Written evidence submitted by the Women's Budget Group

Inquiry: Budget and the NHS Long-term, Health and Social Care Committee
14 August 2019

The Women's Budget Group (WBG) is an independent network of leading academic researchers, policy experts and campaigners evaluating the impact of economics on women and men. We produce robust analysis and aim to influence the people making policy. We also work to build the knowledge and confidence of others to talk about feminist economics by offering training and creating accessible resources. The Women's Budget Group is independent and not-for-profit.

Executive Summary

1. The Women's Budget Group (WBG) welcomes this inquiry into the long-term funding of the National Health Service. To date, inadequate funding has led to a strained health service and a care system in crisis. Women – as the majority of patients, those receiving care, (55.2% in 2016/17) health and care staff (77%) and unpaid carers (80%) – have borne the brunt of these impacts. NHS staff have been under a 1% public sector pay cap since 2010, which has led to a decline in real wages of around 14%. Long term funding plans must reflect the gendered nature of health and care and consider the impact not only on those needing health or social care, and the paid workforce, but on unpaid carers who fill the gap when public provision fails[i].

2. The NHS long term plan should include:

- Spending on health and social care recognised as an investment in social infrastructure, which is as important to society as capital infrastructure.
- Priority should be given to investment in public health and community-based care
- The establishment of a National Care Service that provides care free at the point of delivery and integrated with the NHS and is funded from general taxation at the national level to avoid the entrenchment of regional inequalities.
- Substantial and longstanding investment in the training, career development and pay progression of both social and health care workers so they have equal standing. To achieve this social care needs the equivalent of Health Education England with a statutory duty to direct training and workforce planning. Only then will consistent and rising standards be achieved. Common training in the first year would help to establish collaboration between the two services.

3. WBG believes that any consideration of health also needs to look at integration with social care and other public services. Therefore, sustaining the NHS long term also requires:

- Greater recognition and support for unpaid carers without whom formal social care services would be unsustainable.
- Regulation should ensure that conditions of employment for everyone should be compatible with reasonable care responsibilities and disabilities, which should not disadvantage people in their careers.
- Returning direct provision of both domiciliary and residential care services back to local authorities in order to end reliance on private-for-profit providers of social care, starting with private equity firms and hedge funds which should have no place in the provision of social care.
- Increased funding by both local and central government to restore and develop local services including public transport, libraries, parks and other community leisure facilities which are so essential to the health and wellbeing of all - young and old.

Capital expenditure on the NHS

4. Expenditure on the NHS is clearly needed, and the long-term plan goes some way in setting out how this will happen although promises fail to meet the OBR's projection that demand on the service will increase by more than 4% a year above inflation[ii]. More funding is needed. This should include spending on staff as well as capital expenditure on buildings, equipment and telecommunications.

5. The devastating effects of the shortfalls in funding for the NHS are well-documented (see for example WBG Briefing 2018).[iii] Women have been affected by in a number of ways. For example, admissions to hospital to give birth is the single largest cause of admission to NHS hospitals in England.[iv] Nearly half of England's maternity units closed to new mothers at some point in 2017. Capacity and staffing issues was the most common reason.[v] The Royal College of Midwives reports a shortage of 3,600 in the profession.[vi] The NHS desperately needs a long-term funding plan capable of maintaining high quality care and retaining high quality staff. This means investment in social infrastructure – training, education, childcare and pay – as well as capital expenditure.

Education and training

6. Making the NHS an attractive place to work, is absolutely crucial to its ability to meet demand sustainably. The Women's Budget Group has long advocated for *a substantially increased and sustained* investment in developing the skills and career paths which careworkers need, not only so social care becomes an attractive occupation, but also to improve the quality of care provided. As above this will also deliver for the economy.

7. Women make up 77% of the NHS workforce[vii] with more female nurses alone than male staff in every category combined.[viii] We are acutely concerned about the conditions facing the NHS workforce as reflected in the rising numbers of unfilled staff vacancies. There are concerns that the number of staff vacancies could rise from the current level of around 100,000 NHS staff vacancies (1 in 11 NHS posts are unfilled) to 250,000 by 2030.[ix] The highest numbers vacancies are in nursing and midwifery, with 38,000 vacancies. This is not helped by Brexit which has seen many EEA nationals who are nurses or midwives leaving the UK. Women make up 89% of staff in these categories.[x] Meanwhile the numbers of consultants (two thirds of which are men[xi]) has increased by 64% since 2004.[xii]

