Prevention instead of reaction: creating a robust funding structure for the NHS

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Oxera's response to the 10-Year Health Plan for the NHS

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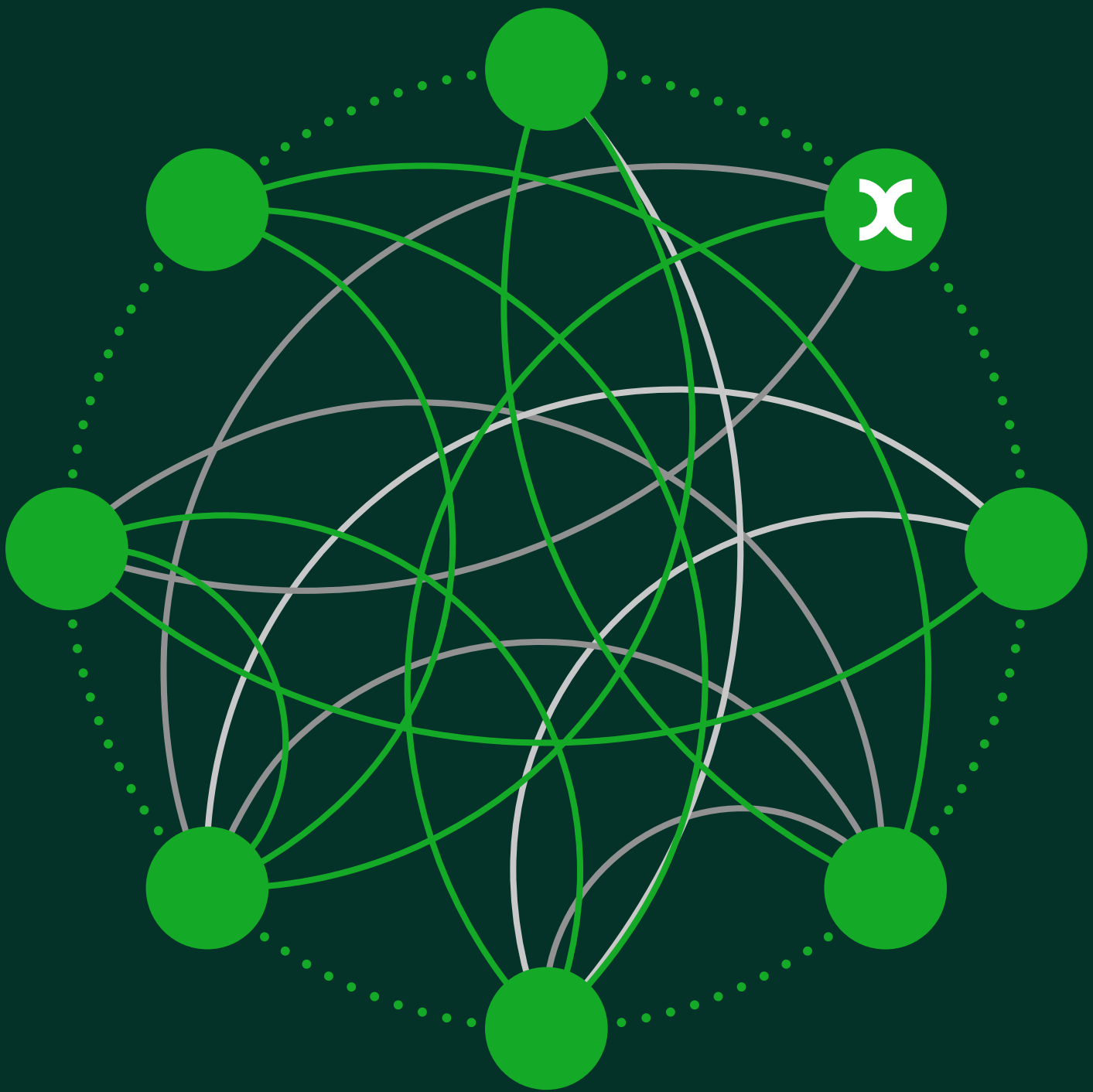

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1 Executive summary

The NHS is at a critical juncture, facing unprecedented pressures from an ageing population, rising health inequalities, and underinvestment in infrastructure. The Darzi Report underscores the scale of these challenges, highlighting the need for systemic reforms to enhance resilience and productivity. In response to the Change NHS consultation, Oxera outlines recommendations to address part of these issues by restructuring the NHS's funding model to focus on prevention, integrated care, and long-term sustainability.

