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ANALYSIS

Are radical changes to health and social care paving the way for fewer services and new user charges?

Current reforms to health and social care services, and radical redesign of the local government finance system, may signal the end of the NHS and local government in England as we know them, argue **Shailen Sutaria, Peter Roderick, and Allyson M Pollock**

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Seismic changes in the organisation, delivery, and funding of health and social care services have been underway since the secretary of state's duty to provide key services throughout England was abolished by the Health and Social Care Act 2012.

One of the acts' major changes was to transfer public health responsibilities to local authorities—described as "one of the most significant extensions of local government powers and duties in a generation."[1] The Cities and Local Government Devolution Act 2016 allows further health functions to be devolved to local authorities.[2]

At the same time, NHS England is implementing sustainability and transformation plans (STPs) covering 44 geographical "footprints" in England.[3] These have been reported to be required to cut 26bn (€29bn; $35bn) from health and social care costs over five years.[4] STPs are intended to pool the budgets of health bodies and local authorities for joint commissioning of health and social care services, creating new organisational forms and care models, such as newly proposed accountable care organisations.[5]

The devolution deals and STPs are being presented to the public and health professionals as a way of integrating health and local authority social care. But missing from the picture is their fundamentally different funding bases: social care is a local authority responsibility and subject to means testing and user charges, whereas NHS services are free at the point of delivery.

These changes are taking place while the NHS undergoes the largest sustained reduction in spending as a percentage of gross domestic product (GDP) since 1951,[6] NHS providers have recorded their highest ever deficit,[7] and there has been a 37% real terms reduction in local authority funding from central government grants from 2010 to 2016 (excluding public health and the Better Care Fund),[8] alongside the ongoing radical and regressive reform of local government finance.

How will these changes and reductions in funding affect access to care, equity, and already widening inequalities? Experience from the last major transfer of responsibilities from the NHS to local authorities suggests they are likely to lead to reduced services and entitlements, more private provision of publicly funded services and, potentially, the introduction of charges for health services.

Effects on services and entitlements

Long stay care was transferred from NHS to local authorities in 1990 under the NHS and Community Care Act. Over the following three decades NHS and local authority provision reduced, private provision increased, and there was a gradual switch to means tested and self funded care as falling government expenditure failed to meet needs.

Although the care in the community policy meant NHS funded beds for geriatric, mental illness, and learning disability care were closing before 1990, closures accelerated after the implementation of the act. NHS long stay beds decreased by 38% from 106 173 in 1992-93 to 65 764 beds in 2002-03 (fig 1⇓). During the same period local government owned long stay beds decreased by 53% from 117 400 beds to 55 600 while the number of private long term care beds increased from 384 900 to 422 200 (fig 1⇓).

Before 1990, local authorities provided most residential care directly. In 1989-90 they supported 129 000 individuals in residential care, 84% of whom were placed in local authority owned residential homes and the remainder in privately owned (for profit and voluntary) homes (fig 2⇓). But in the 1990s policies that incentivised local authorities to outsource care saw a switch to private provision.[9-11]

Reductions in expenditure and the removal of ring fencing have also affected services and entitlements. Ring fencing of the main central government grant to fund social care expenditure (the Personal Social Service grant) ended in 2010 and since then local authority expenditure on adult social care has decreased in real terms from £18.5bn in 2010 to £17.5bn in 2014 (fig 3⇓)—these figures include the NHS funds transferred to local authorities for adults with learning difficulties from 2009. Over the same period spending on older people, adults with physical disabilities and mental health needs, and other adult services decreased by 13% from £13.6bn in 2008-09 to £11.9bn (fig 4⇓). The number of adults receiving non-residential adult social care

services fell by 33% between 2008-09 and 2013-14, with the largest decrease for those receiving meals and day care services (fig 5⇓).

