

# The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015

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**David Cameron promised in 2010 to “cut the deficit, not the NHS”. But how have the Coalition’s policies – including health reforms which are widely viewed as going beyond election commitments – impacted on health?**

- While the Coalition has ‘protected’ health relative to other expenditure areas, growth in real health spending has been exceptionally low by the standards of previous governments. Average annual growth rates have lagged behind the rates that are deemed necessary to maintain and extend NHS care in response to increasing need and demand.
- Forecasts warn of an NHS ‘funding gap’ as wide as £30bn by 2020/21 unless the growing pressures on services are offset by productivity gains and funding increases during the next Parliament.
- Major health reforms emphasising decentralization, competition and outcomes have been implemented. These have transformed the policy landscape for the commissioning, management and provision of health services in England. The overall framework for political responsibility and accountability for health services in England has also changed.
- Minimum care standards, inspection and quality regulation have been revised and strengthened following the Mid-Staffordshire NHS Foundation Trust Public Inquiry.
- Key indicators point to increasing pressure on healthcare access and quality. These include indicators on patient access to GPs, accident and emergency services and cancer care. Public satisfaction with the NHS is considerably lower than a peak reached in 2010.
- The UK’s ranking on OECD “international league tables” remained disappointing for some health outcomes including female life expectancy and infant mortality.
- Suicide and mental health problems remained more prevalent following the 2007 economic crisis.
- Health inequalities remained deeply entrenched. The difference in average life expectancy between men living in the poorest and most prosperous areas of England is nine years, and six years for women.

### What were the Coalition's aims and goals?

In the Coalition Agreement, the Conservatives and Liberal Democrats promised to increase public expenditure on health in every year of the Parliament. The Programme for Government pledged to maintain an NHS that is free at the point of use, and based on need, not ability to pay. Other commitments included a promise to end "top-down re-organisations of the NHS that have got in the way of patient care". Plans were announced to free the NHS from political micro-management; to reduce administration costs; to "enable" GP commissioning; to introduce an independent NHS Board; and to increase democratic participation and accountability.

The Coalition argued in its Programme for Government that Conservative thinking on markets, competition and choice, combined with the Liberal Democrat's emphasis on advancing democracy, would create a radical vision for the NHS and that their shared plans were "more radical and comprehensive than our individual manifestos." Plans for health were set out in the context of a broader vision of a radical, reforming government emphasising the decentralization of power and the creation of a "smaller" / "smarter" state. Plans for restructuring public services were taken forward in the Coalition's "Open Public Services" White Paper. This set out the Coalition's new public service model based on decentralization, competition and outcomes.

### What did the Coalition do?

#### *Health reforms*

The Health and Social Care Act (2012) introduced major reforms which have transformed the policy landscape for health services in England. The overall framework for political responsibility and accountability for the NHS has been changed. Reforms emphasising decentralization, competition and outcomes have been simultaneously implemented and have resulted in new arrangements for health services commissioning, management and provision. The new decentralized organisational structure includes an independent NHS Board; the abolition of strategic health authorities and the existing Primary Care Trusts; and the creation of GP-led clinical commissioning groups (CCGs). On competition, the Act applied a "qualified any provider" rule to commissioning, intended to promote competitive tendering between public, private and third sector providers. In the absence of further reforms, it is widely anticipated that this rule will result in a considerable expansion of the provision of publicly financed health services by non-NHS providers over time. Monitor was given new responsibilities as an economic regulator and to combat anti-competitive behaviour.

On public health, local authorities and new Health and Wellbeing Boards were given a major new role. The public health budget was devolved and a new public health premium was announced. The Health and Social Care Act (2012) established new legal duties to reduce health inequalities. Emphasis on "outcomes" within the new policy landscape is reflected in the new NHS Outcomes and Public Health Outcomes Frameworks.