Key Challenges

The NHS grapples with dual pressures: growing demand due to demographic and socioeconomic factors, and constrained supply caused by workforce shortages, underinvestment in capital, and productivity stagnation. Waiting times have increased significantly, exacerbating the strain on services and eroding patient outcomes. Additionally, health inequalities persist, with deprived areas experiencing disproportionately higher rates of avoidable mortality.

Recommendations

Oxera proposes three key areas for reform:

1 Optimising the Current Funding Model:

- Improve data collection and linkage across services to enhance transparency and allocation efficiency.
- Update outdated funding formulas for public health and general practice to better reflect local needs and workloads.

2 Shifting Funding Priorities:

- Redirect resources from hospital-based care to primary and community services to strengthen prevention efforts.
- Prioritise capital investments in technology and infrastructure to increase productivity and modernise estates.

3 Designing a new Resilient Payment System:

- Adopt principles that allocate funding where it is most needed, empower Integrated Care Boards (ICBs) to make localised

decisions, and maintain robust national oversight to track performance and ensure accountability.

Outcomes

By implementing these reforms, the NHS can create a more agile, equitable, and sustainable health system. These changes aim to reduce reliance on hospital care, address health inequalities, and enable integrated care models that better serve an ageing population.

Next Steps

Oxera encourages the government to integrate these recommendations into the NHS 10-Year Health Plan, laying the foundation for a resilient NHS. This will require bold actions, long-term thinking, and a commitment to innovation and collaboration across stakeholders.

2 Introduction

Oxera Consulting LLP ('Oxera') is pleased to submit a response to the Change NHS consultation on the future of the National Health Service (NHS). The consultation will inform the work to develop the 10-Year Health Plan For England.

Oxera is an economics, finance and data science consultancy with a vibrant public policy and health practice. For over 40 years, Oxera has advised companies, regulators and governments across the UK, Europe and globally on public policy, impact assessments, strategy competition and market investigations, litigation, mergers and acquisitions, and the design of regulation and markets. During 2023, Oxera supported the Times Health Commission to estimate the economic cost of both health inequalities and ill health among the working-age population.[1,2]

We welcome the government's recognition of the challenges facing the NHS and the need to develop a long-term plan to address these.[3] The NHS is a vital and well-loved public service for those living in the UK. Indeed, if you ask many Brits what they are most proud of about being British, the answer will be the NHS.[4] However, if you then ask them whether the NHS is fit to address future health challenges, the answer is often a resounding 'no'. Indeed, the recent Independent Investigation of the National Health Service in England by Lord Darzi (hereafter, the Darzi Report) concludes that the NHS is 'in serious trouble'.[5]

The Darzi Report highlights that this is in part due to the significant external pressures facing the NHS today: an ageing population, stagnant poverty rates and increasing prevalence of poor housing conditions that have led to a surge in multiple long-term health conditions in the UK.[6] However, these pressures are also amplified by insufficient long-term spending on buildings, equipment, data infrastructure and IT ('capital investments'), with the UK lagging behind

[1] Oxera (2023), 'The economic cost of ill health among working age population', January.
[2] Oxera (2023), 'The economic cost of health inequalities in England', October.
[3] Department of Health and Social Care and The Rt Hon Wes Streeting MP (2024), 'The NHS is broken: Health and Social Care Secretary statement', speech, July.
[4] Ipsos (2023), 'NHS at 75: the NHS remains Britons' biggest source of national pride, but public are worried about its future', July.
[5] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', September, p. 1.
[6] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', September, paras 1–14.

other comparable countries.[7] These factors have put NHS services under unprecedented strain, which is evident in the long waiting times. Indeed, at this point, even people with serious, time-sensitive health conditions are now waiting longer than they were 14 years ago to access vital services in the NHS.[8] These issues are likely to get worse in the years to come if no significant measures are taken to improve the NHS's 'critical condition'.[9] As a result it is vital that the 10-Year Health Plan for the NHS seeks to address the future challenges facing the NHS in the coming years and not just the challenges the NHS faces today.

In her Autumn Budget 2024 announcement, the Chancellor recognised the concerning conclusions of the Darzi Report. In response, the NHS received a '£22.6bn increase in the day-to-day health budget and a £3.1bn increase in capital budget over this year and next.'[10] Given the current crisis, this additional funding is needed, but long-term success requires a different approach. Indeed, the solution to solving the NHS's problems cannot be restricted to additional funding only, but wider reforms that improve productivity and introduce the changes needed to focus and join up the limited resources available across health, social care and beyond.[11]

In this consultation response, we present our recommendations for reforming the NHS's public funding structure by considering 'quick wins' with the current funding approach and thinking about the design principles over the long term to make services in the NHS resilient for future challenges. As part of this response, we do not address the question of who funds the NHS including the role for private health insurance. Rather we assume that health in the UK will continued to be funded predominantly by the UK taxpayer and explore how best to structure that funding.

