Institute for Public Policy Research

IPPR

FOR PUBLIC HEALTH AND PUBLIC FINANCES

REFORMING HEALTH AND SOCIAL CARE

IPPR discussion paper

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DISCUSSION PAPER

This report is an IPPR submission of evidence and ideas to the Commission on Health and Prosperity. It does not necessarily reflect the full views of commissioners, and the commission will publish its full blueprint in 2024.

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is an independent charity working towards a fairer, greener, and more prosperous society. We are researchers, communicators, and policy experts creating tangible progressive change, and turning bold ideas into common sense realities. Working across the UK, IPPR, IPPR North, and IPPR Scotland are deeply connected to the people of our nations and regions, and the issues our communities face.

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ABOUT THIS PAPER

This report furthers IPPR's charitable objectives of advancing physical and mental health, relieving poverty, unemployment, or those in need by reason of youth, age, ill-health, disability, financial hardship or other disadvantage.

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SUMMARY

People are spending more years in sickness than ever before. It's a structural force affecting rich democracies around the world, but one that is especially powerful in the UK. Not only is it constraining the quality of modern life, but sickness has also become a serious fiscal threat. The number of people out of the labour market due to sickness is now at an all-time high. There is no road to prosperity for this nation without tackling the tide of sickness head-on.

Meeting this challenge will require commensurate re-orientation of the state and markets toward public health. But the leading edge of health policy will always be frontline services. Health and social care services have a leading role to play in any effort to make the country healthier and more prosperous.

In their current state, they are failing to do so. The number of deaths that could have been avoided with timely healthcare or public health interventions is much higher in the UK than in all other comparable European nations. We estimate that if the UK had an avoidable mortality rate similar to those in comparable European countries, around 240,000 fewer people would have died in the decade from 2010.

This is down to a wide range of factors. Health is about what happens to us in schools, workplaces, welfare services and the places we live. Yet, we cannot ignore that much of this is down to failures in health and care services. To some extent, it is about an inability to access healthcare in a time manner. Of those with a preferred GP, fewer than one in six get continuity of care with them, while over seven million are waiting for planned care in hospitals. Against all logic, in the adult social care market a rising number of requests for care (demand) is being met with a shrinking number finding care providers (supply).

But the quality of care has also declined. As recently as a decade ago, the communication skills of GPs were ranked above their counterparts in most comparable countries. Since then, they have fallen down to near the bottom of the pack. Cancer survival rates remain stubbornly lower in the UK than in virtually all other rich democracies, while dementia mortality is radically higher than it is in our Western European, Nordic and Anglophone peer countries.

Although service performance has been declining, service expenditure has been rising. On our current trajectory, we will increasingly 'spend more to get less'. On the post-pandemic trajectory, new modelling commissioned for this report finds NHS England is on course for spending to rise from 9 per cent of GDP to 11.2 per cent of GDP by 2033/34. This is much faster than the rate at which we expect the economy to grow, suggesting cuts for other public services or rationing of health and social care services.

The trajectory we are on is clearly not sustainable. It is not working for health nor prosperity. We urgently need to change course and remake health and care services for the 21st century, so that they work for public health and public finances alike.

We deliberated with citizens and service users across the country to understand what that could look like. Two design principles emerged: principles that should guide all reforms to the organisation of health and care services.

THE PREVENTION SHIFT: FROM WAITING FOR SICKNESS TO CREATING HEALTH

When the NHS was established, most people lived into their 60s and died from infectious diseases such as tuberculosis. Nowadays, most people live into their 80s, and long-term health conditions, such as diabetes, have far outgrown infectious disease. A treatment service is no longer the right way to organise health and care. We need to transform the reactive 20th century model into a proactive 21st century one.

THE PRODUCTIVITY SHIFT: FROM EFFICIENCY TO EFFECTIVENESS

In the decade after 2010, productivity growth in the health service was considerably higher than in the preceding one. Yet few would argue that public services in the austerity decade were performing better than in the decade before. Therein lies the problem with how productivity is perceived in the public sector. Productivity does indeed need to be driven up, but the focus should be on outcomes, not simply outputs. Put differently, we ought to focus on helping people back into work after treatment, rather than simply counting the number of treatments.

If it is clear what shifts are needed, it is more challenging to identify reforms that will drive them through. This report sets about meeting that challenge. It proposes a suite of reforms to health and care services to transform them for the betterment of public health and public finances. Pursuing IPPR's reform proposals could save taxpayers up to £205 billion over the next decade by freeing up growing sums each year – with the annual saving worth the equivalent of the current UK defence budget by 2033/34.

IPPR'S 10-POINT PLAN FOR THE FUTURE OF HEALTH AND CARE

Prevention: from waiting for sickness to creating health

1. A nationwide roll out of Neighbourhood Health Hubs to coordinate and deliver integrated health and care services in every neighbourhood.
2. A new, rewarding right to salaried employment in general practice as 'consultants in primary care'.
3. A social care guarantee, delivered by replacing unfair user charges with free personal care and driving up the quality of providers with ethical commissioning.
4. In place of centrally set targets, a bold, long-term 'healthy lives' mission for Integrated Care Systems (ICSs), backed by new planning and resource allocation powers to deliver against it.

Productivity: from efficiency to effectiveness

5. A new deal for health and care workers, from better take-home pay to stronger worker rights, to retain and remotivate the workforce.
6. Passing power to the front line, through new forms of worker voice and representation in service design and workplace governance, to unlock innovation.
7. Upgrading digital and physical infrastructure across the health and care system, with investment in diagnostic equipment, buildings, digital connectivity and new technologies.
8. Creating a pipeline of better leaders and managers across the health and care system.
9. New mechanisms for patient and public voice, including a new digital user feedback dashboard and greater use of citizen juries in difficult commissioning decisions.

Financing the future, fairly

10. A five-year funding settlement that grows NHS funding by 3.6 per cent per year and adult social care funding funding by 5.2 per cent per year, to break the feast and famine model and transform services for the 21st century, with revenue raised by progressive tax reform.

1.
THE CASE
FOR REFORM

1.1.
SICKNESS: A GRAVE THREAT TO PROSPERITY

The UK is getting poorer. At the individual level, wages are being eroded by inflation. At the national level, growth and productivity have been stagnant for over a decade (Resolution Foundation 2022). At the same time, the UK is getting sicker.[1] Both in terms of morbidity and mortality, the remarkable progress made in the 20th century and first decade of the 21st century has now stalled – with signs it is even in reverse for some groups (Marmot 2020).

Importantly, as the interim report of the IPPR Commission on Health and Prosperity demonstrated (Thomas et al 2023), these are not unrelated trends. Growing sickness is making us poorer, as individuals and as a nation.

There is, perhaps, no better current example of this than the state of the UK labour market. Over a third of the working age population – whether employed, unemployed or inactive – report a long-term health condition of some kind (ONS 2023a). It is therefore unsurprising that the number of people economically inactive due to sickness has been rising and currently stands at the highest level on record (figure 1.1).

FIGURE 1.1

Two decades of progress on economic inactivity due to sickness has been undone
Number of working age people who are economically inactive primarily due to sickness, seasonally adjusted, UK, 2000–22

Source: IPPR analysis of ONS 2023a

The onset of sickness also has a pronounced impact on individuals' personal finances. IPPR analysis of Understanding Society data has found that the onset of serious illness costs the average person approximately £2,200 annual earned

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1   Growing sickness is being driven by a wide range of factors, including the deterioration of health and care services, cuts to public health and other public services, quality of work and workplace environments and many other social and economic determinants.

income. The impact of this loss of earnings – disregarding other costs of sickness – adds up to a vast national economic cost (figure 1.2).

The onset of sickness has a profound national economic cost
Cost of onset of sickness between 2014-2021, to GDP in 2021

Source: Thomas et al 2023

Economic institutions increasingly recognise the rising tide of UK sickness as one of the gravest fiscal threats facing the country. For example, the OBR's recent annual *Fiscal Risks and Sustainability Report* points towards three particular fiscal implications from rising sickness:

- **Foregone tax revenue**. The OBR estimate that the rise since just before the pandemic in economic inactivity due to sickness, combined with the rise in in-work sickness, has been associated with an £8.9 billion reduction in tax receipts.
- **Higher welfare spending**. The OBR estimate that the impact of the above corresponds to £6.8 billion higher welfare spending per year.
- **Higher healthcare spending**. Finally, the OBR project additional NHS costs, when someone moves from being economically active to inactive, of £1,800 per person per year (OBR 2023a).

Even then, these figures may constitute significant underestimates, given suggestions that the Labour Force Survey may not accurately measure the full impact of sickness on the labour market (Thomas et al 2023).

THE PATH AHEAD
Given the existing consequences of rising sickness, both to individuals and to the national economy, policy makers across the UK should be worried by our current

trajectory of rising sickness. The Health Foundation has estimated that, by 2040, 9.1 million people in England will be living with a major condition. This means the number living with sickness will rise at nine times the rate that the working age population is expected to grow (Watt et al 2023).

Yet this is not a cause for hopelessness. The health and economic impacts of disease are not set in stone. In particular, the costs associated with sickness are not inevitable. There are three broad pathways through which the costs associated with sickness can be mitigated.

- **We need to do more to prevent illness**. The UK's burden of disease is highly preventable. While prevention does not mean people will not get sick eventually, it does mean that the cost of that sickness is reduced, and that the size of the working age population in the UK is maximised.

- **We need to do more to treat and manage illness effectively**. The UK is relatively poor, compared to other G7 countries, at treating illness. Our ability to either cure or alleviate sickness is another tool in reducing the gross amount and complexity of population illness.

- **We need to do more to reduce the cost of a shock diagnosis**. Even if illness cannot be prevented or treated, the cost it has on people's individual economic lives is not inevitable. The social model of disability has long contended that people are disabled by society, not by impairments – and the same is true of health. Our ability to support people with long-term conditions to lead better, more independent lives – including by providing support to find and stay in appropriate work – will be critical to the future of our economy and society.

As it stands, we are not achieving this. One indicator is the avoidable death rate: that is, deaths that can be mainly avoided by effective healthcare and public health interventions. Our analysis with Carnall Farrar (CF) finds that the UK lags behind many other peer countries and that, moreover, the UK would have had approximately 243,000 fewer deaths between 2010 and 2020 if it matched its European peers in avoidable mortality (figure 1.3).

FIGURE 1.3

Avoidable deaths are higher in the UK than in comparable European countries
Avoidable mortality rate per 100,000 population, 2010–2020

There would have been 240,000 fewer deaths in the UK between 2010 and 2020 if the UK matched the average avoidable mortality rate in comparable European nations

— UK — If UK matched European nations
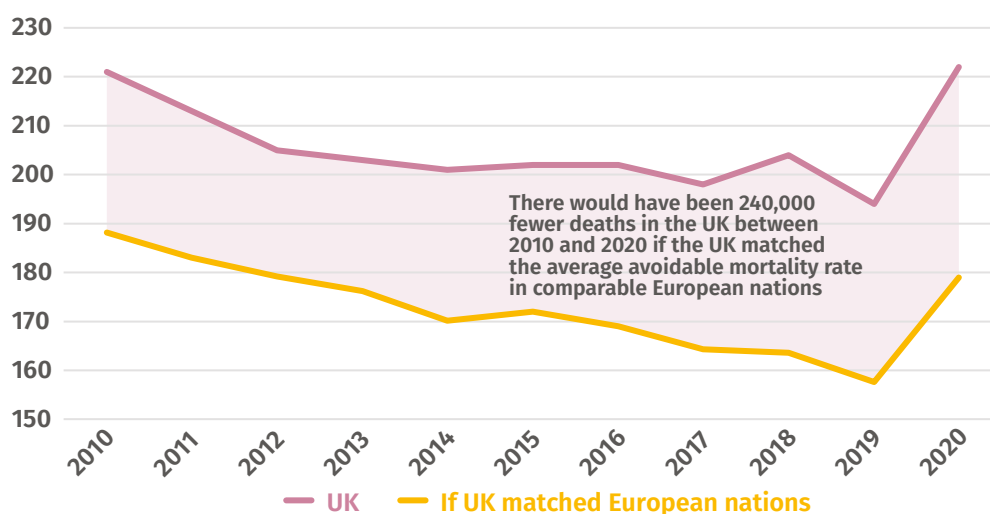
Source: CF analysis of OECD 2022

Note: analysis based on comparable the avoidable mortality rate in the UK to the average seen in comparable advanced democracies in Western Europe

Ultimately, then, the UK finds itself at a crossroads. Unmitigated, a rising tide of sickness will harm individual lives, both in terms of suffering and financial wellbeing, as well as widening inequality, damaging public finances, and reducing UK output. But on the flipside, there is an opportunity: better health could yet put us on the path to greater wellbeing, greater prosperity, and a fairer society.

In this context, it is still important to recognise that our ability to achieve a healthier and more prosperous country is not solely the remit of either the NHS or adult social care. Neither are the sum of what creates a healthy life: that is also down to the environments we live in, the food we eat, the conditions we work in, and the communities around us. However, health and care services are clearly leading protagonists in the story. Indeed, there a range of pathways through which health and care services can support healthy people and prosperous lives (see figure 1.4).

FIGURE 1.4

Health and care services can support broad based prosperity

Fast access to care

Avoiding or reducing the wellbeing and economic cost of sickness depends on fast, effective access to the services people need. If the default is that people need to wait a long time to get the support they need, then their chance of leading a long, independent and prosperous life is reduced.

Good experiences, strong relationships

As more people living with long-term or multiple long-term conditions — for larger proportions of their life — the ability to reduce the wellbeing and economic impact of sickness will become more important. As well as access, this requires an on-going relationship with services — anchored in good communication, on-going condition management, trust and good service experiences

World leading outcomes

Whether delivered by primary prevention (avoiding need), secondary prevention (mitigating and managing need) or cure (innovative treatment), delivering the best possible health outcomes will avoid or reduce economic harm — from barriers to the labour market, to impact on earned income, to a reduced national burden of unpaid care.

Integrated provision and partnership

And even if the NHS and social care cannot prevent or treat a condition, they can still mitigate the economic costs of sickness - by working with employers, integrating best practice employment support like IPS, or providing direct employment opportunities themselves.

Health as an industry

Finally, health and care is a vital and large industry in its own right. As well as supporting and enabling the rest of the economy, health and social care employ millions - while associated industries like the life sciences employ hundreds of thousands. Ensuring these are good, autonomous and fairly paid jobs can support prosperity immediately - and support good health in the longer-term.

Source: Authors' analysis

Given this, this report – the second major IPPR submission to the IPPR Commission on Health and Prosperity – outlines how we can ensure these services can support health and prosperity in the 21st century, and how they can adapt to the changing demands placed on them by our 21st century society and economy.

1.2.
THE STATE OF HEALTH AND CARE SERVICES

The most important justification for collectivised health and care services are their ability to enable good lives. At their best, both healthcare and adult social care can enable the things that matter most in life: our ability to find meaningful work, to have good social relationships, to participate in hobbies and with our community, and to maintain independence well into retirement.

Yet this is not undermined by the recognition that health and care services are also foundational to the strength and resilience of our economy. If these services struggle to prevent need effectively, to treat sickness efficiently and quickly, or to help people manage long-term conditions well, then there is a substantial knock-on impact on both individual and national prosperity.

Indeed, the earliest proposals for a National Health Service were justified in part on economic grounds. The Beveridge report recognised that the status quo model of healthcare was not working for either wellbeing or prosperity, and so proposed a new approach, more compatible with what the demographic, societal and economic realities of the 1940s demanded. In the 21st century, we must now reconsider whether our current status quo is once again insufficient to provide what both our health and our economy needs from it.

To that end, this section audits health and care services in England. Specifically, we identify three key problems.

- **Problem 1: Access.** People are struggling to access the care and treatment they need in a timely manner.
- **Problem 2: Experience.** People are not always treated with respect, listened to or empowered when using health and care services.
- **Problem 3: Quality.** The effectiveness and outcomes of care are poorer than in other countries.

PROBLEM 1: ACCESS

> *'There is a huge hole where you might not see or have any contact with anybody for ages. So you might go to your GP or reach out online... and then you're on the waiting list. But that wait can be so detrimental.'*
> Deliberative research participant using primary care services

In principle, NHS services are available for free, at the point of delivery, based on need. In reality, that is not always the case. It has become increasingly difficult to access healthcare across almost all services, including emergency care, elective care, primary care, mental health, and community healthcare. This is a challenge for people's lives, but also for their prosperity: slow access might mean someone does not get support in time to save their job, or that their condition gets more severe, and thus has greater consequences for their long-term prosperity.

Nearly one in every three people who attended accident and emergency (A&E) this year spent more than four hours from arrival to admission, transfer, or discharge (figure 1.5). This is far higher than NHS England's target of 5 per cent – a target that has proved increasingly elusive for the last decade. Even more worrying is that about one in 10 are waiting longer than 12 hours in the department (NHS England 2023a).

FIGURE 1.5

Waiting times in A&E departments have become progressively longer
Per cent of patients in England spending over four hours in A&E before a decision is made to admit, transfer or discharge
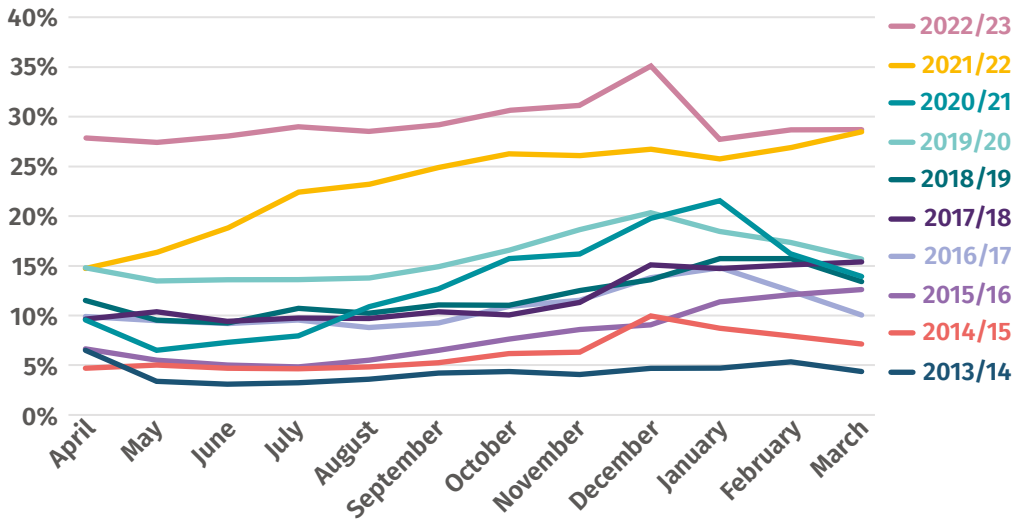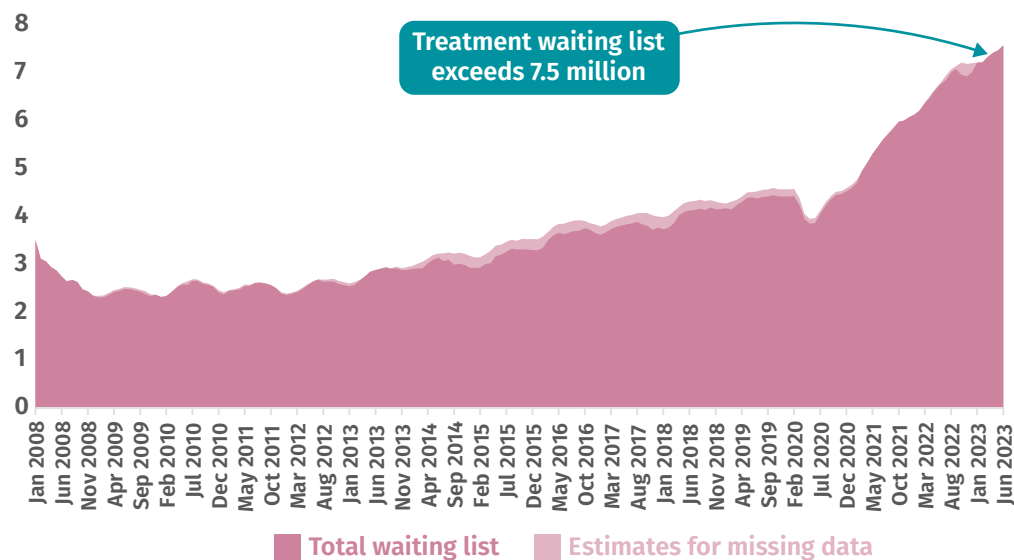

Source: CF analysis of NHS England 2023a

Meanwhile, elective waiting lists in England have reached 7.4 million people, the highest since records began (NHS England 2023b) (figure 1.6). Although healthcare disruption experienced during the pandemic has clearly accentuated this challenge, waiting lists also rose sharply during the preceding decade.

FIGURE 1.6

Elective care waiting lists grew during austerity and ballooned during the pandemic
Number of open consultant-led elective treatment pathways in England (millions)

Treatment waiting list exceeds 7.5 million

Total waiting list   Estimates for missing data

Source: CF analysis of NHS England 2023b

Access to primary care services has also deteriorated. It has become progressively more difficult to get through to GP practices over past decade (figure 1.7). Just 53 per cent said they found it easy to get through to their practice by phone in 2022 (down from 68 per cent in 2021), with only 56 per cent reporting a good overall experience of making an appointment.

Accessing primary care services has become more difficult
'Generally, how easy is it to get through to someone at your GP practice on the phone?'

Source: CF analysis of GP Patient Survey 2022

Similar access problems are found in mental health services. An estimated one in four people with serious mental health illnesses wait more than 12 weeks to start treatment under the care of a consultant psychiatrist, with about three-quarters of those waiting subsequently forced to use emergency services or a crisis line (Royal College of Psychiatrists 2022). Some mental health services, including eating disorder services, are employing rationing measures, and turn away patients because demand for services is so much greater than the staffing and capacity available (Viljoen et al 2022).

Access has also declined for adult social care services, with one in four waiting over six months as of February 2022 (up from one in five in November 2021) (ADASS 2022). This is down to a mix of rising demand for care, and lower supply and capacity (figure 1.8). The result of this growing mismatch is increasingly stringent means- and needs-testing (Bottery 2023) and an increasing dependence on informal carers. Both unmet care need, and a high burden of unpaid care, are likely to hold back labour market participation[2] (ONS 2023b).

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2   Particularly for women, who make up the majority of the informal care workforce.

