Public Inquiry Response:
"Long-term sustainability of the NHS"

To: The Long-term Sustainability of the NHS Select Committee

By: The Intergenerational Foundation

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The Intergenerational Foundation (www.if.org.uk) is an independent think tank researching fairness between generations with regard to such issues as housing, employment, taxation, education, the environment and health . IF's guiding principle is that policy should be fair to all – the old, the young and those to come.

Introduction:
The Intergenerational Foundation (IF) welcomes the opportunity to comment on the long-term sustainability of the NHS, and we would like to make the following points in response to this public inquiry:

1) Ageing and health costs share a complex relationship
The current debate surrounding the long-term sustainability of the NHS appears to be predicated on the questionable assumption that population ageing will automatically lead to higher healthcare costs. Although demographic factors have a strong influence on healthcare costs, this assumption overlooks the body of evidence which suggests that other factors may be of greater significance in determining the future sustainability of healthcare services. The assumption that healthcare costs inevitably rise in lockstep with rising longevity may also divert attention away from examining the precise set of causal relationships between these two phenomena, which appear to be more complex than is often assumed.

IF has recently undertaken a review of the research literature on healthcare costs, which revealed two points that are of relevance to the committee's inquiry. Firstly, most of the analysts who have examined the issue of rising healthcare costs have concluded that demographic change is only one contributory factor: Barker (2014) found that one of the most important explanations was that countries choose to spend proportionally more resources on healthcare as they become wealthier; Newhouse (1992) and Cutler (1995) showed that over 50% of the cost increases observed in America's healthcare system in the latter half of the 20th century were due to technological progress, and Spijker and MacInnes (2013) have modelled projections that show medical progress and the growing numbers of people of all ages living with comorbid medical conditions are likely to be biggest sources of pressure on the NHS in the future, rather than simply the increasing number of older people.

The second important point revealed by this literature review was that medical costs are highly concentrated among a small section of the population, even among the elderly. This was demonstrated by data from Kelly et al. (2015), displayed in Fig.1:

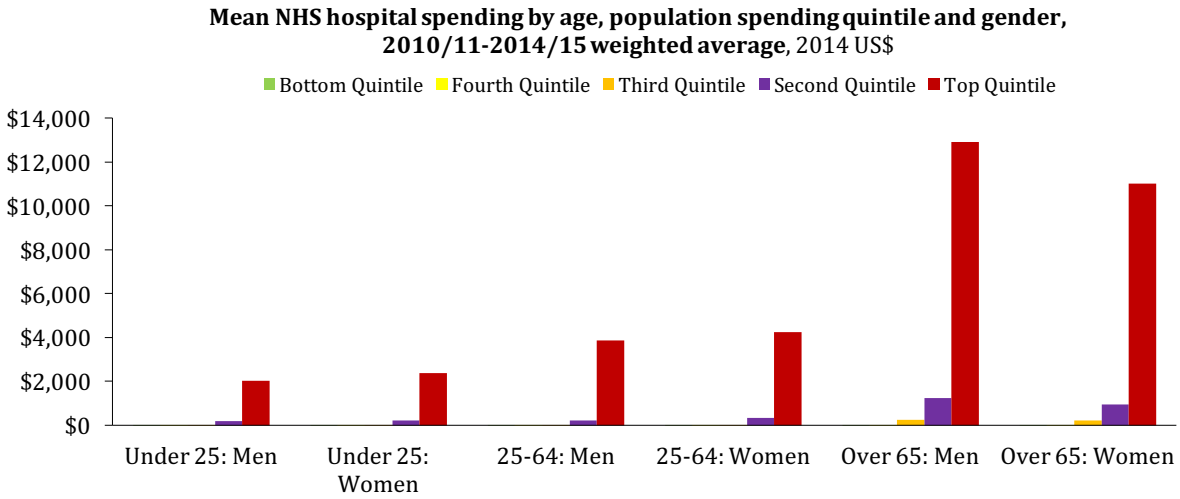

Fig.1 The distribution of patient expenditure in NHS hospitals, using data from Kelly et al. (2015)

Kelly et al. used data from NHS administrative records to show that, if you divide the English population into quintiles on the basis of how much they cost the NHS within a given year, then only the top fifth – the 20% of patients who had the highest expenditure – require any significant expenditure at all, and this holds true across all age groups. Remarkably, she found that in each of the years she analysed, 32% of all healthcare spending was being consumed by just 1% of the population. However, spending on the top quintile of patients was highest overall among the elderly; this is supported by other studies which have shown that healthcare spending on the typical individual rises rapidly during the final few months of their life.