#### *Minimum standards, inspection and regulation*

In 2010, the Coalition established a public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid-Staffordshire Foundation NHS Trust. This followed an inquiry set up by Labour under the same Chair, Robert Francis QC, into serious failings in patient care. The Public Inquiry concluded that there had been a widespread failure of the healthcare system, including regulatory as well as management failure, and put forward two hundred and ninety recommendations with the aim of ensuring the effective enforcement of fundamental standards of care in the future, including minimum standards of care and quality standards. The Coalition moved to strengthen inspection and minimum standards following the Inquiry, accepting the majority of these findings. New minimum standards of care were introduced in 2015. Other measures included a new "duty of candour"; the "friends and family" test; strategies to promote safety, dignity and respect; and revisions to the NHS Constitution. A Chief Inspector of hospitals was appointed and the Care Quality Commission (CQC) introduced a new inspection model. The National Institute for Health and Care Excellence (NICE) issued guidelines on "safe" nursing levels in hospitals. A review of hospitals with higher than expected mortality ratios, led by Sir Bruce Keogh, subsequently led to 11 trusts being put into special measures by Monitor / the NHS Trust Development Authority.

### Other measures

The Government responded to estimates that the NHS needed to make £20bn in efficiency savings between 2011 and 2014/15 with the Quality, Innovation, Productivity and Prevention Initiative (QIPP). The measures adopted included wage restraint policies, cuts to administration budgets and cost savings on drugs and procurement. Comprehensive Spending Reviews announced transfers of the NHS budget to local authorities and pooled budgeting for integrated health and local authority social care services. Other prominent policies included powers for the Health Secretary to close local hospital services; and healthcare charges for arriving migrants and foreign nationals from outside the EU. Plans for minimum alcohol pricing in England were dropped in 2012 but a ban on below cost selling was introduced in 2014. In late 2014, a mental health strategy paper promised the introduction of waiting time standards from 2015.

### How much did the Coalition spend?

Across the UK as a whole, spending on health grew from £116.9bn in 2009/10 to £120.0bn in 2013/14, (in 2009/10 prices), a real terms increase of 2.7 per cent. Cuts of 0.1 per cent and 1.1 per cent in the first two years were followed by real increases of 1.5 per cent and 2.4 per cent in the subsequent two years. The average annual growth rate was 0.7 per cent a year over the same period. In England, real growth in expenditure on the NHS over the period 2009/10-2014/15 is estimated as 4.2 per cent. The average annual growth rate was 0.8 per cent (that is, a small but nevertheless positive figure - Table 1). Year on year growth was negative in 2009/10-2010/11 but positive for each year 2011/12-2014/15 (which is important, given the pledge in the Coalition Programme for real year on year increases in each year of the Parliament).

Real average annual expenditure growth has therefore been positive but exceptionally low. Furthermore, average annual growth rates have lagged behind the rates that are deemed necessary to maintain and extend NHS care in response to increasing need and demand. An estimated minimum 1.2 - 1.5 per cent annual increase in real funding is estimated as necessary just to keep pace with demographic pressures. The extent of the gap between real expenditure growth on the one hand, and need and demand pressures on the other, depends on a complex range