We first examine the overall challenges facing the NHS from an economics perspective. We then set out some possible solutions that will make the current funding structure more effective in distributing scarce health and care resources. Afterwards, we turn to look at how funding can be redirected and prioritised so that the NHS is more resilient to the challenges arising from an ageing population. Finally, we

[7] The Health Foundation (2023), 'Nine major challenges facing health and care in England', November.
[8] Department of Health and Social Care (2024), ''Independent Investigation of the National Health Service in England', September, pp. 3–4.
[9] Department of Health and Social Care (2024), ''Independent Investigation of the National Health Service in England', September, p. 11.
[10] HM Treasury and The Rt Hon Rachel Reeves MP (2024), 'Autumn Budget 2024 speech', 30 October.
[11] Institute for Fiscal Studies (2024), 'The past and future of UK health spending', May.

outline some overarching design principles that may be necessary for the NHS to take into account when deciding on how to distribute funding between its services in the future.

3 Major challenges facing the healthcare system in England

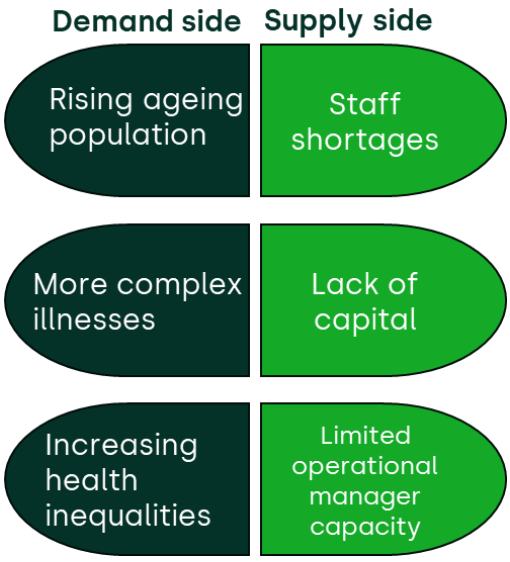
Across many domains, the NHS has continued to do a 'remarkable job'.[12] The quality of care that people receive is generally high, and there have been outstanding results delivered for patients. For instance, as reported in the Darzi Report, the NHS's Diabetes Prevention Programme has decreased the risk of type 2 diabetes by almost 40%. Patients are more likely to have error-free care now than they used to, and care for mental health patients has improved significantly in recent years.[13]

However, the system is facing huge pressure from a number of sources. From an economics perspective, these challenges can be grouped as relating to the limited resources available to treat people (supply side) and to increasing treatment needs from changes in demographic and wider trends (demand side). In this section, we have highlighted three issues on the demand and the supply side. These show just how difficult the challenges facing the NHS are since they interlink with broader social issues.

Nevertheless, there is a big prize in unlocking healthier citizens: people will not only live longer but also healthier lives; and from an economic perspective, can contribute more to the economy during their working lives.

[12] HM Treasury and The Rt Hon Rachel Reeves MP (2024), 'Autumn Budget 2024 speech', 30 October.
[13] Department of Health and Social Care (2024), ''Independent Investigation of the National Health Service in England', September, p. 5.

Figure 3.1 Demand- and supply-side challenges



Source: Oxera.

3.1 Supply-side challenges

The waiting list for NHS care—including patients who have had procedures cancelled or delayed, or have been refused referrals due to a lack of capacity—now stands at historically high levels. And despite recent efforts and additional funding, key NHS targets are routinely missed.[14]

Studies looking into the productivity of the NHS suggest that it is currently a 'big problem'.[15] Put simply, hospitals need more resources and staff now to provide the same level of care that they did before the COVID-19 pandemic. There are some signs of improvement, but productivity is currently still 11% lower than before the pandemic.[16] One of the reasons for the low productivity may be the underinvestment in capital (buildings, equipment, data infrastructure and IT) resulting in more people-hours needed per appointment than would be the case if there were more capital utilised. For example, the UK has fewer CT and MRI scanners[17] than any other comparator OECD country, which contributes to high UK cancer and diagnostic waiting times.[18,19] In

[14] British Medical Association (2024), 'NHS backlog data analysis', November.
[15] Institute for Fiscal Studies (2023), 'Is there really an NHS productivity crisis?', November.
[16] Institute for Fiscal Studies (2024), 'NHS hospital productivity: some positive news', November.
[17] Per million head of population.
[18] The King's Fund (2023), 'Comparing the NHS to the other health care systems of other countries: five charts', 26 June.
[19] The Royal College of Radiologists (2024), 'Diagnostic and Cancer Waiting times data for January 2024', 15 March.