Reduction in expenditure and removal of ring fencing has been closely followed by reduction in services, often achieved by tightening eligibility criteria. For example, in 2005-06, 35% of local authorities funded moderate care needs compared with only 10.5% in 2013-14.[12] A shortfall in funding for adult social care is still predicted,[13] despite piecemeal government announcements in October 2015 and December 2016 to allow limited rises in council tax to pay for care and the March 2017 promise of an additional £2bn from central government up to 2019-20.[14-16]

The effects of reduced expenditure and services are now also being seen in public health services, which moved to local government under the 2012 act. Local authorities are reported to have spent the 2013-14 ring fenced central public health grant on a wide range of services that were previously paid for by council funds as well as public health.[17] The grant was scheduled to be reduced by 9.6% in cash terms over five years to 2020,[18] and the government has announced plans to end the ring fenced central grant and require local authorities to fund public health services through retained business rates.[19] A recent survey of the association of public health directors reported plans for many local authority public health services to be reduced and some decommissioned.[20]

Inadequate funding is also affecting clinical commissioning groups (CCGs), with reports of rationing of fertility treatment[21] and elective hip and knee replacements[22] and restrictions on prescribing over-the-counter medication.[23 24] The language of reconfiguration in the deficit driven STPs masks the scale of proposed or likely closure of acute hospitals, beds, and services as cuts of £26bn in health and social care are implemented.[4] These include reducing the number of acute hospitals from three to two across Leicestershire,[25] closure of two acute hospitals in southwest London,[26] closure of Ealing hospital in west London,[27] and downgrading emergency services across Cheshire and the Wirral.[28]

More private provision of publicly funded services

The legal basis for outsourcing health services, including to private providers, flows from abolition in the 2012 act of the secretary of state's duty "to provide throughout England [key health services] to such extent as he considers necessary to meet all reasonable requirements." That duty was replaced with a duty on each of the 207 CCGs to "arrange for provision" of these services for the populations for which they have responsibility. These changes mirror changes to section 2 of the 1948 National Assistance Act when the duty to provide residential accommodation was replaced by a power to arrange that provision. The legal shift from a "duty to provide" to a "duty to arrange provision" is standard legalese for outsourcing.

From April 2013 to August 2014, a third of NHS contracts awarded went to the private sector.[29] NHS England commissioners' expenditure on private sector providers of secondary care has risen substantially over the past 10 years, reaching 7.7% (£9bn) of total NHS expenditure in 2016-17,[30] excluding primary and social care, individual contracts between NHS trusts and private companies, and any private finance payments.[31] The majority (71.3%) of commissioners' spending on non-NHS providers went to private companies in 2015-16, which saw the fastest annual growth in NHS spending (15%) from 2013-14 to 2014-15 (compared with 11% and 6.7% for the voluntary sector and local authorities respectively).[32]

The private health companies' association, the NHS Partners Network, is helping to develop STPs,[33] and on the back of the government's encouragement of "long term partnerships between the NHS and the private sector," 17 private companies have been paid £2.7m to draw up STPs.[16 34] Under Project Phoenix, the government has renewed its commitment for capital projects for general practices aligned to STPs, now renamed Sustainability Transformation Partnerships. Premises will be funded in part by sale of NHS land and building, financed through the Estate and Technology Transformation Fund and community health partnerships, which involve public-private partnership and Local Improvement Finance Trust (LIFT) schemes.[35-38]

Potential for user charges

A major concern with the reduction of NHS services is that people will be able to obtain them only if they can pay or have insurance. Financially strapped trusts, particularly in wealthier areas, are well placed to charge, and foundation trusts are allowed to make 49% of their income from outside the NHS. Well positioned trusts have already seen large increases in income generated through charging.[39]

The greater involvement of local authorities in health service provision also increases the risk of new charges for what were previously free NHS services. Under the 2012 act the health secretary can impose charges for Public Health England's services but is prohibited from exercising this power to charge individuals receiving those services. However, regulations can be made allowing local authorities to charge individuals for public health services.

At the moment, the regulations for mandatory local authority public health services, which include health checks, open access sexual health services, and child health surveillance, expressly prohibit charging individuals.[40] However, this is because the health secretary chose to impose the prohibition, not because parliament has prevented charging. As local authorities become increasingly squeezed financially, there is a risk that new regulations without the charging prohibition will be enacted.

