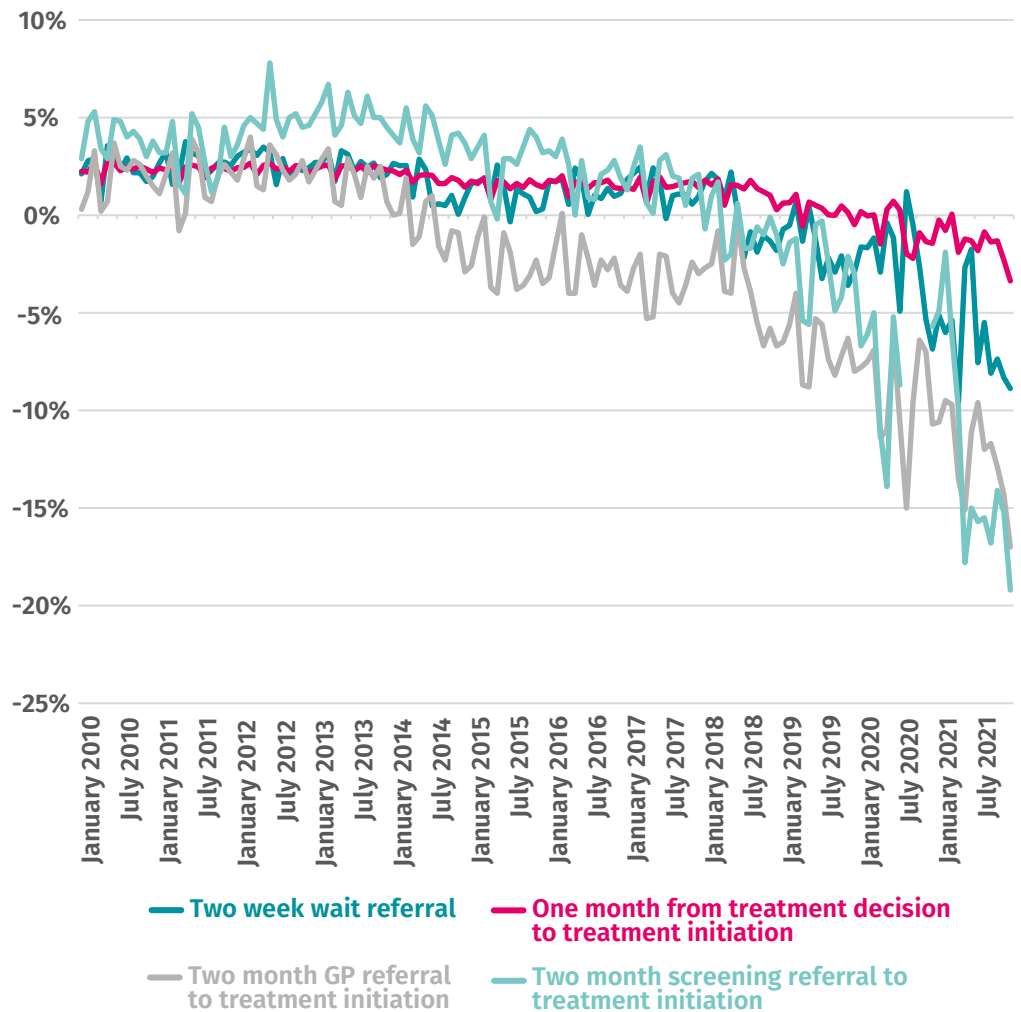
Source: NHS England (2021a)

At the provider level, it is clear that not everywhere is experiencing this challenge equally. Indeed, our analysis shows some providers have maintained performance – but that there has been a growing gap between the best and worst performers in the last decade. Again, this gap has been accelerated by Covid-19.

FIGURE 2.11: THE GAP BETWEEN BEST AND WORST PROVIDERS HAS WIDENED ON KEY CANCER METRICS

Difference between best and worst performing provider, percentage of people seen within requisite time period, monthly data, 2009–latest data
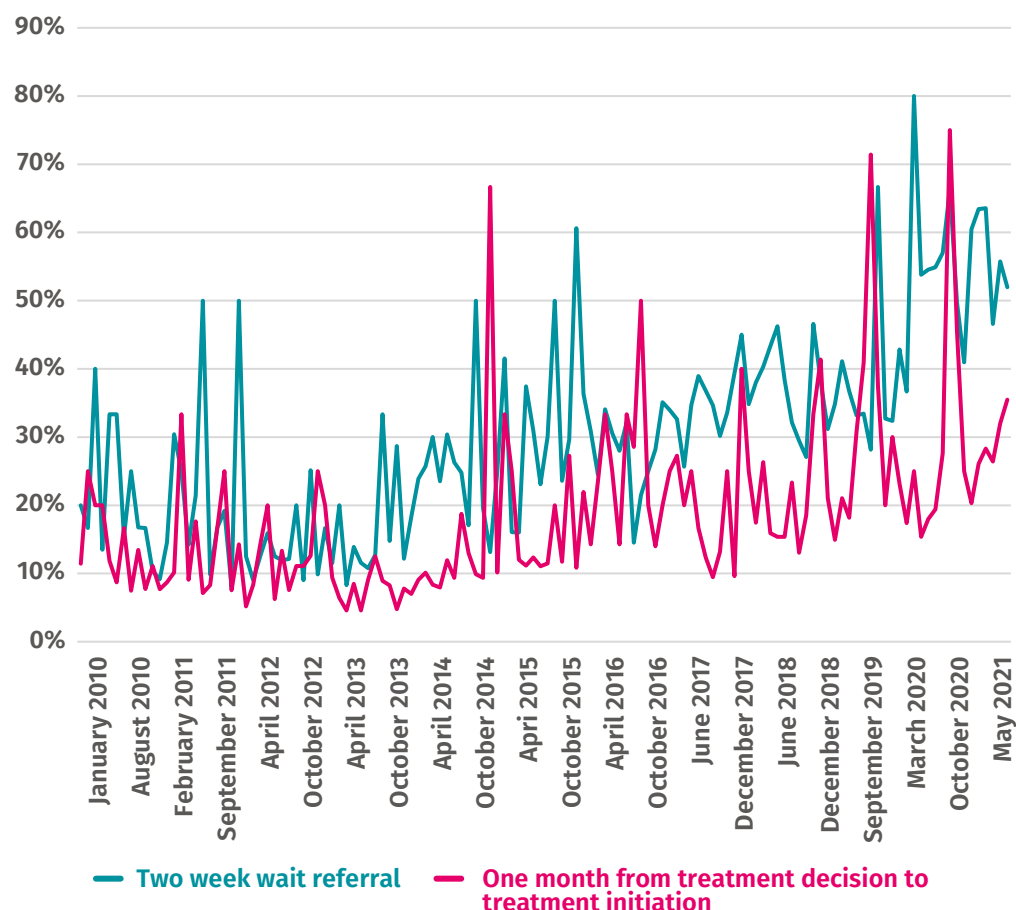
Source: Ibid

It is worrying, in the light of this new analysis, how long it could now take for cancer services to recover to established standards. Analysis by CF of NHS England and National Cancer Registration and Analysis Service (NCRAS) data shows that as much as 37 per cent of full-year activity was lost in endoscopy, while radiotherapy treatment episodes were 13 per cent below expected annual levels (see Patel and Thomas 2021b). The same analysis estimates that, in the first year of the pandemic, 369,000 fewer people than expected were referred to a specialist for suspected cancer, and 187,000 fewer episodes of chemotherapy were performed. The number of cancers diagnosed while still 'highly curable' fell three percentage points (from 44 to 41 per cent), despite early diagnosis being a key commitment in the NHS Long Term Plan for England.

The same analysis suggests that even if the NHS manages to maintain a future activity level of 105 per cent of those seen in 2019 – despite ongoing pandemic disruption and the fact the system was already being run hot – it will be beyond

2030 before we get back to usual radiotherapy treatment activity (ibid). This highlights the need for extra capacity and for much more extensive innovation – including community diagnostic hubs, innovative medicines, primary prevention and well-functioning genomic pathways.

CASE 4: ELECTIVE CARE

At the time of writing, nearly six million people in England were waiting for non-emergency medical treatment (NHS Digital 2021d). This is a huge number and, despite policy interventions in 2021, is likely to grow bigger before it falls (National Audit Office 2021). Even then, the challenge is not simply one of bringing down elective waiting lists as quickly as possible but bringing them down as fairly as possible too.

At the start of the pandemic, elective care was cancelled widely across all medical and surgical specialties. In this first instance, those cancellations were experienced equally by people across all deprivation quintiles (figure 2.12), but there is a clear social gradient in the recovery of elective treatment activity – activity levels have recovered fastest for the least deprived. Equally felt disruption at the beginning of the pandemic has diverged into a widening inequality in access to care.