addition, the NHS is currently facing a serious maintenance backlog that has left the estates in a poor condition, posing safety risks for staff and patients (among other issues).[20]

These unprecedented challenges no doubt have taken their toll on NHS staff, with almost one-third feeling burnt-out[21] and almost half of frontline staff having checked job listings outside the NHS.[22] This is coupled with dissatisfaction with pay which has resulted in industrial action across medical professions in recent years. In certain areas of the healthcare system, particularly in general practice, there is a pronounced shortage of staff and a slower-than-expected increase in recruitment.[23] The NHS has made progress here with the NHS Long Term Workforce Plan, published in 2023, which aims to counter this gap in employment—but the plan requires substantial funding and will take time before it has a positive impact on services.[24]

Finally, there are notable challenges in the management structures of the NHS that were mainly caused by the Health and Social Care Act of 2012. The reorganisation of the NHS that followed the Act led to experienced managers leaving their positions and the NHS losing some of its vital institutional memory. As a result, the commissioning capabilities of the NHS, which could be the channel to distribute resources out of hospital to integrated care, have become weaker than 15 years ago. More generally, the NHS spends less on operational management than other OECD countries, and this may be further exacerbating the productivity problem, given the role that management plays in the allocation of resources.[25]

Despite these supply-side challenge there are some substantial opportunities for the NHS to improve productivity through the introduction of new technology. As Darzi highlights, we stand on the precipice of an AI revolution that can transform care for patients.[26] AI creates wide ranging opportunities to not only discover new treatments and improve diagnoses and screenings but also in helping to reshape

[20] Institute for Fiscal Studies (2024), 'The past and future of UK health spending', 14 May.
[21] The Health Foundation (2023), 'NHS staff burnout highlights desperate need for workforce plan to focus on retention and wellbeing', 9 March.
[22] University of Sheffield (2024), 'A new University of Bath IPR report puts the spotlight on the growing scale of the NHS staffing crisis', 11 April.
[23] British Medical Association (2024), 'Pressures in general practice data analysis', 29 November.
[24] The King's Fund (2023), 'The NHS Long Term Workforce Plan explained', 27 July.
[25] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, Chapter 10.
[26] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, Chapter 7.

pathways, promote prevention and improve the productivity of NHS operations.[27]

3.2 Demand-side challenges

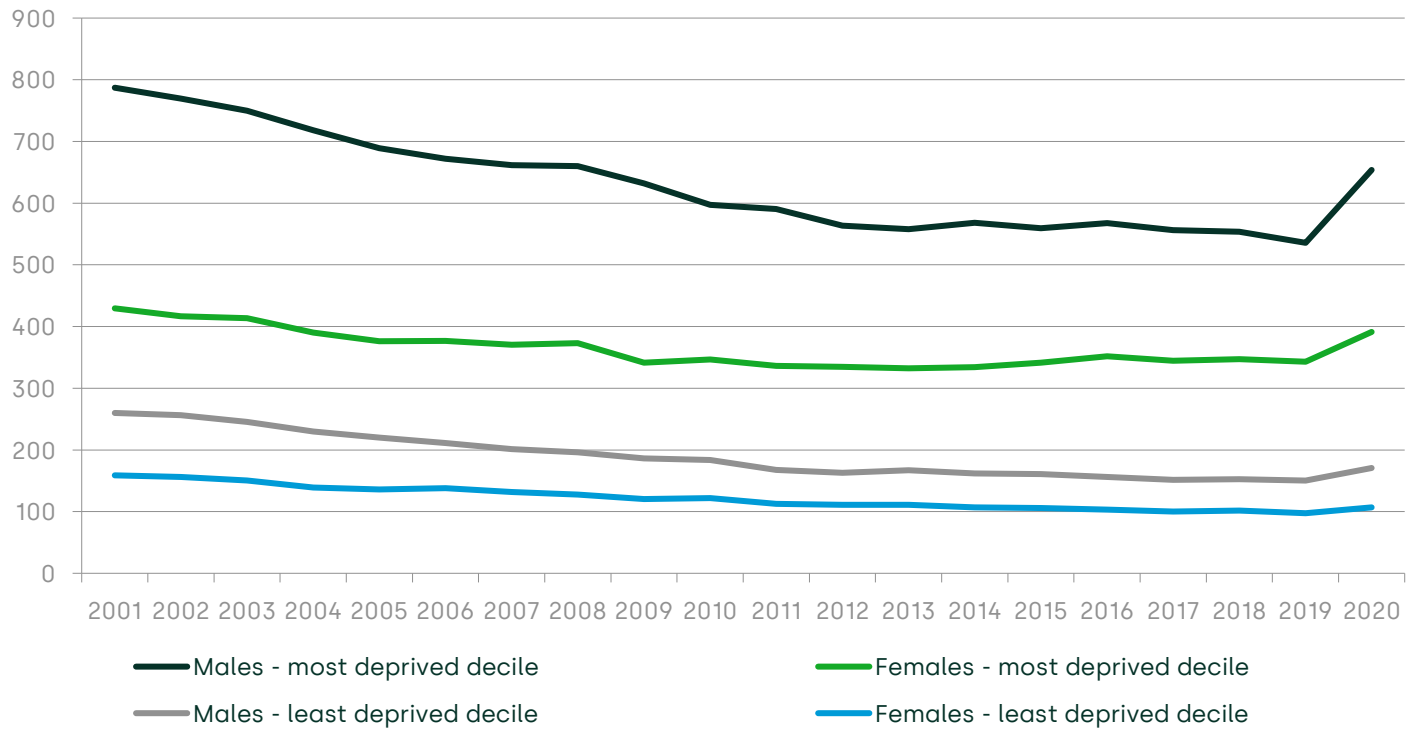
One of the most pressing issues on the demand side is the ageing population, expected to rise over time. This creates further demand for NHS services, particularly if health is not well managed and people end up living a greater proportion of their lives in ill health. To manage this increasing demand from our ageing population, investing in prevention and community services is vital.[28]