The number of people accessing care has fallen even as demand has soared
Percentage change in social care support requests and access, England

Requests for support ▬▬ Number accessing support
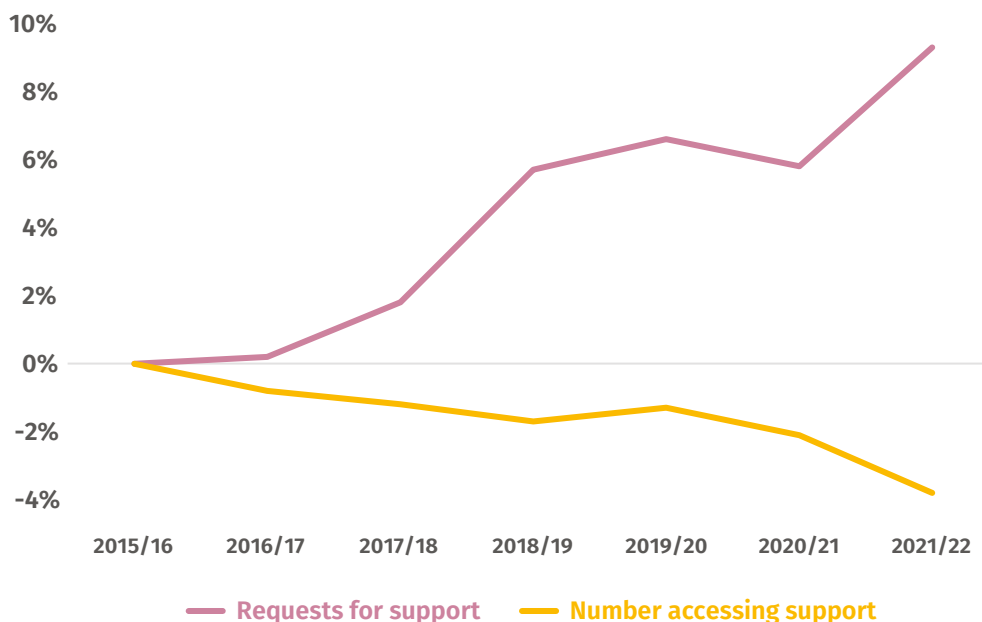
Source: King's Fund 2023

PROBLEM 2: EXPERIENCE

> *'When you're seeing a new person each time, it's not a productive use of time because you spend a lot of that session revisiting your medical history or answering questions that you answered previously, and that communication level isn't there.'*
> Deliberative research participant using primary care services

Compassionate and caring health and care services are not simply a 'nice to have': they are of real importance to both high quality care and patient satisfaction. They are also important for prosperity. As more people live with major or multiple conditions in the future, the extent to which they have a strong, trusting and ongoing relationship with health and care services will define how well they can manage those conditions. In turn, this is vital to their capability to lead a long, healthy and prosperous life even after a shock diagnosis.

Our deliberative research highlighted that people valued two features of their experience above others: firstly, their ability to develop a long-term, equal relationship with healthcare professionals, and secondly, the standard of communication received. Both these aspects of experience have deteriorated in recent years.

For example, it has become more difficult for patients to see their preferred GP (figure 1.9). This has correlated with declining satisfaction with primary care service overall (NHS England 2023c) and is well evidenced to negatively impact patient outcomes (Gray et al 2018).

FIGURE 1.9

It is increasingly difficult for patients to see their preferred GPs
Of those with a preferred GP, per cent responding always or almost always when asked "how often do you see or speak to your preferred GP when you would like to?"
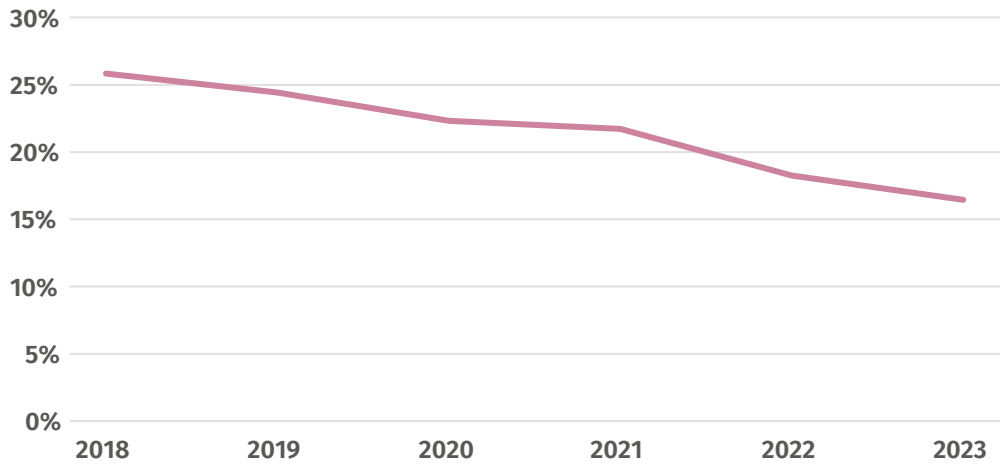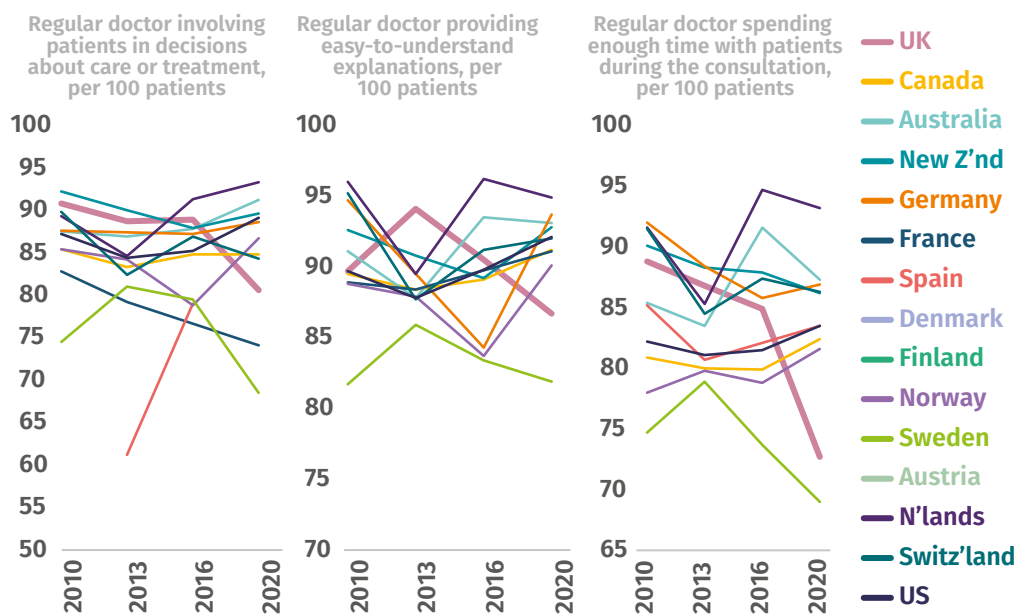

Source: IPPR analysis of GP Patient Survey 2023

Quality of communication has also declined. As recently as 2010, the UK was ranked above most comparable countries on measures of communication quality (figure 1.10). But in the last 10 years, it has fallen behind in terms of doctors providing clear information, spending enough time with patients, and making joint decisions with patients.

FIGURE 1.10

Quality of clinical communication is worse in the UK than most other comparable countries
Per cent responding to survey question

Regular doctor involving patients in decisions about care or treatment, per 100 patients

Regular doctor providing easy-to-understand explanations, per 100 patients

Regular doctor spending enough time with patients during the consultation, per 100 patients

UK
Canada
Australia
New Z'nd
Germany
France
Spain
Denmark
Finland
Norway
Sweden
Austria
N'lands
Switz'land
US

Source: CF analysis of OECD 2021

It is not just in the consulting room that communication is a problem. Our deliberative research also exposed challenges around communication and follow-up in adult social care. One research participant using social care services said, discussing their follow-up plan, 'you have no idea if it's been done...because nobody lets you know'.

PROBLEM 3: QUALITY

In the last 100 years, medicine has made impressive advances in our ability to identify and effectively treat illness. Despite that, outcomes across the life course in the UK - from childhood to older age - have fallen behind those in other, comparable countries. Whether delivered via prevention or cure, an individual's health outcomes will remain the most important determinant of their life chances and prosperity in the decades to come.

Although cancer survival has improved considerably over the past 20 years, the UK lags behind comparable countries on survival rates of the most common cancers (figure 1.11). We estimate approximately 180,000 deaths could have been avoided in the decade from 2010 if cancer mortality rates in the UK matched the European average.

FIGURE 1.11

The UK lags behind most comparable countries on cancer survival
Five year net survival, age-standardised; lung, breast, colorectal and cervical cancer
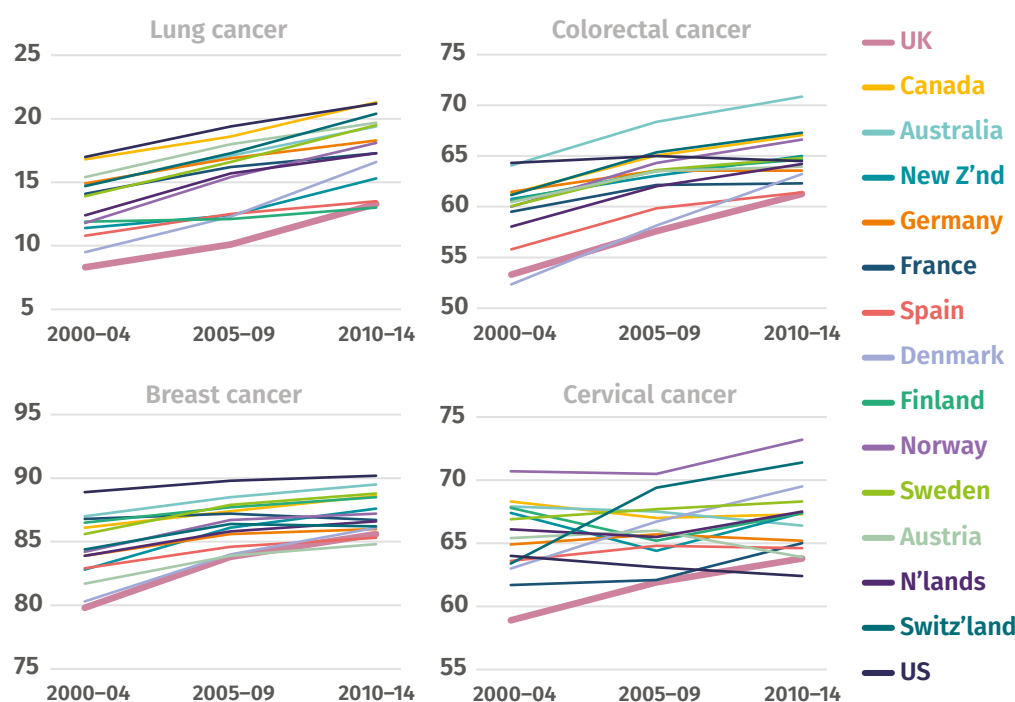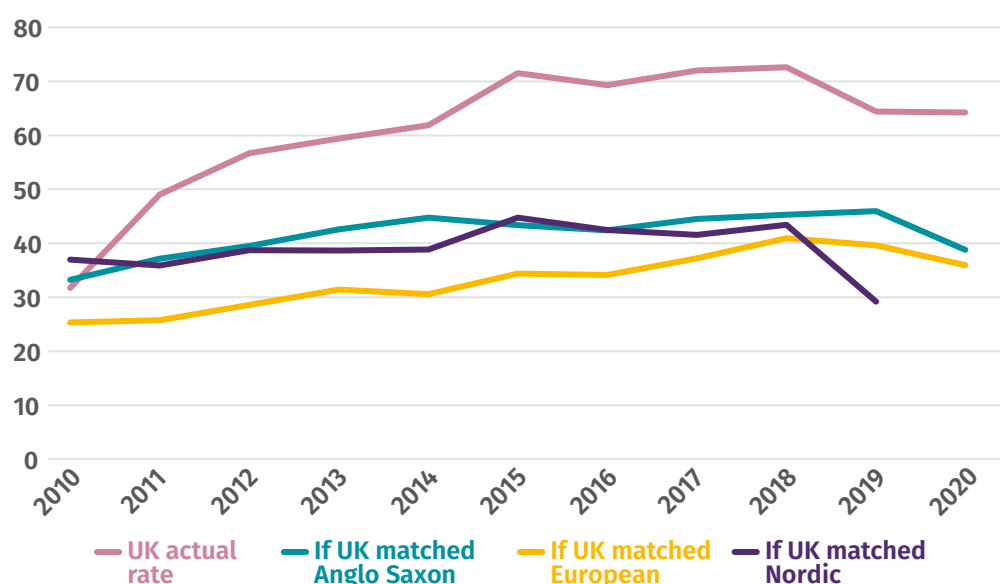

Source: CF analysis of OECD data

Similar trends are found for cardiovascular diseases. Despite vast improvements in cardiovascular outcomes over the past half century (Bhatnagar et al 2016), and the fact that three quarters of cardiovascular disease is preventable (Stewart, Manmathan and Wilkinson 2017), these diseases remain a leading cause of death in the UK (Vos et al 2020). Moreover, the risk of death after a heart attack is higher in the UK compared to most European and other English-speaking countries (OECD 2021).

Deaths due to dementia are rising globally, but at a particularly fast pace in the UK. We estimate approximately 180,000 deaths could have been avoided from 2010 to 2020 if the UK matched European colleagues, or 140,000 if the UK matched Nordic or English-speaking peers (figure 1.12). It is worth noting that many cases of dementia are preventable: one study estimates a third of cases could prevented through better risk factor management such as smoking cessation and reducing social isolation (Livingston et al 2020).

FIGURE 1.12

Deaths from dementia are considerably higher in the UK than in comparable countries
Dementia mortality per 100 population, 2010–2020


Source: CF analysis of OECD data

The prevalence of mental health problems has been rising steadily for decades (Adult Psychiatric Morbidity Survey 2016), with a particularly sharp rise among children and young people. One survey estimates that 18 per cent of children in England aged 7-16 had a probable mental disorder in 2022, up from 12 per cent in 2017. Among those aged 17-19, the trend is even more pronounced: from 10 per cent in 2017 to 26 per cent in 2022 (NHS Digital 2022b).

Despite this rising need, the quality of mental health services is poor. Most children and young people with a probable mental disorder do not receive treatment or support (figure 1.13). The most telling indication of service inadequacy is the rate of adolescent suicide (15 to 19 year olds), which has been rising considerably since 2010 (Bould et al 2019).

FIGURE 1.13

Many young people with probable mental disorders do not get treatment or support from mental health services
*Per cent responding to survey question*
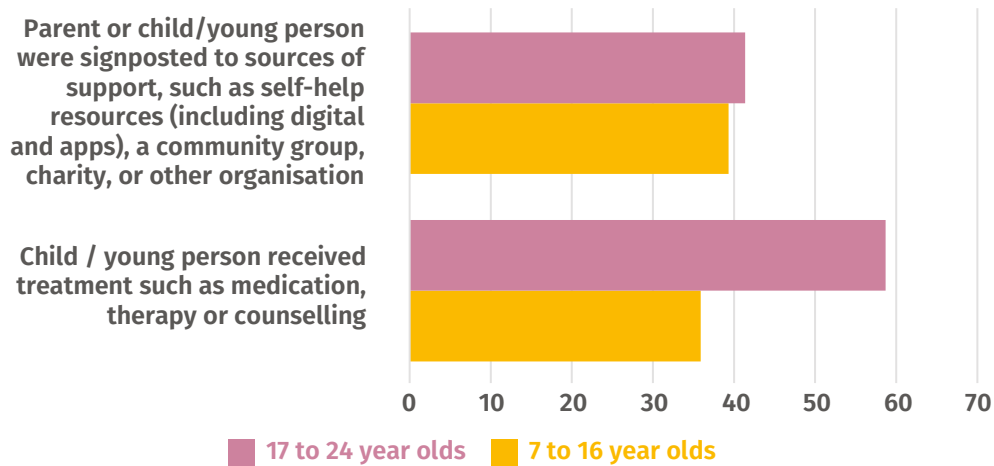
Source: IPPR analysis of NHS Digital 2022b

Finally, there are also indications of low quality in adult social care. There has been a considerable decline in social care-related quality of life ratings in recent years (figure 1.14). This metric captures the impact of care on quality of life across domains ranging from basic functioning, such as feeding and dressing, to higher order domains such as social contact and work.

FIGURE 1.14

Quality of life is declining for those using social care services
Average social care-related quality of life score across social care users, England
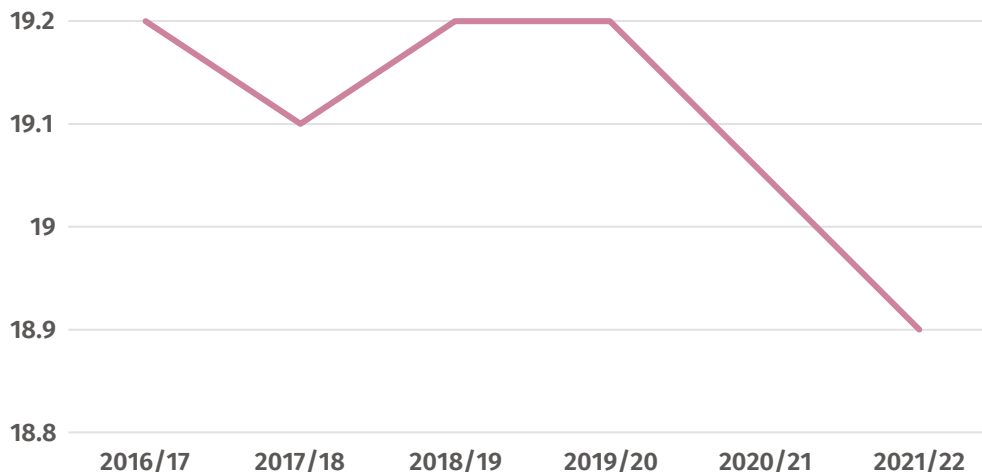
Source: CF analysis of NHS Digital 2022a

Note: this measure is an average quality of life score based on responses to the Adult Social Care Survey. It is a composite measure using responses to survey questions covering the eight domains identified in the Adult Social Care Outcomes Toolkit: control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. It is presented as a score out of 24. In the time period that is shown, the highest score for a single tier or county council in England was 21.4 and the lowest for 16.7. We therefore do not begin the y axis at zero.

1.3.
# A PLAN THAT WORKS FOR PUBLIC HEALTH AND PUBLIC FINANCES

Without reform, we are on a trajectory to paying more but getting less than what we need from health and care services. Put another way, the provision of care is likely to get significantly more expensive in the years to come. But the extent to which that health and care provision meets the evolving needs of society and the economy looks set to become less and less satisfactory.

To quantify this, we worked with LCP Health Analytics to estimate NHS England funding pressures over the next decade.[3] The modelling finds if history repeats itself, following trends since 2004/05 up to the pandemic, NHS England spending is set to grow from 9 per cent of GDP to 10.7 per cent of GDP (or £352 billion in nominal terms) by by 2033/34 (figure 1.15). It will be even higher, reaching 11.2 per cent of GDP by 2033/34, if the post-pandemic pattern of flatlining productivity continues.

FIGURE 1.15

NHS England spending is projected to rise considerably over the next decade
Projected NHS expenditure, 2022/23–2033/34
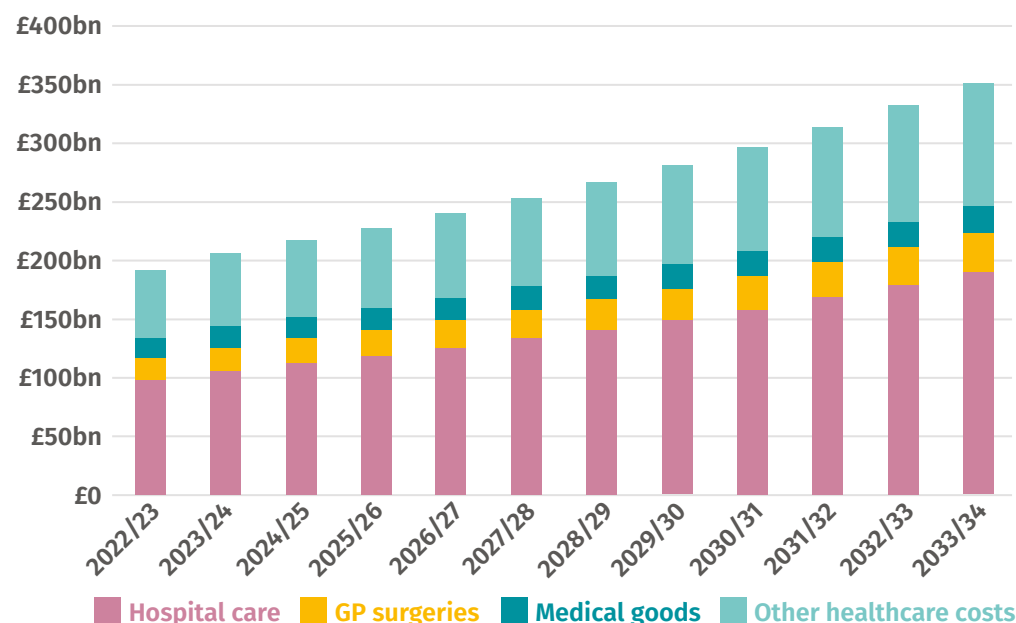

Source: LCP analysis

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3   The model is based on projected changes in population demographics, and analysis of age-, sex- and specialty-specific trends in healthcare service utilisation and unit costs since 2004/05 in England. See appendix for more detail.

Similar is true of adult social care services. Just to keep up with future demand of an ageing population – that is, without rationing provision – the service will need more than its current estimated spending power (figure 1.16).

Social care spending will need to rise to meet the demands of an ageing population
Projected social care expenditure to meet demand at current provision levels 2021/22–2027/28
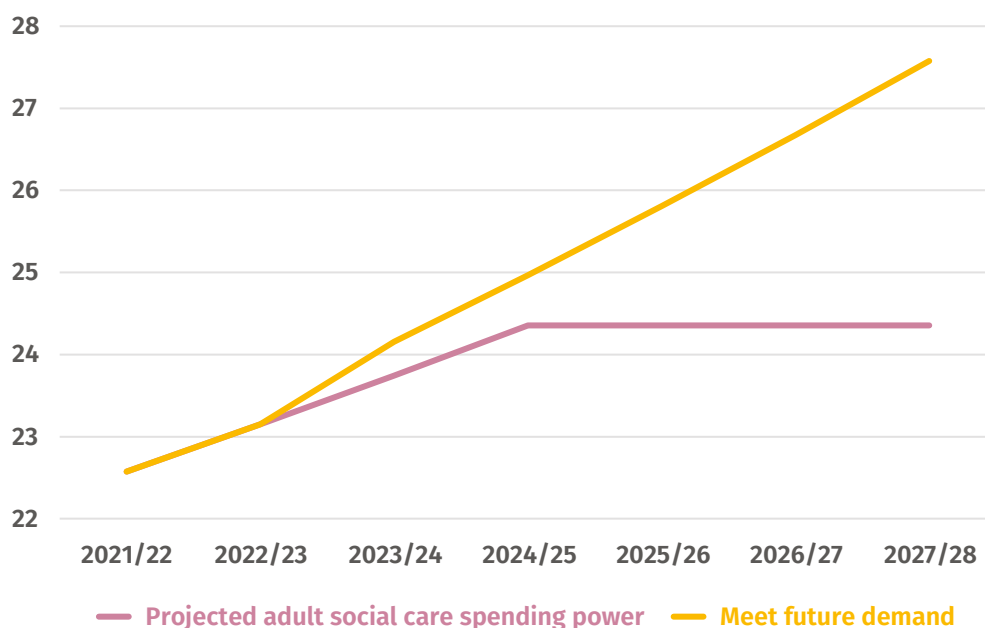
Source: Health Foundation analysis of NHS Digital, Adult Social Care Activity and Finance Return 2021/22.

This speaks to a failure in the current reform paradigm. Over the last ten years, health and care reform has been defined by 'do more, with less'. Attempting to answer rising need, successive governments have used efficiency drives to try to maintain existing provision at lower costs. This analysis shows that this has not worked: 'do more with less' might create very short-term savings, but has failed to deliver good outcomes, for individuals or the economy.

The challenge, then, is to articulate an alternative vision of the future that works for both public health and public finances.

• To devise reform that works for public health and public expectations, we analyse service performance and use deliberative research and public opinion surveys to assess priorities for the future.

• For a plan that works for public finances, we model NHS expenditure trajectories to explore what options exist to ensure better outcomes alongside long-term financial sustainability.

This section examines both in turn.