FIGURE 2.12: ELECTIVE ACTIVITY IS RECOVERING FASTEST IN THE LEAST DEPRIVED PARTS OF THE COUNTRY

Number of admissions for elective procedures by deprivation quintile (IMD)

− 1 = most deprived − 2 − 3 − 4 − 5 − 6 − 7 − 8 − 9 − 10 = least deprived
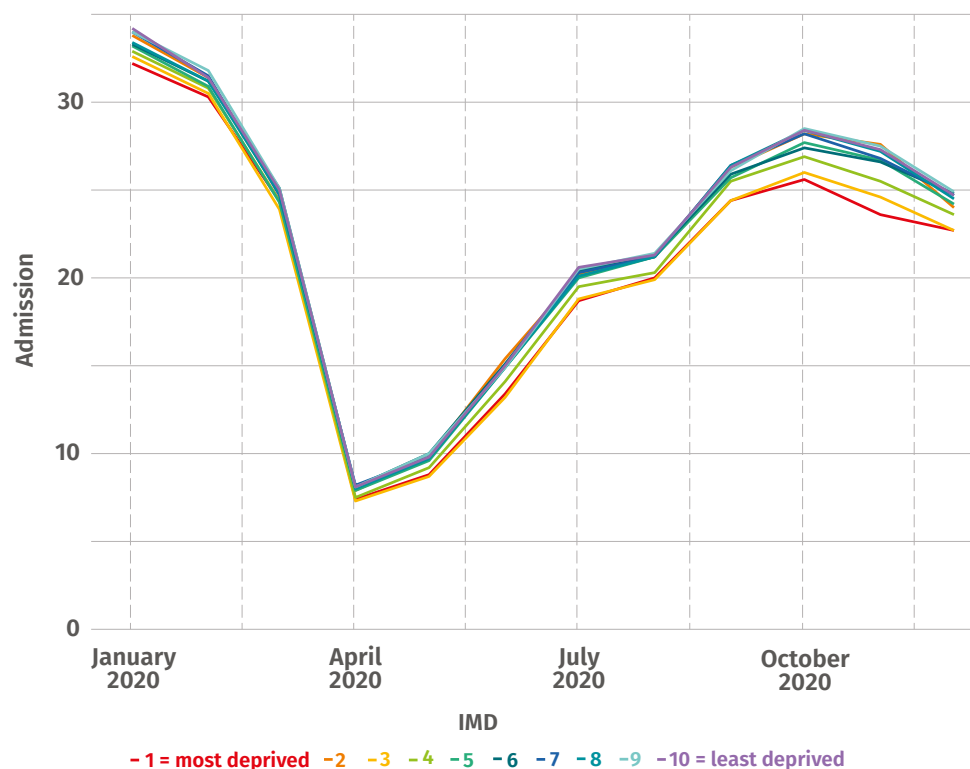
Source: IPPR analysis of Hospital Episode Statistics (2021)

Mapping waiting times against average deprivation levels reveals the scale of this social inequality. The number of people waiting more than 18, 52 and 104 weeks per 100,000 people is generally higher in more deprived parts of England (figure 2.13). At its most extreme, our analysis shows waiting lists 70 times higher in the worst performing area compared to the best.

FIGURE 2.13: WAITING TIMES ARE LONGER IN MORE DEPRIVED AREAS

Number waiting more than 18 weeks per 100,000 people

Number waiting more than 52 weeks per 100,000 people

Number waiting more than 104 weeks per 100,000 people
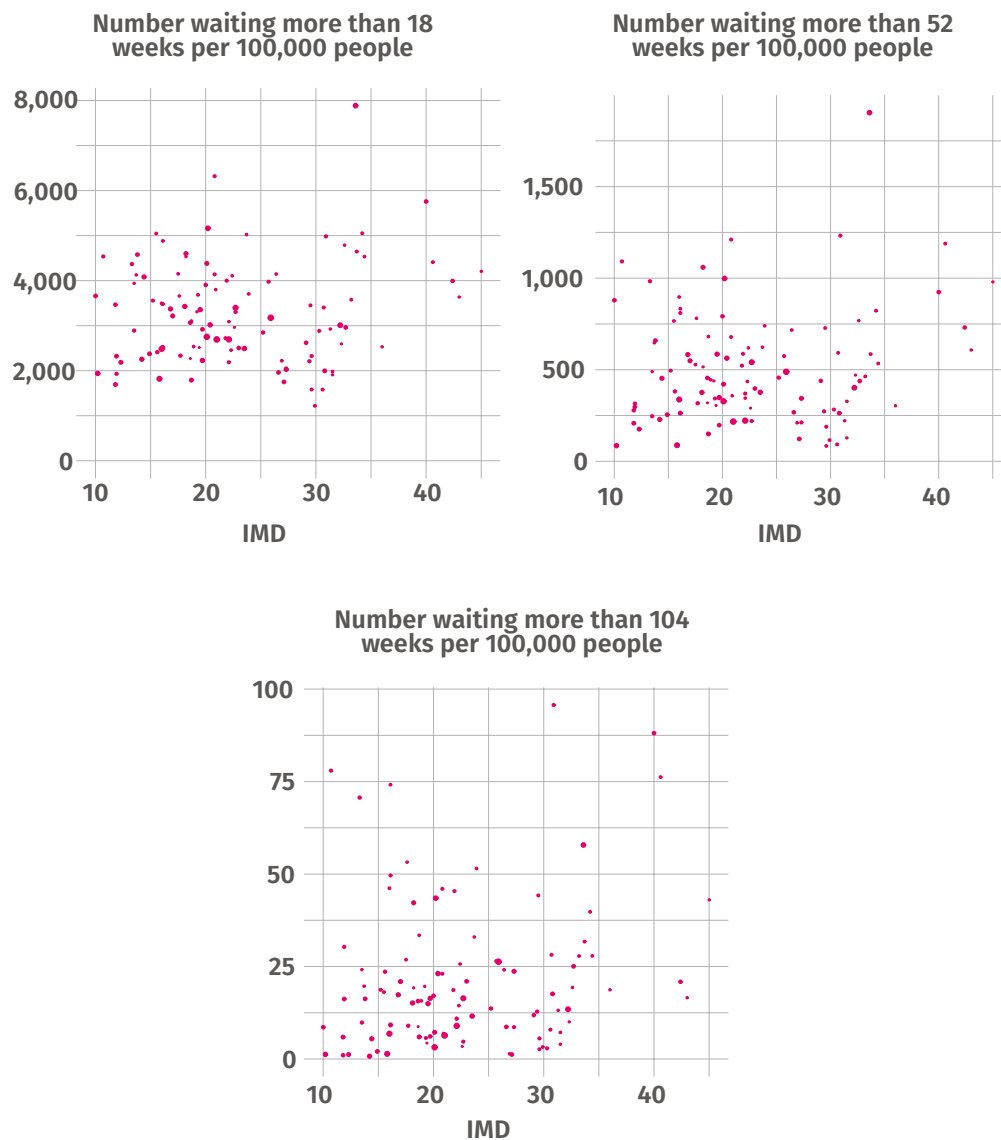
Source: LCP analysis of Hospital Episode Statistics (2021)

The government's funding for elective recovery - originally banded the 'biggest catch-up in history' - is unlikely to be enough to achieve the same kind of rapid progress on waiting lists seen at the turn of the millennium. Indeed, by the government's own estimates, elective waiting lists will continue to grow until 2024. More funding, and a clear sense of the innovations that could best boost activity, are evidently needed.

CASE 5: SOCIAL CARE

The pandemic has devastated a social care system that was already at tipping point. Covid-19 led to a significant increase in the number of deaths in nursing and residential care homes, which have been higher in care homes that rely more heavily on bank and agency staff, and lower in those where staff receive sick pay (Shallcross et al 2021).

The pandemic has also created backlogs and grown waiting lists in social care services. Public data is not currently available, but, based on a November 2021 survey of directors of social care services in England, the Association of Directors of Adult Social Services (ADASS 2021) estimates that:

- 200,000 people are waiting for an assessment of their care needs, with 41,000 having waited over six months
- 166,000 people have overdue reviews of care plans
- 25,000 people who have had an assessment are waiting to receive a social care service, an increase of 20 per cent from September 2021
- 1.5 million hours of commissioned home care could not be provided between August and October 2021 because of a lack of staff.

The state of adult social care is subject to a postcode lottery. Cuts in funding have been focused on more deprived parts of the country - often population dense areas in the North or Midlands. These tend to be areas where demand is rising fastest, as the table below shows - meaning supply is being disproportionately outstripped by demand in some parts of the country.

TABLE 2.1: DEMAND FOR ADULT SOCIAL CARE HAS RISEN FASTEST IN THE MOST DEPRIVED PARTS OF THE COUNTRY

Adult social care average requests for support received 2016/17 and 2020/21 in the 10 most and least deprived parts of England

	Average number of requests for support received from new clients
Most deprived	19,095
Least deprived	7,940

Source: DLUHC (2021)

Government policy on social care is unlikely to address this postcode lottery. In September 2021, the government announced plans to reduce the financial barriers to accessing social care. The proposals would make the means test more generous and set a cap on the amount an individual has to pay for care in their lifetime. This is a small step forward that will make accessing social care easier for some. But it does not go nearly far enough – and is far from consistent with the prime minister's pledge to 'fix social care'. Specifically, it does not undo the inverse care law – people with fewer assets will need to use a greater proportion of their wealth to access social care (figure 2.14).

FIGURE 2.14: DIFFERENT SOCIAL CARE FUNDING MODELS IMPACT DISTRIBUTIVE IMPACT

Proportion of assets depleted under five social care funding scenarios

Legend:
- Government proposal
- Current system
- Cap at 15% of assets
- Dilnot, £46k cap and £125k upper capital limit
- Dilnot, £78k cap and £300k upper capital limit
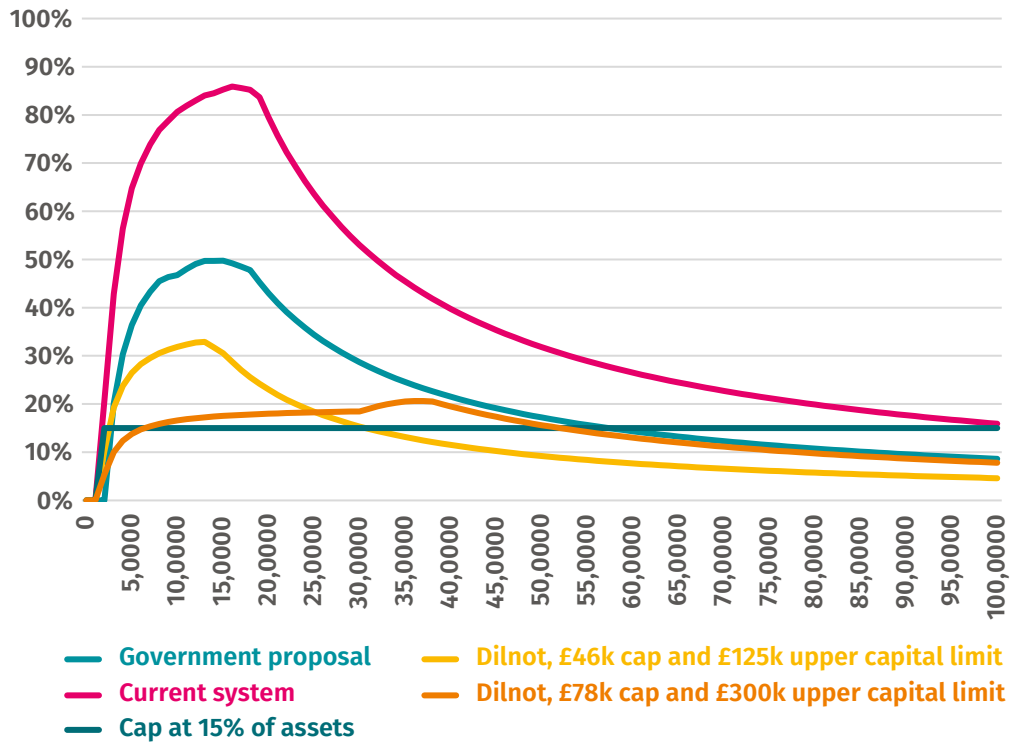
Source: Browne (2021)