Demonstrating the potential for charges, in 2013-14, local authorities earned £2.6bn from sales, fees, and charges in adult social care, accounting for 15% of gross social care expenditure.[41] Local authority revenue from fees and charges for social care for those aged 65 and over increased by 4.4% from 2009 to 2013 despite net spending being cut.[42] Since the Care Act 2014, local authorities have a legal duty to promote the efficient and effective operation of a market for care and support services.[43]

Effect of regressive changes to local authority funding

Funding of local authority expenditure in England, including social care and other council services, has traditionally come from four main sources: central government, business rates, council tax, and fees and charges. In 2010, central government grants accounted for almost 80% of local authority expenditure.[44] Between 2010-11 and 2015-16, government funding to local authorities (excluding the public health grant and Better Care Fund) fell by an estimated 37% in real terms.[8] Analysis by local authorities in the north east showed that the 10 most deprived areas in England saw an average decrease in spending power (a measures of core revenue funding available for local authority

services) between 2014-15 and 2015-16 of 10.5% while the 10 least deprived areas saw an average increase in spending power of 1.1%.[45]

This disparity reflects changes to government funding, such that grants are no longer allocated based on annual assessments of needs and will not reflect changing relative needs and deprivation until they are reassessed in 2020.[42] Crucially by 2020, government plans to decrease and discontinue central grants, including the public health grant, will leave local authorities increasingly reliant on local business rates, which will no longer be pooled centrally and redistributed. These measures are part of the government's policy for local authorities to move towards self sufficiency and "away from dependence on central government," inevitably widening inequalities.[46]

Need for transparency

The zeitgeist of integration and devolution obscures the fundamentally different funding bases for health and social care. As funding decreases, and with single contracts for both services, we expect the distinction between them to blur over time and some health services to fall out of commissioning, and out of NHS funding altogether. Private providers and local authorities—both accustomed to charging and privatisation—may also lobby for concessions to charge for services that were once free at the point of delivery and delivered through the NHS.

It is therefore essential that the public is given access to all the tender documents for joint commissioning and local authority commissioning of health services so that we can see how the distinction between NHS funded care and social care is made, what services are being tendered, how services are being defined, and how charging is dealt with. Most importantly, the evidence for and the effects of these seismic changes on access to care, equity, and widening inequalities must be disclosed and understood.

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Key messages

- STPs, accountable care organisations, devolution deals, joint commissioning of health and social care services, and redesign of the local government finance system are radically changing the NHS and local government in England
- The effect on service provision of the fundamentally different funding bases for health (free at the point of delivery) and social care (means tested) services has been ignored
- The changes are likely to lead to reduced services and entitlements, more private provision of publicly funded services, and potentially more user charges
- People in poorer areas are likely to lose out as funding will depend more on the wealth of local areas and less on the principles of redistribution and need
- The evidence for and effects of these changes on access to care, equity, and widening inequalities must be disclosed and understood