WHAT DO PEOPLE WANT?

Polling finds near universal support of the NHS's founding principles. Table 1.1 shows the ongoing and cross-party support for the NHS founding principles (including their extension into adult social care).

TABLE 1.1

People are committed to free, comprehensive, publicly financed health and care services
IPPR/YouGov polling of 2,014 British adults, fieldwork June 2023. Question: For each of the following statements, to what extent do you think the principle should still apply to NHS services (top) and care services (bottom) today?

	All	Conservative	Labour
(NHS) Free at the point of use when people need it			
Should still apply	89%	89%	95%
Should not still apply	6%	8%	2%
(NHS) Provide a comprehensive service, available to everyone			
Should still apply	85%	81%	93%
Should not still apply	9%	15%	4%
(NHS) Primarily funded through taxation			
Should still apply	83%	83%	93%
Should not still apply	7%	9%	3%

	All	Conservative	Labour
(Adult social care) Free at the point of use when people need it			
Should still apply	78%	77%	86%
Should not still apply	9%	12%	8%
(Adult social care) Provide a comprehensive service, available to everyone			
Should still apply	80%	80%	90%
Should not still apply	7%	9%	3%
(Adult social care) Primarily funded through taxation			
Should still apply	72%	73%	82%
Should not still apply	10%	13%	7%

Source: IPPR/YouGov, Thomas 2023

This should not be mistaken for blanket satisfaction with the state of health and care services. Indeed, our deliberative research saw one message consistently highlighted above all others: people felt health and care services were no longer meeting their expectations. While they understand some of the reasons why health and care services are under strain, patients and service users feel both disenchanted and disempowered by the current state of services.

DELIBERATIVE RESEARCH WORKSHOPS: METHODS

As well as quantitative research carried out with CF, this section is informed by extensive qualitative research consisted of deliberative workshops with four groups of participants (n = 42) who had recent experience of different health and social care services:

1. Secondary mental health services in the last two years
2. Maternity and early years services in the last three years
3. Frequent contact with primary care services due to multiple long-term health conditions
4. Support from social care services due to long-term health conditions or disabilities

Participants were recruited from the general public by a research agency, which ensured the sample was varied in terms of gender, age, ethnicity, geographical location, household income, working status and social segmentation.

This work sought to elicit insights into how to improve experiences across a patient journey, from seeking information and booking an appointment, to relationship-based care provision, to effective and responsive feedback mechanisms. We met with each group for two three-hour sessions, one week apart. All the sessions included a range of presentations, full group discussions and break-out sessions with smaller groups to ensure we heard as much as possible from each participant. Our general approach throughout the sessions was to support and prompt participants to expand their perspectives and thinking on the potential scope, design and delivery of health and social care services. We then identified key themes within each specific service area, and those that were common across multiple groups.

Our deliberative research led to a rather clear vision of what participants wanted from health and care services in the 21st century. First and foremost, they wanted the founding principles to remain: they wanted a free, tax funded, and comprehensive service. This wasn't a blind commitment to an unattainable ideal: participants were able to operationalise how they wanted these ideals to be translated in practice. Participants wanted care to be available when and where they need it, for it to be caring and tailored to them and their needs, and for it to be effective in enabling healthy, independent, and prosperous lives.

Care available when and where I need it (access)

> *'I just want to be seen as soon as possible.'*
> Person using primary care

When people are ill, they should be able to access the care they need when and where they need it. This is partly about reversing the increases in waiting times seen in recent years. But it's also about changing where and how care is delivered. More and more people want to be able to access information and care using technology. But there should always remain access to in-person consultations where and when appropriate, which should be close to home and, increasingly, built around peoples' busy lives.

Care that is caring (experience)

> *'The idea of being an 'expert patient' resonates – that you know yourself best. It's about people listening to what you need to better your own situation in life.'*
> Person using social care

People should receive care that is genuinely caring. They should have the opportunity to build a relationship with health and care professionals who they can trust and who know them, their family and their needs. They should be listened to and should only have to tell their story once because the system is joined up around them. Citizens should be in control of their care, with staff supporting them to make decisions about their health and care that work for them and their lives. They should never be left to feel confused, lost, scared, alone or uncared for.

Care that is effective in enabling healthy, prosperous lives (Quality)

> *'I've actually got a Zoom call next week on understanding diabetes, how to control it, education around food, and lifestyle – so that's excellent in my eyes'.*
> Citizen using the NHS

People should get the best health and care available, based on the most advanced science and technology, for the health conditions they are experiencing. They should expect their local NHS and care providers to deliver outcomes equivalent to the best achieved both at home and abroad. But high-quality care cannot just mean the best treatment once someone has become ill: it must also mean intervening earlier to prevent people from getting ill in the first place. The NHS and care system must become preventative by default.

ARE THE FOUNDING PRINCIPLES THE PROBLEM?

There have been growing arguments that the founding principles of the NHS are behind the problems that we face today. Proponents of this idea point towards contributory healthcare models or social insurance systems as the antidote to our health and care crisis. However, there are numerous reasons why the logic of this argument does not hold:

- **Popularity**: Perhaps most importantly, the public remain almost universally in support of the NHS' founding principles – and even support their extension into adult social care (see tables 1.1). This is likely down to political commitment rather than blind love of the NHS: both our deliberative research and wider polling shows that the public are also very clear when they're dissatisfied with how the NHS is being run, or with the realities of service provision. This means that a shift in the principles that sit behind the NHS would have little democratic mandate and would also be very politically challenging.

- **Outcomes**: While research shows that collective risk sharing is preferable and less regressive than systems primarily funded through out of pocket expenditure and private medical insurance premiums, there is no evidence that the choice of whether to fund health systems through income-based taxes or social insurance contributions makes any demonstrable impact on outcomes (Wagstaff 2009; Edwards 2022). Yet a fundamental change in funding model would have significant opportunity costs, in terms of disruption to the system as well as efforts to create public and staff buy-in.

- **Equity:** While there are examples of fair healthcare systems funded through social insurance, a blunter expansion of the contributory principle is likely to widen inequalities. Payment would constitute a major barrier to access. Even if people on the lowest income were exempted, targeting this group effectively may prove difficult (for example, linking to universal credit may miss significant numbers of people) and achieving full take-up for exemptions, if this requires registration, is likely to prove elusive.

- **Efficiency**: The NHS is a relatively efficient health system by international standards. Comparative studies have regularly placed the UK highly for efficiency – even where it is ranked relatively poorly on outcomes – reflecting wider evidence that tax-funded systems are more efficient in general (Wagstaff 2009). More generally, 'Beveridge' based systems tend to cost less than 'Bismarck' based social insurance systems – and both are significantly cheaper than USA-style systems (ibid).

In other words, the presence of a crisis does not make bad and disruptive ideas suddenly good ideas.

WHAT WORKS FOR PUBLIC FINANCES?

Design principles mean little if they do not translate into institutional reform. The key questions are: what reforms can realise the vision people have outlined; and, crucially, can we afford them? There is concern across the political spectrum and among the public about our ability to afford a high-quality universal healthcare service. We need a credible plan that works for public health and public finances alike.

Working with LCP Health Analytics, we have modelled NHS England expenditure projections over the next decade and analysed to what extent the spending growth can be slowed by realistic improvements in health status and service productivity. We model three scenarios.

1. **Repeating history:** productivity grows in line with historic trends (broadly covering the period from 2004/05 to 2018/19).
2. **Post-pandemic new normal**: productivity growth in the health service flatlines.
3. **Reform**: productivity grows half a per cent faster per year than historic trends (2004/05 to 2018/19) and healthy life expectancy begins rising from 2027/28 in line with the gains seen in the 2000s (approximately 0.95 per cent pa).

FIGURE 1.17

Prevention and productivity reforms can limit spending growth in the NHS
NHS England spending as a share of GDP under three different scenarios
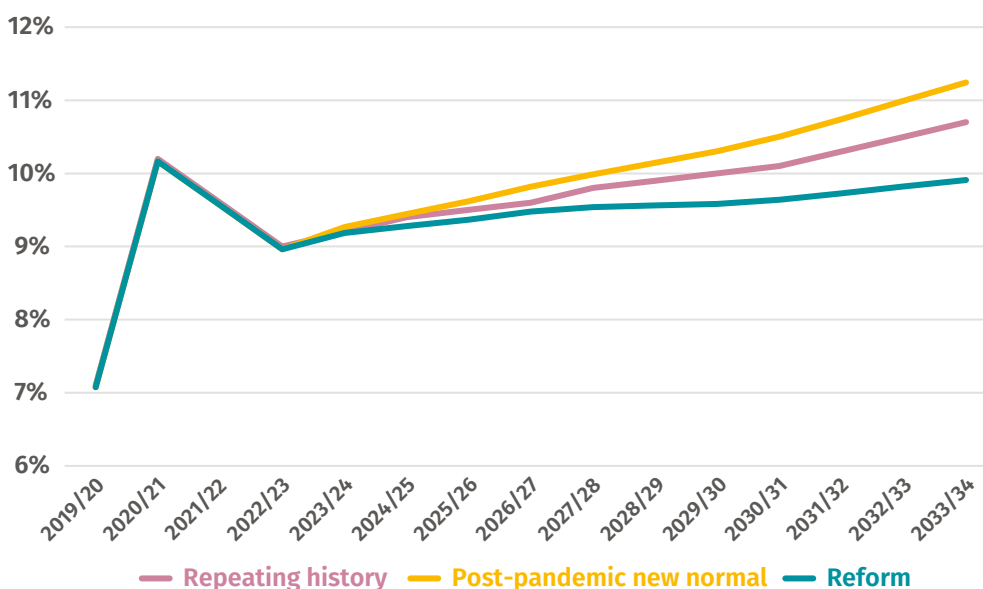
Source: LCP analysis

Without reform, healthcare financing will become increasingly unsustainable, with a real risk of taxpayers paying more for worsening services. But if our 'reform' scenario can be realised, NHS England expenditure could be kept below 10 per cent of GDP in a decade's time. Compared to the 'post-pandemic new normal', this could save taxpayers an estimated £205 billion cumulatively over the next decade – with the annual saving worth the equivalent of the current UK defence budget by 2033/34. Even we are able to escape the post-pandemic trajectory and bend back to the 'repeating history' scenario, we will spend more but get less than what we need. Compared to the 'repeating history' scenario, our modelling finds reform can can save taxpayers £115 billion over the coming decade.

Two shifts are vital in delivering the 'reform' future.

SHIFT 1: PREVENTION – FROM WAITING FOR SICKNESS TO CREATING HEALTH

In 1948, the year the NHS was founded, life expectancy in the UK was approximately 66 years for men and 71 years for women (ONS 2015). Only about 7 per cent of the population was older than 65. Most people died from infectious diseases such as tuberculosis, pneumonia and flu (ONS 2017). Society urgently needed an illness service everyone could access, regardless of income or social status.

75 years later, we still have an illness service, but the health and care challenges we face are different. Life expectancy has grown by 13 years for men and 12 years for women (ONS 2015). And almost one in five people in the UK today is over 65. Chronic diseases have outgrown infectious diseases by some margin. The leading causes of death are dementia, heart disease, stroke and cancer (ONS 2022). One in five 10-year-olds is obese (NHS Digital 2021).

In short, the epidemiological transition has outpaced the health and care system transformation. We will always need services that respond to ill health because, sadly, people will always fall ill. But we also need to invest in services that can support people to lead healthier and more independent lives, by seeking to prevent ill health before it damages people's lives and livelihoods.

Our failure to achieve a health service, rather than just an illness service, is a profound social failing: preventable ill health, disability and frailty are infringements on our freedom and dignity. But it is also economically damaging, as it prevents people from participating in the labour market, and often increases the cost to the state by requiring more costly intervention later.

Simply put, the case for promoting health through our services, rather than just treating illness, is irrefutable. But while better prevention has been a policy goal of health policy for decades, the reality has been one of overpromise and under-delivery. What is missing from our health policy is not an understanding of the end goal, but of the policy and institutional reforms needed to get there. This report sets out to change this by putting forward a bold but deliverable prevention agenda across health and care.

In upcoming chapters, we set out how this can be achieved by:
- **Putting primary and community care at the heart of prevention** to proactively prevent disease and deterioration.
- **Delivering a social care guarantee** to enable dignified, healthy lives in the community.
- **Unlocking 'prevention-first' services,** with Integrated Care Systems (ICSs) allocating resources more effectively across the health system.

SHIFT 2: PRODUCTIVITY: FROM EFFICIENCY TO EFFECTIVENESS

Public sector productivity increased by an average of 0.7 per cent per year from 2010 to 2019, a marked improvement over the preceding decade. NHS productivity has been even higher at almost 1.2 per cent over the period (see figure 1.18).

During austerity, quality of healthcare declined but productivity growth was high
Public sector total factor productivity (TFP) (annual % change)
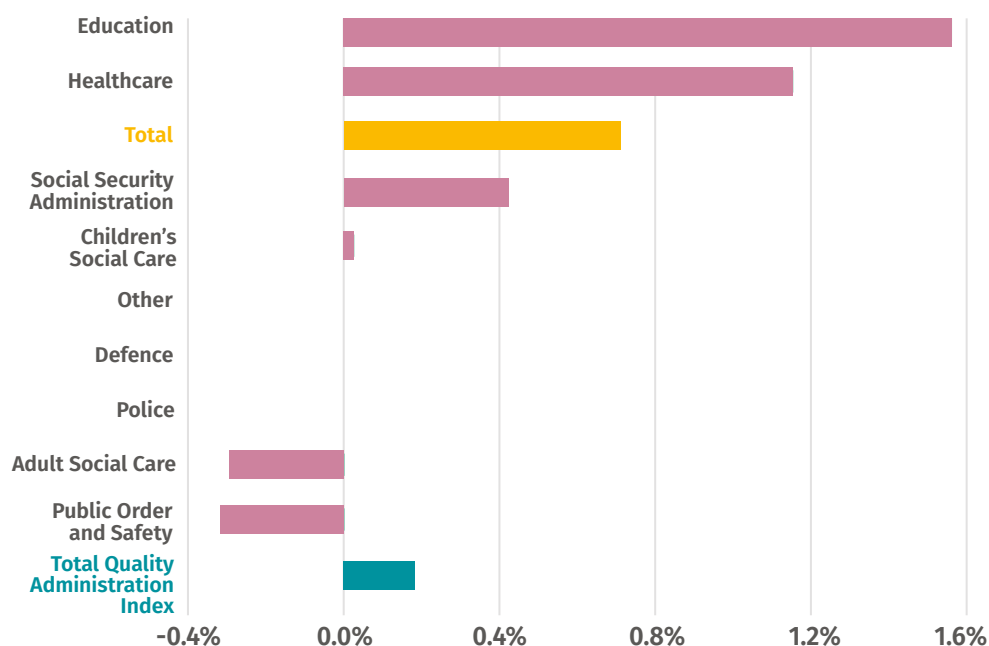
Source: Van Ark (2022)

This would usually be considered a success. Greater productivity implies a more efficient public sector, which should mean a better use of taxpayers' resources, better outcomes and a more productive economy. But in reality, few would argue that public services in the austerity decade were performing better and delivering more effectively for society than in the decade before. In fact, most would argue the opposite.

This fact exposes the weakness in the way we measure and (usually) go about driving up public sector productivity. Productivity is mainly defined as the amount of outputs produced for a given number of inputs. Broadly speaking, there are two approaches to increasing productivity in the public sector.

- **Strategy 1**: you can constrain resources (the denominator), meaning public spending or numbers of staff. Ideally, this leads to delivering more or the same for less. But equally productivity will still increase even if the output decreases, as long as inputs fall faster.

- **Strategy 2**: you can increase the outputs (the numerator), meaning increasing the amount and quality of outputs delivered. This could be taken one step further, as discussed in more detail below, if we focussed on outcomes not just outputs (eg returning back to work after an operation, rather than simply the number of operations completed).

In recent decades under the coalition and Conservatives, the government has focussed primarily on the first strategy, through an austerity approach to public

services. Unsurprisingly, this is largely reflected in the outcomes for public services. Between 2010 and 2019, 0.2 percentage points of the 0.7 per cent annual productivity growth were due to quality improvements, with the rest down to constraining resources (van Ark 2022).

We argue that going forward we need to shift our approach to productivity from strategy 1 to strategy 2. Indeed, we further argue for redefining what we mean by productivity: see information box. This would mean focussing on the outcomes we really care about, rather than just outputs: *from efficiency to effectiveness.*

FROM EFFICIENCY TO EFFECTIVENESS

A recent paper by Bart van Ark at the Productivity Institute sets out the Public Sector Delivery Chain.

Budgets → **Inputs** → **Outputs** → **Outcomes**

He argues that there are three areas of productivity to focus on:

1. **Budget efficiency**: turning available budgets into the inputs required (staff cost, real estate, materials).
2. **Organisational productivity**: this means 'doing things right' (for example, delivering more and better surgeries for a given set of inputs)
3. **Effectiveness**: this means 'doing the right things' meaning delivering the right outputs to achieve the outcomes we are really seeking.

He correctly argues that the public sector focuses mainly on the first two approaches to productivity, and that we increasingly need to focus more on the third. In health this would mean, for example, shifting towards prevention, to deliver a healthier population.

In upcoming sections, we set out how this can be achieved by:

- **Retaining, motivating and skilling the workforce** to reboot staff productivity after the pandemic.
- **Investing in digital and physical infrastructure** to resolve bottlenecks and unshackle innovation.
- **Redesigning the improvement infrastructure** to unlock new sources of innovation and progress.

These shifts are not controversial or novel. To some extent, they have been the focus of policy makers for some time. But if it is clear *what* shifts are needed, it is considerably trickier to know *how* to drive them through. That will be the focus of the remainder of this report.

2.
THE PREVENTION SHIFT

Since the advent of the NHS, health and care policy has almost exclusively focussed on the 'supply side': the question of how to expand service provision to keep up with growing need and expectation. This has often come at the exclusion of demand side policy: how we can lower the level, and cost, of population health needs. In the context of rising sickness, growing complexity, and population ageing, the latter is vital.

Many policy levers to modulate demand for health and care services sit outside of these services, for example: taxes to change consumption patterns of unhealthy foods, tobacco, and alcohol; social security to reduce poverty and material deprivation; regulations to ensure work contributes to, rather than harms, our health; and built environments that work for people with impairments or multiple chronic conditions.

This is why – as the Commission on Health and Prosperity has argued – we need a shift to preventing sickness and deterioration of illness. Specifically, our first interim report recommended that the UK government develop a health equivalent of a net zero target, and hardwire it into legislation and across all forms of government. This mission could have a variety of articulations, but we specifically propose an aspiration to make the UK the healthiest country in the world, and to ensure every region has a healthy life expectancy above the state retirement age, over the next 30 years.

This mission would recognise the fundamental reality that, when it comes to health, the NHS was never meant to 'go it alone'. Neither Beveridge's nor Bevan's vision of a National Health Service saw universal healthcare as a silver bullet: the former set out policies on four other 'giants', while the latter intended a similarly ambitious (and health-led) intervention on housing.

This is not to say that the NHS and social care system cannot play a defining role in supporting healthier, more prosperous lives. While some estimates suggest these services only account for between 10 and 20 per cent of the disparities in health outcomes in the UK, few doubt they are the biggest single variables in defining our health – and the routes through which the most immediate improvements could be delivered.

The problem NHS and social care face, in contributing fully to this mission, is that they remain sickness orientated institutions. Perhaps because they were designed in a period of highly acute need, both our healthcare and adult social care services remain reactive, led by acute settings, and inclined towards 'one size fits all' solutions. While treating sickness will remain a vital function of both services in the 21st century, the changing nature of health needs and demography urgently calls for the construction of a complementary 'prevention service' – through which we proactively identify, prevent, and manage need, in the interest of supporting independent, flourishing lives.

In delivering a prevention shift, we call for **three structural reforms** to enable the shift.
1. Putting primary and community care at the centre of prevention.
2. Delivering a social care guarantee.
3. Unlocking 'prevention-first' services with Integrated Care Systems.

This section discusses how each could be achieved.

2.1.
PUTTING PRIMARY AND COMMUNITY CARE AT THE CENTRE OF PREVENTION

Excellent primary care is a precondition of any shift towards prevention. Once considered the 'jewel in the crown' of the NHS, this has become a focal point for public dissatisfaction (Butt, Clery and Curtice 2022). As demonstrated in section 1.2 of this report, patients are finding it difficult to access primary care services in a timely manner, and their experiences of interacting with these services have worsened. In this moment of crisis, there is an opportunity to remake primary care for the 21st century and embed it at the heart of a 'prevention-first' NHS.

Despite evidence linking good primary care to both better outcomes and lower expenditure (Starfield, Shi and Macinko 2005; Kringos et al 2013), the acute sector has often been prioritised for new capacity, resource and powers. There was virtually no growth in primary or community healthcare activity per person in the first two decades of this century, but considerable growth in hospital activity (Tallack et al 2020). The share of NHS expenditure accounted for by hospitals has increased, whilst the share accounted for by primary and community healthcare services fell (NAO 2020). And, perhaps most significantly, there has been a 163 per cent increase in hospital consultants over the past 25 years, compared to no growth in GP numbers (figure 2.1). This helps explain the dominance of an acute-led, reactive approach to healthcare over a proactive, prevention-orientated approach.

FIGURE 2.1

GP numbers have flatlined while the hospitals doctor workforce has burgeoned
Growth rate in NHS occupations (per cent), relative to 1998
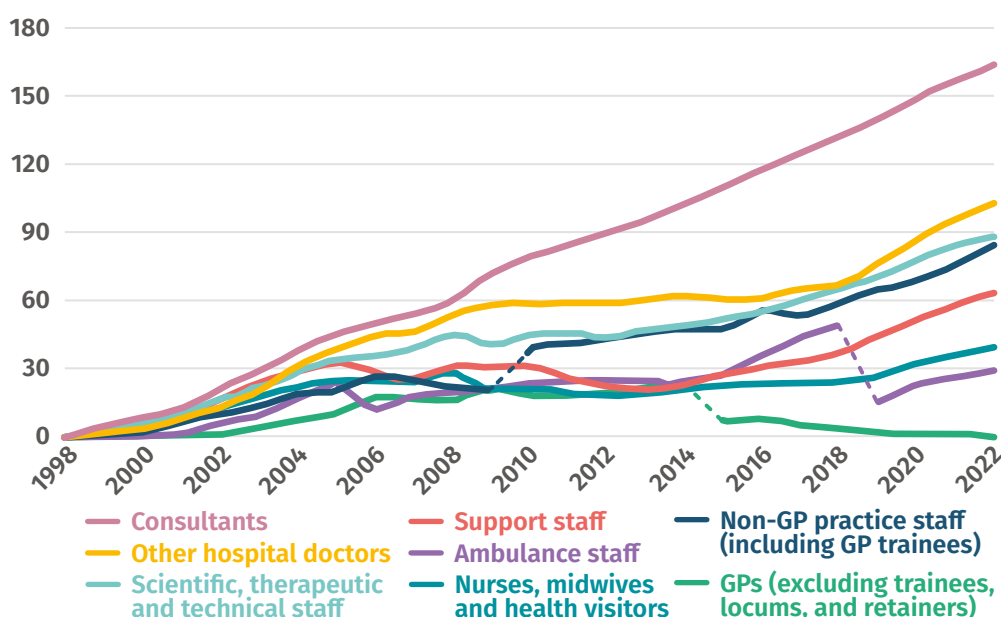
Source: (Appleby 2023)

Note: Thinner lines indicate data breaks because of changes in definitions or data collection

Redirecting resources from acute hospitals toward primary and community services is important. But shifting resources, without reform, is not enough to meet the scale of the challenge the health system is facing. Policy makers must also recognise that the dominant model of primary care is simply not well placed to meet the growing quantity, and complexity, of population health needs in the 21st century.