**Table 1: Historically low annual real growth in public spending on health is witnessed under Coalition (UK)**

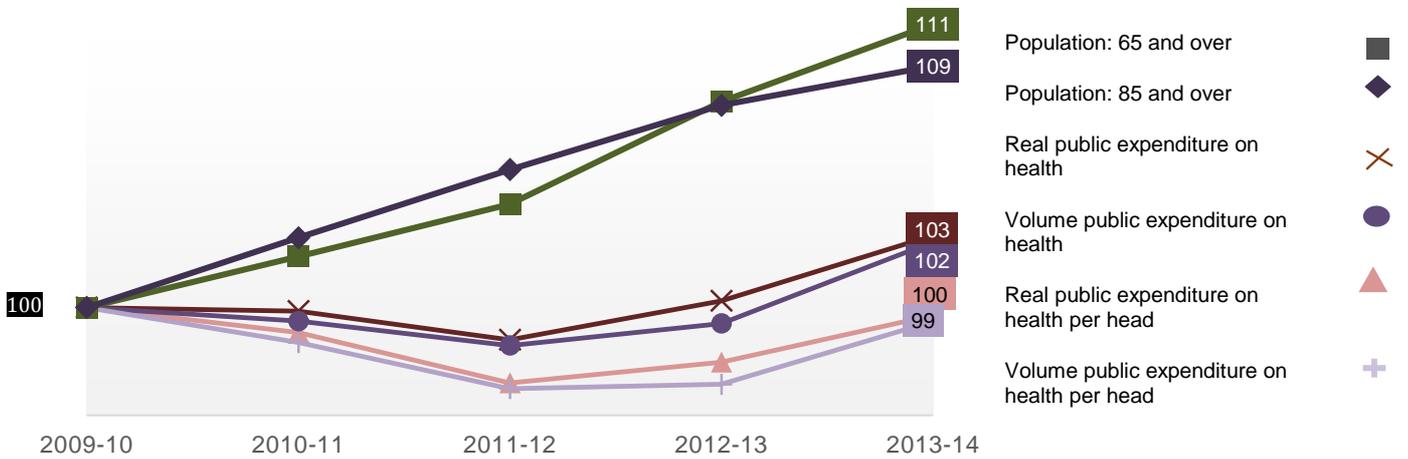
Average annual growth rate (% , real terms)	
Historical trends	
Historical trend (1950/1-1996-7)	3.6
Historical trend (1950/1-2009/10)	4.0
Conservative (1979/80-1996/7)	
Thatcher (1979/80-1982/3)	3.2
Thatcher (1983/4-1986/7)	2.4
Thatcher / Major (1987/88-1991/2)	3.3
Major (1992/3-1996/7)	3.8
Labour (1997/8-2009/2010)	
1st term (Blair: 1997/8-2000/1)	4.4
2nd term (Blair: 2001/2-2004/5)	8.6
3rd term (Blair/ Brown: 2005/6-2009/10)	
- Blair (2005/6-2006/7)	4.4
- Brown (2007/8-2009/10)	4.5
Coalition (2009/10 to 2013/14), UK	
Coalition (2009/10 to 2013/14) England	0.9
Coalition (2009/10 to 2014/15), England, DEL, including planned expenditure (Budgeting Framework, plans as of July 2014)	0.8

**Sources:** Authors calculations using data in HM Treasury (2014) and (Harker, 2011). For further details of data sources and notes: see table 1, full health paper.

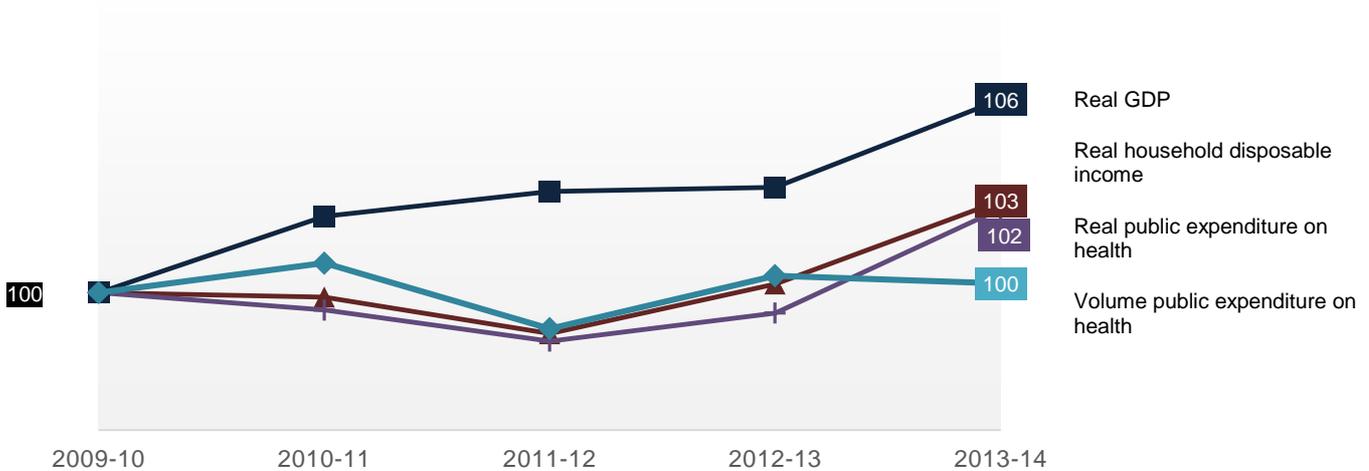
of factors, including non-demographic pressures, technological change and offsetting productivity increases. However, real average annual growth rates for health over the Parliament are notably low when compared to these rates. Forecasts paint a bleak picture regarding a growing funding gap within the NHS during the next five years. As analysed by the Nuffield Trust, Monitor and in the NHS’s Five-year Forward View, this gap could reach £30bn by 2020/21 unless offset by productivity gains and funding increases.