Moreover, these reforms do little to alleviate growing waiting lists in social care services, which are limited primarily by the state of the social care workforce. Approximately 430,000 care workers leave their job every year, and there are around 112,000 vacancies at any one time (Skills for Care 2020). Two further policies will further exacerbate the care worker shortages. The imposition of mandatory Covid-19 vaccination, which came into effect in November 2021, will lead to 17,000 to 70,000 care home staff leaving their jobs, according to government estimates (DHSC 2021). Furthermore, the new immigration rules that came into place on 1 January 2021 mean labour migrants cannot come to the UK to take up most care worker roles, which will significantly restrict the labour supply of a sector heavily dependent on migrant labour. The likely consequence is growing waiting lists and difficulty accessing social care service, despite the government's reform to financial barriers.

PART 2:
AN OPT-OUT BY THOSE WHO CAN

There has often been a fear that the NHS will be privatised, in a sudden act of parliament of free trade agreement. Research elsewhere has shown that this is unlikely, and that the NHS' own spend on private provision does not seem to be rising quickly (Buckingham and Dayan 2019).

However, there is a second, more worrying challenge that threatens to define the NHS's 'new normal' after Covid-19. We call this trend the 'opt-out'. In short, this refers to people supplementing their public healthcare entitlement with private products – insurance, out-of-pocket expenditure or similar – as a direct consequence of NHS access or quality falling behind what is possible.

If leaders do not act to build back better, the opt-out is likely to increase – with dentistry one example of what the eventual end point might look like. Naturally, this would have consequences for care – a single-tier, universal NHS is better for equality, for innovation spread, for real world data and for clinical research. Other research shows a one-tier public healthcare system is more accountable and more efficient.[8] But more importantly, allowing a two-tier system to emerge would go against the clear public preference for the NHS to maintain its founding principles of 'free at the point of delivery, based on need, funded by general taxation'.

One of the best indicators of this trend in practice is the rise in out-of-pocket expenditure to pay for healthcare directly (in other words, from private bank accounts) and the rise in voluntary insurance (either personal, or through employers). Figures 3.1 and 3.2 compare trends in the UK to other G7 nations since Organisation for Economic Co-operation and Development (OECD) records began.

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8   Of course, that is not to say the NHS performs perfectly on these items – as Part 3 will show, there are many places where the government should leverage the natural advantages of the NHS to improve the spread of innovation, the personalisation of care and progress on health inequalities.

Healthcare funding from out-of-pocket expenditure as a percentage of GDP, G7 nations, 1970–2020 or latest data
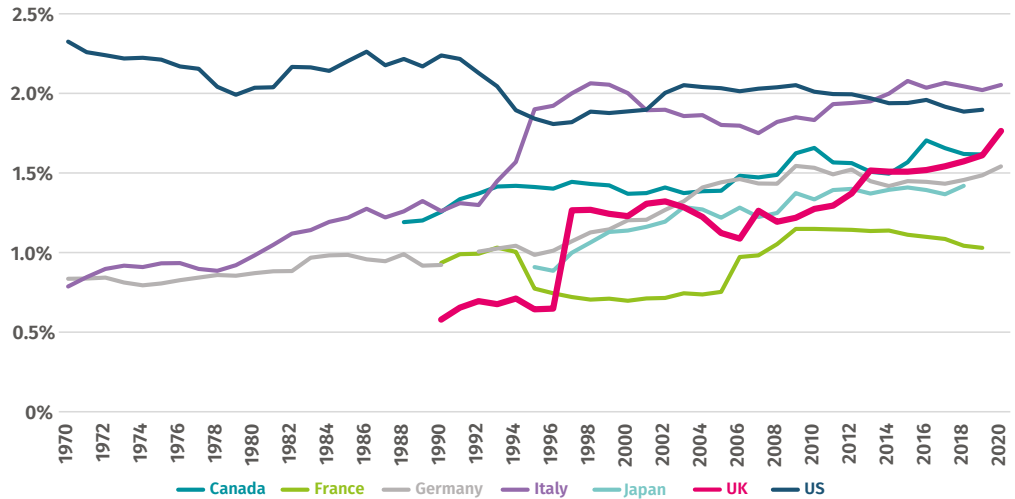
Source: OECD (2021)

FIGURE 3.2: HEALTHCARE SPEND VIA VOLUNTARY SCHEMES HAS INCREASED IN THE UK

Healthcare expenditure from voluntary schemes as a percentage of GDP, G7 Nations, 1970-2020 or latest data
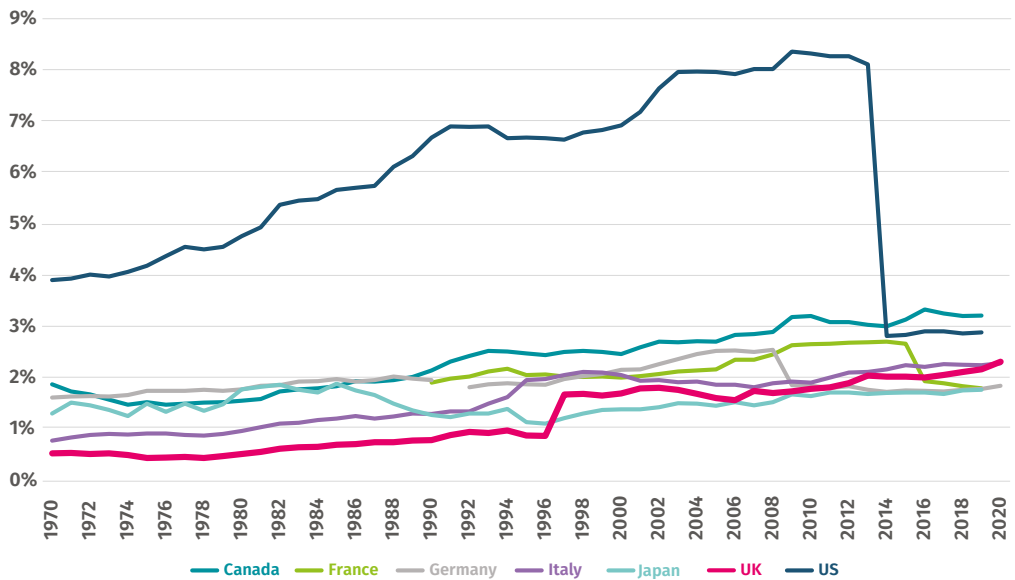
Source: Ibid

Out-of-pocket expenditure in the UK has risen faster than any other G7 nation since the 1970s. Having been the country least likely to use direct out-of-pocket expenses – a legacy of the nature of the focus on tax funding during the NHS's conception – we now rely on them more significantly. They have nearly quadrupled as a proportion of GDP in half a century. During the same period, NHS spending as a per cent of GDP only doubled, from around 3.5 per cent (1970/71) to around

7 per cent (2016/17). Overall, that means private healthcare expenditure rising from around 2.6 billion (USD) to around 49 billion (USD).

This trend was not inevitable.[9] North American countries like the US and Canada have seen out-of-pocket expenses decline, at least as a percentage of GDP, while France and Japan have held steady, broadly speaking.

Figure 3.2 shows a rise in healthcare spend through all voluntary schemes. Again, this increase is higher in the UK than in the most comparable countries. In the 1970s, the UK was the G7 country least likely to fund its healthcare through voluntary schemes. Total spend of this kind was 0.54 per cent of GDP in 1970 (and 0.45 per cent of GDP in 1975). As of 2020, it has increased five-fold from its peak low, to 2.33 per cent of GDP – the fastest rise of any G7 nation in the period. Both these statistics are challenges to ensuring the NHS is a system that a) universalises the best and b) does so based purely on need.

THE IMPACT OF THE PANDEMIC

IPPR/YouGov[10] polling of a representative sample of 3,466 adults in Great Britain (fieldwork carried out 16–18 November 2021) found strong public perception that – as it stands – private healthcare is better than the care provided through the NHS.

TABLE 3.1: PRIVATE HEALTHCARE SERVICES ARE NOW SEEN AS BETTER THAN NHS SERVICES

Poll question: 'Thinking about the overall quality of the healthcare provided by the NHS and private healthcare providers, which of the following statements comes closest to your view?'

Response	% (Population)
Healthcare offered by the NHS is better than private healthcare	12
NHS healthcare and private healthcare are equally good	33
Care offered by private healthcare services is better than NHS healthcare	36
Don't know	19

Source: Authors' analysis of IPPR/YouGov polling

Three times as many people think private healthcare is better as think NHS healthcare is better. Moreover, our polling showed how significant disruption to NHS services could push an increase in private healthcare. Since the pandemic began, a significant number of around one in three people in Britain – the equivalent of around 16 million adults, if extrapolated to the whole population[11] – said that they found it difficult to access health services they needed through the NHS. That is almost as many as managed to access the services they needed (33 per cent).

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9   In other words, it was not an unavoidable consequence of a growing or ageing population.