The largest study of this kind, Cutler et al. (2007)'s longitudinal analysis of 10,000 American Medicare recipients (America's system of public health insurance for the elderly) between 1991 and 2009, concluded that "compression of morbidity" had taken place over this period: disability-free life expectancy had grown over twice as quickly as overall life expectancy, with the result that the typical person was living "longer but fitter" instead of "longer but sicker". These findings were echoed by Aragon et al. (2015), whose analysis of 15 years' worth of detailed patient-level spending records within the NHS was that spending on medical interventions in the year of death has risen more rapidly than overall medical spending; in other words, it is the number of people who are dying – rather than ageing per se – which could potentially endanger the long-term sustainability of the NHS.

What makes this research especially pertinent to the committee's inquiry is that Aragon et al. also observed that death at younger ages is actually more expensive, on average, than death at older ages, possibly because there are more potential treatment options which doctors and patients are willing to try to prevent someone from dying at a younger age. This suggests that further increases in longevity could actually *reduce* demands on the NHS over the longer term as long as a) disability-free life expectancy continues increasing more quickly than overall life expectancy, and b) variations in healthy life expectancy are addressed. On the latter point, investing in public health interventions which should increase healthy life expectancy (such as anti-obesity and anti-smoking campaigns) is likely to prove cost-effective over the long term.

2) Healthcare spending is really about *politics*, not demographics

Despite the evidence given above that healthcare costs and ageing have a complex relationship, it is inevitable that demand for healthcare services will continue rising in the UK because a) an older population will have higher mortality, b) more people of all ages will be surviving for longer with multiple comorbidities, and c) medical progress will continue advancing, broadening the

range of treatments which doctors can offer their patients.

However, it often seems to be assumed in the debate about NHS sustainability that rising *demand* will automatically lead to rising *costs*. A number of expert bodies, most notably the Office for Budget Responsibility (OBR), have produced projections of what NHS spending is likely to be in future years on the basis of changes in the demand curve for healthcare (which are themselves usually based on demographic projections of what Britain's population will look like in future). However, the narrow focus of such exercises on demographics means they run the risk of overlooking the reality that the most significant factor governing how much we spend on the NHS is politics. Throughout the history of the NHS, different governments have invested wildly different amounts in funding the NHS, depending on whether or not it was one of their major policy priorities (Fig.2):