In the UK as a whole, growth in real and volume expenditure on health between 2009/10 and 2013/14 was less than the modest increase in GDP. It also lagged behind 10.5 and 9.0 per cent increases respectively in the population aged over 65 and over 85. There was no growth in real expenditure per capita over this period (that is, in expenditure adjusted for general inflation) whilst volume growth per capita (adjusted for NHS specification inflation) was just negative (Figure 1).

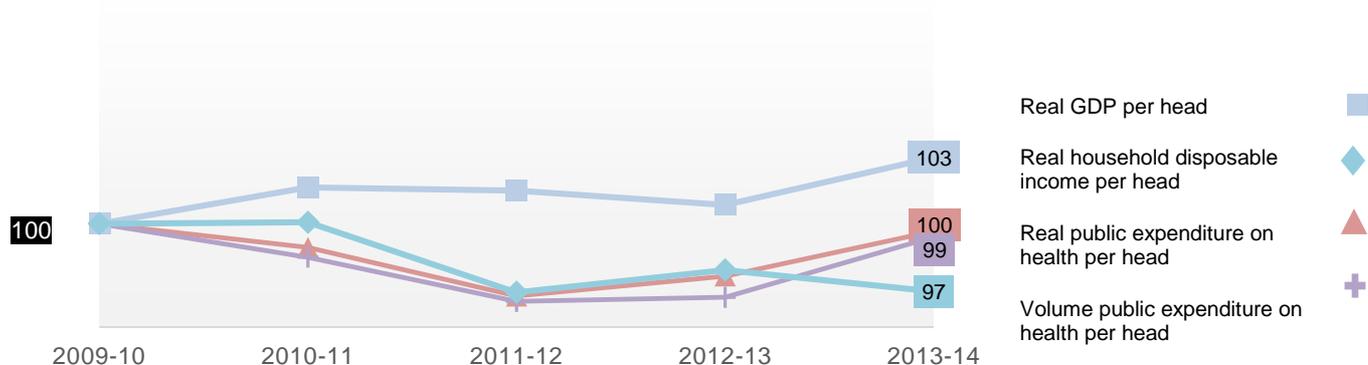
**Figure 1a**  
Growth of Public Expenditure on Health vs. Growth of Population (UK)



**Figure 1b**  
Growth of Public Expenditure on Health vs. Growth of GDP & Household Income (UK)



**Figure 1c**  
Growth of Public Expenditure on Health vs. Growth of GDP & Household Income  
(UK, per capita)



**Sources:** Authors calculations using data in HM Treasury (2014), DH (2014b) and GDP deflators from the same edition; blue Book 2012 online resource; and ONS Population estimates. For further details of data sources and notes: see table 1, full health paper Figure 11.

*Healthcare indicators point to increasing pressures on access and quality, whilst satisfaction with the NHS declined*

A number of key healthcare indicators point to increasing pressures on access and quality. Although still just meeting the operational standard set in England for waiting times between GP referrals and treatment, the proportion of patients treated within 18 weeks fell between 2010 and 2014. The percentage of individuals for whom the (revised) A&E target was met fell from 98.4 per cent in the first quarter of 2010-2011 to 95.1 per cent in the first quarter of 2014-15, with particular pressure evident in the last quarter of 2012-13, when the target was breached (94.1 per cent). Major A&E departments (as a group) have failed to meet this target consistently since the third quarter of 2011-12 (with the exception of Q2 2012-13). Continuing pressure on the A&E departments is evident this winter, with weekly data showing that in the first week of December 2014, 91.8 per cent of patients were seen in four hours - the worst performance since April 2013. More pressure on cancer waiting lists is also evident whereby provider-based figures show a drop during 2013-14 in the proportion of patients receiving definitive treatment within 62 days of an urgent GP referral, breaching the operational standard of 85 per cent during three consecutive quarters between January and September 2014. Overall public satisfaction with the NHS, measured by the annual British Social Attitudes Survey fell from a high of 70 per cent in 2010 to 60 per cent in 2013.