10   All figures, unless otherwise stated, are from YouGov Plc. Total sample size was 3,466 adults. Fieldwork was undertaken between 16th - 18th November 2021. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

11   IPPR extrapolation using official population estimates

TABLE 3.2: THE PANDEMIC HAS MADE IT VERY HARD FOR PEOPLE TO ACCESS THE NHS SERVICES THEY NEED

Poll question: 'Which of the following, if any, best describes your experience of accessing healthcare services during the coronavirus pandemic?'

Response	%
During the pandemic, I have found it difficult to access the healthcare services I need through the NHS	31
During the pandemic, I have been able to access the healthcare I need through the NHS	33
During the pandemic, I have not needed to access healthcare services	31
Can't remember	6

Source: Authors' analysis of IPPR/YouGov polling

We asked all who said they found it difficult to access NHS services what they did next. 12 per cent of people, having not been able to get the care they needed, used a private alternative (extrapolated to the population, the equivalent of over two million attributable to the pandemic's disruptions). 26 per cent considered it but decided not to go ahead. Those most likely to access private healthcare were people living in London (18 per cent), people in social grade ABC1 (16 per cent – twice as many as in social grades C2DE), and people aged 65 years old or over (15 per cent).

TABLE 3.3: A LARGE MINORITY OF THOSE WHO STRUGGLED TO ACCESS NHS SERVICES WERE PUSHED TO PAY FOR NON-NHS ALTERNATIVES

Poll question: 'You previously said that you found it difficult to access the healthcare services you needed through the NHS during the coronavirus pandemic. Did you consider accessing private healthcare instead?'

Response	All (%)
I considered private healthcare, but decided against it	26
I did access private healthcare	12
I did not consider accessing private healthcare	59
Don't know	3

Source: IPPR/YouGov polling of 1,095 GB adults who said they'd found it hard to access NHS services during the pandemic

To further test the 'opt-out', we posed a vignette to all respondents on what they would do if they were diagnosed with a non-emergency condition and were told they would need to wait longer than 18 weeks to start treatment.

TABLE 3.4: A LARGE MINORITY (17 PER CENT) WOULD, HYPOTHETICALLY, GO PRIVATE IF NHS ACCESS FELL BELOW ACCEPTABLE LEVELS

Poll question: 'Patients in England have the right to start treatment for non-emergency conditions within a maximum of 18 weeks of a GP referral, according to the NHS Constitution. The proportion of patients unable to start treatment within 18 weeks of referral has increased because of the pandemic. Imagine you needed treatment and knew that you would have to wait longer than 18 weeks from referral to begin treatment. Which of the following, if any, best describes what you would do in this situation?'

Response	All (%)
I would wait to receive treatment with the NHS, because I cannot afford private healthcare	59
I would wait to receive treatment with the NHS, because I do not approve of private healthcare	10
I would arrange private healthcare	17
Don't know	14

Source: IPPR/YouGov polling of 1,095 GB adults who said they'd found it hard to access NHS services during the pandemic

As above, this shows a relatively large willingness to go private – and that many are put off because of affordability, rather than more normative reasons like disapproving of private healthcare on principle. However, from the perspective of a two-tier system, the fact that 59 per cent would wait because they cannot afford an alternative (as opposed to normative disagreement with private healthcare 'on principle') is more telling. It implies that these trends – if continued – would lead to the creation of a two-tier health system. Those people who could not afford to opt out would find themselves unable to access the best and latest care and treatment.

THE PUBLIC SUPPORT THE CORE NHS PRINCIPLES

Our public perceptions research shows that – despite some of the challenges faced by the health service – public support for the core principles of the NHS remains strong. Most people – from across regions, demographic lines and party-political allegiances – support a universal, comprehensive, free and tax-funded health system.

This is a clear mandate to new leaders – both nationally and locally, in government and opposition – that their job is still to create and ensure the future of a health service that genuinely universalises the best for all. Or in other words, the move to the market isn't because of a change in democratic will – people are being forced to choose between private care or poor care, despite the fact they desperately want a comprehensive NHS.

TABLES 3.5: THE NHS'S PRINCIPLES REMAIN ALMOST UNIVERSALLY POPULAR TODAY, ACROSS PARTY AND DEMOGRAPHIC LINES

Poll question: 'To what extent, if at all, do you think the NHS should be free at the point of delivery?'

Response	% (Population)	% (Labour)	% (Conservative)	% (Liberal Democrat)
Should (total)	88	93	89	96
Should not (total)	4	2	7	1
Don't know	8	5	4	3

Poll question: 'To what extent, if at all, do you think the NHS should provide a comprehensive service available to everyone?'

Response	% (Population)	% (Labour)	% (Conservative)	% (Liberal Democrat)
Should (total)	88	92	86	94
Should not (total)	7	3	12	3
Don't know	6	5	3	2

Poll question: 'To what extent, if at all, do you think the NHS should be primarily funded through taxation?'

Response	% (Population)	% (Labour)	% (Conservative)	% (Liberal Democrat)
Should (total)	79	85	81	88
Should not (total)	10	7	10	6
Don't know	12	9	8	6

Source: IPPR/YouGov polling[12]

In fact, the public's support for the NHS model goes far beyond the current, pandemic-informed moment. New IPPR analysis of almost 50 years of Ipsos MORI Issue Index data – covering over 400 individual representative samples – shows that healthcare/NHS/hospitals have been the biggest concern for the public since the late 1980s. Indeed, since the 1987 general election, healthcare has topped the index a massive 30 per cent of the time.

12   Party refers to how a respondent voted in 2019 general election

FIGURE 3.3: HEALTH/HEALTHCARE/NHS/HOSPITALS HAS BEEN THE MOST CONSISTENT PUBLIC PRIORITY SINCE THE LATE 1980S

Relative policy priority of health according to over 400 Ipsos MORI Issue Indexes, September 1974 to October 2021
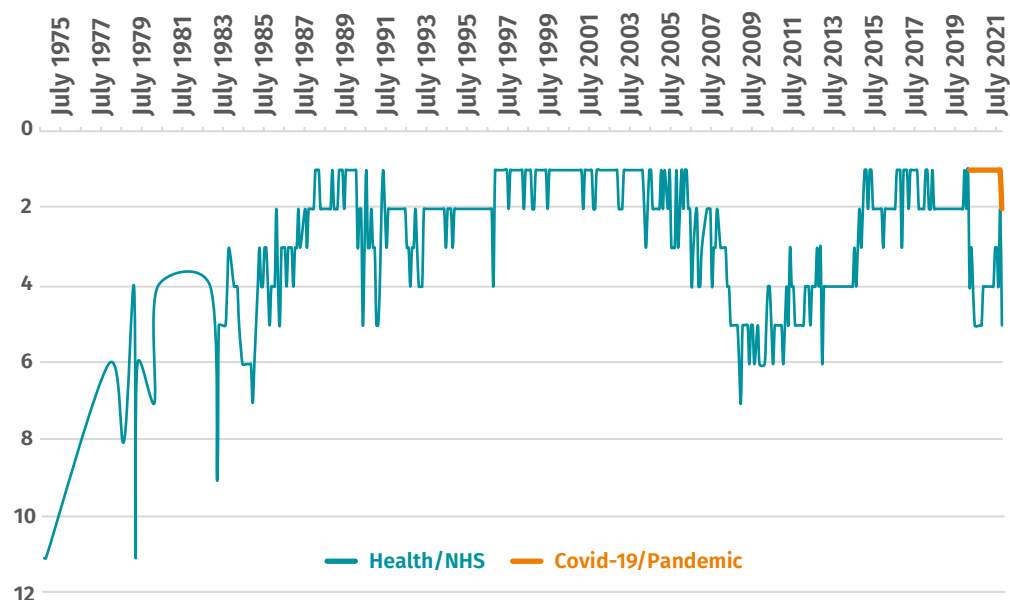
Source: Ipsos MORI (1974–2021)

If political and NHS leaders want to live up to the public's wishes and democratic expectations, they need to put forward a funding and reform plan that maintains the principles of the NHS – revitalised for the 21st century. That is, they cannot settle with 'doing the minimum to get through Covid' or 'recovery' – they must build back better. The consequence of not being ambitious would be felt at the ballot box. The government will remember how costly it can be when the public does not trust it on the NHS – the Conservative party does far better when it does not cede a massive lead on healthcare to Labour in the run-up to an election. Opposition parties will recognise the counterfactual – a lead on health is important to electoral success.

Outside the NHS, IPPR research shows that universal social care – funded from taxation – is also popular with the public, including across party lines. Our 2020 analysis found support for more investment in social care (comprehensive), for social care to be funded by general taxation, and for the principle of free at the point of need to be extended into care (Quilter-Pinner and Sloggett 2020). This should help expand ambition among new leaders from healthcare, and to a full range of health and care services.

PART 3:
'UNIVERSALISE THE BEST'

Our overall conclusion is that a long-term decline in NHS access and quality, rapidly accelerated by the pandemic, has begun to catalyse a trend of people supplementing their tax-funded public entitlement to healthcare with private products. These include insurance products (perhaps via employers or alongside mortgages), direct payment for procedures, or 'waiting list fast passes' that provide quicker access to a GP, physio or therapist.

The more optimistic conclusion is that this trend is not yet so advanced as to be irreversible. The model of dentistry or eyecare has not yet spread to the whole National Health Service, even though the trajectory towards that is clear. There is still time for decisive policy action, to revitalise health and care for the 21st century.

This leaves our new cohort of health and care leaders with a generation-defining choice. On the one hand, they could decide that the NHS no longer has the ability or right operating model to deliver a truly universal service and embrace a two-tier system, perhaps as a way to put some constraint on its continued expansion.[13] We argue that this would be a mistake, for a range of reasons.

