Evidence presented to the Health Select Committee: Public Expenditure in the NHS

Introduction:

The following is key evidence submitted as part of written evidence, or from witnesses to the committee in the Health Select Committee's inquiry into public expenditure in the NHS. All evidence in this report is already publicly available.

As reported in the The Times on March 11th 2015, at a Health Select Committee meeting on March 10th to work to agree a mutually acceptable report into NHS public expenditure, all members of the Opposition present at the meeting voted against attempting to work towards a report agreed on a basis of compromise.

In the public interest, this report publishes in one place the following information which was either submitted as evidence, available as part of the Select Committee's evidence online, or is already otherwise publicly available.

Summary:

The weight of evidence received by the committee showed:

1. There had not been an extension of charges or top-ups during the current parliament, and that these are not planned;
2. Very little increase in private sector providers since 2010;
3. A general trend of declining administration costs in the NHS;
4. No evidence that TTIP poses a threat to the NHS.

It should be noted that this information is only valid up until present day, and does not provide an indication of future trends.

On invitation, no member of the committee was able to provide evidence submitted to the committee that contradicted the evidence received as referred to above. However, the authors of this report are happy to welcome any factual evidence to the contrary given to the committee, which may have been overlooked.

Whilst interpretation of any evidence is open to the individual, the authors are concerned that this information, appropriately contextualised, should not be kept from the public for party-political reasons; and that this is contrary to public interest and the spirit and purpose of a Select Committee; and brings the Committee into disrepute.

The following report covers the evidence received on points 1-4, as well as additional issues raised which the authors felt worthy of note, which are raised in point 5. This is by no means comprehensive, as a full Select Committee report would have been, but is an attempt to outline issues of concern which the authors believe merit public airing and scrutiny.

1.Charges and top-ups

No evidence given to the committee could be found suggesting that since 2010 there either had been, or would be additional charges or top-ups to the NHS in the future, and all witnesses said this was undesirable.

The Five Year Forward View says:
"...nothing in the analysis (above) suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of Government" (p.38)

The authors are happy to acknowledge any evidence suggesting the contrary that can be found that was submitted to the Select Committee inquiry.

In terms of spending, the following chart illustrates English NHS spending from 2009-10 to 2015/16, real terms in 2014/15 prices (£bn)

Key Points:
1. Spending in total fell by 0.7%, and per head by 1.6% in 2010/11, but subsequently rose year on year to +1.3% and 0.8% respectively.

The Health Foundation

Table 1: English NHS spending from 2009/10 to 2015/16, real terms in 2014/15 prices (£bn)

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total DEL in cash terms (£bn)	98.42	100.42	102.84	105.22	109.72	113.30	116.36
Total DEL excluding depreciation in real terms (£bn)	108.84	108.06	108.72	109.41	112.03	113.30	114.75
Annual change in Total DEL spending, excluding depreciation, in real terms		-0.7%	0.6%	0.6%	2.4%	1.1%	1.3%
Total DEL excluding depreciation, per head, in real terms (£)	2,085	2,053	2,047	2,045	2,081	2,089	2,101
Annual change in Total DEL expenditure per head, in real terms		-1.6%	-0.3%	-0.1%	1.7%	0.4%	0.6%

Source: PSNA Sector Expenditure Analysis 2014 (HM Treasury); 2014 Autumn Statement (HM Treasury). Spending per head based on author's calculation using Office for National Statistics population estimates and correspondence with HM Treasury as of 13/01/2014.

http://image.slidesharecdn.com/slidepack-nhsfinancesbriefingchartsandtables-150122104636-conversion-gate01/95/nhs-finances-the-challenge-all-policital-parties-need-to-face-charts-and-tables-24-638.jpg?cb=1423821112

2. Private Providers – the numbers:

Evidence submitted to the committee demonstrated that private provision in the NHS has increased, but the increase is modest and has slowed since 2010.

Simon Stephens told the committee: ...

"about 6p in the pound is being spent with private providers – independent sector providers. About another 3p... relates to payments to local authorities, charities and the voluntary sector."

Key Points:

1. Independent provider admissions has increased by 0.57% in all admissions, and by 0.9% in elective admissions since the introduction of the Health and Social Care Act.

2. The percentage of Foundation Trust income from private patients as a percentage of the total has fallen from 1.5% in 2005/6 to 0.9% in 2013/14.