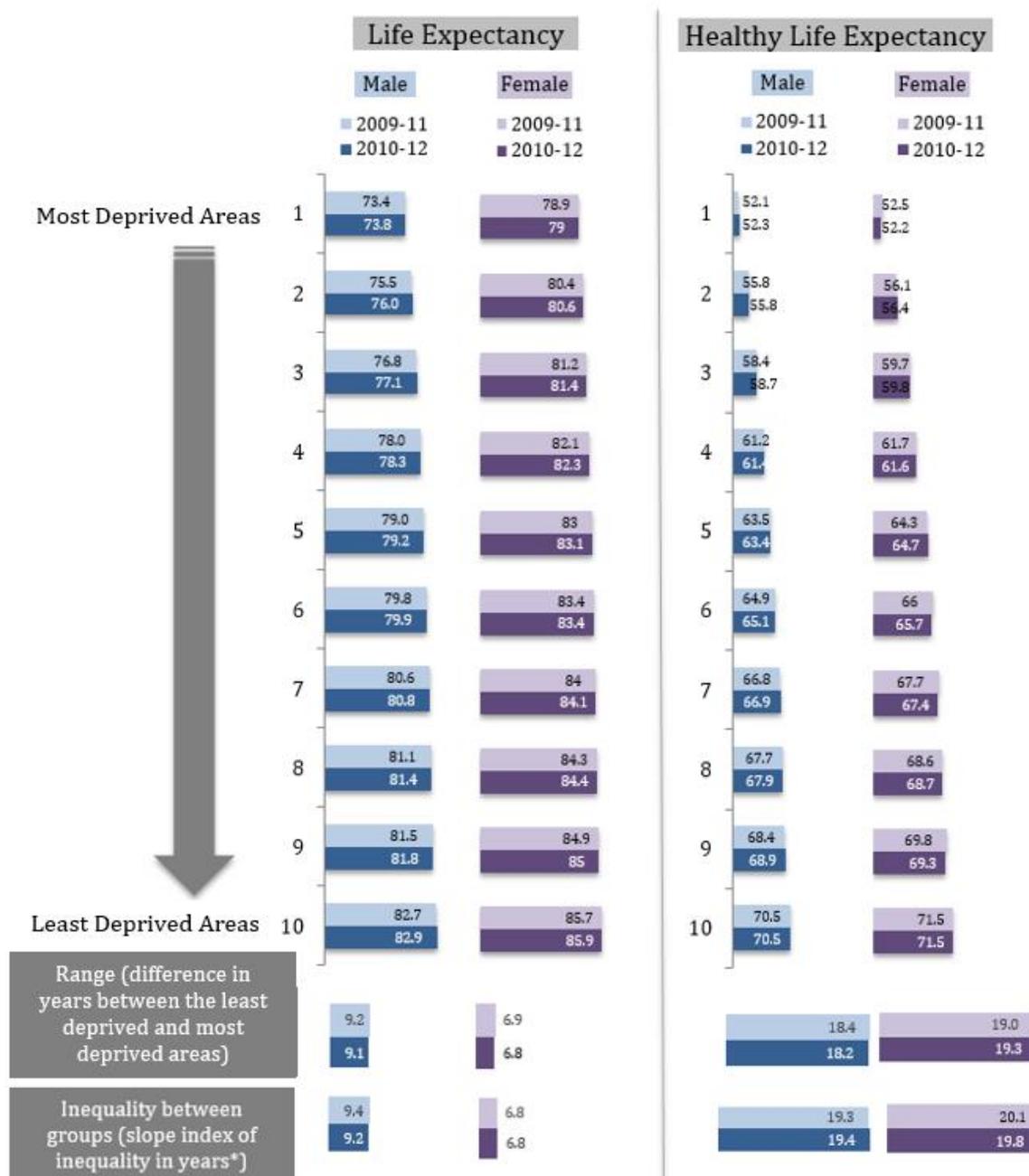
*Obesity, smoking and alcohol consumption remained key concerns, and health inequalities remained deeply entrenched*

Adult obesity continued to increase over the period although signs of improvement amongst the youngest children continued to be evident. There were few signs of an “Olympics effect” on physical exercise rates. Overall smoking prevalence continued to decline between 2009 and 2012 in England. However, in Great Britain, there were increases between 2011 and 2012 and the social class gap widened. More positively, the percentage not meeting alcohol recommendations improved.