- **Democratic will:** By far the most important case for revitalising the NHS is almost universal support among the public for its founding principles. People of all political voting persuasions overwhelmingly support the NHS's founding principles.
- **Equality:** Avoiding a two-tier system in healthcare supports both social and economic justice. While healthcare is just one (albeit large) variable in explaining health variation, it is an important foundation for, and lever against, inequality. In turn, action on health inequality can have significant economic value – with IPPR estimates suggesting that closing the health gap between the North of England and the rest of England would be worth over £20 billion per year to the economy (Thomas, Round and Longlands 2020).
- **Performance:** Evidence suggests public healthcare is more equal, efficient, transparent and accountable (Modi 2018).
- **Economy:** In addition to the well-established link between health and wealth, NHS capacity has become the most important variable in keeping the economy open. If the NHS is run hot, and that leads to a two-tier system, it is likely the health service will be greater.
- **Innovation:** A national NHS is a huge potential advantage to UK innovation. It allows us, at least in theory, to collect first-rate real world data, perform live and world-leading clinical trials, and give an entire population access to the best innovation. Our focus should be on harnessing this potential, not least in the context of the government's ambition to be a science superpower.

Instead of accepting a two-tier system, we argue that 2022 must mark the first year in a revitalisation of the NHS. With the growing risk of an 'opt-out' from universal, public-funded healthcare, we argue the aspiration should be for public healthcare so good, a reasonable person wouldn't choose to go private. In other words, we

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13   NHS spend as a proportion of GDP and of total public spending has increased significantly since its formation.

argue for a much greater focus on the original Nye Bevan commitment that the NHS must 'universalise the best'.

Such an aspiration predicates a focus not only on better health and care for all, but sustainable health and care for all. In the short term, we need to move away from a model where health and care services face huge pressure in the summer, followed by near collapse in the winter. In the long term, we need an approach to health and care that is resilient to the major health threats we face in the next few decades.

We set out these three aims in the introduction: living with Covid-19; building back better; and preparing for an uncertain future. There are three common variables that will form a vital foundation for achieving each of these aims, and that should form the immediate basis of the government's priorities for health and social care in 2022.

- **Capacity:** NHS and social care capacity is key to the country's ability to get through care backlogs, to withstand new virus variants and to be resilient in an uncertain future. It is also among the most important variables in the government's ability to keep the economy open.
- **Culture:** Universalising the best means that we need to hold healthcare to the highest possible standards. We need cultural paradigm shifts towards prevention, innovation and collaboration – supported by both local and national leaders.
- **Resource:** While reform is important, the need for funds in health and care cannot be ignored. By our estimates, adult social care faces the biggest immediate shortfall. Local public health teams are still contending with real-term cuts embedded during austerity, while the NHS can expect a significant funding shortfall in 12 months' time on the current trajectory.

The recommendations that follow are immediate and indicative priorities to support leaders in revitalising health and care services. While we cannot ignore the serious problems evident in the data, our analysis does also show that brilliant health and care remains possible but patchy across England. Our national mission must now be about making the best care the new normal.

CAPACITY
The government should enshrine a definition of sustainable health and care in law

Arguably, it was reasonable for the government to be predominantly reactive at the start of the pandemic. With little time to increase NHS capacity, little in the way of pandemic preparedness planning from previous governments,[14] and insufficient time to radically improve population health or recalibrate social care, they might reasonably contend that they could only be reactive.[15]

However, two years on, the reality of Covid-19 now makes a shift towards a longer-term approach, built on sustainability, long overdue. 'Learning to live' with Covid-19 will not mean the virus disappears, but, rather, it becomes endemic. Moreover, without global uptake of vaccines, new and unpredictable variants will continue to emerge. If we do not pre-empt this, then we are likely to experience regular disruption to NHS services, lives and livelihoods – and increased or longer-term backlogs for essential health services, like mental health, cancer treatment or cardiovascular disease. Moreover, continuing to run the NHS at the top of its

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14 At least, for a non-influenza disease outbreak.
15 This is not to say their strategy was optimal – much has been written on the public health approach chosen in 2020, including both successes (vaccine development, lateral flow tests) and failures (delays to initial lockdowns, over-eager stimulus packages like Eat Out To Help Out).

capacity – rather than the top of its game – risks a catastrophic loss of workforce numbers, morale and productivity.

Sustainable health and care is about good services, but also economic confidence. Whether or not the NHS risks being overwhelmed is now the key determinant of whether the government needs to put in place restrictions. The prime minister has indicated that his government is highly unlikely to redeploy the use of extreme public health measures, like full lockdowns, but a great many sectors will still be worried by the perennial risk of restrictions on consumers and business activity. More NHS capacity will give more options for a cohesive public health and economic strategy.

An approach that waits until a crisis to build in new capacity is sub-optimal. There is evidently real value in flexible capacity, like field hospitals. But, in other ways, a failure to pre-empt crisis seriously limits our options – for example, it takes years, rather than weeks, to train new healthcare professionals. Invariably, waiting for a crisis before acting means one of three things: severe NHS pressures, public health restrictions or care disruptions.[16]

Overall, this is likely to prove more costly than making an up-front investment in sustainability, as IPPR has shown elsewhere (see Thomas 2020). Very short-term interventions almost always come with a cost – Nightingales are more expensive than normal beds; redeployment and long working hours harm retention and increase locum/overtime rates; private bed capacity can help in a pinch, but is very expensive. The more proactive the strategy the better, particularly in a period where we can expect health shocks in both the short and long term.

On this logic, we recommend the government commits to a common, long-term and statutory definition of sustainable health and care. We recommend that definition draws from international definitions – specifically:

> *"a health systems ability to continually deliver the key health system functions of providing services, generating resources, financing, and stewardship... in pursuit of its goals of improving population health"*
> Source: PHSSR (2020, p4)

This definition is particularly strong because it encompasses both inputs and outputs: that is, it defines sustainability as about both the right resource and capacity, but also the right access, experience and quality of care. Building on this, we recommend any statutory definition of sustainability includes measures of capacity and quality.

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16   Or some combination of the three.

TABLE 4.1: A STATUTORY DEFINITION OF SUSTAINABILITY IN HEALTH AND SOCIAL CARE

Type	Indicators	Justification
Capacity	NHS vacancies, illness and burnout	Workforce shortages are the biggest barrier to the NHS's long-term goals, undermine resilience, and have prevented Nightingale schemes from working.
	Hospital occupancy levels	Occupancy of 85 per cent or less has been shown to allow acute hospitals to manage demand spikes effectively. This is essential in an era of unpredictable Covid-19 variants.
	Social and community care capacity	These settings support efficient, high-quality care, help prevent need and maintain independence, and help ensure discharge and acute capacity.
Outcomes	Waiting times	Including for emergency and ambulatory care, for mental health and care services, and for general practice.
	Patient-reported experience measures	A vital indicator of the NHS's ability to universalise the best and a key driver of the 'opt-out'. Available for primary care, cancer and other clinical priority areas.
	Innovation	Innovation is crucial to 'universalising the best'. Metrics like the Office for Life Science's competitiveness indicators should be part of any definition of sustainability.

Source: Authors' analysis

To ensure this definition then has a bearing on practice, we recommend that a statutory duty to maintain sustainable health and care is placed on each of the Secretary of State for Health and Social Care, the prime minister and the chancellor. The former is obvious – but can do little without the cross-government coordination offered by the prime minister, or the funding controlled by the chancellor.[17]

We also recommend that moves are made to increase visibility of sustainability, and whether government policy is adequately prioritising the long term in health and social care. The best way to achieve this would be bestowing an independent body with the capacity and remit to evaluate the government's performance on sustainability at regular intervals.

This could be a new body, or a duty allocated to the UK Health Security Agency (UKHSA), who are well placed to examine sustainability from both a short-term and a long-term perspective. Whichever body is chosen, both an annual assessment of government performance against its statutory duty – and a data dashboard, providing real-time metrics – would help ensure transparency and accountability. The definition of sustainability – and the new accountabilities for government and national NHS bodies – could be implemented independently or integrated into the NHS and Social Care Bill moving through parliament.

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17   For more on the limitations of the powers of the Secretary of State for Health and Social Care, see Thomas 2021b.

We recommend the government delivers a new deal for workers to improve retention and recruitment

The government has shown an ability to be innovative in creating bed capacity, where needed – through the Nightingale field hospital model in 2020, and the community-based beds opened in 2021/22. However, a bed is useless without healthcare professionals, and staffing shortages are undermining both the government's aspirations to get through care backlogs during Covid-19's troughs as well as its ability to prevent the NHS from being overwhelmed during its peaks.

While the few weeks between a new variant and a pandemic peaking constitute too little time to sufficiently increase workforce capacity, the government does have levers over labour supply that work more quickly than simply training new nurses and doctors (though this is important). Our analysis – covering two years of polling, qualitative interviews and a literature review – shows at least nine available levers.

FIGURE 4.1: LEVERS AVAILABLE FOR A MORE SUSTAINABLE WORKFORCE

Source: Authors' analysis

This is not necessarily exhaustive, but rather indicates the range of options open to leaders – both national and within local bodies like ICSs and PCNs – interested in creating more sustainable staffing conditions.

In both 2020 and 2021, IPPR polling has explored attitudes among a representative group of health and care professionals towards their working conditions (see Thomas and Quilter-Pinner 2020; Patel and Thomas 2021b). In both cases, we have shown that chronic shortages and burnout before the pandemic have now translated into real difficulties in coping for many health and care staff. Alarmingly, our findings that a large proportion of staff are considering leaving the sector are now translating into record numbers actually leaving the sector.[18]

Our polling also indicates which levers might be most effective in the eyes of workers themselves: namely, better pay, more flexibility and improved working conditions, and better mental health. We recommend the government announces an ambitious new retention plan, with policies covering each of these domains.

- **Pay:** The 2021 pay award of three per cent has been immediately undermined by high inflation and a cost-of-living crisis. As such, we recommend the government commit to a five per cent + CPI pay rise for health and care staff (for social care, delivered through commissioning arrangements). Moreover, we recommend the government looks to guarantee pay against cost of living – by committing to a cost-of-living adjustment in December 2022, should inflation increase.