8. Staff shortages are due to both fewer numbers entering health services and staff leaving the NHS, with a worrying number leaving at younger ages. There has been a failure to train sufficient numbers of staff with a large decline in the number starting nursing after the early 2000s.[xiii] A loss of bursaries led to an 18% drop in applicants for nursing places between 2016 and 2017, the biggest fall in nursing applicants on record.[xiv] The number of nurses in training are low by international standards (half that of the USA or Australia).[xv]

9. Lack of adequate training in health and social care have immediate consequences for the NHS because one in ten older people's admissions to hospital are linked to their medicine intake, the majority thought to be avoidable. The quality of care is linked to the very low level of training social care workers receive and therefore the skills they develop. Half have no relevant care qualifications and only a third had achieved or were working towards their Care Certificate. This was introduced in 2015, is not mandatory and only designed to train new care workers in the basic skills needed in their day to day work. Dementia care was only included in two fifths of the recorded training categories completed and medication, safe handling and awareness was included in only half. There is also a need to consider training in social care, WBG deals with this below.

10. The shortage of nurses in care and nursing homes also exacerbates the problem of lack of training in medication among care staff. In the 17,000 residential care and nursing homes where the health of the 400,000 residents is more fragile residents are prescribed an average of seven medicines a day,

costing the NHS an estimated £250 million each year. Altogether these residents accounted for 250,000 emergency hospital admissions and it is estimated that 30-40% of these admissions would be avoidable with better care and support. In 2019, NHS England as part of their NHS long term plan are trailing a scheme to recruit 200 clinical pharmacists and pharmacy technicians to reduce over-medication in care homes. However, it is hard to see how effective they will be without properly trained care workers to support them.[xvi]

Social care

11. The social care system is widely recognised to be in crisis. The current system is drastically underfunded and organised in fragmented, regressive and inefficient ways: in England,[xvii] 1.4 million people over 65, one in seven, now have unmet needs for help with tasks such as getting up, washed and dressed[xviii]. This is a 20% increase in just two years. Despite growing numbers of older people, spending on adult social care fell by 8% in real terms between 2009/10 and 2016/17[xix] and an estimated 400,000 fewer older people received publicly supported social care as the eligibility criteria were tightened in response to insufficient resources.[xx]

12. Spending on social care is desperately needed. **WBG recommends a new National Care Service (NCS), working closely with the NHS.** The NCS should provide care and other forms of support free at the point of use to all who need them. It should also be charged with developing policy and making investments so that people of all ages and abilities retain, and hopefully enhance their capabilities.

A National Care Service

13. Putting that into practice will entail what has been called "co-production". This includes "professionals and citizens shar[ing] power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities".[xxi] Such an idea differs from current practice in that: decision-making power is shared, not just users consulted; support is planned, not just reactive to immediate needs; users contribute to that support in whatever way they can, so that others do not just "do for" them; the aims are not only to benefit individuals but also the community as a whole; and it is recognised that even those with reduced capabilities can contribute to that. Co-production methods are thought to be particularly suitable for developing preventative strategies, such as investment in retaining capabilities into the future.[xxii]

14. The key conditions for the successful exercise of consumer sovereignty are simply not met when it comes to the market for care. As a result, care that is produced for profit tends to be of poor quality, and the scandals that regularly occur in the current system are not so much exceptions as the tip of an inevitable iceberg of systemic failure. Delivering high quality care through the principles of co-production will require repudiating the profit motive and developing new institutional forms for care provision.

15. The National Care Service would be in essence a public sector institution; however to foster co-production and innovation it should be open to collaborations with other non-profit oriented enterprises and co-operatives. In transitioning to such a system, the large chains should be brought into the public sector but smaller providers that can demonstrate high quality, good employment practices and a willingness to adapt should be offered grant funding provided they become non-profits and work to locally set objectives.

16. Currently social care is largely provided in people's own homes. Any transition to residential care then comes so late, and in response to such extensive care needs, that no-one would willingly

choose to make it. Other countries have a wider range of housing possibilities for the elderly than in the UK, some that enable a relatively seamless increase in care support. New institutional forms of housing should therefore be developed to make such housing a reality in the UK.