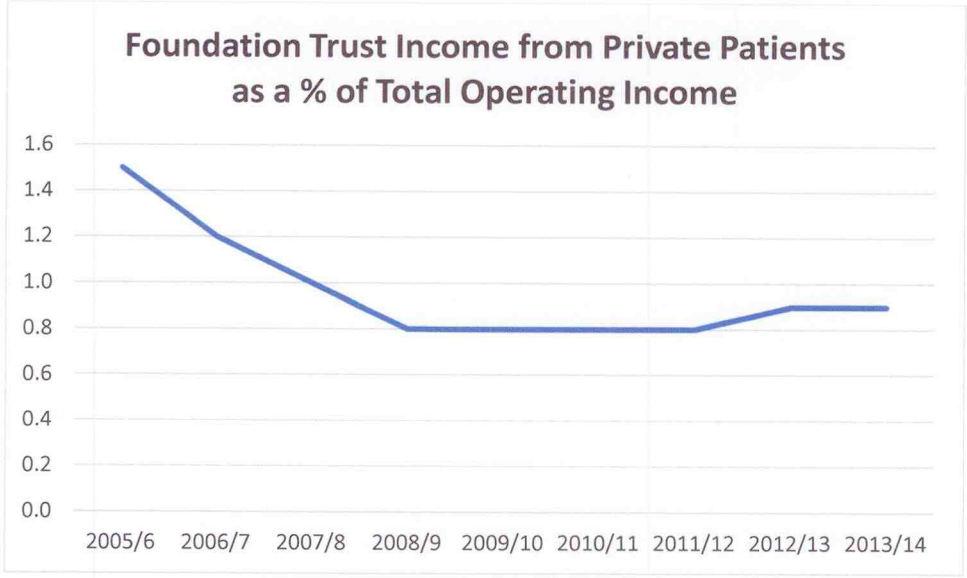
The following is taken from Hospital Episode Statistics Data (HES).

Elective Admissions		
Year	Independent Provider	Public Provider
11/12	3.90%	96.10%
12/13	4.34%	95.65%
13/14	4.80%	95.20%
All admissions		
11/12	2.17%	97.82%
12/13	2.44%	97.56%
13/14	2.74%	97.26%

(extract from Hospital Episode Statistics (HES) Data)

The following is from figures taken from NHS Foundation Trusts' publicly available annual accounts.

	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Private patient income	98.4	124	165.2	190.1	223.5	252	303.7	358.4	389.4
Total operating income	6,762.4	10,143.4	16,162.2	22,769.1	27,890.6	30,431.8	35,928.4	38,940.5	41,443.8
Private patient income as a % of total operating income	1.5%	1.2%	1.0%	0.8%	0.8%	0.8%	0.8%	0.9%	0.9%


Foundation Trust Income from Private Patients as a % of Total Operating Income
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0
2005/6
2006/7
2007/8
2008/9
2009/10
2010/11
2011/12
2012/13
2013/14

3. Administration Costs in the NHS:

The following table is an extract from The Health Foundation, Funding Overview, 'Historical Trends in the UK' (January 2015).

Key points:

i) Expenditure on administration as a percentage of total spend has fallen from 5.1% in 2009/10 to 2.7% in 2015/16.

ii) Actual expenditure has fallen from £5.57bn to £3.08bn

The authors emphasise that there are still areas of significant concern in administration costs, including the re-hiring of individuals under different structures, at unnecessary excess cost to the tax-payer (the so-called 'revolving door'), issues of excessive hiring of management consultants, and note there remain significant improvements to be made. However, the overall fall in administration costs must nevertheless be noted, and have accelerated since 2012. The Health and Social Care Act was passed in 2012.

Administration costs

The cost of NHS administration has fallen considerably during the current parliament. From 2009/10 to 2013/14, administration costs fell by an annual average of 13.5%, from £5.6bn to £3.1bn. The largest drop in spending was a fall of 36% between 2010/11 and 2011/12. This was a result of the 2010 Spending Review, which instructed the Department of Health to reduce administration costs by one third in real terms by 2014/15 against a 2010/11 baseline.[6] This target is likely to be reached even though administration costs are set to rise to £4.1bn in 2014/15, representing a 29% reduction compared to 2010/11. In 2015/16, administration costs are set to be reduced by a further 26% in just one year (see table 2).[1]

Table 2: NHS administration cost from 2009/10 to 2015/16, real terms

	NHS Administration cost £bn	Total spend £bn	Admin cost as a percentage of total spend	Annual change
2009/10	5.57	108.83	5.1%	-
2010/11	5.84	108.06	5.4%	4.9%
2011/12	3.74	108.72	3.4%	-35.9%
2012/13	3.82	109.41	3.5%	1.9%
2013/14	3.12	112.03	2.8%	-18.4%
2014/15	4.13	113.30	3.6%	32.6%
2015/16	3.08	114.75	2.7%	-25.5%

Source: *Public Sector Expenditure Analyses 2014* (HM Treasury); Correspondence with HM Treasury as on 13/01/2015.

http://www.health.org.uk/public/cms/75/76/313/5368/Funding%20overview_NHS%20finances.pdf?realName=sq6CCu.pdf

4. TTIP: The evidence received:

No factual evidence suggesting a threat to the NHS from TTIP could be found in the evidence submitted to the Health Select Committee.