- **Working conditions:** There is much that can be done to improve working conditions. Last year, we made three recommendations that remain highly relevant today. First, a move to make flexible working available to all, without any conditional requirements. Junior staff are particularly impacted by the NHS's rigid and demanding clinical rotas. Second, a guarantee of annual leave entitlements for five years and a commitment to avoid reducing annual leave because of sickness. Covid-19 pressures and illness are costing many healthcare professionals precious leave – allowing it to roll over would support rest. Compensation should be paid for continuous denials of annual leave requests. Finally, all health and care workers should have a clear entitlement to breaks and water and food within (or close to) their place of work. Meeting basic needs during long shifts is vital to morale, productivity and safety.

GETTING THE BASICS RIGHT

Small interventions can make a big difference on retention. Research by the Modern Society Initiative has estimated the potential costs of a workforce retention crisis at over £20 billion in training costs alone. Their work also identified eight 'low hanging fruit' interventions that could prevent this:

- free parking
- more lockers
- free water
- free coffee
- dedicated staff communication
- uniform washing services
- 24/7 hot food
- provision of better staff rooms.

They recommend a £1 billion welfare fund, to embed these practices across health and care. This would be significantly cheaper than retraining a significant proportion of the workforce (Watkins et al 2021).

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18   The 27,353 voluntary resignations in July to September 2020 coincide with the aftermath of the first pandemic's peak, circa April 2020 (Saunders and Duggan 2022).

- **Mental health:** Mental health is one of the biggest drivers of people leaving the NHS and of NHS absences, both of which proved major challenges in 2021. We recommend all health and care staff are given a personalised mental health care plan, if they'd like one – with priority access to bespoke and group interventions. Capacity to deliver these interventions could be increased by working with a wider range of (qualified) counsellors and psychotherapists.

As the spring 2021 pay negotiations show, it is easy to slip into short-sighted workforce policy when we've got through Covid-19 peaks and variants. As such, there is also a role for incentivising more long-term policy-thinking. To achieve this in the NHS, we recommend two adjustments to the current pay review process.

- **Power to explore working conditions:** The government often notes that pay is only one factor in recruitment and retention – with some research showing overwork and burnout are more important variables. As such, we recommend that the pay review bodies have their remit expanded to make recommendations on working conditions, including factors like annual leave, flexible working, entitlement to food and breaks, cost of parking and registration fees, progression, and employment equality.
- **A wider set of evidence:** The Treasury's focus of short-term affordability has disproportionate influence over recommendations by the pay review bodies. We recommend their terms of reference are adjusted to take account of the long-term economic benefits of good pay – including stronger consumer demand, increased government tax receipts, better public health and a more sustainable NHS workforce overall.

To support more balanced pay and working condition negotiations in adult social care, we reiterate our long-standing recommendation for sectoral collective bargaining. Unlike the NHS, social care workers do not benefit from the same representation by royal colleges, the same professional standards or the same formal pay review processes. A new 'royal college' style body for social care would help drive up employment standards and professionalise the social care sector (see Dromey and Hochlaf 2018).
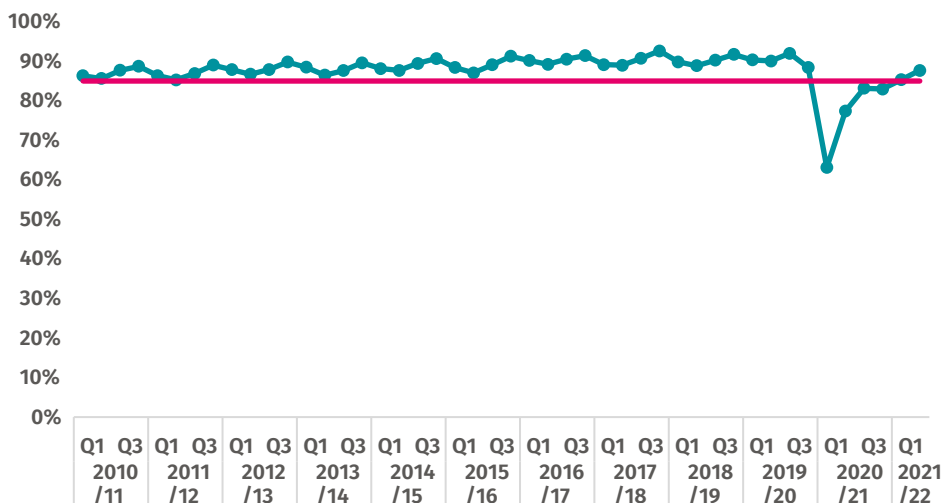
We recommend the government sets a target to increase bed capacity to 85 per cent. This should include a commitment to more acute beds but should also see significant efforts to expand community and social care capacity
Evidence from before the pandemic indicated that hospital occupancy levels above 85 per cent make it difficult to manage demand spikes (see Bagust et al 1999; Cooke et al 2004; NHS Providers 2017).

The pandemic makes it even more important that hospitals have enough free beds and space to plan for demand spikes. Covid-19 creates a perennial risk of seasonal and variant-driven spikes in hospitalisations. Healthcare management is further complicated by a large amount of 'hidden health needs' – with analysis by pensions and investment experts Lane Clark & Peacock (LCP) showing that millions who would have been expected to come forward with serious health needs, from cancer to mental health, have not yet done so but will inevitably need to.

The NHS regularly had an occupancy rate well above 85 per cent in the 2010s. This briefly changed during the first Covid-19 peak, during a period where almost all non-Covid-19 NHS activity paused. However, occupancy levels have moved back above 85 per cent – despite the most recent data coming before the 2021/22 Omicron surge. This is likely to increase further in future data releases and is a hard indicator of hospital settings under unmanageable pressure.

FIGURE 4.2: NHS HOSPITALS HAVE REGULARLY FACED UNSAFE LEVELS OF OCCUPANCIES

Source: NHS England (2021b)

As such, and at the very minimum, we recommend that the government sets a central commitment to reduce average NHS capacity to 85 per cent, with a focus on building capacity in trusts where occupancy is highest. We also recommend that the government commissions new studies on the link between occupancy rate, demand management and emergency waiting times – reflecting that Covid-19 is likely to lower the appropriate average hospital occupancy level.

The bluntest tool available in decreasing occupancy rates is to increase hospital beds. Total overnight bed stock has decreased by almost 20,000 beds since 2010, despite population growth (ibid). As such, government should use its commitment to 40 new hospitals to ensure at least half of these are restored in the next two years – a target of 10,000 beds. In the intermediary period, the government should retain, build on and use its ability to reduce occupancy rates through flexible capacity like community-level field hospitals (prioritising areas where occupancy is highest).

However, more beds should not be the sum of the government's strategy. A greater stock of beds can lead to people staying in hospital longer than needed (sometimes called Roemer's law; see Delamater et al 2013). The government needs to balance the healthcare management benefits of more beds against the need to ensure people get care – where appropriate – in home and community settings. Evidence shows this is better for the patient and cheaper overall (see Thomas 2021a).

OTHER CAPACITY NEEDS: DIAGNOSTICS

Bed capacity and occupancy is immediately vital, to ensure sustainability. However, getting through care backlogs and building back better rely on diagnostic capacity. For example, Lane Clark and Peacock identity that a consequence of the pandemic is many millions living with undiagnosed conditions, that we'd have otherwise expected to diagnose. The solution is more diagnostic capacity, preferably in the community. This is particularly important, given England's lack of diagnostic equipment compared to other countries (see Patel & Thomas, 2021). The logic behind Community Diagnostic Hubs, 'one stop diagnostic centres' being rolled out to support early cancer diagnosis, should be expanded to other clinical priorities.

Analysis by IPPR and CF shows a significant opportunity to expand the capacity for domiciliary social care in England. Specifically, our analysis shows that there is variation in the amount of domiciliary care provided in even very similar local authorities. Given that home care is often about maintaining independence and preventing need for more acute services, this is likely to increase strain on hospitals – while a lack of capacity to provide support at home will also likely make effective discharge from the NHS more difficult. Just by closing this variation between similar local authorities, 80,000 more people could get care in their home or community – saving £1.1 billion from social care budgets and £1.6 billion from NHS budgets.

This would take funding for more, and better models of, domiciliary care – which we discuss in the funding section of this report, below. However, the government also has reform options available to increase people's right to care in their home and/or community. For example, they could adapt the Care Act 2014, to place a duty on local authorities to give people a right to 'care in a place they call home'. In practice, this right would mean the following.

- **Better data and more accountability:** The centre (national bodies) should work with local authorities to agree and set targets on providing a certain proportion of care in the community based on local authorities with similar social, economic and demographic contexts.

- **Increased scope for and access to independent advocacy:** Carers and care recipients who do not believe the latter's right to care in the place they call home is being met should have the means to secure independent advocacy. Local authorities currently have a duty to arrange independent advocates when people have 'substantial difficulty' in being involved in their care and support assessments – and not receiving care in a suitable place should be considered above that threshold (DHSC et al undated). This would mean more resource and access to advocates at the local authority level.

- **A central complaints process:** Where an individual, advocate or carer feels a right to care in a place they call home is not being met, there should be a centralised complaints procedure. In the first instance, this could be facilitated by a specialist care-at-home unit within the Local Government and Social Care Ombudsman.

This would be in line with wider moves across health and care towards shared decision-making, where care isn't done to people, but rather there are meaningful ways in which they can action the power of their voice and preferences.

CULTURE

The definition we've put forward of sustainability includes quality of care, as well as capacity. This is important in ensuring that health and care genuinely universalises the best and avoids 'opt-out' normalising a two-tier system. As such, we agree that a genuine plan to build back better is a vital companion to plans to increase capacity.

In the interest of both short- and long-term sustainability, three paradigm shifts are vital.

1. **The innovation shift:** The NHS was formed to ensure everyone had access to the best possible care. We need to do more to harness the advances made possible by medical research.
2. **The integration shift:** Health and care is better when it is co-ordinated and collaborative. We need to do more to deliver a culture of collaboration and thriving health economies across the country.
3. **The prevention shift:** Resilient health systems maximise the power of prevention – to avoid disease, and to help people live well with diagnoses.