Ultimately, delivering a shift to prevention through primary and community care relies on negotiating two potentially competing reform priorities:

CONTINUITY: UNLOCKING PERSONALISED PREVENTION THROUGH LONG-TERM RELATIONSHIPS BETWEEN GPS AND PATIENTS, FOR THOSE THAT NEED THEM

Continuity of care can help make services more preventative, but this potential has gone broadly untapped. Classically defined as 'person-focussed (not disease-oriented) care over time' (Starfield 1998), trusted, long-term relationships with primary care professionals are a precondition for effective, personalised prevention.

But continuity of care with GPs is on the decline (see figure 1.7 in section 1.2). This is a particular problem for people with multiple long-term conditions. While we recognise that some may prioritise faster access over seeing a health professional with whom they have developed a trusted relationship, those with long-term health conditions are liable to much worse outcomes without personalised and relationship-orientated care. One participant in our deliberative research said,

> *'in order to have continuity of care, I would be prepared to sacrifice frequency… instead of having a two-weekly appointment, I'd be prepared to go to a once-a-month appointment.'*

The evidence behind continuity unlocking better outcomes is strong: continuity of care with primary care professionals is associated with demonstrably lower mortality rates (Gray et al 2018; Baker et al 2020). A consistent GP is also better able to assess clinical risks and prevent acute hospital admissions (Barker et al 2020; McCartney 2023).

Furthermore, continuity of care can help patients manage their conditions more independently. Older patients, those with multiple comorbidities or mental health difficulties, and patients receiving terminal care derive particular benefit (Jeffers and Baker 2016). As one of our research participants put it:

> *'When you're seeing a new person each time, it's not a productive use of time because you spend a lot of that session revisiting your medical history or answering questions that you answered previously, and that communication level isn't there.'*

Embedding continuity for those who can benefit most does not necessitate a 'one size fits all' approach. It is clear – from wider evidence, as well as our own deliberative work – that some people will be happy with a transactional, quick appointment with the best suited professionals, while others (particularly those with long-term or complex needs) will prioritise long-term, ongoing relationships. Embedding continuity means a consistent, accessible and variable offer based on patient need and priorities.

SCALE: BETTER ACCESS TO A WIDER RANGE OF WELL-INTEGRATED SERVICES IN THE COMMUNITY

The majority of primary care is still delivered by small, privately owned general practices. While this may enable the development of long-term relationships with GPs and local communities, it is a constraint on the ability to scale up the service offer in primary care and integrate it with other services (such as community mental health services, social care services and so on).

Across larger populations, it is more feasible and cost effective to expand the service offer (such as extended GP opening hours and out-of-hospital diagnostic services) and co-locate a wider team of health and care professionals (across primary, community, mental health, hospital and social care services) to deliver integrated care.

Successive initiatives, from the Five Year Forward View to the NHS Long-Term Plan, have attempted this. While incremental progress has been made, they have largely failed to scale primary- and community-based services and shift care out of hospitals.

Primary Care Networks (PCNs) are the most recent institutional vehicle driving through this agenda. They bring general practices together to work at scale – and alongside community, mental health, hospital, pharmacy, and social care services – to provide higher quality and better integrated care to patients, and better coordinate efforts to improve the health of the 'neighbourhood' population (usually about 30,000 to 50,000 people).

Although some PCNs are making considerable progress in realising the benefits of at-scale working, in many neighbourhoods the network is more symbolic than substantial. Claire Fuller notes in her review of PCNs that a 'next step in their evolution' is required (Fuller 2022).

## CONTINUITY VS SCALE: RELIEVING THE TENSION WITH A HUB AND SPOKE MODEL

On the face of it, there is a tension between asking GPs to recentre the importance of developing long-term trusted relationship with patients, while also scaling up the services patients can access outside of hospitals – all while the number of GPs relative to the size of the population declines (Palmer 2019).

Both continuity and scale have a role to play in delivering 'prevention-first' services, and it is difficult to say which has greater power in improving population health and public finances. To avoid a trade-off of continuity against scale, primary reform must relieve this tension.

To do that, we propose an evolution in the PCN model. We recommend the 'network' model is developed into a 'hub and spoke' model, with a central Neighbourhood Health Hub created at the centre of every PCN (figure 2.2).

FIGURE 2.2

Network model to hub and spoke model diagram
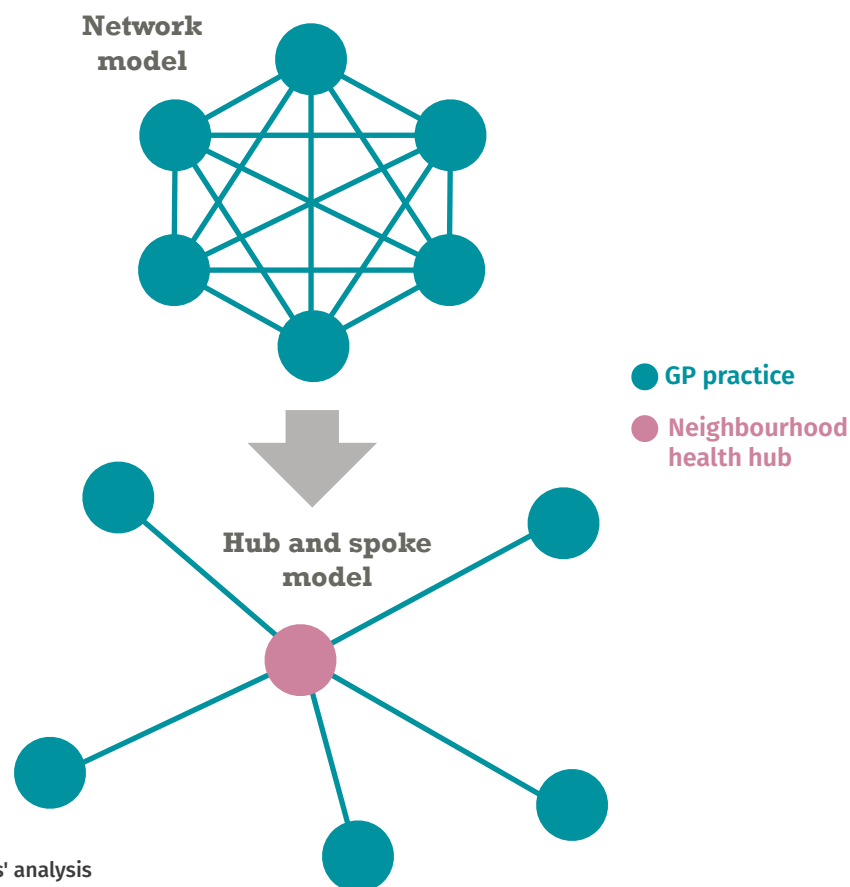
Source: Authors' analysis

A hub and spoke model allows the separation of responsibilities: the hub is focussed on delivering scale, while the spokes (individual GP practices) are focussed on delivering continuity.

Currently, PCNs can provide a range of 'enhanced' services (such as depression counselling, atrial fibrillation screening, smoking cessation, care home support) and access pots of funding to support this expansion – mainly using their already existing primary care workforce. In reality, with GPs stretched thin, it is difficult to dedicate time to expanding service provision, and many of the additional funding pots go untouched. The creation of primary and community care hubs can help.

The hubs should, at a minimum, join up primary care, community care and mental healthcare, as well as outpatient hospital and diagnostics in a single site where patients can access 'teams without walls'. That means bringing together more out-of-hospital services under one roof, as well as moving some hospital services (such as diagnostics, outpatient clinics and so on) into the community.

However, ideally, the offer from hubs should be more expansive by bringing non-NHS services into the hubs – local authority services, such as public health and social care services, and voluntary or charitable services, such as those delivering social prescribing, debt advice or advocacy services. The most powerful levers to improve health relate to the social drivers of health, to earlier diagnosis, and to support people with long-term conditions in leading flourishing, prosperous lives. This is the break in the status quo of doing things that the rise of chronic, multiple conditions in the 21st century demands.

Beyond this overarching vision, we do not suggest that service provision arrangements are prescribed from the centre. Different places have very different health and care needs, and different health and care economies. This means that the optimal composition of a 'hub and spoke' model will look different in Blackpool, Lambeth, and Norfolk. With guidance and support from the centre, we suggest that ICSs and PCNs should work together to work out the appropriate service offer, based on local assets and local population health needs.

These hubs should not have any directly registered patients, but instead act as a second order 'mega list' of all patients covered by a PCN. This will ensure that local relationships between GP practices and their communities are not eliminated, but the benefits of scale can also be realised. We propose all 'population health management' and 'enhanced service provision' responsibilities are shifted to the hubs (and therefore taken away from individual GP practices, who can focus on continuity). With high quality data analysis and public health leadership, hubs should be able to stratify risk, identify drivers of poor health locally and tailor services accordingly to improve health outcomes. And by removing responsibility of these non-clinical responsibilities from individual practices, those working in the 'spokes' can focus on delivering continuity.

We propose the contracts awarded to PCNs are transferred to these hubs. This contract should be redrawn to ensure it can adequately fund sufficient full-time staff for the hubs. The hubs will naturally employ a range of professions, from psychotherapists to data analysts, but their leadership should come from a small team of GPs with experience in population health management, or public health consultants employed full-time at the hub.

Hubs should be set up by ICSs as public sector institutions, with finances administered through the NHS (as opposed to privately owned businesses). Funding for new, purpose-built facilities should come from the Infrastructure Restoration Fund described in section 3.1.

> **RECOMMENDATION**
> - **PCNs evolve into a hub and spoke model network, with a Neighbourhood Health Hub established at the centre of every PCN. Extended services provision and population health management responsibilities should be transferred to these hubs, while 'spoke' GP practices should focus on providing continuity of care.**

SECURING THE FUTURE OF GENERAL PRACTICE

A hub and spoke model can only deliver if there are enough GPs with enough time to work in them. On current trends, there will not be. Under current policy, the Health Foundation estimates one in four GP posts will be vacant in 2030/31 (Shembavnekar et al 2022).

Being a GP has become a more taxing job. GPs in the UK now spend less time with patients compared to their counterparts in 11 other rich countries surveyed by the Commonwealth Fund, and are least satisfied with their administrative burden compared to their international counterparts (Beech et al 2023). Feelings of dissatisfaction and burnout are high: three-quarters report their workload to be unmanageable or unsustainable. Workload, particularly non-clinical workload, is the leading reason why people leave general practice (RCGP 2023).

In this context, GPs are increasingly reluctant to take on extra work. While the creation of Neighbourhood Health Hubs will transfer some of the non-clinical work

away from those working in individual practices, partners will still find their time constrained by the administrative tasks and financial risk of running a partnership – the equivalent of running a small business.

We thus recommend one further reform to secure the future of primary care at the centre of the health system: a right to salaried employment in the NHS for all newly qualified GPs, with pay aligned to hospital consultants. Over time, this offer should be extended to existing GP partners, although no partner should be forced to take up these salaried roles.[4]

This shift may seem radical. But it is in fact starting to happen already. In recent decades we have seen a substantial drop in the number of GP partners (down 20 per cent since 2014) and a rise in the proportion of salaried GPs (up 50 per cent since 2014) and in-training GPs (almost double since 2014). This is set to speed up with more GP partners likely to retire – the average age of GP partners is high and rising – and younger GPs increasingly reluctant to become partners themselves (Nosa-Ehima 2018).

FIGURE 2.3

The number of GP partners is in decline
Composition of general practice, headcount 2006-2022, England only
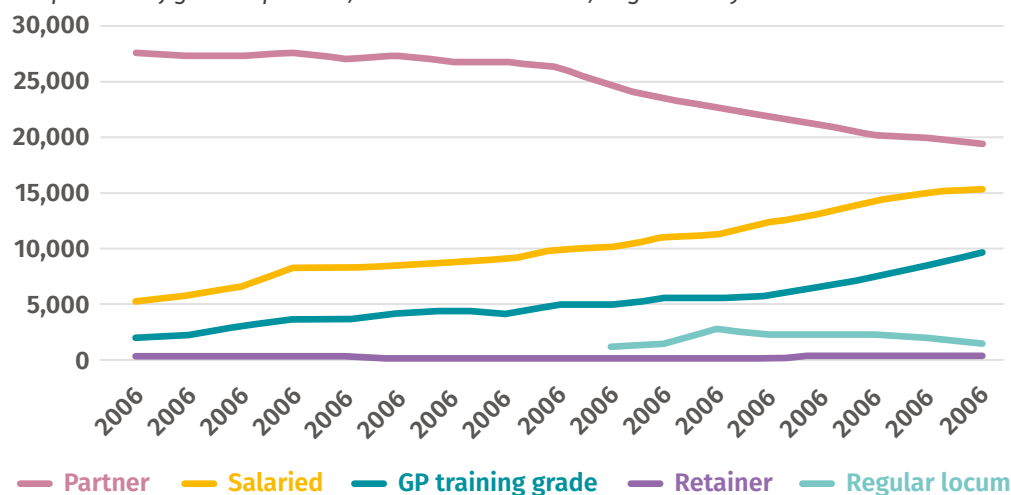
Source: NHS Digital 2022

The shift to a salaried model has an innate ability to make general practice a more attractive, and more sustainable career option, Specifically, by taking away the burden of business administration, it offers the opportunity to cut bureaucracy and allow greater focus on patient-facing work. Beyond this, it would also allow more team-based working, allowing more staff to operate at the 'top of their licence'.

But beyond these implicit benefits, leaning into a salaried model also offers the state an opportunity to redefine what it means to be a salaried GP, and create a more modern version of the career. In IPPR research with young general practitioners, we found that young professionals want portfolio careers that provide opportunities for leadership, research, innovation, and partnership work. Indeed, such opportunities could be built into different types of salaried GP roles.

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4   This part of the policy needs to be phased in, as it will result as administration, and ownership of practices will have to be transferred from existing partners to another organisation or business. In our view, primary care is critical infrastructure for the country (ref Coyle) and should therefore be in public ownership: as such ICSs should offer to purchase any GP practice where partners have decided to take up the offer of salaried employment.

- GP directors, with responsibilities for leading networks of general practitioners at the place level.
- Academic GPs, with bespoke time allocated to provide links between general practice and research, and to undertake research directly.
- Link GPs, with time allocated to develop links with community care, social prescription services and the voluntary sector: building meaningful integration at the neighbourhood level.
- Specialist GPs, with specific and developed skills in a specific area of general practice, such as end of life care or mental health.

A salaried model would provide a unique opportunity to build in time and funds for these important functions, far more effectively and at far greater scale than the partnership model.

The alternative is to allow the partnership model to decline at pace. This would risk heaping a significant administrative burden on an increasingly small number of overworked, partner GPs. Worse, it could lead to partner GPs struggling to get out of their contracts and practices at retirement. This is not a viable vision for an area of healthcare as integral to the future as primary care.

> **RECOMMENDATION**
> - **All newly qualified GPs are offered salaried employment in the NHS as 'primary care consultants', with pay aligned to hospital consultants. Over time, the offer of salaried employment should be expanded to GP partners.**

SMART INVESTMENT

That healthcare spending tends to flow to hospitals, rather than primary and community care services, speaks to a wider challenge in our approach to healthcare: namely, that we struggle to invest in the right places. This is particularly pronounced in three areas (table 2.1).

TABLE 2.1

Priorities for smart investment in prevention-critical areas

Theme	Description
Early years	For most of us, the majority of our cost to the NHS will come towards the end of our life. NHS expenditure correlates strongly with age and is particularly high in the last year of life (Cylus et al 2018). Ultimately, the best prevention opportunities come much closer to the beginning of life – and particularly in the first 1,000 days. The NHS is not good at taking these very long-term opportunities, despite clear evidence that early years interventions reduce healthcare expenditure over an individual's life course (Marmot 2020).
Mental health	Mental health problems are associated with around half of those who have exited the labour market due to sickness. It is a leading cause of morbidity in the UK, but we remain some way off achieving 'parity of esteem' – a state where people living with a mental health condition have an equal chance of a long and fulfilling life as those with a physical health condition.
Community healthcare	The majority of healthcare expenditure in England is on hospitals, with far less invested in community settings. This is despite successive governments seeking to shift expenditure out of hospitals. Efforts to increase the number receiving care in the community have been dominated by closing hospital beds, rather than investing in the community, in the last 10 years.

Source: Authors' analysis

In each case, the system's inability to invest in these priorities limit the NHS's capacity to shift towards prevention, to maximise prosperity, and to ensure value for money. Yet distinct opportunities exist on each theme, which could be put into practice.

First, the Health in Pregnancy Grant – a lump sum transfer of £190 to all pregnant women in the UK and administered by primary care. While the scheme only ran for two years (2009-11), recent evaluation of the scheme found that (Reader 2023):

- The benefit improved infant health, particularly the health of babies born to younger or lower income mothers.
- The benefits could not be explained by antenatal health attendance, better nutrition or lower smoking rates – suggesting lower stress and precarity as a potential mechanism.
- The birth weight effect following cash transfers is larger than previously thought.

The decrease in prematurity and the increase in birth weight linked to beginning benefits in pregnancy (as opposed to at birth) are particularly significant. High birth weight is associated with much better long-term health – indeed, research has also found that the lifetime earning benefit for babies positively impacted by the scheme would be three times higher than the total cost of the policy.

Investment in community mental health services also has significant potential. One analysis showed that 58 per cent of community mental health services, and 81 per cent of child and adolescent mental health services, reported being unable to meet current demands for inpatient services (NHS Providers 2021). Further research has shown that 12 per cent of waits for community mental health services are longer than 6 months, and that 6 per cent of patients are waiting more than a year (RCPsych 2022) This is despite mental health problems having been associated with an economic cost 'worth at least £118 billion' (Mental Health Foundation 2022).

Evidence shows what investment would be needed to deliver parity of esteem. A 2019 IPPR study suggested that total mental health funding would need to increase at 5.5 per cent real terms per annum, compared to average NHS funding growth of 3.6 per cent real terms per annum (Reader and Quilter-Pinner 2019). The specific figures are likely to be different, three years from this study – but the essential conclusion holds: it makes sense for health, and prosperity, for new NHS expenditure to disproportionately flow to mental health service provision.

Finally, despite promising rhetoric on shifting care into community settings and spaces, NHS community healthcare services have not been allocated the requisite funding to deliver this shift.

Instead, attempts to shift care into the community have been guided by an overly literal translation of Roemer's Law: that 'in an insured population, a hospital bed built is a bed filled'. As such, the dominant strategy for shifting care into the community in the last decade has been the closure of significant numbers of hospital beds, on the assumption that less bed capacity will incentivise the system to better prioritise who needs acute care, and who can be best supported in the community.

In practice, this has not worked. Without combining this policy with corresponding greater capacity in the community sector, community care services have come under increasing strain. While data on pressures in community healthcare is less comprehensive, indications include:

- Community healthcare bed occupancy levels had reached 91 per cent, above the established safe level, in 2015 (NHS Confederation 2019) District nursing numbers have fallen by 43 per cent since 2009, with other community healthcare professions also experiencing shortages (NHS Confederation and NHS Providers 2022)

Specific services – from sexual health services, to school nursing, to health visiting – have faced difficulty providing genuinely universal coverage over the last 10 years (Waters 2022b, SAPHNA 2021, iHV 2020)

There is a clear need for an approach that genuinely shifts care into the community when it is appropriate. This will require an incentive for the system to fund community care capacity, a disincentive to overfocus on hospital settings, and funding to make reform possible. To this end we reiterate a previous IPPR recommendation for a one-off community care capacity fund. We have previously suggested a fund equal to the savings from bed occupancy closures between 2010 and 2020, plus a 'rebate' equal to ongoing annual savings. We calculated that this would be worth £2 billion per year investment in extra community sector capacity.

While, as this report argues, we need a streamlining of targets, this specific target would have the benefit of pushing the system towards greater prevention, a less acute model of care and towards greater efficiency.

RECOMMENDATION
- **The government develops and delivers a 'smart investment' strategy, prioritising areas where significant health, prevention and prosperity benefits are possible, but which have otherwise been deprioritised in recent years. We suggest a strong focus on early years, mental health and community services, and specifically recommend the roll-out of a new Health in Pregnancy grant.**

2.2.
DELIVERING A SOCIAL CARE GUARANTEE

SOCIAL CARE: STUCK IN THE 'TOO DIFFICULT' BOX

Excellent adult social care is fundamental to a good society in the 21st century. Its aim is simple: to help people with impairments or long-term conditions, of all ages, to lead good lives. The narrowest definition of this service includes support in getting up, getting dressed, eating meals and shopping, and taking medication.

But social care, at its best, is more aspirational. It is there to help people maintain independence, purpose, and dignity. It can ensure we all have access to activities and people that bring joy, connection and meaning. As one witness described it to the House of Lords' Adult Social Care Committee, social care should help all people live 'a gloriously ordinary life' (House of Lords 2022).
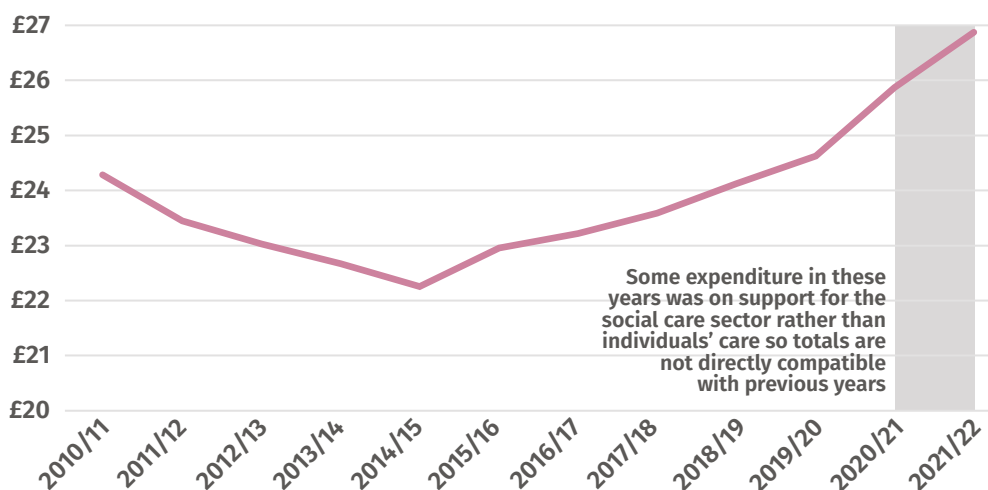
This makes good social care a central pillar in the shift to prevention. When we get social care right it intervenes early to ensure that people get the support they need at home, helping them to live independently and preventing a deterioration in health and frailty that would otherwise result in shorter or worse lives (as well as additional cost to the taxpayer).

As it stands, our social care system is failing to achieve this. Over three decades there have been countless white papers and commissions to address the flaws in our system, but no fundamental reform. The latest of these attempts – the care cap proposed by Boris Johnson – was scrapped following the fall of the Truss government and, as result, social care is back once again in the 'too difficult' box.

FIGURE 2.4

There was limited growth in adult social care spending during austerity
Adult social care spending over time, £bn

Some expenditure in these years was on support for the social care sector rather than individuals' care so totals are not directly compatible with previous years

Source: NHS Digital

This failure to deliver funding and reform has left the social care system with a number of challenges.

The most frequently discussed of these is the issue of **affordability.** Unlike the NHS, social care is only free for people who have savings below £23,250 (a 'means test') and who meet a 'needs test'. Everyone who has more resources than this has to contribute towards the cost of social care. For a small group of people these costs can end up being 'catastrophic': over £100,000. It is this latter group who have concerned politicians most when discussing social care reform.