In a letter from Jean-Luc Demarty, the Director General, to the Chair of the Health Select Committee, and publicly available, the position was clarified in some detail as following.
"Therefore, in effect all publicly funded public health services are protected in EU trade agreements, and this approach will not change for TTIP."

(Bold added) Full letter in annex.

"1. Is it the EU's negotiating position that publicly-funded health services should be excluded from TTIP?
This is the effect of the EU's approach to public services in all trade negotiations since the General Agreement on Trade in Services (GATS) in 1995. In the case of TTIP, it is clear in the negotiating directives given to the Commission by the Member States. This says that the EU must preserve the quality of its public utilities and that services supplied in the exercise of governmental authority should be excluded from the agreement. At the same time all bilateral agreements take GATS as a starting point. This means as follows:
• We explicitly exclude services supplied in the exercise of governmental authority: this exception is valid and is significant for a number of public services (e.g. justice, policing).
Beyond this, in all its trade agreements the EU then takes a broad horizontal reservation which reserves the right to have monopolies and exclusive rights for public utilities in EU Member States at all levels of government.
In addition, the EU retains very broad sectoral reservations in its trade agreements for public services (public education, public health and social services, and water). This means that public authorities at all levels do not have to treat foreign companies or individuals the same way as EU ones and do not have to provide access to their markets.
It is also worth explaining that even without the above reservations and exceptions, the EU trade agreements leave EU governments at all levels free to regulate all services sectors in a non-discriminatory manner. For example, they are free to deciding on (i) the licencing requirements necessary to be allowed to provide a particular service or (ii) the quality standards that suppliers have to meet.
Therefore, in effect all publicly funded public health services are protected in EU trade agreements, and this approach will not change for TTIP."

The committee received no factual evidence which contradicted the above statement. However, the authors note that matters such as these ultimately can be determined in the courts, although research indicates that a decision has never previously been lost or overturned in the UK.

5. Additional Issues:

i) The Five Year Forward View:
In addition to questions and concerns over the content of the five year forward view, questions were raised over whether a five year forward view is sufficient, and whether a longer-term plan needed to be scoped out, in order to meet long term challenges.

ii) The Better Care Fund
Concerns were raised over the origin of funding for the Better Care Fund; the short-term nature of the plan, and its possible de-stabilising effect from funding from health.

These are by no means an exhaustive list of issues and questions raised which would have been given greater analysis in a full report. However this document is designed to make easily accessible, in the public domain, evidence submitted to the Health Select Committee in its inquiry into public expenditure in the NHS, which is already currently publicly available in less accessible format.

More evidence on points i) and ii) above can be accessed on the Health Select Committee Website - http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/public-expenditure2/?type=Oral#pnlPublicationFilter

Conclusion:

The factual evidence received by the committee during this inquiry showed:

1. There had not been an extension of charges or top-ups, and that these are not planned
2. Very little increase in private sector providers
3. A general trend of declining administration costs in the NHS
4. No evidence that TTIP poses a threat to the NHS.

It should be reiterated that this report does not, and could not anticipate future trends.

The authors regret the necessity of this report and believe that politics should be removed from the NHS funding debate. We very much hope that in future an open, evidence-based and honest conversation can be held about the NHS and its funding, as befits Members of Parliament, and Health Select Committee members, performing their public duty to be honest with the electorate.

Robert Jenrick MP
Charlotte Leslie MP
Andrew Percy MP

March 11th 2015

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EUROPEAN COMMISSION
Directorate-General for Trade

The Director General

Brussels, 11 DEC. 2014
TRADE/JLD

Dear Dr Wollaston,

Thank you for the note of 3 December 2014 including a number of questions from members of the House of Commons Health Committee about the Transatlantic Trade & Investment Partnership (TTIP) negotiations.

I am pleased to enclose our responses to your questions below.