The Public Health Outcomes Framework for England includes two overarching indicators to monitor progress in preventing premature deaths: a comparison of life expectancy between different groups, and an assessment of “healthy” life expectancy. Averaged over three-year periods, the figures available illustrate that health inequalities are deeply entrenched. Figure 2 gives figures for 2009-11 and 2010-12 for men and women living in more or less deprived areas (divided into deciles). It shows a continuing gap of nine years in average life expectancy between men living in the poorest and most prosperous areas and more than six years for women. The gap for “healthy” life expectancy is wider still at 18 years for men and 19 years for women.

The UK’s ranking on OECD “international league tables” remained disappointing for some health outcomes including female life expectancy and infant mortality.

Figure 2: Inequalities in life expectancy and healthy life expectancy between those living in the most deprived areas (1<sup>st</sup> area deprivation decile) and least deprived areas (10<sup>th</sup> area deprivation decile) (UK, 2009 – 2012)



Source: ONS (2014f Reference table, 2014t). Notes: see notes attached to full health paper, table 17.

*Suicide and mental health problems remained more prevalent following the economic crisis*

The incidence of suicide and poor mental health appear to have increased in period coinciding with the economic crisis and downturn. Following improvement in age standardised suicide rates for England going back to 1981, there was a significant rise between 2007 and 2012. The increases were particularly notable among men, with the rate for men aged 45-59 rising from 19.4 to 25 deaths per 100,000 population. North West and North East England both had relatively high rates with increases over the period (though neither of these increases were statistically significant).

Based on data from the Health Survey for England, the overall percentage identified as at risk of poor mental health increased by 1.6 per cent between 2007 and 2012 with a particularly striking increase amongst women. Notable increases are observed amongst middle aged men and women, especially men in the 40-44 and 49 age bands, with

4.4 and 3.6 percentage point increases respectively. Amongst women, the biggest rises were amongst those aged 16-24, 40-44 and 55-59. Social inequalities were marked with prevalence of mental health risk especially amongst individuals who report a longstanding illness or disability compared to those who do not; amongst people from the Pakistani/Bangladeshi and African/Caribbean/Black ethnic minority group compared to those who are White; and amongst individuals from the poorest households relative to those with higher household equivalent income.

There is evidence that downturn and crisis may have put downward pressure on the consumption of fruit and vegetables. The social determinants approach recommended in the Marmot Review (2010), and reflected in the new Public Health Outcomes Framework, puts emphasis on underlying social determinants of health such as poverty, unemployment, long term receipt of benefits, early years education and housing conditions. The 2014 Update of the Marmot Indicators identified deterioration in relevant social indicators since the downturn and crisis. It also pointed towards poor children's development and insufficient income to live a healthy lifestyle as likely causes of health inequalities in the future.

### Conclusions

It is early days in terms of the overall evaluation of the impact of the health reforms. In the medium term an evidence base will be required to determine what impact different factors such as organisational decentralization, increased competition, emphasis on outcomes, new inspection regimes, duties to address health inequalities and the new arrangements for public health are having on access to healthcare and the quality of provision, as well as on improving health outcomes and addressing health inequalities between different social groups.

#### *Continuity or break with the past?*

The NHS remains free at the point of delivery, based on need not ability to pay. No major changes were made by the Coalition to its financing model and the NHS continues to be funded through general taxation and National Insurance contributions. Challenges elsewhere to the 'right to health' – such as high out-of-pocket payments and healthcare depending on ability to afford private insurance – continue to be avoided in the UK. The private healthcare sector – beyond services commissioned by the public sector – is limited. Private spending on healthcare remains low as a proportion of GDP and expenditure on private medical insurance has remained stable.

There are continuities between the Coalition's health reforms and those undertaken by Labour. The previous Government's programme included decentralisation policies (such as the creation of autonomous foundation trusts), commissioning based on a purchaser-provider split, and practice based GP commissioning. Competition and 'patient choice' policies extended the use of private treatment centres to provide NHS services. There was an emphasis on achieving greater democratic participation and accountability.