Furthermore, evidence demonstrates that older people tend to live with multimorbidity,[29] which means that to achieve good outcomes it is essential to have integrated healthcare, effectively coordinating the requirements and complications of different chronic conditions.

In a recent Oxera study, we estimated the economic cost of health inequality in England by examining the loss of output resulting from a person dying prematurely due to an avoidable death. We found that people in the most deprived areas were over four times more likely to die from an avoidable cause than those in the least deprived areas. While progress was made between 2001 and 2012 to reduce the gap in avoidable mortality rates between the least and most deprived local authorities in England, avoidable mortality has stagnated since.[30]

[27] The Health Foundation (2024). Priorities for an AI in health care strategy. 1 December.
[28] This was highlighted by Andrew J. Scott (2024) in his book *The Longevity Imperative: Building a Better Society for Healthier*, Longer Lives.
[29] National Institute for Health and Care Excellence (2023), 'Multimorbidity: How common is it?', June.
[30] Oxera (2023), 'The economist cost of health inequalities in England', 31 October.

Figure 3.2 Avoidable mortality rate by deprivation deciles



Note: The number of avoidable deaths in 2020 includes deaths from COVID-19.
Source: Office for National Statistics (2022), 'Socioeconomic inequalities in avoidable mortality: England analysis', last accessed 19 November 2024.

As health inequalities are influenced by individuals' socioeconomic conditions—such as levels of income, employment, education and exposure to crime—addressing health inequalities requires a holistic approach focused on welfare, education, housing and health. A recent report by the Health Foundation projects that chronic pain, type 2 diabetes, anxiety and depression are expected to increase at a faster rate in the most deprived areas.[31] Notably, these conditions are all, to some extent, preventable and can be managed in primary and community settings.[32]

Another challenge currently facing the NHS and the economy more broadly is the rising number of working-age people that are economically inactive due to ill health. Indeed, previous Oxera analysis shows that the number of people reporting health problems or

[31] The Health Foundation (2024), 'Health inequalities in 2040: Current and projected patterns of illness by deprivation in England', April.
[32] The Health Foundation (2023), 'Nine major challenges facing health and care in England', 3 November.

disabilities connected with the back and neck, mental illness and nervous disorders has risen sharply, and the lost output due to ill health stands at c. 7% of the UK's gross domestic product (GDP).[33] This is adding further demand on NHS services from a population who would otherwise be expected to be healthy. Rising inactivity can create a downward spiral of declining health and leaving the labour market, which can further exacerbate health problems.[34] A recent report by the Institute for Fiscal Studies (IFS) found an expected rise in the working-age population claiming health-related benefits,[35] further adding to the pressures facing the NHS and wider fiscal pressures with more people out of the labour force.