However, this is far from the only challenge facing our care system (and, in terms of the prevention shift, not the most important). There are two other challenges which were referenced in section 1.2:

- **Access**. The lack of historical funding increases, combined with growing demand, has led both to the 'means test' failing to match inflation and to the 'needs test' becoming harsher. This has led to a decline in the number of older people receiving social care even has demand has increased (although there has been an increase in working-age people receiving social care). This has led to a rise in unmet need and in the burden of informal care. This is particularly problematic for the prevention agenda, because many people are going without the care they need until they hit crisis point – which results in worse outcomes and higher costs.

- **Quality**. The ongoing pressures on the care system – and the lack of reform – have also put pressure on quality in the system. This is yet to show up in declining CQC ratings, though one in six providers are still rated 'requires improvement' with many seemingly unable to improve. It can also be seen in self-reported outcomes, particularly relating to social connection and quality of life. This speaks to a growing quality challenge: care is often adequate and safe, but the wider services that help people to connect and thrive have been cut.

In the absence of reform and increased funding, this is likely to get worse. This is because our population is aging, with a corresponding increase in demand for social care support. This demand is exacerbated when people live longer, but longer in ill health, as they are now.

Moreover, medical science is enabling more people to live with previously fatal conditions. This is clearly a good thing – but one that increases demand for care. In lieu of a collective solution, the burden of this increase falls on 'unpaid carers' (predominantly women) – indeed, the latest census showed the proportion of people providing 20 to 49 hours of unpaid care rising sharply between 2011 and 2019 (ONS 2023c).

This justifies a far more ambitious plan for social care reform. And any workable social care reform agenda going forward must set out plans to address all the challenges set out above. The issue of affordability – and the risk of catastrophic care costs – is vitally important. However, it is worth recognising that this issue impacts relatively few people overall, and by definition they tend to be relatively better off (as they haven't met the means threshold). It is arguably more important that reform addresses the issues of access and quality that plague the current status quo.

A PLAN FOR SOCIAL CARE REFORM
A recovery package: access and quality
Delivering a better care system will require more than just money. However, a funding boost for social care is a prerequisite of any reform. Over time, as we set out later in this chapter, this will need to include a fundamental shift in entitlements and a long-term settlement. However, this will require significant

consensus building and large amounts of investment. As a first step we recommend a recovery plan funded by a short-term boost in resources.

This funding settlement should aim to meet three tests, which together will help to start to address the three challenges set out in the previous section (particularly access and quality):

- **Meet growing demand**. The coming years are likely to see a significant increase in the number of older people in need of care. Additional funding is required to meet this demand. Without this resource the access and quality challenges are likely to get worse.
- **Improve access**. There is a need to increase funding, on top of meeting growing demand, in order to improve access. This would enable the government to increase the 'means threshold', to take inflation into account, and to return the 'needs test' to previous levels.
- **Improve quality.** The rate which providers are paid has not kept up with rising costs. This has led to providers cutting costs. Additional funding should ensure staff are paid properly and get adequate training, as well as ramping up the provision of a wider array of additional services that help drive connection, purpose and meaning.

The full cost of these is set out in figure 2.5 below. For further detail, and a five-year funding settlement recommendation, see chapter four of this report.

Social care needs a funding boost to keep up with demand and improve access
Additional cost of improving access and quality of care, £bn
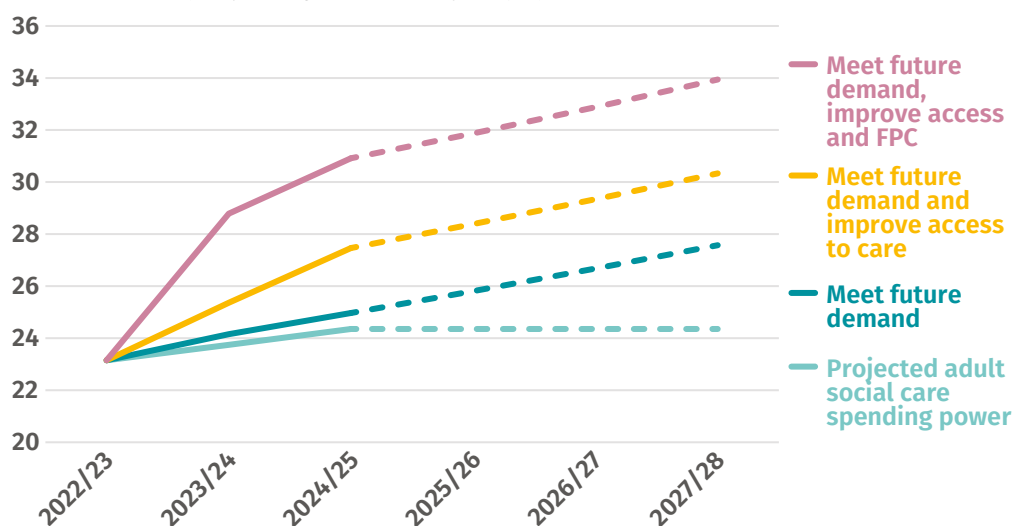
Source: IPPR analysis based on Health Foundation modelling

Higher quality care: delivering through the market

Just putting more money into the system and hoping it will drive better care is no plan for reform. In the NHS the majority of care is delivered by the state. This means it can directly shape how additional funding is used to deliver better outcomes. In social care the majority of provision is delivered by private or third sector organisations.

We do not propose to shift the ownership model of care directly. However, we do call for the state to effectively shape the market for care in ways, that ensure

additional funding helps deliver more accessible, preventative and higher quality care. The best local authorities already do this: using their purchasing power to cultivate high quality providers and push ineffective providers out of the market. This should become the norm.

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PROVIDER TYPE AND QUALITY

There is some evidence that the provider type, and their business model, has an impact on quality. Previous IPPR research has shown that on average private companies are more likely to receive 'inadequate' or 'requires improvement' from CQC than either public or not for profit providers (Quilter-Pinner 2019).

This is likely to be driven by:
- **Workforce.** Private providers have lower levels of staffing, higher staff turnover, lower rates of pay, and lower levels of training.
- **Instability.** Private providers – particularly those with risky financial models – are more likely to face financial instability, which is linked to resident distress and mortality.
- **Size**. Small really is beautiful: there is an established link between provider size and quality. However, on average private providers tend to be larger, to benefit from economies of scale.

Of course, there are many private care companies that provide excellent care for those they serve, just as there are voluntary sector or state providers that fail to meet the standards we expect of them. A simple 'state is good, private is bad' narrative is too simplistic.

Instead, it is the business and care models of any provider that determines quality. Organisations that put people before profit – investing in their workforce and creating a culture of care – will deliver better outcomes. This is what commissioners should be seeking to commission for.

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The funding deal set out in chapter 4 would be a major opportunity to help rebuild the capacity of local government to commission actively, and would require commissioners to shape the market more actively in their areas to drive better care. We argue that, to achieve this, government should introduce a new *Better Care Charter*. This charter would demand that all providers receiving state funding meet certain conditions in order to drive quality and value for money for the taxpayer.

These conditions should include:
- **Workforce**: Contracts should only be awarded to organisations that pay the real living wage, provide adequate training and support and engage in sectoral collective bargaining.
- **Quality**: Contracts should only be awarded to organisations with a track record of high quality care (or, in exceptional circumstances, organisations with a clear plan for improvement, or new providers with promising new care models).
- **Transparency**: Contracts should only be awarded to organisations that can evidence that they pay their fair share of taxation, that they are financially sustainable, and that they are prepared to share key data they generate with commissioners in order to facilitate monitoring of provider stability and quality.

This agenda would not demand that all services are insourced. Nor would it arbitrarily give preference to organisations with specific ownership models. Such an approach would be too simplistic. Instead, it would look to determine who provides

care based on their ability to meet the standards we should expect of organisations providing care to some of the most vulnerable people in our society.

> **RECOMMENDATIONS**
> * **A new *Better Care Charter* that ensures all care providers are of good quality, pay workers properly and are financially transparent.**
> * **The use of commissioning to drive out poor providers, and the Social Care Transformation Fund to create new innovative ones.**

Community-first care

Higher pay for care workers and a funding boost to improve access are both important steps in the right direction. However, these steps alone will only ensure our current care model is delivered to more people and to a higher standard. The core argument of this chapter is that we need to pivot to a preventative model of care to deliver better outcomes and reduce the cost to society.

We argue that the key shift required to achieve this is the creation of a *Community First* approach (Thomas 2021). This is defined as a system where preventative, proactive community or home-based interventions are the norm. This is in contrast to our current system, which too often waits for people to deteriorate before providing the right support. As a result, a higher proportion of people end up in a hospital or a care home than in comparable countries. This is both counter to what people say they want and more expensive for the state.

TABLE 2.2: MORE PEOPLE DIE IN A HOSPITAL OR CARE HOME IN THE UK COMPARED TO THE EUROPEAN AVERAGE

Location of death, selected European countries vs the UK

	Home	Hospital	Care home
European average	33%	44%	18%
UK	23%	47%	28%
Difference	-10%	3%	10%

Source: (Hunter and Orlovic 2018)

Previous IPPR research has shown that whilst some health and care systems in England have made significant progress towards shifting care into the community, others are falling behind on embedding more innovative care models (Thomas 2021). We found that if every local authority provided care equal to the upper quartile among comparable authorities, 80,000 more individuals over 65 years old would receive care at home, and £1.1 billion of savings could be realised per year from social care budgets (ibid).

There are a range of models – a few of which are detailed in the case studies below – which are already pointing the way to a better system. These, and a whole host of other community-first approaches, should be spread across England to ensure that everyone who needs care can benefit from them. This would significantly improve outcomes, and would also be more efficient.

CASE STUDIES

Buurtzorg

Care for older people is often fragmented, with multiple different professionals from the health and social care system administering care during a day or week. This can be distressing, lead to uncoordinated care, and inhibit the development of meaningful relationships between the carer and older person. An alternative model known as Buurtzorg has been developed in the Netherlands and subsequently applied in other countries (including the UK) as well.

Buurtzorg is a unique district nursing system which has garnered international acclaim for being entirely nurse-led and cost-effective. The Buurtzorg model gives far greater control and autonomy over patient care to the nurse, who undertakes all health and care-related tasks (rather than tasks being segmented across a number of specialisms). The model consists of small self-managing teams, each with a maximum of 12 nurses. Teams provide coordinated care for a specific catchment area, typically consisting of between 40 and 60 patients.

Although this model relies on highly qualified nurses undertaking more simple tasks (such as washing and helping people get dressed), Buurtzorg has been shown to cut long-term care costs by between 30 and 40 per cent (RCN 2016). It has also been shown to deliver more integrated care, higher levels of patient satisfaction, higher staff satisfaction and a reduction in emergency healthcare usage.

Shared Lives

Social care is often transactional rather than relational, with a task-based 15-minute model, often performed by numerous different carers. This severely limits quality and continuity of care, as well as people's wellbeing as they get older. Social care should be both 'social' and 'caring': too often it is neither. But there are a range of new models that are being developed which look to address this.

One of the best known is Shared Lives. This is a membership body which trains potential carers (ordinary people in the community) and matches them with adults who need support. Carers welcome older people (or those with learning difficulties, physical disabilities and mental health issues) into their families or communities, and often into their home, as an alternative to traditional care services in residential institutions.

Currently, more than 9,000 Shared Lives volunteers are now supporting more than 13,000 vulnerable adults across the UK. These carers are paid, but the evidence is clear that this still saves significant money (for the individual or the local authority) – up to £26,000 per year compared to the cost of residential care. This model has also been demonstrated to deliver significantly better outcomes, particularly with regard to social isolation and loneliness.

Extra-care housing

Retirement communities (sometimes called extra-care housing) consist of purpose-built, self-contained homes to help people maintain independence as they age. Features usually include flexible, onsite care provision 24-hour staffing, and dining and leisure facilities. Currently 75,000 people live in retirement communities (about 0.6 per cent of the older population) but this is significantly lower than in comparable countries.

There are a number of evidenced benefits of retirement communities, including:

- reduced risk of hospital admission, with unplanned hospital admissions down from eight–14 days to one–two days over a 12-month period
- reduced risk of – and delayed need for – care home admission
- a reduction in incidences of social isolation and loneliness
- reduced cost of social care at both lower and higher levels of social care needs
- reduced cost to the state, including the NHS.

RECOMMENDATIONS
- **The introduction of a Right to Care at Home with a target for shifting care into the community.**
- **The creation of integrated community and nursing care teams all using the Buurtzorg model (see case study above).**
- **£1 billion per year of the recovery package to be used as a social care transformation fund, to create and spread the best home care models.**

Longer-term aspiration?

The changes set out above would go a long way towards delivering a fairer and better system in the short-to-medium term. But, in many ways, they still represent incremental improvements to the same underlying system. There is a strong case that in the longer term there is a need for a bolder, more fundamental reform. Two proposals have been put forward in recent years to this effect.

- **A cap on care costs**. The Dilnot Review in 2011 proposed the creation of a cap on care costs. This would mean that no-one would have to pay more than a certain amount of money towards their care over a lifetime. If this threshold was reached, the state would cover any additional costs. It was intended to end (or limit) the risk of facing catastrophic care costs. This proposal was also proposed again in 2022 under Boris Johnson.
- **Free personal care.** A review of options for social care reform in 1999 under New Labour recommended a policy of free personal care, which was subsequently implemented in Scotland. This makes the 'care' component of social care (unlike the accommodation costs), free at the point of need. This would essentially break down the division between the NHS and social care that dates back to 1948 (Quilter-Pinner and Hochlaf 2019).

Both of these reforms come with significant additional benefits – though they would help to solve different problems – and create different 'winners'. As such, we compare their respective merits in table 2.3.

Free personal care would improve access and quality of care, but the Dilnot care cap better addresses catastrophic care costs

	Free personal care	Dilnot care cap
Access/unmet need	Induces some unmet need (would increase publicly funded care recipients by 232,000)	Doesn't increase the number of people benefitting from care
Quality	Enables significant integration with NHS and may improve prevention	Doesn't improve quality or integration with the NHS
Affordability of care	Some reduction (two-fifths) in number facing catastrophic care costs	Reduces the number of people facing catastrophic care costs but not completely
Fairness/equity	Creates equality between NHS and social care users but subsidises relatively wealthier care users	Mainly protects the incomes of a small number of relatively wealthier care users
Cost/efficiency	Around £5bn a year and benefits 232,000 people.	Costs £2.1bn and only benefits c. 50000 people.
Political feasibility	Simple to explain and popular with the public.	Very complex and difficult to explain.

Source: Authors' analysis drawing on Bottery et al 2018 and Independent Age

Given this, while we do not discount the idea of a Dilnot style cap on care costs as a useful reform, we suggest that free personal care is the better long-term goal.

Indeed, it is likely to be highly popular with patients. In June 2023, IPPR/YouGov tested the views of British adults (n = 2014) on the future of adult social care. Specifically, we explored whether people wanted to see the NHS's founding principles extended to adult social care, and how they wanted service provision to be funded in the future. Key findings included that:

There was high consensus on the NHS's founding principles being extended to adult social care. 78 per cent agreed it should be free at the point of use; 80 per cent agreed it should be comprehensive and available to all; and 72 per cent thought it should be funded through general taxation

Only 4 per cent thought that adult social care should be fully or mostly funded by user charges. By contrast, 68 per cent thought social care provision should by fully or mostly funded by the government.

The most popular taxes to increase social care provision were increases to the top rate of income tax (51 per cent); wealth taxes (47 per cent); and business taxes (41 per cent).

We discuss options for funding this in the concluding chapter of this report.

RECOMMENDATION
- **The government commits to delivering free personal care by the end of the 2020s.**

2.3.
UNLOCKING 'PREVENTION-FIRST' SERVICES WITH INTEGRATED CARE SYSTEMS

Integrated Care Systems (ICSs) are one of the most promising routes for delivering a prevention-orientated approach to health and care. By focussing, across providers, on outcomes, their theoretical promise is a system where the right service provides the right intervention at the right time – a shift from the status quo of overly siloed (and indeed often competing) public service provision.

Put another way, as Patricia Hewitt noted in her recent review (Hewitt 2023), ICSs could shift the system from one focussed on activity and narrow targets, to one focussed on outcomes and prevention:

> *'The truth is, unless we make the change [...] the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope.'*

Yet simply creating ICSs is not enough to do this on its own. Achieving the vision set out by Hewitt will require ICSs to achieve a real shift in the culture, operating model and relationships that define health and care.

As it stands, the move towards genuinely prevention-orientated system working remains nascent within ICSs. This is understandable so early in their life cycle – but also indicates a risk that, beyond changing the names of governance structures and various committees, they may yet fail to achieve any meaningful change. We suggest three next steps in continuing the evolution of integrated care, and delivering on their theoretical potential in practice.

1. Shift ICSs to a mission-orientated approach, to hardwire greater ambition and incentivise system working
2. Simplify national targets, to allow for a focus on delivering against the mission.
3. Give ICSs the permission and freedom to allocate resource to long-term priorities and reform.

THE PROBLEM WITH TARGETS

The clearest challenge ICSs face in shifting from an activity-orientated and acute-led model of health and care provision is the dominance of the urgent over the important. Put another way, it is very difficult to make long-term, meaningful change when short-term (and relatively low importance) targets like A&E waiting times define accountabilities (we discuss this further in section 3.1).

Indeed, health and care systems are saturated with poorly formulated targets. We do not argue that targets cannot be an effective lever, or that there is no place for national aspiration. Rather, we contend that there are good targets and bad targets.

Good targets are well-curated, focus on outcomes, and speak to standards that are relevant to the whole country. Bad targets are activity-orientated, focus on things

that have little bearing on population health outcomes, and incentivise a 'one size fits all' approach to care provision. Examples of bad targets include the four-hour wait target in A&E, which has incentivising clinicians to game the system instead of focussing on patient care.

Not all targets are harmful in their own right. But each contributes to a saturation of priorities, each with limited impact on overall longevity or healthy life expectancy, and each driving attention away from the long term and towards the short term. As one Integrated Care Board (ICB) chief executive put it (Timmins, Naylor and Charles 2022):

> *'All my interview questions were about health inequalities, population health, social and economic wellbeing, and about how I was going to lead. A completely values-based interview. Which was brilliant. I want that. But that is not what the government wants us to be focussed on at the moment. What I am going to be measured on is not those things. [I am] going to be [measured on] a safe winter, the money being delivered, waiting times, and basically getting performance there or thereabouts'*
>
> **An ICB Chief Executive**

As such, we reiterate the conclusions of the Hewitt review and the Messenger review (Messenger 2022) – and NHS England's own conclusions – that targets should be stripped back. As Hewitt puts it:

> *'ICSs hold enormous promise, bringing together all those involved in health, wellbeing, and care to tackle both immediate and long-term challenges. To do this effectively, national and regional organisations should support ICSs in becoming 'self-improving systems' given the time and space to lead – with national government and NHS England significantly reducing the number of national targets, with certainly no more than 10 national priorities'.*

We suggest going one step further and abolishing the 'System Oversight Framework' which contains over fifty national targets for ICSs. In its place, a smaller set of 'milestone' metrics should be developed (by ICSs in tandem with NHS England) that mark delivery against a new overarching mission for ICSs.

EMBEDDING MISSIONS WITHIN ICSS

If the aspiration is to reduce the number of national priorities, to give ICSs the space to lead as 'self-improving systems', then we also need to ask what good priorities look like.

In the first interim report of the Commission on Health and Prosperity, we contended that mission orientated approaches have significant advantages. Indeed, national missions have a strong evidence base – with research showing that success is most likely when missions are stretching, are combined with strong institutions and clear accountability, and set delivery mechanisms.

To that end, we recommended a new *Healthy Lives Mission* – a new thirty-year target to make the UK the healthiest country in the world, and to tackle health inequalities between places. We suggested this was combined with a health equivalent of the Climate Change Committee, a 'what works' centre and significant investment infrastructure.

Maximising gains in healthy life expectancy will mean different things to different places. This means that the articulation of a healthy life expectancy mission at ICS level is likely to be different, depending on the local population, the most

significant population health challenges, and the specific assets/strengths available at place level.

As such, to support genuine ambition at the ICS level, we recommend that each ICS is supported to generate its own mission for health and prosperity. Each mission should have three components:

1. **It should be genuinely ambitious**. A mission to slightly increase the number of good jobs, in order to support health, is weak. A mission to eradicate occupational illness is stronger.

2. **It should be a mission that can be broken down into smaller components**. Missions are only meaningful if they can be backed by meaningful delivery plans. Net zero is delivered in five-yearly intervals, and we suggest a similar approach here.

3. **It should clearly speak to each of the ICSs' four purposes**: improving outcomes, tackling inequality, enhancing productivity and supporting the economy.

We suggest ICP boards (as opposed to ICB boards) take charge of developing the strategy and 'milestone' metrics for ICSs to deliver on the national mission. Directors of Public Health, where possible, are likely to be particularly well trained to lead mission strategy development.

The extent to which these missions are salient will depend on how they are held to account. There are two directions in which accountability should run:

- From the centre. Regulators will need to change their approach from assessing accountability to assessing outcomes. We recommend that the CQC are tasked with developing a framework to assess progress towards missions.

- From the public. Most importantly, missions will need to match public expectations and priorities. There is limited infrastructure to collect public insights and to ensure they are meaningful within ICSs. We suggest a standing citizen assembly in each ICS to support design of missions, and to hold them accountable once they are set. Each assembly meeting should be public, and each should deliver an annual report on progress.

In turn, the ability of ICSs to deliver against a healthy life expectancy mission depends, to a large extent, on their ability to shift resource allocation 'upstream' to services focussed on prevention of sickness or deterioration. That often means moving resources out of acute hospitals and into primary, community and social care services.

A major barrier to achieving this is the financing system. The biggest stream of revenue for hospitals is 'payment by results' (PbR): a fixed payment for a particular kind of activity, from a nationally determined and priced list. The more of each activity a hospital carries out, the more it gets paid.

While there is some evidence this increased treatment volumes and efficiency *within* hospitals, there is also evidence that it is a considerable barrier to 'system' working. That is because PbR disincentivises collaboration with other parts of the health system. There is no incentive to fund preventative health activities – in fact it actively disincentivises such activity.

The idea that more activity equals more revenue is antithetical to a shift to 'prevention-first' services. To give ICSs much greater freedom over how to fund their hospitals and how to allocate resource across provider types, we recommend an end to the purchaser-provider split in the NHS in England. Trusts should be abolished and brought under ICSs, bringing the purchasing and providing sides of the health system back together. This would follow precedent from New Zealand, Scotland and Wales, where the purchaser-provider split has been abandoned to allow more effective planning.

By giving ICSs the autonomy to decide how to fund their hospitals and how to distribute resources across provider types, systems can develop financial frameworks that are complementary to delivery against their mission. It is important for ICSs to have freedom to develop this framework, rather than a new framework simply being imposed by NHS England, in order to unlock much better system-wide planning. This would de facto end the purchaser-provider split in healthcare in England, bringing it closer to the organisation of healthcare in devolved nations.

In addition to this freedom over resource allocation, a 'one system, one budget' approach brings several other opportunities that could facilitate the shift to prevention.

- Creating 'vertically integrated' pathways to prevent the development of late-stage disease, as in the examples of integrated working between primary, community and hospital specialists to prevent diabetes leading to end-stage renal disease.
- Harmonising electronic operating systems across hospital and community sites and creating a single ICS-wide electronic patient record system.
- Reduced transaction and frictional costs associated with commissioning of services, allowing more focus on planning and delivery.
- A shift away from the culture of constantly asking for more funding, to a culture of better managing resources in the interests of public health and public finances.