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Figures

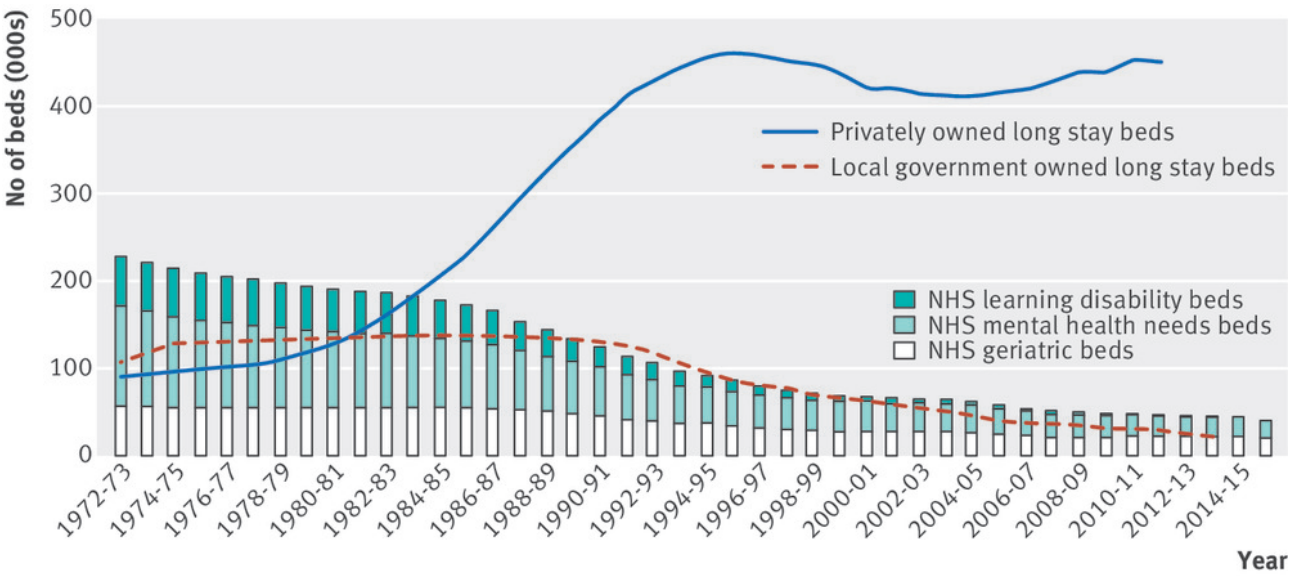

Fig 1 Average daily number of NHS geriatric, mental health needs, and learning disability beds and number of available long term beds by provider, 1972-73 to 2015-16 (data from Health and Social Care Information Centre and LaingBuisson Care of older people UK market report, 27th ed)

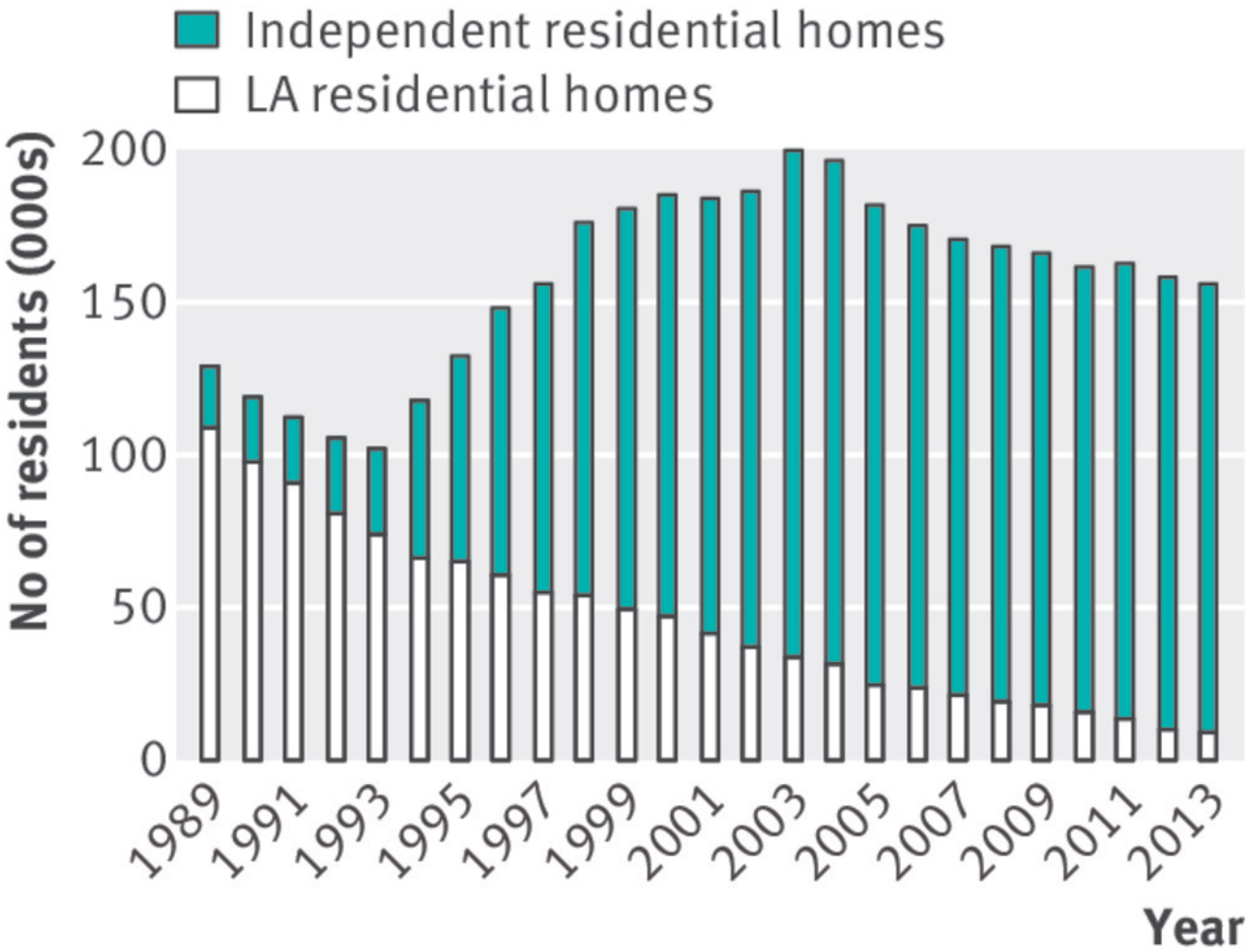

Fig 2 Local authority supported adults in residential care, by provider type, 1989-2014. (Adult social care activity data PSS, SR1 and S1 returns obtained from Health and Social Care Information Centre. From 2003 data includes clients formerly in receipt of preserved rights, from 2004 data includes former Boyd Loophole residents. In 2012, 1840 learning disabilities service users were recorded as permanent admissions as a result of funding being transferred from NHS to council. Previously they would not have been included)