On innovation, we recommend new national missions for the spread of innovation, further developing the life science vision

The life science vision had a welcome focus on missions:

> *"The vision will also focus on specific 'missions' that are technology or disease specific. In each there is an opportunity to take a VTF-type approach, with a single empowered decision maker to mobilise private and public sector investment... These areas have often been ignored due to the cost and complexity of developing products for these indications... the regulatory environment, which must be more enabling of activity in these areas, and the access and uptake of successful products"*
> Source: HM Government (2021, p9-10)

This focus on missions is welcome – and IPPR has long made the case for a mission-based approach to innovation (see Kibasi et al 2018).

However, more needs to be done to ensure these topline missions impact on missions. A good mission requires the following.

- Identification of long-standing problems (as per the vision).
- Long-term plans for action on those problems, including credible sub-goals and milestones.
- Funding commitments for research and the spread of innovation.
- Tangible commitments on other enablers, such as clinical research capacity or regulatory flexibility (Parkes 2019).

As it stands, these key traits of 'missions' are still missing from the Life Science Vision. A bespoke 'mission strategy' for each of the disease/technology areas cited in the Life Sciences Vision – developed with medical research charities, life science companies, academia, civil society and researchers – would be a welcome next step.

These strategies should recognise the long-standing challenge of adoption and spread in a complex system like the NHS. Our qualitative analysis with healthcare professionals and senior managers supported missions as a way to give a vital sense of joint purpose. They also identified three key enablers, which should be seen as integral to adoption and spread. These should form a common core to each new mission strategy.

The first enabler is permission. There is a growing consensus that regulation and governance in England must evolve. Lighter touch regulation and easier data-sharing were levers that helped in the initial pandemic response and would be popular and effective changes if made permanent. Moreover, a lighter touch regulatory regime would reduce bureaucracy and perverse incentives that can have a negative impact on patients (such as defensive data-sharing arrangements within the NHS). We recommend the government outlines, for each innovation mission, specific steps towards lighter touch regulation.

Second is capacity. Innovation takes time. For example, adopting a new innovation might require a process of adaptation – to make it fit for local ways of working, care pathways and population health needs. However, very few managers or clinicians have bespoke time to do this. Those who do, use evenings and weekends – even then, a resource that has become much rarer, given pressures on the NHS during the pandemic. We recommend the government uses its individual innovation mission strategies to create a new 'innovation adoption' role. This would create a community of clinical leaders with time in their job description to focus on innovation spread.

Third is networks and peer support. The use of these in driving quality improvement has been made clear in other sectors. For example, the London Challenge, a London-based secondary school improvement programme moving the focus from competition to collaboration, much as integration might offer the opportunity to do today. High-performing providers were partnered with those with bigger challenges or worse outcomes to work together on a set goal. Importantly, the focus was not on naming and shaming, but rather on 'steps to success'. Evaluation has linked the scheme to large improvements in London education outcomes (see Thomas et al 2020). We recommend ICSs work to deliver similar schemes in their footprint – using their unique local knowledge to embed collaboration, mentorship, peer support and constructive help. Again, we recommend a similar system of peer support is introduced in each individual innovation mission statement.

We recommend a shift away from top-down levers for integration, and a focus on leadership, data and community assets

Integration has theoretical promise but has proven difficult in practice (Patel 2021). Previous attempts in England and devolved health systems have failed to deliver significant benefits for two reasons. Firstly, because they have often ground against the competition-orientated reforms from the last 40 years, which has fragmented the system. Second, because they have too often focused on structural change – 'reorganising the deckchairs' – rather than culture change.

On the former, the government's reforms have promise, insofar as they undo some of the unhelpful fragmentation of the health system introduced in the Health and Social Care Act 2012. However, they are liable to repeat the latter's mistake; that is, they risk focusing too much on structures, rather than cultures.

One of the most important determinants of success will be the right leadership. Leaders at every level of the health and care system – PCN directors, Trust executives, council CEOs and ICS board members to name a few – will shape whether integration leads to genuine system-working and meaningful collaboration. But this will take a very different skillset to acute-sector leadership, where senior staff have sometimes been too often rewarded for insular thinking, competition, and risk aversion.

ICSs should herald a move to a new and more modern type of leadership. West Yorkshire and Harrogate ICS provides a good case study of what is needed, in practice. There, leaders have developed strong collaborative relationships, have shown an ability to prioritise public health and social care over acute priorities, and have excellent board relationships (ibid).

The centre (national bodies) cannot simply 'command' brilliant system leadership across the country. But policy can help create a sustainable pipeline of brilliant and innovative leaders, over time. To that end, we recommend that every ICS creates its own leadership development academy. This should provide a fast-track to promising managers. Within the scheme, there should be significant movement between sectors – with opportunities in schools, housing, local government, policy, voluntary sector, research settings and business. This will correct limitations in other NHS management schemes – such as the NHS Leadership Academy – and help ensure leaders think in systems.

A second challenge is whether Integrated Care Systems have local partners to collaborate with. A decade of austerity, and the unequal impact of the pandemic,[19] mean some places have thriving health economies with capacity and energy to collaborate. In other places, there are fewer assets – with the NHS one of the only major employers and procurers in the area.

If this isn't addressed, the risk is avoidable variation, and our analysis suggests inequalities would widen between deprived/affluent and North/South areas. As such, and in line with the government's 'levelling-up' aspirations, we recommend a new £4.7 billion multi-year community health-building fund. Unlike the formal 'levelling-up fund', this should be allocated transparently on the basis of inequality, deprivation, integration maturity and unmet population health need. Moreover, it should not be used for routine operational costs, but rather to support the voluntary sector, co-operatives, social enterprises, ethical businesses, community groups and others vital to good outcomes.

A proportion of this fund should be ringfenced to engage communities, and to build local trust between citizens and the NHS. This would arguably work better at a PCN than an ICS level. Moreover, there are many instances where better health

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19   Which has disproportionately hit urban places, the North of England and the most deprived parts of the country.

has arisen through communities taking a more active role in their health – from the mutual aid groups of the Covid-19 pandemic, to demands for progress on HIV/AIDs in the late 20th century.

To help embed this within the government's definition of integration, we recommend £800 million of the fund is used to provide each Primary Care Network with £200,000, on average, to fund new or scale pre-existing community projects. PCNs should use best practice techniques to identify community groups for funding. While there should be pre-agreed objectives, communities should have ownership of this funding, in line with the principle of subsidiarity. Budgeting responsibility would be delegated to community representatives.

Each PCN should be tasked with identifying two criteria to help allocation.

1. PCNs should identify the socio-economic issue having the biggest impact on local health outcomes. This can be supported by a new Lane Clark and Peacock and IPPR health disparity tracker, which shows key material challenges facing each local authority – from skills to child poverty, to education, to income inequality.

2. The most excluded groups: PCNs should identify the key excluded groups within their natural community, to ensure the money is spent on schemes with the biggest marginal gains. They should look to work directly with these groups and their representative/community bodies.

The projects would take a discretionary people-led approach whereby community representatives from across medical groups and local organisations can facilitate meetings and share ideas to understand local needs. Funding given should cover the cost of meeting spaces and consequently fund holistic answers to local help needs. This may take the form of new allotments, community centres, youth centres or counselling services. The resulting schemes should be actively embedded in moves to personalised care, social prescribing and shared decision-making.

COMMUNITIES AND THE NHS CO-CREATING ALLOTMENTS (TO EMBED WITHIN POLICY RECOMMENDATION)

Oxford Terrace and Rawling Road Medical Group, Gateshead, had been in negotiations with the local council for many years about acquiring a garden to offer an alternative space for patients to support their recovery. The aim of this project was to utilise therapeutic approaches to patient care and recovery.

With support from local organisation Best of Bensham and the donation of £2,000 from Gateshead Carers Association, the Oxford Terrace and Rawling Road Medical Group is now able to refer patients to a shared allotment space as part of their social prescribing offer. Patients are assessed on an individual basis whether visiting this space would be beneficial for their health. This is a notable example of the NHS working with local organisations, incorporating personalised care with community care (NHS England 2021c).

We recommend the government puts prevention at the heart of both healthcare and cross-government health strategy

Prevention offers many benefits.

• Good population health reduces demand on the NHS.

• A healthier population is likely to be less susceptible to Covid-19 as it becomes endemic, or to inevitable new variants.

- Relatedly, a focus on prevention is likely to increase resilience to future health shocks, from new pandemics to climate change.
- A healthier population is also good for the economy (see Hochlaf and Thomas 2020).

There are major opportunities in both primary (preventing unnecessary illness entirely) and secondary (ensuring people with a diagnosis can live good lives) prevention.

Within healthcare, one opportunity is a recalibration of NHS activity towards supporting people with one or more long-term conditions. The timing for this shift is excellent. Covid-19 has demonstrated the need for a broad definition of health, while the move to integration has outcomes and population health at its heart.

Yet, despite Covid-19 and despite the clear burning platform of an ageing population before it, relative spend on preventative healthcare has stagnated in the UK. International data indicates it has remained at a stable 0.5 per cent of GDP for the last decade, while domestic research has put prevention at a consistent five per cent of healthcare spend (OECD 2021).

As Covid-19 becomes an endemic, and in the face of growing health vulnerability, prevention should represent a greater proportion of health activity going forward. We recommend the government acts proactively and makes an immediate commitment to double the relative amount of the healthcare budget spent on prevention by 2030. This is likely to have long-term benefits – the balance of evidence strongly indicates that preventative interventions are good value for money and come with significant economic benefits, like improved productivity (see Martin, Lomas and Claxton 2019).

Beyond the NHS, the government should aim to deliver cross-government strategy on the major causes of preventable illness – particularly, obesity and alcohol- and smoking-related diseases.

There have been some recent positive developments on obesity – notably, the summer 2020 obesity strategy. However, ministers have since missed opportunities to go further – for example, by implementing the recommendations contained in the 2021 National Food Strategy.

There are further opportunities to disincentivise unhealthy products and to make healthy food more accessible – in the spirit of making the healthy choice the easy choice. On the latter, expanding the government's successful sugary drinks levy would be a sensible choice. Such non-essential food taxes have been highly successful elsewhere, including in Hungary and Mexico. We recommend an immediate 8 per cent tax on foods with a calorie density greater than 275kcal/100g.