Giving ICSs greater freedom lets them go further and faster. Setting them a mission gives them a destination. These reforms together are, we believe, vital to realising 'prevention-first' health and care. Future work from the Commission on Health and Prosperity will unpack these proposals in greater detail.

RECOMMENDATIONS
- **A new overarching mission is set in every ICS. The 'System Operating Framework' is abolished – thereby removing centrally set targets for systems – and replaced by a leaner set of 'milestone metrics' that indicate delivery against the mission. These metrics should be co-developed by ICSs and NHS England.**
- **Greater autonomy over resource allocation is devolved to ICSs, including over how to finance hospitals, allowing them to shift funding and interventions 'upstream'. This will de facto end the purchaser-provider split in England.**

3.
THE
PRODUCTIVITY
SHIFT

Productivity gains in health and care services have all but ground to a halt over the past three years. By 2024/25, the NHS budget will be 2.9 per cent higher than under pre-pandemic plans, and the number of full-time equivalent nurses and doctors will have grown by 10 per cent since 2019 (Warner and Zaranko 2022). Despite that, treatment volumes across most healthcare services are mainly at or below 2019 levels (ibid).

This is leading not only to long waits, but also to rising care thresholds. For instance, mental health services are now admitting individuals later and achieving less significant improvements than in 2013 (Wyatt et al 2019). The number of people accessing social care has also fallen since the pandemic, even as demand has increased (Bottery and Mallorie 2023).

We urgently need to drive up the effectiveness of health and care services, for public health and for public finances. This means a focus on outcomes-led productivity growth. The difficult question is not *what,* but *how*.

Fortunately, there is untapped expertise on how public sector productivity gains can be achieved. For example, Bart van Ark describes three drivers of effectiveness in public sector delivery (van Ark 2022):

1. **People:** an agile workforce with investment in managerial talent, softer skills, and ownership of working arrangements by those most involved in delivery.
2. **Technology:** digital transformation, data for connected delivery, and continuous improvement.
3. **Organisation:** adaptive business design, resource focus on key bottlenecks, and responsiveness to contextual needs.

Mirroring this framework, we propose a **three-part agenda to restart the engine** of health and care productivity growth.

1. Retain, remotivate and reskill the workforce
2. Invest in digital and physical infrastructure
3. Redesign improvement infrastructure to unlock innovation

It is important to point out that this agenda is not entirely separate from the prevention shift already discussed in this report. Put simply, the later the intervention in any disease process, the more complicated the care provision. To deliver a healthier, more prosperous future for this country, we need to coordinate both prevention and productivity shifts in our health and care system.

3.1.
RETAIN, REMOTIVATE AND RESKILL THE WORKFORCE

The composition of the health and care labour force – its size, skill mix, and productivity – is perhaps the single most important determinant of how effectively our services deliver health and, therefore, prosperity. Yet we face a workforce crisis in both health and social care, and a status quo where working conditions and the nature of work in health and care actively undermine efforts to deliver the best possible care, in the time available, rather than empowering it.

In the face of this challenge, NHS England's recent long-term workforce plan will go some way to boosting recruitment (NHS England 2023c). Increasing the number of training places is an intuitive solution to a chronic shortage in staff. However, the productivity of staff remains a vitally important and missing component of that plan. Recruiting hundreds of thousands more staff, without creating an environment in which they can thrive, is clearly a suboptimal approach. On this, the long-term workforce plan goes nothing like far enough.

Three levers are particularly useful in delivering a strategy for workforce productivity.
1. **Retention**. Losing experienced staff members unnecessarily, even where they are replaced with newly recruited workers, is clearly inefficient. It substitutes inexperience for experience and harms the institutional memory of health and care services.
2. **Skills**. Having more highly skilled staff – working in the right places and in the right ways – improves productivity. There are particular opportunities to deliver a more professionalised, highly skilled workforce in adult social care, where better training has often been recommended, but too rarely made a reality.
3. **Environments**. Creating work environments that make staff sick is obviously unfair – and it leads to both lower productivity in work and the loss of experienced staff. More so even than the wider economy, the health and care sector has seen a significant impact of sickness on its labour force – and targeted action is needed to rectify this.

RETAINING EXPERIENCED STAFF
As a direct result of the clash between rising pressures and under-supported staff, the NHS and social care are now stuck in a vicious cycle of despondency and departure. Failed retention has become the immediate-term driver of our staffing challenges, with voluntary resignations spiking since the pandemic (figure 3.1) and a full 12.5 per cent of the NHS workforce leaving their post in the year to September 2022 (NHS England 2023d). Even worse 29 per cent of social care workers departed last year, without the hiring surge that would have been needed to compensate (Skills for Care 2022).

FIGURE 3.1

Voluntary resignations in the NHS have risen since the pandemic
Voluntary resignations from hospital and community NHS, Q1 2011/12 - Q2 2022-23
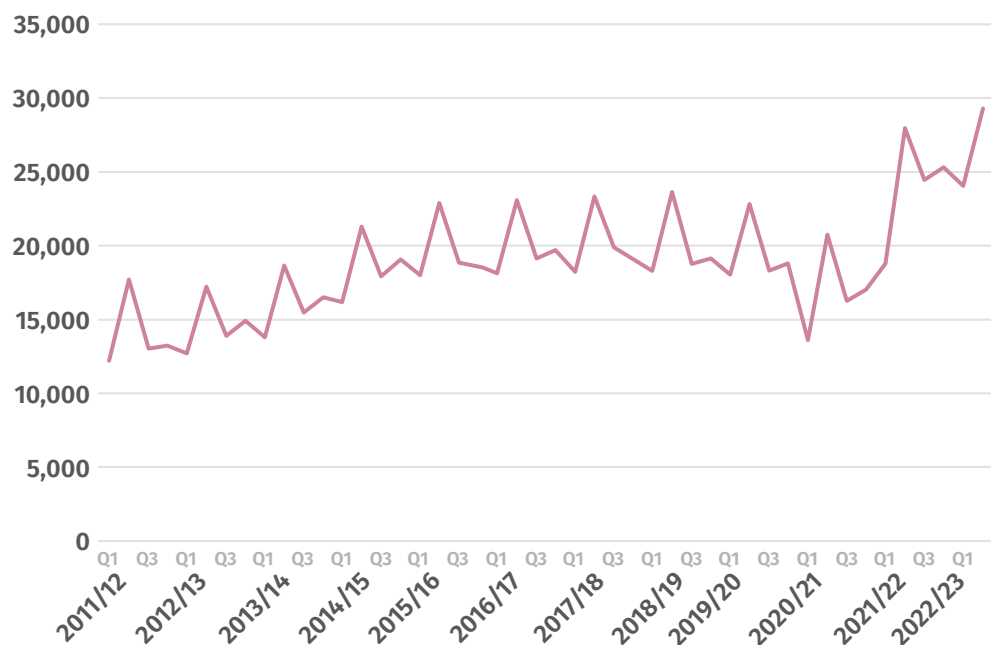
Source: IPPR analysis of NHS England 2023d
Note: Analysis excludes voluntary resignation due to relocation or promotion, as likely to constitute substitution. Seasonal impact is observable.

This mismatch between workforce and demand has now become self-perpetuating. In a well-staffed and well-resourced team, health and care workers can provide the care for each patient that brings intrinsic motivation (we discuss the importance of intrinsic motivation more in section 3.3). However, once system pressures become too great, the workforce is stretched thin, and staff start to struggle. This culminates in exhaustion, illness, and absence (Dewa et al 2014). Then the wider team fall under increased pressure, and further departures ensue. The NHS and social care have long ago reached this breaking point, as recent industrial action across the UK makes clear.

Even when new hires keep up with record departures, the inability to retain staff is inefficient for finances and productivity. Empty posts, even over the short term, require expensive agency staff cover and further spending on recruitment of a replacement (Waters 2022a). In the meantime, treatment is delayed – at the expense of health outcomes and the prosperity surge that timely care can offer (Williamson and Patel 2023). Furthermore, one new hire does not equal one departure. Research shows staff turnover is more damaging for productivity if a service loses its most proficient members, and can only recruit more novice staff (Hausknecht and Holwerda 2013). It is concerning that most new hires are junior doctors and healthcare assistants, with vacancies among experienced staff from nurses to senior consultants (Neville and Cocco 2023).

A recent report by the Institute for Government highlighted that experienced practitioners in the health service are leaving (Freedman and Wolf 2023). They are replaced by junior staff who have, for obvious reasons, less of the institutional knowledge and experience needed to optimise patient flow effectively and efficiently through the health system. Their analysis of data from the Nursing and Midwifery

Council, for example, shows a decline in the number of nurses with over 30 years of experience and rapid growth in those with under five years of experience. They concluded 'staff churn does seem to be a significant factor in current hospital productivity problems'. This resulting loss of institutional knowledge, along with the higher burden of training new recruits, holds back productivity. The NHS estimate the financial impact of replacing a fully-trained nurse is up to £12,000 (NHS SBS 2022).

Both trends need halting. Better take-home pay is one obvious lever, but as frontline workers on strike in recent months have highlighted, better working conditions and greater autonomy in the workplace are others. We focus on these three levers, as they are most consistently highlighted by staff themselves (Thomas et al 2023).

Improving take-home pay

Recent industrial action across the NHS has shown the limitations of the current Independent Pay Review process. The board was unable to find a solution that worked for both staff and employers; nor was the process able to react to sudden changes in the wider fiscal context, such as rising inflation.

The limitations exposed in this process mean that, even if one-year pay awards are negotiated in the short-term, disputes and poor outcomes remain likely in the future. To this end, the review process needs adjusting, to ensure that fair, transparent decisions are more likely in the future. Specifically, we recommend:

- Removing affordability as a consideration within the process. Affordability of pay decisions is a political decision, not an objective judgement. The pay review body should limit its recommendations to long-term workforce considerations and labour market conditions. This would not mean government could not still make decisions based on affordability – but it would be clear that such decisions were political.
- A new 'force majeure' clause in favour of workers. In contracts, force majeure clauses allow negotiations to be reopened when a sudden shock occurs, such as high inflation. This reflects that such shocks were not part of the initial decisions. The pay review process should be automatically reopened when such events occur. Again, this would not force the government to take the review body's recommendations, but would allow for an objective assessment of what new fiscal conditions should mean for pay.

We recognise that this would not support adult social care staff, who are among the sector's lowest paid professionals but are in most cases not included in public sector pay negotiations. To this end, we suggest steps are taken to promote and embed collective bargaining, specifically, through a new Royal College for Social Care, which should seek to promote and facilitate this process.

An under-considered lever to increase take-home pay for health workers is loans forgiveness. Any nurse, midwife, or physio who started their course after 2017 is saddled with tuition fee debt that was never charged to their predecessors. Nurses graduating last year faced an average debt of £47,600 on graduation, plus 7.1 per cent interest rates to pay. Repayments are automatically deducted from salaries. Student debt could be written down in intervals, creating a strong incentive for people to remain working in the health services, and may even attract more people into the profession. We recommend student loans are relieved for nurses and allied health professionals in 25 per cent chunks at intervals of three, five, seven and nine years of FTE service in the services.

There are yet more creative approaches to increasing take home pay for health workers. For example, it is commonplace for health workers in the UK to have to self-fund professional examinations and licencing fees. This is not common in other sectors of the UK economy, nor is it is common in the healthcare in many

other countries. Absorbing some of these costs would speak particularly to the junior doctor workforce (and stem their exodus from the NHS) as they bear a disproportionately high financial burden for exams and licensing they have little choice but to enrol in.

Greater control over working time

Clinical rotas in the NHS are rigid and demanding, particularly for junior staff. Inflexible working hours and poor work-life balance is the main reason people leave the NHS (NHS England 2020). This falls hardest on women, who bear disproportionate caring responsibilities outside of work, and make up 77 per cent of the NHS workforce.

Flexible working refers to where, when and how much people work. There has been a step change in flexible working in the NHS during the pandemic, with more work performed remotely and greater flexibility to accommodate childcare and caring responsibilities. A poll of health leaders in 2021 believe greater flexible working in the NHS had been one of the most positive shifts to have occurred during the pandemic (Patel et al 2021).

Despite progress, flexible working is not consistently available to all occupational groups and often requires a valid reason. NHS employers have now shifted to ensure employees can now request flexible working from day one. But to realise 'flexibility by default', a goal of the NHS People Plan, employers will need to go further than that. This could include remote working for outpatient clinics, and NHS investment in digital rota technology that supports teams to allocate their own leave efficiently and fairly.

NHS employers should proactively design for flexible working arrangements (for example, more self-rostering) and ensure it is consistently available to all staff levels without conditionality. This is especially important to tackle gender inequalities in the NHS; indeed, flexible working would go a long way to addressing the NHS gender pay gap (Timewise 2019). If flexible working does not become the 'new normal' in the NHS, workforce inequalities will entrench further, productivity will stall, and the numbers leaving will rise higher.

Greater autonomy at work

Experienced health and care staff are at the root of great care. It is only through their commitment, passion, energy, creativity and compassion that better care is delivered. But, as it stands, we are squandering this resource by limiting their autonomy. Our system crushes these deeply human tendencies by pushing them to work longer and harder to deliver on top-down targets. In short, we are squeezing out their agenda and autonomy through mechanisms of control rather than unleashing their potential. Indeed, evidence shows autonomy in healthcare is lower than in comparable professions (see figure 3.3).

Health professionals have less autonomy at work than other professionals in public and private sectors
Comparison of average autonomy among professionals in the public and private sectors (1 = 'none', 4 = 'a lot')
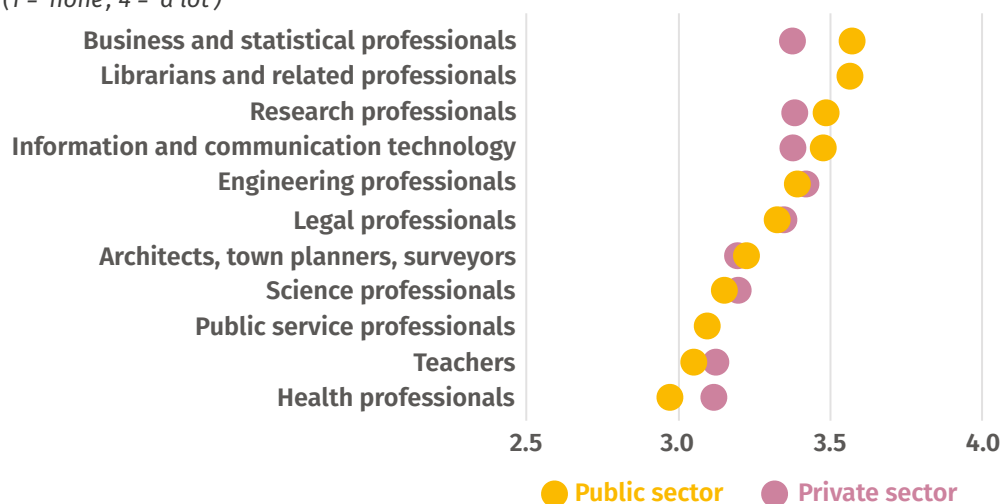
Source: NFER analysis of Understanding Society 2020

Staff autonomy has the power to reverse workforce despondency – to transform workplaces from places of dread and drudgery to passion and purpose (Laloux 2014). Evidence links authentic and empowering leadership to improvements in staff wellbeing – including burnout levels – and work behaviours, from self-rated job performance to offering suggestions to improve patient care (Wong and Cummings 2009).

As recent evidence to the Health and Social Care Select Committee (House of Commons 2021) made clear:

> *We have evidence that shows that organisations where there is more ability for staff to take part in making decisions and influencing how things are decided are the trusts that have lower mortality rates. They have better outcomes generally for patients and better outcomes generally for staff.*
> Professor Jeremy Dawson, Professor of Health Management, University of Sheffield

Passing power to the frontline in the health service could be operationalised as follows.

- **Freedom to deliver better care.** Fewer than half of NHS staff feel 'confident that their organisation would address a concern' about service design or workplace choices, according to the most recent NHS survey (NHS England 2022b). NHS and care workers know what is best for the people they serve. We recommend that these daily service design questions be devolved to the lowest level: the team that delivers the service. This can only be delivered on an organisation by organisation basis, through excellent leadership that gives permission and by giving staff freedom to think and test these things (see section 3.3).

- **A voice in the organisation.** We propose embedding shared decision making, through an allocation of seats on hospital and care provider boards to employee representatives. This would enable true worker representation on the key issues that shape the organisations culture and practice, in line with the German codetermination model. Employee representatives would be elected by the workforce, with representation of roles proportionate to workforce composition.

- **Putting the team back in the NHS.** The best working environment arises when a team collaborate and support one another over time. Prior to 2005, the NHS 'firm' system relied on consistent teams under a named doctor, which supported ongoing learning and informal feedback between colleagues (Timm 2013). However, fragmented shifts and training rotations now mean a junior doctor may work with a different consultant, registrar, senior nurse and physio each day. Rebuilding consistent multidisciplinary teams through a range of ICS-led models could restore motivation and improve autonomy across the NHS and care. For instance, a UK surgical training pilot scheme with longer team rotations and geographical certainty found trainees achieved higher standards and reported over 10 percent higher training satisfaction levels (HEE 2022).

RECOMMENDATIONS

- **Student loans are relieved for nurses and allied health professionals in 25 per cent chunks at intervals of three, five, seven and nine years of FTE service in the services. We also recommend professional examination and licensing fees for all NHS workers, including doctors, are shifted from employees to employers.**
- **A Royal College for Social Care is established. It should seek to promote and embed collective bargaining across the sector.**
- **Health and care employers should give employees greater control over, and notice of, their working hours and work patterns.**
- **NHS Trusts should create 'worker boards', to contribute to corporate governance alongside existing executive boards.**

A SKILLED WORKFORCE

The right skills to deliver a prevention-orientated, modern health system are a clear determinant of productivity. Opportunities to learn and progress are also likely to support retention, with evidence suggesting this is a key motivator for health and care staff (Patel and Thomas 2021).

While the NHS has some continuing professional development infrastructure, it is insufficient to provide the real transformation needed. The picture is bleaker in social care – a sector dominated by 'unskilled' work, and where training opportunities are limited. This section explores how both the NHS and adult social care can move towards a more highly skilled, productive future.

Long-term skills planning

The long awaited NHS Workforce Long-Term Plan lays out a vision for staff numbers required over the coming decade. We support this long-run horizon planning, but it can only succeed with sufficient and targeted investment – yet this plan lacks clarity on new funding to meet this need. There is also no equivalent plan for social care, where understaffing risks patient wellbeing and impairs efficient flow of people from healthcare to more appropriate care settings.

Despite promises by NHS England to review this plan 'at least every two years', there is no formal ongoing mandate to update recommendations as the optimal productive composition of the workforce inevitably evolves over time. We recommend the creation of an independent workforce projection body with statutory footing. This body would enable better long-term planning to create a future workforce with a skills composition better matching health and care needs, and, with its legal footing, hold the government and NHS England to account on delivering against this agenda (in a similar way to the Climate Change Committee).
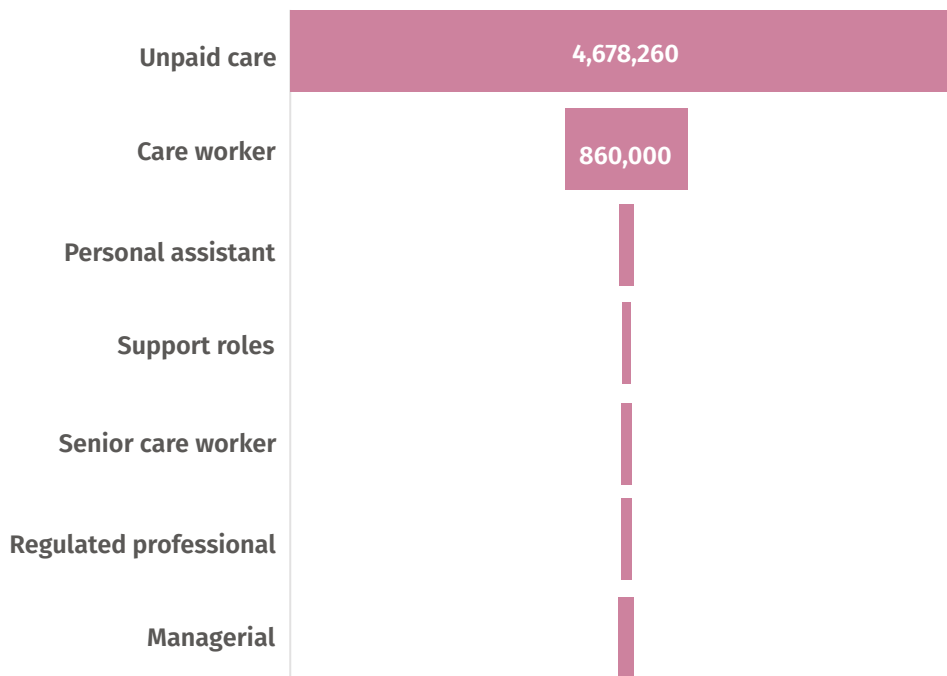
Professionalising social care

There is significant scope to upskill the social care workforce and drive up the quality of care. Put differently, if care is going to meet the challenges of the 21st century, it will need to move past its current, uneasy status quo of being delivered by a mix of unpaid labour (predominantly delivered by women) and low paid, low skill, low status workers.

FIGURE 3.4

The care sector is predominantly made up of unpaid and low paid workers
Composition of those doing care work, paid or unpaid, England, latest data

Unpaid care	4,678,260
Care worker	860,000
Personal assistant	
Support roles	
Senior care worker	
Regulated professional	
Managerial	

Source: IPPR analysis of ONS 2021, Skills for Care 2022

Evidence shows that social care training improves outcomes and supports integration between services (Eaton 2000; Quilter-Pinner 2019). On this basis there have been previous attempts to introduce common training standards in social care – including the Care Certificate, introduced following a similar

recommendation in the Cavendish Review (Cavendish 2013). However, take-up of the certificate has been slow, concerns have been raised about the quality, and the expectation is that care workers do the training unpaid in their own time (Dromey and Hochlaf 2018).

This seems to be a particular challenge in the independent (private) sector, where fewer care workers have the Care Certificate (figure 3.5).

Levels of qualification are lower in private sector care providers
Level of qualification (percentage) by employer, latest data (2022)
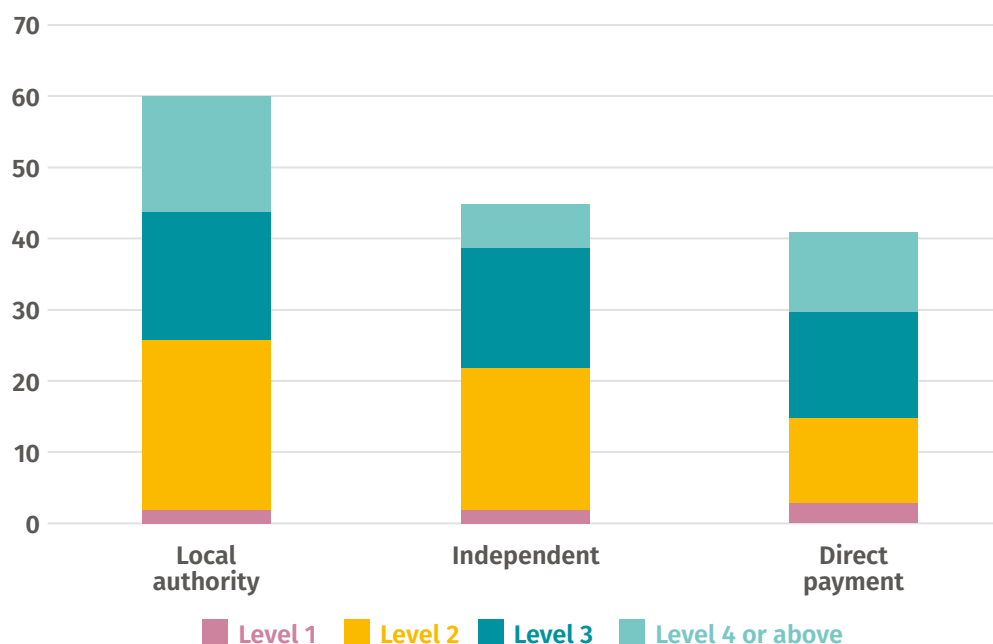
Source: IPPR analysis of ONS 2021, Skills for Care 2022

We recommend four steps to support professionalising the care sector:

1. First, government should make a level 3 care certificate an expectation in the sector. This should not bar people from taking up jobs in the sector – indeed, the level 3 qualification requires people to be working in the sector already. Rather, the expectation should be that the qualification is completed within two years of working in the sector.