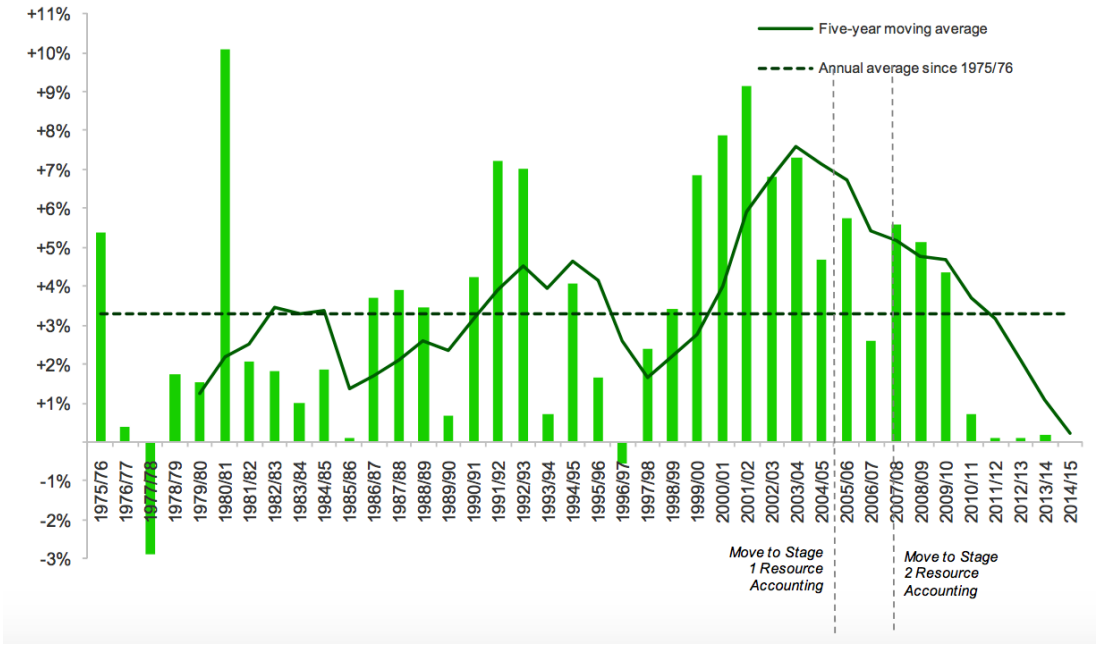

Fig.2 Annual percentage change in real terms NHS expenditure and planned expenditure in England, 1974/75 to 2014/15 (reproduced from Harker, 2012)

The inconsistent nature of these changes in NHS funding suggests that they have had only a cursory relationship with the actual demand for healthcare. Instead, they broadly reflect the political salience which different governments have placed on the NHS: there was clearly a very big shift in emphasis between the 1997–2010 New Labour administrations and the 2010–15 Coalition government, for example. International comparisons show that the UK is currently spending slightly less than the OECD average on healthcare (9.8% of GDP against 10.3%); there are other countries which have a similar level of development to the UK that spend significantly more or less (just among other European countries, Switzerland spends as much as 11.5%, while Iceland spends as little as 8.8%) (OECD, 2016).

IF is not in any sense ideologically committed to either shrinking or enlarging the state; these comparisons are included merely to suggest that there is no "right" level of GDP to spend on healthcare purely on the basis of our demographic profile. Many experts would argue that even if demand for healthcare was flat, more should still be spent on the NHS to improve the quality of service it offers. IF would argue that the NHS's current short-term financial problems have more to do with a lack of political will to provide an adequate level of funding to finance the levels of service which the public currently expects to receive than it does with healthcare being "unaffordable". We strongly believe that there needs to be a much more honest public debate

about what degree of service citizens expect the NHS to provide, and how much they are willing to spend on funding it, than is currently taking place. Overall, the key question governing the NHS's long-term sustainability is not "can supply keep up with demand?", but "can the political and public will to pay for the NHS be sustained?"

3) If the public wants higher spending on the NHS then higher taxes shouldn't fall on the young

A clue as to what the public's priorities are regarding the NHS has been provided by the Health module from the British Social Attitudes Survey (Appleby et al. 2016). This asked a representative sample of UK adults the question "If the NHS needed more money, which of the following do you think you would be prepared to accept?" and asked them to pick from a range of possible answers. Altogether, around 35% of respondents selected an answer which would involve raising more tax to pay for the NHS, although they were split between raising existing taxes and creating a new "NHS tax" with some degree of hypothecation.

Other opinion polls have consistently shown that the NHS is one of the leading priorities for additional government spending. Obviously, this suggests that the public wants a more a generously-funded NHS. If that is the most popular answer to the NHS's sustainability challenge, then IF believes very strongly that the targeting of any future tax increases should be as progressive as possible, which will include making wealthier older people pay their fair share of the burden rather than simply increasing taxes that fall mainly on those of working age, such as Income Tax and National Insurance. This is broadly the same argument that was made by the Barker Commission (2014b) in their proposals for a more sustainably funded health and social care service:

"Given that we are seeking to spread the burden of care more fairly, and given that on average the present generation of pensioners is relatively well off (both compared to past pensioners, and to the likely prospects for the present generation under 40), it seems right that many of the tax and other changes we propose should, at least initially, affect this group."

The Barker Commission suggested a range of measures which they estimated could raise an additional £3 billion per year, including making pensioners pay prescription charges, means-testing universal benefits and levying National Insurance contributions on people who work beyond State Pension Age. Some kind of new tax on wealth, especially the private property wealth that disproportionately belongs to the Baby Boomer cohort and is currently very lightly taxed, was also suggested as a longer-term source of additional funding (perhaps by lowering inheritance tax reliefs). More ambitiously, the Institute for Fiscal Studies has called for a review of the £19.5 billion of tax relief which is currently given each year to private pension savers, most of which regressively benefits the well-off. IF would support all of these recommendations, if the public is really in favour of spending more money to maintain current levels of service.

Conclusion

If you would like to learn more about the work of the Intergenerational Foundation or would like to organise a meeting to discuss the points we raise further, please contact:

Liz Emerson, Co-Founder
Email: liz@if.org.uk Mobile: 07971 228823

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