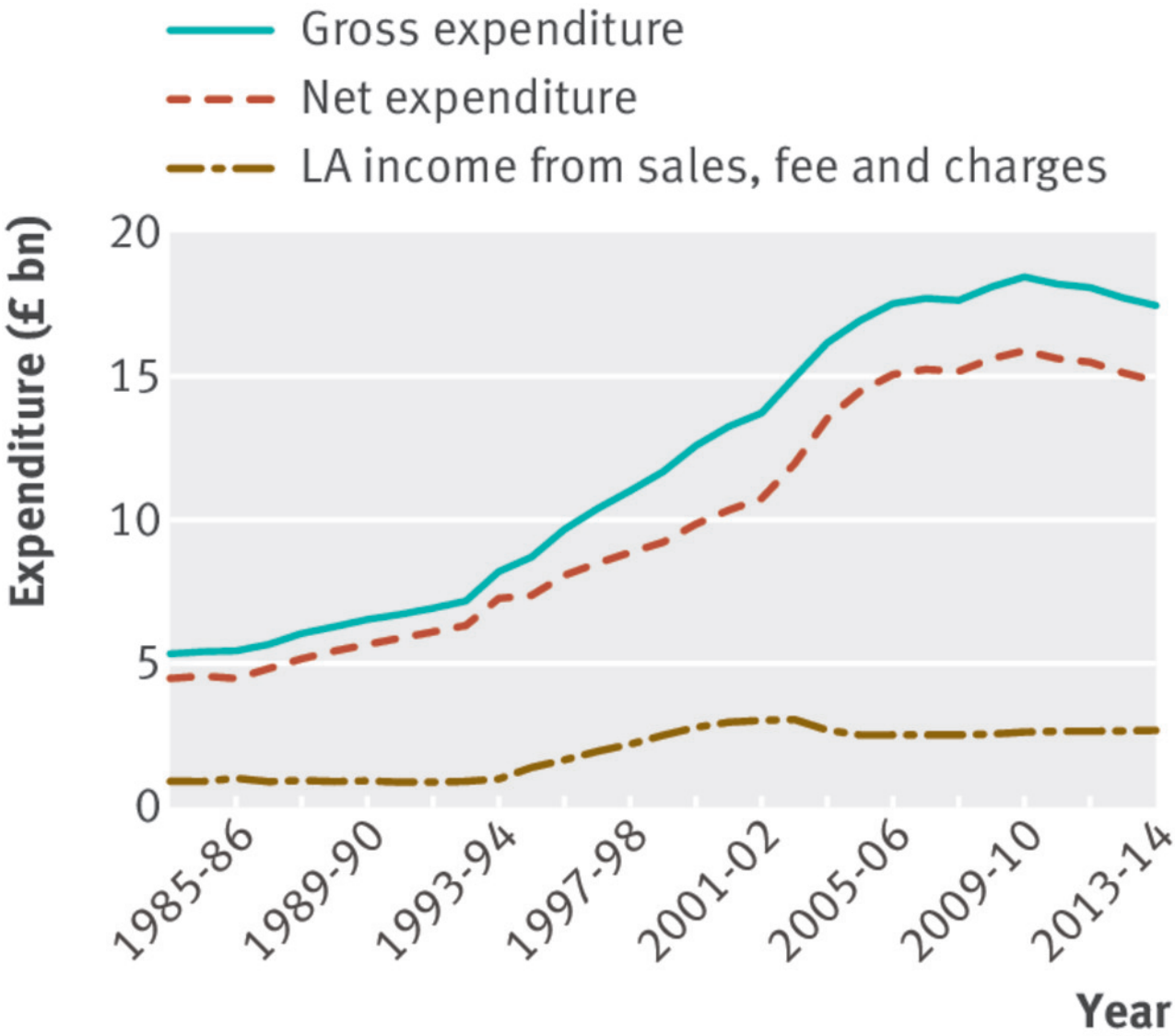

Fig 3 Total gross and net expenditure on personal social care by English local authorities, 1983-4 to 2013-14. (Gross expenditure=running expenses+employee costs minus other non-local authority income (eg, grants, NHS); net expenditure=gross expenditure minus sales, fees, and charges; data from Health and Social Care Information Centre)