3.3 Recommendations in the Darzi Report for a resilient NHS

The Darzi Report is a comprehensive analysis of the challenges facing the healthcare system (including those covered in sections 3.1 and 3.2) and sets out some recommendations for the forthcoming 10-Year Health Plan for the NHS to address these challenges. These are:

- re-engage staff and empower patients;
- lock in the shift of care closer to home by hardwiring financial flows;
- simplify and innovate care delivery for a neighbourhood NHS;
- drive productivity in hospitals;
- tilt towards technology;
- contribute to the nation's prosperity;
- reform to make the structure deliver.[36]

While the Darzi Report rightly identifies the themes that need to be considered to fix the NHS, it is not in scope of the Report to outline *how* these themes could be achieved. The NHS needs a system-wide response to its challenges, which the 10-Year Health Plan will aim to achieve.

In section 4, we consider one particular recommendation set out in the Darzi Report: how to update the funding structure to achieve a shift of care closer to home. In this context, we also provide recommendations on how to improve the NHS's funding structure to ensure that funding is more effectively supporting the NHS's aims. These represent some

[33] Oxera (2023), 'The economist cost of ill health among the working-age population', 17 January.
[34] See, for example, Waddell, G. and Burton, A.K. (2006), 'Is work good for your health and wellbeing'.
[35] Institute for Fiscal Studies (2024), 'Health-related benefit claims post-pandemic: UK trends and global context', 19 September.
[36] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, pp. 12–13.

simple changes that ensure alignment with the actual aims of the NHS as it stands. While a more radical overhaul of the UK's health system may be inevitable, fixing the obvious issues with the current system is the right place to start from our perspective.

4 Our funding recommendations for 10-Year Health Plan for healthcare

In the following, we set out our funding recommendations for the NHS 10-Year Health Plan for the NHS in detail. Specifically, we first examine how the current funding structure can be made more effective, by improving the quality of data collection across services and improving the allocation of funding for public health and general practice services. We then outline how funding over time can be shifted from secondary to primary and community healthcare services ('closer to home') and from day-to-day spending to long-term capital investment. Finally, we set out some design principles that should inform a more comprehensive reform to the current funding structure of the NHS.

4.1 Making the current funding structure work more effectively

Within the current NHS funding structure, the funding that services receive is not always proportionate to the quality and quantity of care they provide. Our view is that there are three issues that warrant consideration in the 10-Year Health Plan:

1. the lack of high-quality data collection across NHS services;
2. the use of outdated data for the funding of public health;
3. the use of an inadequate formula to allocate general practice funding.

All of these factors need to be addressed to ensure that services can operate efficiently. We therefore consider that they should be implemented quickly as they could help to address some of the immediate challenges facing the NHS. We discuss each issue in turn below.

4.1.1 Improve data collection across services

The Darzi Report recognised that within the NHS, 'what gets measured, gets funded.'[37] This means that accurate, high-quality data collection needs to be a priority across NHS services, to make sure that funding is allocated where it is needed.

However, the quality of the data collection within the NHS is currently inconsistent between services. For the acute hospital sector, patient-

[37] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, p. 80.

level data has been collected centrally for hospitals since 2007. On the other hand, there was no data held for mental health services before 2016 and almost no data collected for community services until 2021. Indeed, data collection for community services remains 'poor' today, due to the high number of metrics that need to be filled out by NHS staff. The Darzi Report highlighted that it is 'impossible to get precise headcount figures'.[38]

Community services cover a range of important activities, including specialist nurses (e.g. for diabetes and heart failure), musculoskeletal therapy and cardiac rehabilitation.[39] Without appropriate data collection, measuring the productivity or the quality of outputs these services are providing becomes a challenge. This, in turn, makes the proper management and funding of these services a challenge, as no data is available to shed light on their effectiveness and weaknesses.

The appropriate funding of NHS services is also currently affected by the lack of data linkage between different bodies in the healthcare sector. Performance data is not automatically shared between the Integrated Care Systems (ICSs), NHS England and the Department of Health and Social Care (DHSC). This means that national bodies need to separately follow up with the ICSs to monitor whether their targets are being met.

The Hewitt Review highlights that this currently leads to a large number of ad hoc requests to ICSs from NHS England and the DHSC. The bureaucratic burden on the integrated care systems from these requests is significant, and channels away their resources and staff from delivering better health outcomes.[40] The manual completion of ad hoc requests is also error-prone, and means that the picture of where resources should be targeted is not necessarily complete between national bodies.[41]

To solve these issues, increasing the automation of data collection and interoperability of NHS data is necessary. The Federated Data Platform (FDP) that is currently being developed by NHS England, DHSC ICSs and other groups is a step in the right direction in this context. This platform aims to provide a minimum data-sharing standards framework so that

[38] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England' , 12 September, p. 80..
[39] NHS England (n.), 'What are community health services'.
[40] NHS Confederation (2024), 'The Hewitt review: where are we one year on?', 26 July.
[41] Department of Health and Social Care (2023), 'The Hewitt Review: an independent review of integrated care systems', 4 April, p.61.

all bodies can communicate with each other effectively.[42] However, many of the Hewitt Review's recommendations have so far not been implemented. For instance, it appears that a rapid review of all existing data has not taken place in the entire year since the report was published.[43]

The steps set out by the Hewitt Review should therefore be targeted at, in the first place, streamlining data collection across the NHS, including sharing the data held by NHS England with ICSs to increase performance.