2. Funding should be allocated for qualifications to be undertaken for free and in paid hours. Many sectors provide paid time for study.

3. The government should publish more detailed pay grades for social care workers, with more delineation between care worker roles, based on expertise, qualification level and years of experience. This should include guidance on new role titles and pay brackets, building expertise into the sector. The funding for this should be provided by central government and delivered through commissioning arrangements.

4. Finally, to further entrench progression in the sector, and build integration between health and care, the government should build a new apprenticeship pathway – where care workers with the highest level of qualifications can undertake apprenticeships into NHS roles. This could include pathways into, for example, nursing associate, nursing, pharmacy services assistant, podiatry or healthcare scientist practitioner roles.

Ultimately, the expectation should be that greater professionalisation – supported by time and funding from government – not only increases the attractiveness of social care as a career, but also boosts retention, reduces pressure on unpaid carers, and helps build UK resilience.

Digitally skilled workforce

The Topol review, and several reports since, have considered various approaches to establishing digital, data and technology pipelines (Topol 2019). Training across all common healthcare roles, such as doctors and nurses, is starting to incorporate digital skills training. But particularly important is growing the informatics workforce in health and care. We recommend the data and informatics workforce in health and care is professionalised. A General Council of Health Informatics should be established for the professionalisation and regulation of data, digital and technology roles as well as those with hybrid clinical and informatics roles.

Improving digital literacy among health and care leaders is also important. The Hewitt review highlighted the lack of in-house digital expertise across systems (Hewitt 2023), despite most systems having board-level representation for their digital transformation agenda. The NHS Confederation could facilitate peer learning between more and less digitally mature ICSs, while the NHS Digital Academy should expand the number of places on its graduate and apprentice schemes to grow the pipeline of future digital leaders.

RECOMMENDATIONS

- **The establishment of an independent, statutory health and care workforce planning body. It should be tasked with projecting future workforce needs and holding the government to account on delivering these needs.**
- **A level 3 social care qualification should be made the expectation in adult social care roles, with funded time allocated to staff studying for that qualification.**
- **A General Council of Health Informatics should be established for the professionalisation and regulation of data, digital and technology roles as well as those with hybrid clinical and informatics roles.**

BOOSTING WORKFORCE HEALTH

Industries across the economy are struggling with the labour market impacts of long-term sickness. Yet it has been too rarely mentioned in the policy and media debate that this impact is particularly pronounced in health and care. Health and care is among the industries with the highest rates of sickness absence (figure 3.6). This has worsened substantially since the Covid-19 pandemic began, mainly due to occupation-related risk, but notably was higher than other industries even before the pandemic.

FIGURE 3.6

Sickness absence is high in the health and social care sector
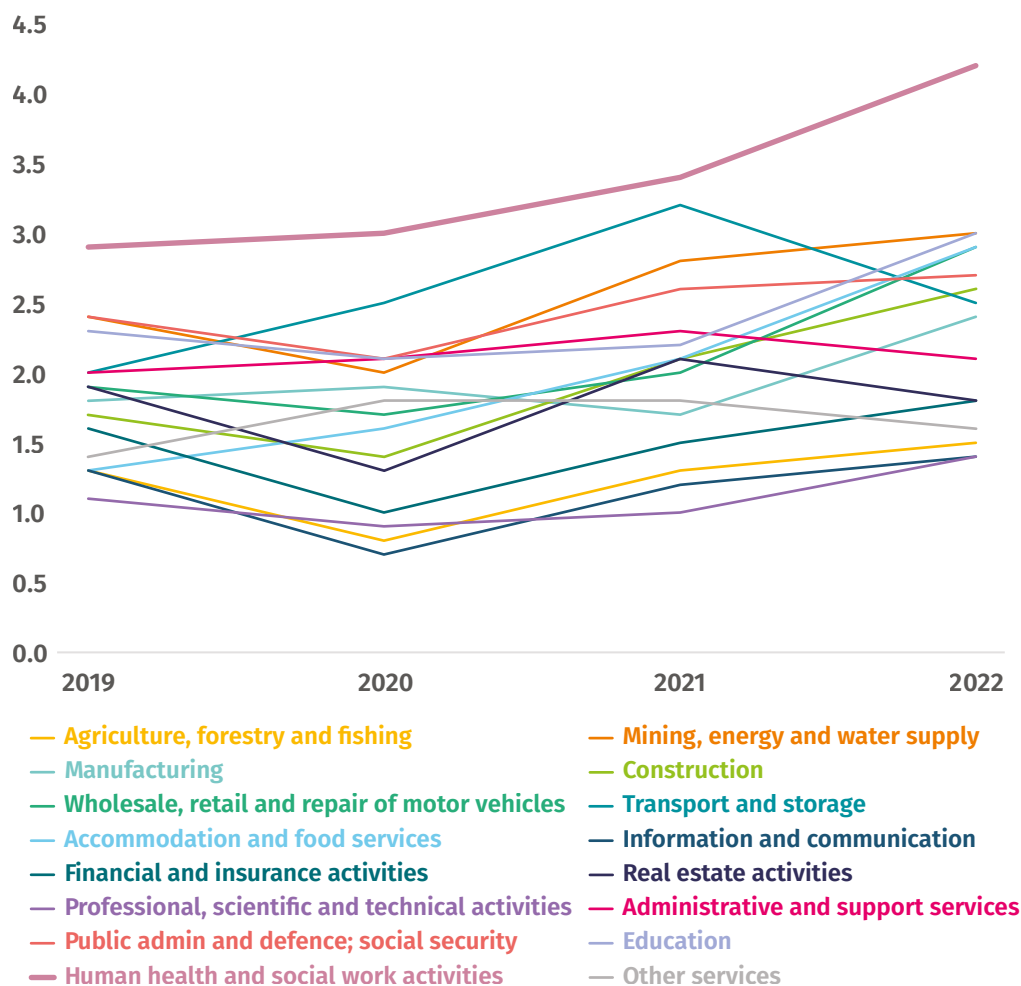
Source: IPPR analysis of ONS 2023f

In-work sickness has been associated with both lower productivity and wider fiscal cost by the OBR, and we have already outlined why poor retention of experienced staff constitutes a challenge. More needs to be done to support the health of the health and care workforce.

Mental health problems are a leading cause of sickness absence. Research has long found that health and care staff have a higher incidence of mental health problems than the wider population. This makes better mental health support an obvious priority. Options include:

- Greater opportunities for all staff to access clinical psychological supervision, either one to one or as groups
- Access to psychological, psychotherapeutic and counselling services through a fast-track scheme
- Personalised mental health care plans for health and social care workers
- Expanded access to existing specialist NHS mental health for social care and non-clinical staff
- Access to trauma services, similar to the access provided to armed force veterans through programmes like the Medical Assessment Programme (MAP).

Beyond this, the government have recently launched a consultation on increasing the reach of Occupational Health Services among private sector employers. This includes a policy of encouraging NHS leavers to consider a career in Occupational Health, but says little on how occupational health services can be expanded within the NHS itself. We suggest any provisions and obligations placed on businesses are also placed on NHS employers, and that the NHS is made a priority for any increased, national occupational health offer/standards.

RECOMMENDATIONS
- **Mental health services are expanded for health and care staff, including through a fast track to support.**
- **The NHS and social care are made the frontline of any expansion in occupational health.**

3.2 INVEST IN DIGITAL AND PHYSICAL INFRASTRUCTURE

Low capital investment (the kind of investment which pays for long-term infrastructure like buildings, diagnostic scanners, and IT software) is one of the leading barriers to treating patients efficiently and effectively (Warner and Zaranko 2022; Freedman and Wolf 2023). The UK dramatically cut capital investment levels under austerity, resulting in a decade of much lower investment than virtually all other comparable countries (figure 3.7). Social care, where capital financing is mainly private, is also subject to very low levels of investment (DHSC 2022).

FIGURE 3.7

Capital investment in health is lower in the UK than in other comparable countries
Capital expenditure per current PPP and capita
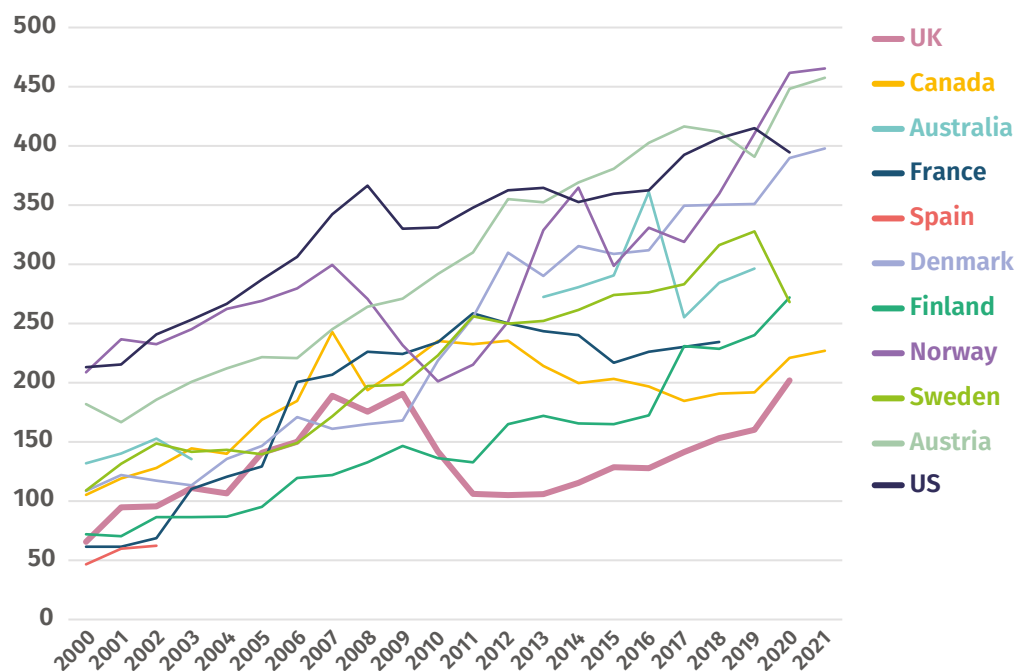
Source: CF analysis of WHO Global Health Expenditure Database

There are two main ways poor quality infrastructure holds back improvement: creating bottlenecks and constraining innovation.

CREATING BOTTLENECKS

At the core of discussions around health service productivity since the pandemic has been this seeming paradox: why, despite sizeable increases in funding and staff numbers, have treatment volumes failed to grow at a commensurate rate?

The answer is best illustrated by queues of ambulances lining up outside emergency departments. Funding more paramedics and ambulances, as the

government has done, is of little value if there isn't a bed for the patient in the department: they simply have to wait outside. Bottlenecks like this exist across the entire health and care system, and since the pandemic, virtually all have grown.

The underlying reason is low numbers of beds, scanners, computers and consulting rooms in crumbling buildings – what we refer to as 'infrastructure'. The UK has some of the lowest numbers of hospital beds per person, and fewer scanners per person, than almost all other comparable nations (figure 3.8).

The UK has fewer beds and scanners than most comparable countries
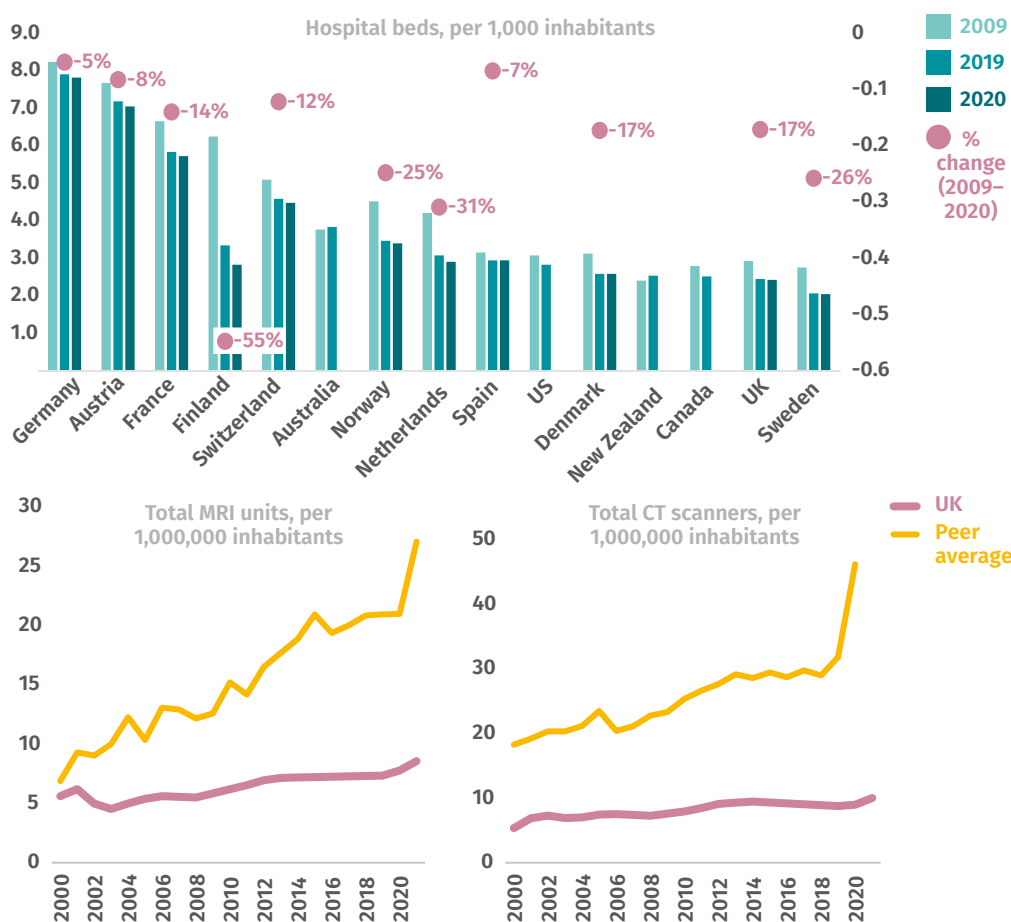
Source: CF analysis of OECD 2021

42 per cent of NHS hospitals have been forced to close wards or key services due to structural and repair issues since 2020 (Hewitt 2023), as incidents from floods to electrical issues force the closure of A&E departments, wards, and operating theatres. The economic cost then accumulates rapidly through both expensive emergency repairs and missed opportunities for service provision.

Put simply, capital underinvestment has expanded bottlenecks across health and care services. This is the crux of why more staff and large day-to-day spending is not translating into more health and care provision. Resolving these bottlenecks, by upgrading infrastructure across services, is key to improving the efficiency and effectiveness of health and care services.

CONSTRAINING INNOVATION

Poor quality infrastructure not only holds staff back from being able to do their current jobs: it also holds back innovations that could transform their work and drive step changes in productivity. Digital infrastructure is particularly important to this. Indeed, as in the private sector, digital technologies and artificial intelligence (AI) are the focus of hopes for productivity improvements in health and care.

Better quality digital infrastructure, both hardware and software, can unlock innovation. This will drive productivity growth in numerous and unpredictable ways. But there are two pathways in particular that are worth considering.

Freeing up the frontline

27 NHS trusts were still forcing staff to chase around for paper notes as recently as 2021 (Carding and May 2022). As a starting point, digital infrastructure means a paperless NHS. An original target of achieving this by 2018 was missed and redefined, with the current target set as nine in every ten NHS trusts to have electronic health records by the end of this year (and all by March 2025), and for 80 per cent of CQC-registered adult social care providers to have digital care records by March 2024 (DHSC 2023).

AI technologies can also assist and automate administration in health and care. If deployed appropriately, they could better enable professionals to focus on patients. For example, GPs in the UK are the least satisfied with their administrative burden compared to counterparts in comparable countries surveyed by the Commonwealth Fund (Beech et al 2023). One study estimates approximately 44 per cent of administrative tasks carried out by staff in general practice are 'mostly' or 'completely' automatable using currently available technology (Willis et al 2020). Integrating these technologies into clinical care is likely the most powerful immediate-term policy lever to allow GPs spend more time with patients.

Pre-empting illness to improve outcomes for less

Our ever-expanding knowledge of biology means we can pre-empt illness, not just wait for it. And technological advances mean we can translate this knowledge into widely felt benefits. The UK boasts high-resolution health records on an entire population going back decades, a thriving life sciences sector, world-leading universities and a national health service. We led the world in human genome sequencing and translational research for prevention of many diseases, but more recent years have seen a slowing down of digital and data momentum, with other countries overtaking the UK (Tony Blair Institute 2022b).

NHS data is an exceptional and globally importance resource. At a service level, the NHS has been leveraging predictive analytics powered by AI to identify patterns and trends in patient data. This has helped improve the management of hospital bed occupancy, resource allocation – such as ventilators during the pandemic – and patient flow optimisation, contributing to more effective healthcare (Dawoodbhoy et al 2021; NHS England 2021).

Utilising this data for prevention as well as allocation can drive gains in productivity for health outcomes, not just treatment volumes. This includes identifying early intervention opportunities to keep people living healthier and more prosperous lives (Our Future Health 2023). The NHS is also seeking to become the first national health care system to offer whole genome sequencing as part of routine care. This could transform patients' lives by more accurately predicting risk of severe disease, improving early diagnosis and better matching therapeutics to disease variants. By analysing large datasets through a single NHS analytics platform, AI algorithms can also help predict disease progression, identify high-risk patients, and facilitate proactive interventions.

A CAPITAL PLAN

Recent increases to the Department of Health and Social Care's capital budget now mean the UK performs relatively well on capital investment compared to other OECD nations. However, the problem is less the existing budget, and more the consequences of the sustained underinvestment that preceded it (2010-2019). The cumulative capital investment in the UK between 2010 and 2019 was £33 billion lower than the average in EU14 nations (Rebolledo and Charlesworth 2022).

To help rectify the consequences of this underinvestment, we recommend that the UK commits to catching up the 'missed investment' compared to EU14 nations. We recommend the creation of a ten-year Infrastructure Recovery Fund of £33 billion across this period (equivalent to an average £3.3 billion per year). This is a relatively modest increase on the current capital investment plans as described in the spring budget 2023. But in maintaining the commitment to a stable and growing capital budget, it has the additional benefit of offering providers and policy makers significantly more certainty.

The case for investing in health and care infrastructure is clear. While each ICS will have its own priorities, there is a role for national government in aligning the capital regime to wider ambitions to support productivity and deliver a shift to prevention. We suggest three priorities for new capital investment – each tied to aspirations to increase productivity and to support prevention.

1. Building a hub and spoke primary care infrastructure to support the shift to prevention. As already outlined in this report, primary and community care will be central to efforts to support a prevention-led approach to health and care. This will require significant infrastructure, including more space in community settings and the creation of Neighbourhood Health Hubs across the country (see section 2.1 for further discussion).

2. Improving early diagnosis. The UK has significantly less diagnostic equipment than comparable nations. Equally worrying, there is evidence that our equipment is often 'obsolete' (see for example Future Care Capital 2021).

3. Shifting to digital. Digital presents one of the most exciting frontiers in prevention, and can support well managed, productive health and care settings. Yet consistent national investment in technology is limited.

RECOMMENDATION
- **The creation of an Infrastructure Recovery Fund to undo the consequences of sustained divestment from capital observed between 2010 and 2019. We suggest this infrastructure fund focusses on transforming primary care infrastructure, shifting to digital and improving early diagnosis.**

3.3.
REDESIGN IMPROVEMENT INFRASTRUCTURE TO UNLOCK INNOVATION

Health systems around the world are responding in diverse ways to the disruptive power of technology. In Israel, surgeons are operating with virtual reality headsets, while in parts of the US, precision medicine and genomics are already normal practice.

Once a leader in advancing the technological frontier in healthcare, the UK has fallen behind most peer countries (Tony Blair Institute 2022a). While we have made some progress in digitising health and care, we are yet to see the full force of technology in redesigning it. This is key to make health and care more productive in the years ahead.

The barrier is not access to the latest technologies, including AI-assisted tools. It is that integrating new technologies into service provision requires significant complementary investments, including co-invention of new processes, operating models and human capital (Brynjolfsson, Rock and Syverson 2021). These complementary investments are often called 'intangible' assets.

There is strong evidence of the growing importance of intangible assets in improving productivity in the private sector (Haskell and Westlake 2017). There is no reason to expect this relationship between organisational structure and productivity to be different in the public sector: if anything, the reverse is true (Coyle 2022). For example, work by Diane Coyle and colleagues has found that the removal of bureaucratic layers in NHS hospitals during the pandemic softened 'the vertical and horizontal boundaries of services and hierarchies in hospitals, and enabled more coordination' (ibid).

The growth of bureaucracy in health and care services has choked innovation and quality improvement. The intangible assets of services need upgrading – here we refer to this as redesigning the 'improvement infrastructure'. We propose two complementary approaches.

1. **Rewiring top-down** management and oversight to open up innovation
2. **Plugging in the voice of patients and staff** to unlock innovation from the bottom up.

TOP-DOWN REWIRING

Policy makers over the last four decades have drawn primarily on top-down, market-inspired management and oversight mechanisms to drive improvement in public services. These approaches started from a simple insight: that *in the absence of market forces, public services suffer from weak or misaligned incentives*. This led to:

- **the import of private sector practices** to the workings of healthcare services. This included performance indicators (such as targets) and performance management (such as regulators); and

- **the introduction of quasi-markets,** such as choice for 'consumers' (where funding follows service users through the system) and competition, via contracting out, between providers, often including private and third sector organisations.