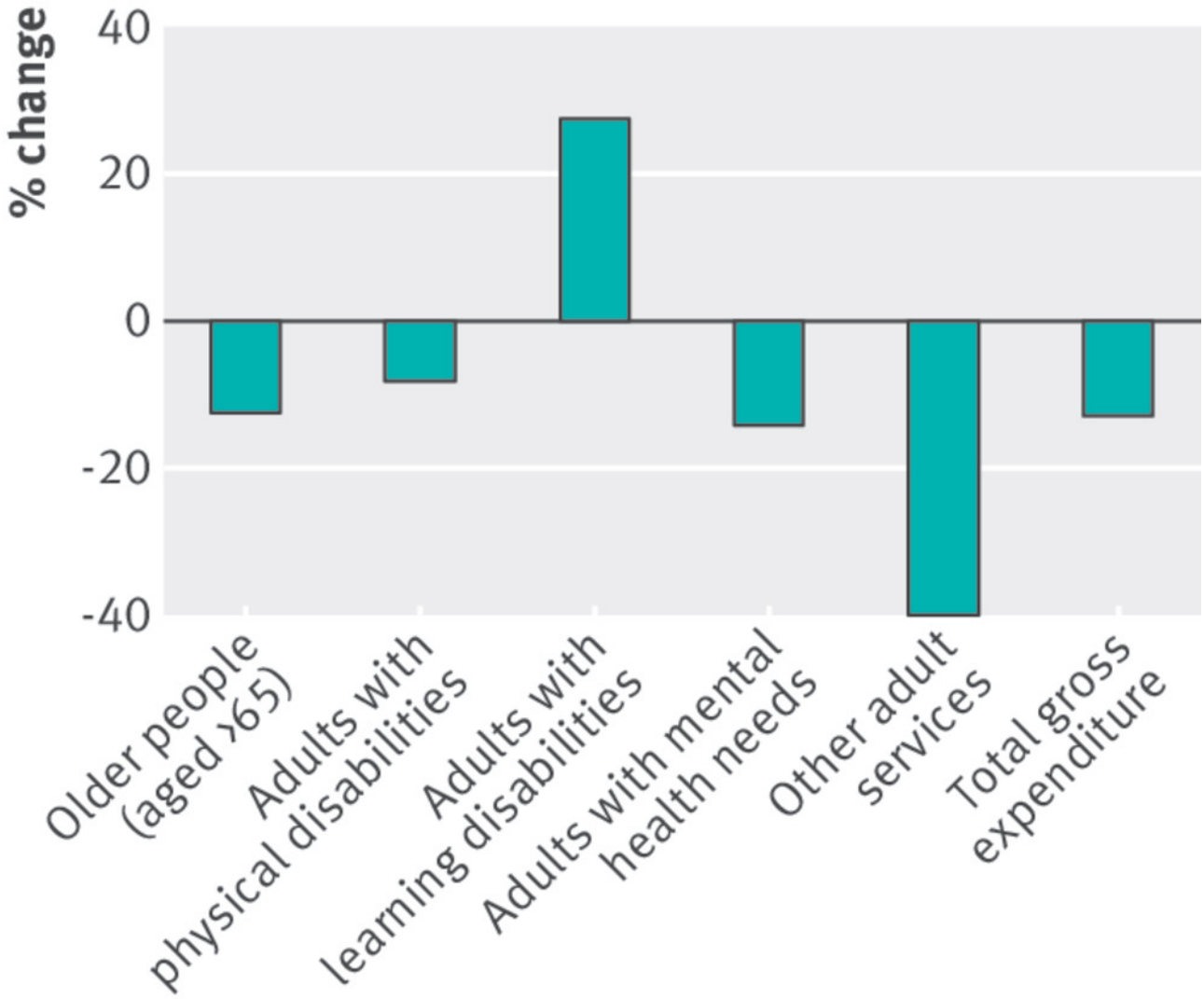

Fig 4 Gross expenditure by local authority on adult social services by type and year (in real terms; data from Health and Social Care Information Centre)