However, other factors suggest a break with the past and a significant and deeply entrenched new policy landscape for health services in England. There has been a major shift in commissioning, management and delivery models. Specific changes pointing to a discontinuity with previous arrangements that are cited in the literature include: the extent of the shift towards a decentralized organisational structure; the likely magnitude of the shift towards private provision of publicly financed healthcare services in the future; the possibility of hospital trusts retaining 49 per cent of private patient revenue; the introduction of a trust failure regime; the central role of competition brought about by the "any qualified provider" rule; emphasis on anti-competitive behaviour; and the potential application of international competition rules.

Furthermore, whereas reforms under Labour were introduced incrementally against the backdrop of unprecedented growth in resources, major health reforms have been implemented under the Coalition in an extremely short time period against a backdrop of a real resources squeeze. The speed and scale of the reforms as well as their compulsory (rather than opt in) nature has resulted in considerable controversy, costs and organisational upheaval, as well as creating a myriad of new and untested bodies and systems. Multiple reforms have been implemented simultaneously. Meanwhile, growth in real public expenditure on health has lagged behind need; and key indicators suggest growing pressures on healthcare access and quality.

### Challenges confronting an incoming Government

Key challenges confronting an incoming Government in 2015 include:

- The continuing squeeze on NHS resources – with expenditure lagging behind need and demand. Authoritative forecasts suggest that funding gap will increase considerably in the absence of real funding increases and productivity gains.
- Signs of pressure within the system are increasingly evident. This includes pressure on waiting times, A&E departments, cancer waiting lists and public satisfaction with the NHS.
- Demographic change, the increasing prevalence of dementia, obesity, smoking and alcohol misuse will continue to present continuing challenges for public health as well as NHS services. The NHS Five Year Forward View (NHS 2014) highlighted that investment in preventive care, and new care models such as integrated health and social care services, are important routes towards lower demand and greater efficiency. However, there is growing recognition that productivity rises alone will be insufficient to meet the funding gap.
- The Coalition's health reforms raise significant challenges for policy implementation. Challenges include the fact that many of the bodies created by the reform process - such as Clinical Commissioning Groups, Health and Wellbeing Boards and new foundation trusts – remain in their infancy. A growing number of foundation trusts are in deficit. The Coalition has also sought to implement a new public services model which emphasizes a changed role for the central state focusing on minimum standards, quality and outcomes.
- On minimum standards and quality, following the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust (2013), the effectiveness of the management, inspection and regulatory system in identifying and addressing poor and substandard care remains at the top of the health agenda. An incoming Government will face the continued challenge of ensuring that new minimum standards are enforced and that the overall system for management, inspection and regulation is effective.
- Challenges also arise in relation to the overall framework of political responsibility and accountability for improving health outcomes and reducing health inequalities. Under the new arrangements for health in England, the NHS Outcomes Framework and the Public Health Outcomes Framework play critical roles as accountability tools. Challenges include the underdeveloped evidence base on the effect of provider type (independent, private and public) on quality; under-developed evidence on inequalities; and the absence of benchmarks and targets for evaluating progress. In relation to public health, questions are being asked about whether local public action is (or will remain) aligned to national public health goals; and whether all of the relevant policy instruments are genuinely within local hands.
- Some health outcomes remain disappointing by international standards, whilst health inequalities between different population subgroups remain deeply embedded. Progress in improving health outcomes and tackling inequalities will be the key barometer of failure or success.

### Further information

The full version of this paper *The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015* is available at <http://sticerd.lse.ac.uk/dps/case/spcc/WP16.pdf> This is one of a series of papers produced as part of CASE's research programme *Social Policy in a Cold Climate* (SPCC). The research, concluded in 2015, examines the effects of the major economic and political changes in the UK since 2007, focusing on the distribution of wealth, poverty, inequality and social mobility.

Social Policy in a Cold Climate is a research programme funded by the [Joseph Rowntree Foundation](#), the [Nuffield Foundation](#), and [Trust for London](#). The views expressed are those of the authors and not necessarily those of the funders.