17. This should enable more coordinated, collective forms of care too. For example, local care centres could be set up that include a day centre, sheltered housing and a residential home, from which domiciliary services are run so that people can seamlessly receive the level of care they need and retain/develop capabilities and relationships in their own community. Such centres, if made sufficiently desirable, should have the side effect of freeing up under-occupied accommodation and so contribute to reducing the housing shortage. They should also help with keeping people active longer, safe in the knowledge that the level of care that they need in the future will always be available without disrupting their current social relations and support.

18. Employers currently invest very little in training their staff. Social care workers should have much longer training courses, similar to those for nurses as well as the opportunity to acquire new skills as they progress in a career. Three-year training courses for care workers should be developed, based on a different idea of what care should achieve, enabling people to live their lives in the way that they want, rather than simply doing things for them. This would require a complete overhaul of training, so that care workers could draw on the broader set of skills and knowledge needed to care in these ways. The first year could be shared with nursing training as happens in Germany for example. This would improve the much-needed collaboration between health and care services, which is much needed. WBG also calls for nursing bursaries to be reinstated. A similar scheme should be introduced for social care students. These are particularly important if older women are to be attracted to these courses, especially if part-time study is also possible.

Spending on social care is an investment

19. Investment in social infrastructure builds the social and human capital that is just as important to the NHS' future productivity and sustainability. Like roads, for example, high quality childcare helps parents get to work and like investing in skills, it enables parents to take jobs where they can be more productive as well as improving children's educational outcomes and therefore national productivity in the long-run.

20. The Chancellor should therefore invest in social infrastructure, particularly the care sector, which would not only address the urgent crisis in care but also boost employment, far more than equivalent investment in physical infrastructure. In fact, Women's Budget Group research shows that investing 2% of GDP into the health and social care sector would create 1.5 million jobs in comparison with half as many, 750,000 if the same amount was invested in construction[xxiii]. It would also reduce gender inequalities in employment which construction investment would worsen unless mitigating measures about gender industrial segregation are put in place.

21. The benefits of spending on social care are widely ignored, largely because it is seen as welfare spending the long-term effects of which are rarely assessed, and a cost rather than an investment. National accounting rules enshrine that bias, by counting expenditure on physical assets alone as investment from the capital account, while all expenditure on care, even though it builds up human and social capital, comes from the current account. To remove the bias against investment in social infrastructure, all investment should be evaluated in the same terms. This will require developing new accounting methods to guide public policy. Although the public are not necessarily particularly interested in accounting methods, it would be important to explain why they are being adopted and to incorporate them, not the SNA classification, in any revised Fiscal Credibility Rule.

22. Massive investment in our social care infrastructure is now needed. Not only will the country gain the future benefits of such investment, it will also gain in the short-term by employment and growth being created. Investment in social care has long term benefits, but it also leads to far greater employment benefits in the short-term than investment in physical infrastructure. For example, research by the Women's Budget Group has shown that up to 1.5 million jobs would be created in the UK if 2% of GDP was invested in the care sector, compared to 750,000 for an equivalent investment in construction, the typical focus of physical infrastructure investment.[xxiv]

Public health

23. Women have also suffered from reductions in funding for public health services. The 2013 transfer of responsibility for public health services to cash-strapped local councils was associated with major cuts and public health funding is expected to be reduced by 14% between 2015 and 2020.[xxv] In 2015 responsibility for health visiting was transferred to local authorities. Since then the workforce is reported to have fallen by 20%. The Royal College of Nursing has expressed serious concern about cuts to local authority children's health services with falling numbers of health visitors and school nurses.[xxvi]

24. We therefore recommend that public health and community-based services receive immediate attention. We are concerned that the transfer of responsibilities for public health to local authorities has resulted in wide regional disparities in provision. For example, the proportion of 6-8 week reviews completed for new born children varies from only 57% in London to over 90% in the North East and in some areas is as low as 10%.[xxvii]

25. There is evidence to indicate that the strain on acute hospital services can be reduced by strengthening community provision for health and social care.[xxviii] The last 8 years have seen a steady growth in all areas of hospital activity. Emergency admissions have risen by 14% since 2008/09. [xxix] Evidence indicates that up to 50% of hospital beds are occupied by people who could be cared for in community settings.[xxx] Cuts to health and social care services simply lead to increased costs for emergency interventions. Increased funding for public health in local authorities must therefore be included in any long term plan for the NHS, especially if these services continue to be decentralised. This includes increased funding by both local and central government to restore and develop local services including public transport, libraries, parks and other community leisure facilities which are so essential to the health and wellbeing of all - young and old.

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