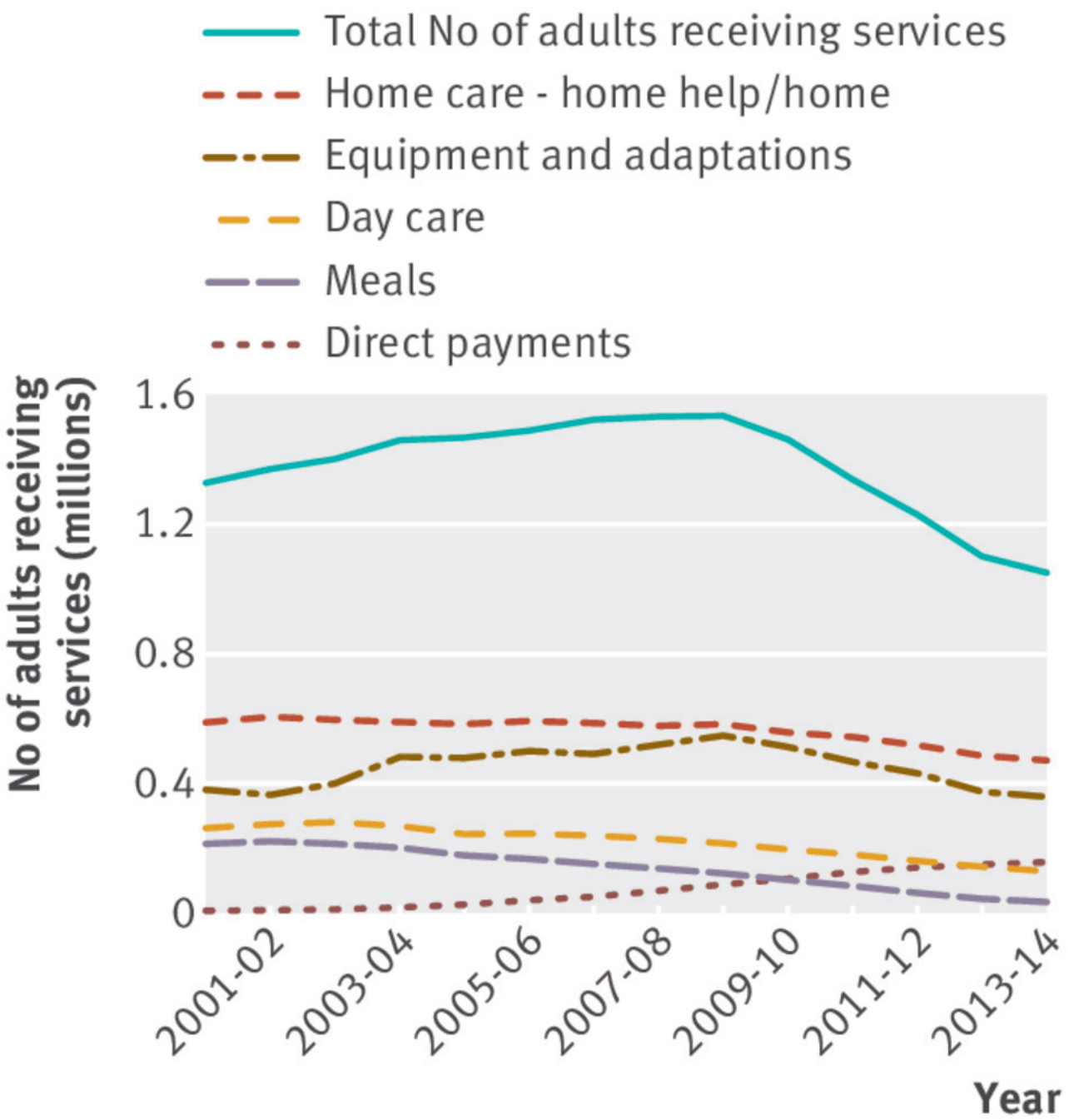

Fig 5 Number of adults receiving one or more social care services in England, by type of service, 2000-01 to 2013-14 (data from Health and Social Care Information Centre. Direct payments have been expanded from direct payments to existing/new direct payments and personal budgets in 2009-10. Respite, transport, professional support, and non-classified "other" services not shown)