1. Is it the EU's negotiating position that publicly-funded health services should be excluded from TTIP?

This is the effect of the EU's approach to public services in all trade negotiations since the General Agreement on Trade in Services (GATS) in 1995. In the case of TTIP, it is clear in the negotiating directives given to the Commission by the Member States. This says that the EU must preserve the quality of its public utilities and that services supplied in the exercise of governmental authority should be excluded from the agreement. At the same time all bilateral agreements take GATS as a starting point. This means as follows:

- We explicitly exclude services supplied in the exercise of governmental authority: this exception is valid and is significant for a number of public services (e.g. justice, policing).

- Beyond this, in all its trade agreements the EU then takes a broad horizontal reservation which reserves the right to have monopolies and exclusive rights for public utilities in EU Member States at all levels of government.

- In addition, the EU retains very broad sectoral reservations in its trade agreements for public services (public education, public health and social services, and water). This means that public authorities at all levels do not have to treat foreign companies or individuals the same way as EU ones and do not have to provide access to their markets.

It is also worth explaining that even without the above reservations and exceptions, the EU trade agreements leave EU governments at all levels free to regulate all services sectors in a non-discriminatory manner. For example, they are free to deciding on (i) the licencing requirements necessary to be allowed to provide a particular service or (ii) the quality standards that suppliers have to meet.

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Therefore, in effect all publicly funded public health services are protected in EU trade agreements, and this approach will not change for TTIP.

2. **What would be the consequences for the provision of NHS services, including hospital, primary care and community services, if they were not specifically excluded from TTIP?**

As above, in effect all publicly funded public health services, including NHS services, will be protected in TTIP.

3. **Does the definition of public-funded Health Services include private companies who run such services paid for from public funds? Does it include third sector organisations?**

Yes, as long as the services are publicly funded, it does not matter how they are delivered.

4. **The Chief Executive of NHS England quoted Sr Garcia Bercero to the Health Committee on Tuesday 28 October 2014, saying "We can already state with confidence that any ISDS provisions in TTIP could have no impact on the UK's sovereign right to make changes to the NHS. I hope that this information clearly demonstrates that there is no reason to fear either for the NHS as it stands today, or for changes to the NHS in future, as a result of TTIP." Can you comment on this statement? Do you agree with this interpretation?**

Yes. This statement remains perfectly correct.

5. **In your letter of 8 July to John Healey, you say that the experience of negotiating the EU's trade agreement with Canada provides an example of how the rights of Member States to change policy without detriment can be included in such agreements. Could you explain how that has been achieved in the Canadian example, and how this might be relevant to TTIP?**

See the response to question 6 below.

6. **Can you explain what is meant by positive and negative listing, and which one is relevant for the TTIP negotiations?**

The choice of listing is a technical point, as the same outcomes can be achieved through either method.

Under the positive approach, the Parties first define sectors where they want to take commitments, i.e. to open markets or to bind the existing level of liberalisation. In the second step, the Parties can take reservations from the undertaken commitments.

Under the negative approach, there is no first stage, but only the second one. This means that all sectors are committed but the Parties can take reservations.

Furthermore, a negative list includes two Annexes with reservations. Annex 2 includes measures to which no ratchet mechanism applies. "Ratchet" is a mechanism which captures future autonomous liberalisation and does not allow backtracking from it. In simple words, this means that if a Party of an agreement liberalises a sector this becomes automatically binding in future, and the Party cannot revert to the previous level of openness.

The EU practice is for all reservations related to sensitive sectors such as public services to be included in Annex 2 so that the ratchet mechanism does not apply.

7. **Is there any opportunity after the exclusion of any public services from TTIP for other countries to challenge that exclusion and, if so, what is the process?**

No.

8. **Is there any action that a Member State can take outside the negotiation process to ensure that health or any other public services are exempted from the provisions of TTIP or any other trade agreement?**

As above, in the Commission's view there is no need to take any further action to ensure this result, as public services are always protected in EU trade agreements.

9. **The National Institute for Health and Care Excellence (NICE) undertakes appraisals of new drugs and health technologies to assess whether they should be provided through the NHS using a custom designed cost-benefit analysis process. Is it possible that decisions not to authorise a drug or other treatment made through that process could be challenged under TTIP?**

No, this is not part of the negotiations.

10. **If a private, charitable or social enterprise provider is running a service, could that be taken back into public ownership at a future date and what would be the procedure for doing so in order to avoid penalties?**

Yes. As long as contractual and property rights are respected (as they already must be under EU and national law), it is completely up to the public authorities whether to bring a service back into the public sector. TTIP would not have an impact on public

authorities' right to reverse decisions to contract provision of services to an external operator, whether that operator is private, charitable or a social enterprise.

I trust that this information will assist you and the Committee in your deliberations about TTIP. Should you require any further detail, please do not hesitate to be in touch.

Yours sincerely

Jean-Luc DEMARTY