Any revenue secured through this levy could then be used to subsidise healthy food. Subsidies have lots of potential and are not widely used by government. We recommend that the government provides all families experiencing food poverty an entitlement to £21-worth of free, healthy and sustainable food per week (in a major expansion of the Healthy Start voucher scheme). This would have a maximum cost of £1.5 billion per year (Hochlaf and Thomas 2020).

The same 'tax and fund' model could be adopted in tobacco control. While the UK has had better progress on smoking rates than obesity levels, England is set to miss its 'smoke-free generation by 2030' target without further intervention (Cancer Research UK 2020). We recommend a 'polluter pays' approach that requires tobacco companies to pay the cost of tobacco control, in addition to their existing obligations. In the first instance, that would mean a £270 million levy on tobacco companies in England, with all funding invested into local, regional and national smoking cessation services (see ASH 2020).

CULTURE SHIFTS: SUMMARY OF RECOMMENDATIONS

On innovation, we recommend individual mission statements are developed for each of the missions outlined in the Life Science Vision. To support adoption and spread – a long-term challenge in the NHS – we recommend each of these missions outlines a) regulatory flexibilities that will support adoption, b) a scheme to allow clinical leaders time to focus on adoption, adaption and spread of innovation, and c) a scheme of peer support, to allow fast adopters to mentor areas with slower uptake.

On integration, we recommend reforms are re-orientated away from structural change and towards culture change. This should include leadership development programmes for every ICS, designed to create the next generation of system leaders – with a focus on secondments. It should also include a £4.7 billion fund to ensure thriving health economies across the country, recognising more deprived parts of the country are unlikely to have the same 'health assets' to support integration as more affluent parts of the country. Of this fund, £800 million should be used to support community engagement projects at the PCN level.

On prevention, we recommend the government sets a target to double the amount of healthcare spend used on prevention (primary, secondary or tertiary) by 2030. We also recommend the government builds on the logic of their obesity strategy (summer 2020) and delivers further public health measures on obesity, alcohol and tobacco. This should combine tax and investment, with levies set on a 'polluter pays' basis, used to support healthy choices (healthy food subsidies, local stop-smoking services).

RESOURCE

NHS funding announcements have been welcome, but the health service still faces a cliff-edge

There were two big health funding announcements in the second half of 2021. First was the announcement of a new Health and Social Care Levy – a 1.25 per cent increase on National Insurance contributions to fund health and (later) adult social care. Second, an increase in NHS funding in the 2021 Spending Review. The table below compares NHS funding expectations before and after the announcement.

TABLE 4.2: COMPARISON OF NHS FUNDING (2021 SPENDING REVIEW) TO 2018 FINANCIAL SETTLEMENT

	2021/22 (baseline)	2022/23	2023/24	2024/25
New, £bn	136.1	151.8	157.4	162.6
Projected (from five-year settlement, 2018), £bn	134.4	141.1	149.0	157.3 *(projected)*

Source: Authors' analysis of HM Treasury (2021) and HM Government (2018)

This amounts to an average annual real terms' growth of 3.8 per cent for NHS England/Improvement – up from the average of 3.4 per cent in Theresa May's 2018 funding settlement.

However, given that NHS funding experienced a record deceleration between 2010 and 2018 – and given the sheer scale of the impact of Covid-19 – it is reasonable to explore whether this large-sounding funding settlement is sufficient to achieve world-class outcomes. To do this, we need to explore two factors. First, whether the NHS has enough money to deliver transformation, innovation and quality improvement, and, second, whether the NHS has enough money to deal with the impact of Covid-19 to date.

On the former, the LSE-*Lancet* Commission on the Future of the NHS has given the most comprehensive answer. Its extensive review suggested that, to achieve aims on transformation and innovation, NHS funding would need to grow by at least four per cent per year (real terms) (Anderson et al 2020). On the latter, the best evidence comes from joint estimates by NHS Providers and NHS Confederation, who put the impact of Covid-19 at £10 billion per year for the 2021 Spending Review period (NHS Confederation & NHS Providers 2021).

The table below compares that to the healthcare funding outlined at the spending review. Notably, while NHS funding looks stable for 2022/23, the shortfall picks up significantly in years two and three. Beyond any direct challenge to the health service, this will also challenge whether funding from the Health and Social Care Levy can really be directed from the NHS and into adult social care.

TABLE 4.3: COMPARISON OF ESTIMATES OF NECESSARY NHS FUNDING TO 2021 SPENDING REVIEW ALLOCATION

	2022/23	2023/24	2024/25
4pc Real Terms, £bn	141.4	150.2	159.5
+ Covid-19 and pensions	152.7	161.5	170.8
Deficit, £bn	0.9	4.1	8.2

Source: Authors' analysis of HM Treasury (2021) and HM Government (2018)

Of course, we should not mistake funding as the solution to all the NHS's problems. It needs a reform agenda to ensure money is well spent and does translate into world-class outcomes for people. That is why we have only come to funding after outlining our recommendations for reform going forward. Nonetheless, the right funding remains a key enabler of positive change – and one the government should return to at the 2022 spring budget.

Adult social care has not been fixed – we need a shift to a more preventative model of 'community-led social care'

Social care was also in scope of the autumn 2021 health and social care levy. However, it will not receive a substantial increase in funding until 2023 (and then, there are concerns that funding from the health and social care levy will need to be redirected from the NHS to social care, which may be impractical).

At that point, some of the funds will be used to provide a cap and floor on care costs. While this will be unlikely to increase the accessibility or quality of social care support, it will reduce the number of people who experience catastrophic costs (though, even then, not entirely). This has been broadly modelled on proposals by Sir Andrew Dilnot – with one major departure. Only personal

expenditure, not state expenditure, will count towards the cap on costs, heavily skewing the system towards property owners in the south of England.

While avoiding catastrophic care costs is an important goal for government policy, social care cannot be considered 'fixed' until these goals are incorporated. By IPPR's previous estimates, these could be achieved with a £10 billion uplift in social care budgets.

- Funding to ensure people have access to brilliant care in their community or home: As already argued in this report, there are major opportunities to provide more preventative social care, earlier, in the places and communities people call home. This has been a pressing issue in the US, where investment in domiciliary care has been a priority for president Biden's stimulus. An equivalent investment in the UK would total £5 billion every year for eight years – split between access and quality to home care – and would significantly improve the efficiency and quality of our overall care system (Thomas 2021a). A lack of funding is the key problem with the government's recent social care white paper, which expressed this aim, but had too little detail on delivery.

- Funding to ensure everyone can receive personal care: Unlike the NHS, social care does not have a mechanism to universalise the best or a working concept of 'free at the point of delivery, based on need, funded by tax'. We reiterate our call for free personal care, with estimates suggesting this would cost £5 billion per year (Idriss et al 2020).

Local public health teams demonstrated their value during the pandemic – and should see historic cuts reversed, and more certainty over budgets

Public health funding has experienced significant cuts since 2013/14. New analysis for this paper estimates total cuts to the public health grant, in real terms, at over £700,000. The highest cuts have been to sexual health services (£170 million) and substance misuse programmes (£250 million).

TABLE 4.4: PUBLIC HEALTH FUNDING 2014/15 AND 2021/22

Service	Budget (real terms) 2014/15	Budget 2021/22	Total change
Sexual health	740,000,000	574,000,000	↓ 168,000,000
Health check	94,000,000	70,000,000	↓ 24,000,000
Health protection	41,000,000	35,000,000	↓ 6,000,000
National Child Measurement Programme	21,000,000	21,000,000	↓ 512,000
Public health advice	76,000,000	51,000,000	↓ 25,000,000
Obesity	120,000,000	94,000,000	↓ 26,000,000
Physical activity	84,000,000	114,000,000	↑ 30,000,000
Substance misuse	920,000,000	673,000,000	↓ 247,000,000
Tobacco control	177,000,000	91,000,000	↓ 85,000,000
Children 5-19	287,000,000	263,000,000	↓ 24,000,000
Misc	587,000,000	438,000,000	↓ 149,000,000
Total	**3,150,000,000**	**2,420,000,000**	**↓ 724,000,000**

Source: Authors' analysis of DLUHC (2021)

We have previously shown how these cuts were highest in the most deprived parts of the country and in places where Covid-19 deaths have been highest (Thomas 2019; Thomas, Round and Longlands 2020).

There remains a clear case for restoring investment in the public health grant. The grant provides large improvements in quality of life, at a value well above the government's standard value-for-money threshold (Martin, Lomas and Claxton 2019). Its value was further reiterated during the pandemic, with IPPR research showing a correlation between areas that experienced the largest public health grant cuts and total Covid-19 deaths (Thomas, Round and Longlands 2020).

Moreover, our qualitative work identified a lack of certainty in budgets as a key challenge facing directors of public health. Budgets are often not confirmed by central government until the last minute, making planning processes difficult, and sometimes leading to service cuts. We suggest a three-year budget cycle for directors of public health, providing them with the financial certainty they need to deliver local services effectively and efficiently.

TABLE 4.5: OVERALL MULTI-YEAR FUNDING RECOMMENDATION FOR HEALTH AND SOCIAL CARE

	2022/23	2023/24	2024/25
Overall increase needed	£12.6 billion	£15.5 billion	£20.2 billion

Source: Authors' analysis

FUNDING: SUMMARY OF RECOMMENDATIONS

Our analysis suggests that the NHS is still on track to experience huge funding difficulties in the coming years. We recommend the government commits to a funding uplift worth £8 billion by 2024/25.

Social care also faces funding difficulties, not least, because its longer-term budget is thought to be dependent on reallocating money from the NHS. This is unlikely to be possible. We recommend a £10 billion per year uplift to support free personal care and an increase in the quality and accessibility of home care services.

Local public health services have shown their huge value during the pandemic, but they still face the consequences of a large real-terms funding cut as a legacy of the austerity decade. We recommend a multi-year funding settlement for directors of public health, based on undoing the cuts, increasing budgets in line with NHS rises and providing more certainty over what funding will be available.

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