In addition, NHS England should prioritise an ICS leadership development programme to drive forward digitalisation. At the moment, there is an acute lack of digital leaders who have the capabilities to deliver the NHS's digital transformation agenda. This gap needs to be addressed urgently to meet the NHS's future needs.[44]

4.1.2 Update data for funding of public health services

While improving the quality of the data collected is a necessary pre-requisite to ensuring that funding is allocated to match need, current systems do not even make use of the data that is available. Public health services use outdated data to determine the amount of funding allocated by central government to upper-tier local authorities for public health services. This should be updated immediately to address obvious and persistent inequities.

The public health grant is given to local authorities to provide a range of preventive services, including in relation to drug and alcohol, smoking, obesity and health check programmes. Since 2015/16, the public health grant per person has been reduced by 28% in real terms. This average reduction has been disproportionately weighted against local authorities, with more deprived areas like Blackpool seeing greater cuts to their public health grants.[45]

Besides the real-term reduction in public health grants, there is evidence of misallocation between local population needs and the funding that local authorities receive. This is because allocations for public health grants are based on outdated data on upper-tier local authorities that have been rolled over year-to-year since 2014/15. For example, in 2022/23, Slough received a share of public funding that was 35% lower

[42] NHS Confederation (2024), 'The Hewitt review: where are we one year on?', 26 July.
[43] NHS Confederation (2024), 'The Hewitt review: where are we one year on?', 26 July.
[44] NHS Confederation (2024), 'The Hewitt review: where are we one year on?', 26 July.
[45] The Health Foundation (2024), 'Investing the public health grant', 8 April.

than its share of estimated needs,[46] whereas Kensington and Chelsea received 116% more than its estimated needs. The per capita funding for public health is also lower in areas with older populations.[47] This is particularly problematic given the important role that local authorities play in providing preventative services. The misallocation in funds could further exacerbate health inequalities between geographies across England.

As a result, it should be a high priority to update the data to the latest available and the formulae used to allocate public health spending so that local population needs are accurately reflected.[48] This would ensure not only that preventative services—which have a fundamental role in managing demand—are well targeted, but also that gaps in health inequalities are not further exacerbated.

4.1.3 Renew the Carr-Hill formula for funding of general practitioners

Funding is also distributed inefficiently between services due to the formula that determines the amount of money allocated to general practitioners (GPs).

Almost half of the funding that GPs receive is through 'global sum payments', which cover core services and are estimated based on the Carr-Hill formula. This formula takes into account: patient age and sex, long-standing illness, and standardised mortality rates for patients under 65.[49] Other sources of payment include the Quality and Outcomes Framework and payments for Enhanced Services such as minor surgeries.[50]

Whereas many important factors in determining health demands are considered, the Carr-Hill formula used to estimate global sum payment currently does not match GPs' workload. This is because it does not take into account the following.

1 The impact of deprivation on health and associated larger demand in certain areas around England.[51]

[46] Needs for public health are estimated based on age/gender groups, children in poverty, standardised mortality rate under 75 and sparsity.
[47] Institute for Fiscal Studies (2023), 'How much public spending does each area receive? Local authority level estimates of health, police, school and local government spending', August.
[48] Institute for Fiscal Studies (2023), 'How much public spending does each area receive? Local authority level estimates of health, police, school and local government spending', August, p. 39.
[49] British Medical Association (2024), 'Global sum allocation formula', 19 August.
[50] The King's Fund (2020), 'GP funding and contracts explained', 11 June.
[51] Kontopantelis, E., Mamas, M.A., Marwijk, H.V., Ryan A.M., Bower, P., Guthrie, P. and Doran, T. (2018), 'Chronic Morbidity, deprivation and primary medical care spending in England in 2015-16: a cross-sectional spatial analysis', 14 February.