FIGURE 3.9

Policy makers over the last three decades have drawn primarily on top-down bureaucratic and market mechanisms to drive quality improvement
A framework for improvement in public services
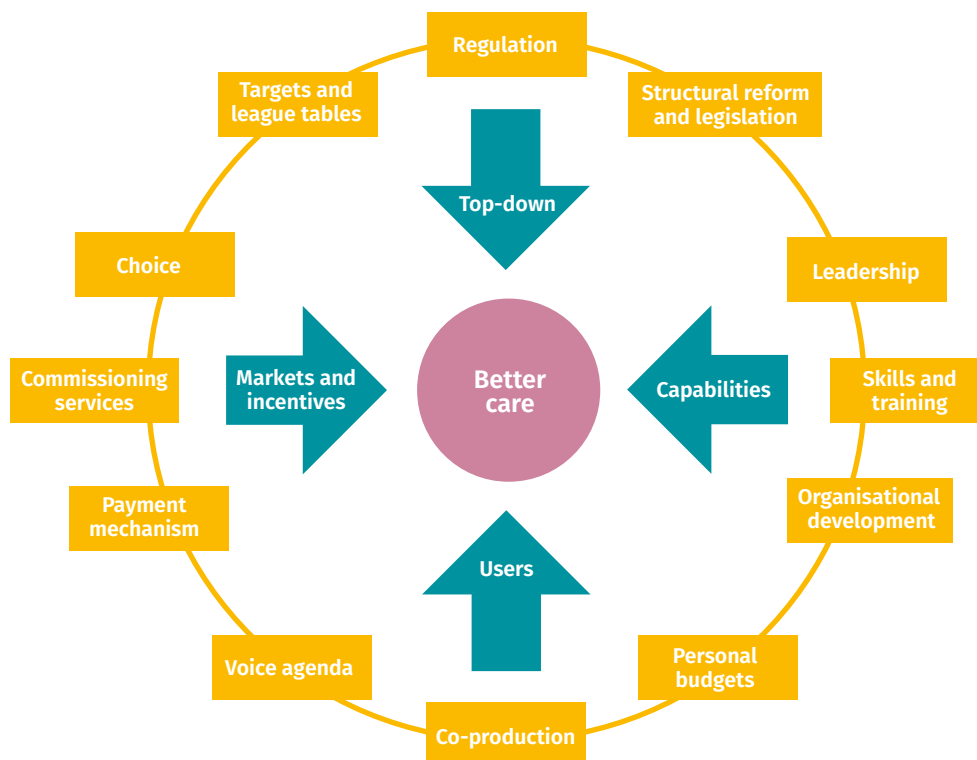
Source: Adapted from Cabinet Office (2006)

A recent review by IPPR (Quilter-Pinner and Khan 2023) suggested that:

- There is evidence that some levers, such as targets, can drive improvements for tame, rather than complex problems (for example, increasing activity in hospitals vs increasing support for people with chronic conditions), though they often come with undesirable side effects, such as gaming or falls in performance in non-measured outcomes.
Meanwhile, other components of this agenda seem to have had more limited positive impact. For example, competition and outsourcing in public services, can reduce costs, but usually to the detriment of quality and fairness (for example by providers reducing input costs such as staffing levels or pay).

Overall, as one of the founders of this agenda, Michael Barber, has argued, bureaucracies and (quasi) markets can help providers of health and care to get from 'poor' to 'good enough', but they almost consistently fail to help them to get from 'good' to 'great'. Put differently, they can prevent a 'low floor' but not unlock a 'high ceiling' in performance. The reason for this is fairly simple: 'extrinsic motivators', such as financial incentives or top-down micromanagement and accountability, can achieve compliance, but cannot drive the motivation and innovation required for excellence.

In that context, we propose rewiring top-down management structures, to open up room for innovation and kick-start a new era of productivity growth in public services, focussed on outcomes, not just outputs.

Relinquish control

The founder of the NHS, Nye Bevan, famously once said that 'the sound of a dropped bedpan in Tredegar [his Welsh constituency] should reverberate around the Palace of Westminster'. This sentiment, whilst a laudable expression of the importance of healthcare, has been rather too faithfully codified into the NHS's DNA. Top-down command and control remains the status quo. While this led to efficiency improvements in hospitals in the 2000s, it is now failing to drive even those – let alone improvements in health outcomes.

In recent years this control infrastructure has been built around two main mechanisms. First: targets, such as those applied to waiting times in primary and acute care (though increasingly targets have also been put in place for quality improvement via the NHS Long-Term Plan). And second: regulation, undertaken primarily by the CQC in England (though NHS England also takes on a regulating role). CQC uses a system of provider inspections, with performance measured against national standards. The CQC's ratings and reports are published for transparency, and poor performance can result in an intervention by the CQC.[5]

These mechanisms can help drive better outcomes in the short-term but come with unintended consequences such as gaming, as well as the crowding out of intrinsic motivation. They also fail to help providers move from 'good' to 'great'. We therefore argue for the need to review and strip back targets to a bare minimum (to ensure a basic national entitlement) and instead focus on setting long-term, outcome-based, motivational missions for our health and care services instead. As outlined in section 2.1, we recommend the current Systems Operating Framework is scrapped and replaced by a single healthy life expectancy mission, with ICSs proposing their own metrics to evaluate progress against this mission.

In addition, we should radically reform our approach to regulation through the CQC and NHS England. Regulation should be increasingly data-led rather than inspector-led. Where a more granular understanding of performance is needed, this should be learning-focussed. The relationship between regulator and providers should almost always be one of partnership, in which CQC experts are involved to provide more expertise and support. Hard levers should only be used when all else has failed. CQC has undoubtedly started on this journey, but there is more work to be done (CQC 2022).

RECOMMENDATIONS
- **A review and stripping back of targets in the NHS. The Systems Operating Framework should be scrapped and replaced by a single mission to improve healthy life expectancy, with ICSs proposing their own 'milestone' metrics to assess delivery against this mission.**
- **A reduction in the amount of NHS central guidance and planning processes which take up time with limited gain.**
- **Reform of the regulatory functions of CQC and NHSE to focus on learning and support, and a shift away from using 'hard levers' of regulation as a last resort.**

Pipeline of better leaders

If top-down targets, regulation, or quasi markets are not going to be the main drivers of improvement, then what will? Experts increasingly argue that the key is culture change within organisations, to focus on continual innovation, learning and

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5   This intervention may be 'informal' (for example, provision of recommendations or support) or 'formal' (for example, putting a hospital into special measures or even closing it down).

improvement (Ham 2014). The best organisations tend to focus on shared inspiring social missions (purpose), be accountable and responsive to the people they are serving (downward to citizens), be team based, collaborative and nurturing for staff, and have a laser focus on continual learning and innovation.

The key influence on organisational culture is the leadership of an organisation (Kings Fund 2015). Leaders can create a shared purpose and identity, recruit and nurture talent, encourage trust and cooperation, and enable collective learning which is more likely to succeed (Sfantou et al 2017). Indeed, high quality management and leadership within a system or organisation feeds through to performance including staff satisfaction, as well as patient outcomes (ibid).

This is challenging to the NHS and social care, where leadership churn in is significant. For example, a recent Kings Fund study found that eight percent of executive director posts are vacant and that the median tenure of a NHS chief executive is just three years (with other estimates suggesting it was even shorter) (Anandaciva et al 2018).

Moreover, there is also evidence of what has been called the 'inverse leadership law', where the most vacancies and shortest tenures at leadership level are found in the trusts with most challenges levels of performance (ibid). Notably, the HSJ has found that the median tenure of a chief executive of an 'outstanding' trust was more than seven years, compared with just 11 months for a chief executive of a trust in special measures.

But creating the right culture and driving continuous improvement is not just about the person at the top: it is also about the managers in the middle. Management in services like the NHS is often given a bad reputation by the media (managers are seen as inefficient bureaucrats) and by staff (often because management is deployed to control, not to enable). But in truth, the health and care systems in England are under-, not over-managed. Better quantity and quality of management results in better care (Jones, Horton and Home 2022). We need enabling management to free up the frontline and support transformation efforts.

How can we create better leaders and managers? First, we must raise the status and importance we place on leaders and managers. Second, we must end the 'fire and hire' and 'shout and shame' culture towards leadership in the service. Third, we should invest significantly more in leadership training and support, especially in building up distributed leadership in ICSs (Patel 2021). Finally, we should create more and better peer-to-peer learning, coaching and mentorship opportunities. These build on recommendations highlighted to the government in the recent Messenger review (Messenger 2022).

RECOMMENDATIONS
- **A doubling of funding for the NHS Leadership Academy, and investment in other leadership programmes.**
- **ICSs should create their own leadership and management development programmes. Leaders should also be moved around different providers and services. They should get access to continuous coaching and peer-to-peer mentoring.**
- **All ICSs to have a director of improvement/innovation/transformation, with a team to lead on improvement.**
- **About 10 per cent of middle and senior clinical staff time to be reserved for either personal development or improvement work.**

PLUGGING IN VOICE

Rewiring top-down structures can free up room for more innovation. But the source of that innovation still needs to be plugged in. This innovation can be found on the front line, from users and staff.

Recent IPPR work finds the evidence is increasingly clear that unlocking **intrinsic motivation** of patients and staff is a stronger driver of productivity growth than creating behaviour change using **extrinsic stimuli** (reward and punishment), as in the top-down bureaucratic and market approaches (Quilter-Pinner and Khan 2023).

Unlocking intrinsic motivation is how to get from 'good' to 'great', or to achieve a 'high floor' and 'no ceiling'. We need to redesign how our services work, stripping back extrinsic motivators and seeking to create conditions that unlock the intrinsic motivations of staff and citizens to drive performance, innovation and behaviour change. This raises the question: how can we unlock the power of patients and staff to drive productivity improvements?

For staff, the answer is passing more power to the front line. Policies to achieve this, by increasing staff autonomy at work and voice in corporate governance, are considered in section 3.1. They will need to come alongside efforts to ensure frontline staff have enough protected time to work on service redesign and quality improvement, rather than simply adding it as an additional responsibility to fit into the day job (as with, for example, the requirement to complete clinical audits for junior doctors).

For patients and service users, their voices can be driving force for innovation and improvement – if there is a well-functioning feedback mechanism and policy responsiveness.

Policy makers have in the past sought to unlock the power of citizens in our health and care services to drive improvements in service delivery. The most comprehensive attempt to do this started under New Labour in 1997, but there have been successive waves of reform since then under the coalition and Conservative governments. These attempts have focussed on introducing and expanding patient choice, so that citizens no longer 'passively receive the services that are provided by the state monopolist, but actively choose between offers from competing providers that best match their needs and demands' (Lee, Jilke and James 2020). This is supposed to drive up provider quality by allowing people to move between worse and better providers, and therefore create incentives to improve quality and thus maintain 'market share'.

However, studies into the effect of these reforms – and wider experiments in choice and competition in public services – suggest that the impact was limited. Some studies such as Propper, find 'broadly…positive effects' in terms of quality, but are also clear that this effect was relatively small; and other studies are less conclusive.

While there remains a good case for 'choice' in health and care services, it is unlikely that this is a catalyst for quality improvement and better productivity growth. To truly unlock the power of patients as a source improvement and innovation, we advocate a new approach: 'voice, not just choice'.

A key aspect of this is improving the responsiveness of health and care services to patients and users. Across society we have experienced a 'feedback revolution', enabled by the rise of the information age, which has greatly amplified the voice of citizens. Online feedback mechanisms are routinely embedded into services (such as AirBnB) or delivered via a third party (such as Tripadvisor). This live user feedback gives both service providers and customers valuable intelligence that not only informs consumer choice but drives service improvements.

However, this revolution has yet to transform health and care services. Notably, while mechanisms such as the NHS Friends and Family Test, and the introduction of Patient Reported Outcome Measures (PROMs), have generated significant amounts of useful data, there is significant evidence that they have stalled in their roll out and implementation, and could deliver more value for services and citizens.

USER FEEDBACK IN THE NHS

The NHS Friends and Family Test

The NHS Friends and Family Test has been running since 2013 and enables people to give short, anonymous feedback on care received. It was extended to staff in 2014, and these data are now collected as a mandatory National Quarterly Pulse Survey.

By the end of 2019, the Friends and Family Test had generated more than 75 million pieces of feedback, with the total rising by about one million every month. The results are collated nationally and published monthly. The feedback form asks about people's experience of care (from very poor to very good) and ways it could have been better.

Nine out of ten responses are positive, and the 2019 NHS Staff Survey found that almost six in ten staff think patient feedback is used to inform decisions. But the Friends and Family Test has been criticised for being time-intensive, generating unrepresentative data and providing little insight for practitioners.

Patient reported outcomes (PROMs)

PROMs capture patient views of their care in a robust and reliable way. The introduction of PROMs in the English NHS in 2009 was considered world-leading at the time, and focussed on before and after experiences in four elective surgery areas: hips, knees, varicose veins and hernias.

The response rates are good, costs of data collection and analysis reasonable, and the dataset has been described as 'extraordinarily rich'. Yet while the PROMs programme exists in NHS bodies across the UK, it has not maintained its early momentum. The English NHS reduced the number of procedures which are subject to PROMs collection, and data is currently not being published due to data linkage issues (NHS Digital 2023).

Smartphone coverage is now the norm. Routine, embedded, live feedback by the users of services and frontline staff should increasingly become the norm. This feedback should be curated into dashboards, and would provide a live snapshot of user experience which can inform service design and improvement, as well as informing citizens' use of public services.

The ultimate aim should be that anyone – citizen or frontline staff – can pick up their smartphone to provide live feedback on any public service they use or work in. These data should, ultimately, be publicly available so that people can see the experience of others using the same public service, as well as the responses by service providers (such as updates on service changes as a result of feedback).

CODESIGNING HEALTH AND CARE SERVICES

Creating feedback mechanisms can also be achieved through involving citizens in service design and commissioning. We recommend that the shift to ICSs be used as an opportunity to formally embed patient and public 'voice' in health and care policymaking. The specific mechanisms will vary for each ICS, but promising initiatives include:

- **Involving those with 'lived experience' in care, as community health workers and advisors codesigning and delivering programmes.**

  'You're sharing information based on your own lived experiences... you could ask challenging questions...you could influence future policies'
  Participant in a mental health session

  High impact examples include mental health services by and for refugee communities in Melbourne, Australia (cohealth 2022) and diabetes peer support by South Asians in East London (Bromley-by-Bow Centre 2018).

- **Deliberative assemblies for health and care policy at the ICS level**

  ICSs could better involve the wider population in decisions about health and care that do not have a straightforward answer, but involve careful value judgements. For instance, Coventry and Warwickshire ICB used public deliberation to weigh up whether waiting list algorithms should adjust for individual health conditions, ability to work, or area of deprivation (Williamson and Patel 2023). A majority felt prioritisation should take individual health into account, but not include non-clinical factors like the ability to work. They felt addressing health inequalities was important, but these 'interventions needed to take place upstream to the waiting list'. Each ICB should tailor pragmatic waiting list assessment to the needs and preferences of the community they serve.

RECOMMENDATIONS
- **The creation of a mechanism for live user feedback to be curated into dashboards and made available to staff and citizens.**
- **Using the shift to ICSs to embed citizen voice more in the design of services, including through the use of citizen juries.**

4.
FINANCING THE FUTURE, FAIRLY

This report has set forward the first steps of a new, more sustainable, and more modern vision of both health and care services. Our contention is that this meets the intersection of a) what patients and service users want, as derived from our qualitative and public opinion research; b) what future prosperity and health needs demand from health and care services; and c) what can be delivered within a sustainable expenditure envelope. That is, it's a plan that works for public finances and for public health.

Our burning platform is the desperate societal and economic need for flourishing health and care services in the years and the decades to come.

In establishing this plan for the future, we have focussed on moving from our current trajectory – 'spending more, getting less' – and towards a more sustainable approach of delivering excellent health and care that supports the economy and delivers excellent value for money.

However, it is important to note that while this is ultimately less expensive in the long run, under this plan spending on health and care services will have to go up. To some extent, this is desirable. There is little point to economic growth if it does not enable good lives for people across this country – in which excellent public health and care services are an important component.

Our analysis with LCP Health Analytics suggests that continuing with the status quo creates an NHS England funding pressure of 4.1 per cent per annum real terms growth for the next five years. Should the NHS experience productivity flatlining – that is, the permanent loss of productivity following the pandemic shock – we estimate this funding pressure will be higher at 4.6 per cent real terms grow per annum.

However, if the reforms described in this report are pursued and successfully implemented, we estimate that the NHS would require 3.6 per cent per annum over the next five years. Table 4.1 outlines our proposed five-year funding settlement for NHS England (resource spending) over the next five years.

TABLE 4.1

IPPR's proposed funding settlement for the NHS and adult social care services in England

NHS England resource spending[6]	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Nominal budget (£bn)	160.8	171.9	180.6	189	198.3	208
Cumulative real growth (22/23 prices) (£bn)		6.9	12.6	18.9	25.6	31.7
Real growth (%)		4.30%	3.40%	3.70%	3.70%	3.30%
Adult social care spending (no FPC)						
Nominal budget (£bn)	23.2	26	28.6	29.9	31.2	32.8
Cumulative real growth (22/23 prices) (£bn)		2.2	4.3	5.2	6.2	7.2
Real growth (%)		9.60%	8.30%	3.40%	3.40%	3.40%
Adult social care spending (with FPC)						
Nominal budget (£bn)	23.2	29.4	32.1	33.4	34.9	36.6
Cumulative real growth (22/23 prices) (£bn)		5.5	7.6	8.6	9.7	10.7
Real growth (%)		23.60%	7.60%	3.30%	3.20%	3.20%

Source: IPPR analysis based on LCP (NHS) and Health Foundation (social care) modelling

This table focuses on RDEL and does not account for any uplift in capital investment. Between 2010 and 2019, there was a cumulative shortfall of £33 billion in the UK compared to EU14 levels of investment. As in section 3.1, we recommend catching up through an Infrastructure Restoration Fund worth £3.3 billion a year, over 10 years.

A long-term commitment to this level of funding would have several advantages. First, it would provide certainty. It has been well documented that the 'feast and famine' model of NHS funding in England is suboptimal: it leads to us spending on the wrong things in times of feast and cutting the wrong things in times of famine. Further, it would provide an opportunity to 'lock in sustainability' and to build public confidence in the future.

Future financing of adult social care has more factors at play. Not only are there rising demand pressures, as in healthcare, but there are more fundamental questions around entitlement and access. We outline projections for social care expenditure under several scenarios in figure 4.2.

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6   NHS England nominal figures are based on LCP projections of total government spending on healthcare, adjusted down by 16 per cent. This is because NHS England costs make up 84 per cent of total government spending on healthcare, according to analysis by the health foundation. LCP base their projections of government spending on healthcare on total spending figures from the DHSC annual report and accounts 2021/22.

FIGURE 4.2

Adult social care expenditure projections
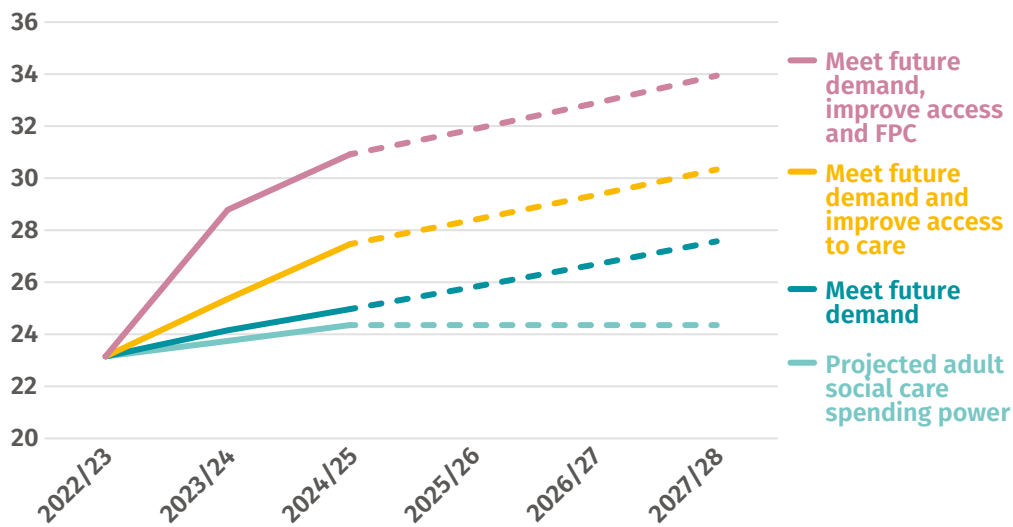
Source: IPPR analysis based on Health Foundation modelling

Note: *Meet future demand* means meeting the expected growth in demand from an ageing population. *Meet future demand and improve access* means accounting for an ageing population and increasing local authority budgets by 10 per cent to increase the amount of care people receive or to expand care to more people (or both). *Meet future demand, improve access and FPC* builds on the previous policy options but also adds a free personal care offer that is already present in Scotland. These costings are based on unpublished data from the Health Foundation, previous modelling can be found here. To model the cost of the free personal care we used the same method as the Health Foundation.

RAISING REVENUE FOR HEALTH AND SOCIAL CARE SERVICES

It is unavoidable, then, that sustainable and flourishing NHS and social care services – meeting the needs of people, society and the economy – will necessitate tax rises. This is likely to be true whether government pursues the reform plan outlined in this paper or not: indeed, we have shown that, without our reforms, even more money will be needed.

To deliver on the plans outlined in this report (including free personal for adult social care services), the Exchequer would need to find £58 billion in additional total revenue over the period 2023/24 to 2027/28. Considerable amounts of this could come from economic growth. If income growth, and therefore tax revenue, is higher than is currently forecasted for the coming years (table 4.2), much of the additional revenue needed for public services could be found.

TABLE 4.2

Higher economic growth can raise more revenue for public services

	2024/25	2025/26	2026/27	2027/28
Increase average earnings growth by 0.5% per annum	3.3	6.9	10.6	14.3
Increase average earnings growth by 1% per annum	6.8	13.9	21	28.4

Source: IPPR analysis using the IPPR tax-benefit model, DWP 2020 and OBR 2023b

However, as the future finances of health and care services cannot be solely dependent on economic growth – and indeed, future economic growth is conditional on good health and care – we do not account for potential future growth in our estimate of funding needed. If growth is better than expected, it may be possible to decelerate funding growth: but the performance of health and care services should not be conditional on GDP and earnings going up.

In terms of the specific taxes that could generate the necessary revenue, we do not make a single recommendation here. This is ultimately a political decision, and one that should be considered against other priorities by the Chancellor. Instead, we urge consideration of three criteria in establishing which taxes should be raised to fund public services:

- **A revenue test**: revenues raised must be commensurate to the revenue gaps we have estimated.
- **A stability test**: revenues should raise a similar and predictable amount each year.
- **A fairness test**: taxes raised to fund health and social care services should be progressive.

Table 4.3 estimates the revenue raising potential of a range of tax reforms that we believe largely meet those three tests .

TABLE 4.3
Revenue raising estimates for different tax reforms

	2024/25	2025/26	2026/27	2027/28
Increase all income tax rates by 2%	17.9	17.9	17.9	17.9
Increase all higher and additional income tax rates by 4%	13.3	13.3	13.3	13.3
Increase the higher contribution rate for employee National Insurance contributions from 2% to 12% for employees in line with the lower NICs contribution rate	21.4	22.2	23.1	24.4
Equalise the rates paid on Capital Gains Tax to those with income tax	16.7	21.2	19.7	19.9
Equalise the rates, and introduce a rate of return allowance	3.2	4.1	3.8	3.9

Source: IPPR analysis using the IPPR tax-benefit model, DWP 2020, OBR 2023c, Nanda et al 2019

Note: All analysis excludes rising income taxes for labour income in Scotland, which is devolved. Otherwise modelling increases all relevant rates of income tax across labour income, savings and dividend income. For capital gain tax modelling, estimates include a behavioural response. A rate of return allowance allows for some financial return for holding assets in line with bond yields. For further details and a detailed outline of the approach taken, see Nanda et al 2019.

There is little room left to procrastinate. We can either persist blindly with the status quo, spending more and getting less, or we can boldly finance the reform plan this report outlines to transform health, care and prosperity for the decade to come.

Despite profound challenges across the system today, there is still a future where health and care services work for public health and public finances. This report charts a course to get there. It is an important step on the journey to improve health and prosperity in this country. It is not the only step: health is a whole society responsibility and more must be done across the state and markets. Yet there is considerable scope to drive this agenda -- even lead this agenda -- by reforming health and care services. Undeniably, doing this this will take political courage. The dividend is not simply a healthier and more prosperous country, but a new political coalition sustained around an NHS that works again.

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