2 The increasing time that GPs spend going over essential patient follow-ups and associated administrative work. As the British Medical Association (BMA) describes it: 'In reality "part time" as a GP very often means working a number of additional unpaid hours just to get through the large numbers of appointments and essential patient follow-up (administrative) work'.[52]

As such, for the global sum payment to reflect the requirements of the local population and actual workload, it needs to be updated to include a multiplier for the level of deprivation, and an allowance for the additional workload associated with follow-ups. It is important to note that any allowance for additional workload needs to be benchmarked against the efficient GP to maintain the incentive of high performance. These metrics should be calibrated using data on workload and demand at the local level.

However, even if the formula is improved, the annual increases in payments have not kept up with inflation over the last five years. This has rendered it difficult for GPs to meet rising costs. As a result, hundreds of practices have gone out of service.[53] This led to GPs voting to take collective action in July of this year, for the first time ever.[54] In response, the current health secretary promised to 'reset the relationship' between GPs and announced an additional £82m to employ newly qualified GPs.[55]

The two factors above suggest that without proper revisiting of the funding allocation of funding to GPs (see section 4.2 for how this can be done), the current struggles of GPs—who are usually the first point of contact in accessing the healthcare system—will continue.

4.2 Shifting the funding to where it is needed most

Besides making the current funding structure work more effectively, it is also necessary to adapt it for future challenges the NHS will face. In response to an increasingly ageing population with more complex healthcare needs, it will be necessary to increase preventative care so that the number of in-patients is reduced as much as possible. At the same time, the NHS will need to ensure that it is resilient to future demand by increasing its productivity.

[52] British Medical Association (2024), 'Pressures in general practice data analysis', 29 November.
[53] Nuffield Trust (2024), GPs are taking 'collective action'. What does that mean?, 9 August.
[54] Nuffield Trust (2024), GPs are taking 'collective action'. What does that mean?, 9 August.
[55] British Medical Association (2024), 'Pressures in general practice data analysis', 29 November.

In effect, this means that two big shifts in funding need to take place over the next few years: from hospitals to primary and community care and from hospitals' day-to-day spending to investments in hospitals' technology and estates.[56] Below, we discuss how both of these shifts can be achieved.

4.2.1 Achieving differential growth across services

As set out in the Darzi Report, NHS funding needs to shift from care in hospitals to care in the community to increase preventative care. Since the COVID-19 pandemic, we have seen the opposite happening: funding for hospitals has increased, partially to support the 17% rise in staff numbers between 2019 and 2023. Over the same time period, funding for primary care and community services declined, not keeping up with rising cost pressures.[57]

It is evident that funding needs to be prioritised for the community as the population ages, with a focus on prevention. Older generations are more likely to be living with more than one long-term condition which require coordination and close, frequent contact with healthcare practitioners. A more integrated, community-based healthcare service would be better prepared to respond to these challenges. The pressing questions in this context are: How do we achieve the shift to preventative care? And how can we balance this against the persistent challenges that hospitals are facing?

There are no easy answers here. One option worth exploring is to commit to delivering differential growth across services as the NHS Long Term Plan intended. This entails that rather than cutting budgets for hospitals, a shift to primary and community services could be achieved through re-shifting the resources that would primarily be used to grow hospital budgets into primary health services.

The actual extent of this shift will need careful consideration and discussions with all relevant stakeholders in the NHS. A national leader who was interviewed for the NHS Long Term Plan suggested, for instance:

'A shared commitment that this year, we are going to, rather than growing our acute base by 4%, we're going to grow it by 2%, and the

[56] NHS Confederation (2023), 'Investing to save: the capital requirement for a more sustainable NHS in England', 28 November.
[57] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England' , 12 September, pp. 76 and 86.

balance of the resource we're going to put into these services, and we expect that to have this impact.'[58]

The impact of this may not be felt immediately, as resources would shift slowly over a number of years. However, this should be more politically palatable and help provide the incentives to hospitals to find and introduce the technological solutions to become more efficient. If differential growth is pursued consistently, the total extra money that primary and community services get would be substantial and could help transform these services in the long term and reduce the pressure on hospitals in the longer term.[59]

Figure 4.1 Differential growth

Source: Oxera.
Note: The extent of the shift shown in this figure is purely illustrative.

The challenge facing the shift from hospital to the community will take time and can, on the face of it, look daunting. However, such a service transformation has been achieved previously. The NHS successfully improved mental health services through the gradual replacement of acute care provided in institutions with a community-based model. The transformation did not happen overnight and required the interaction of several factors, including innovation in service delivery and management structures, but it has eventually been successful. The choice of care models should be driven by local needs, and managing physical health would be no different.[60] These factors are important to

[58] The King's Fund (2024), 'Making care closer to home a reality', February.
[59] The King's Fund (2024), 'Making care closer to home a reality', February.
[60] The King's Fund (2014), 'Service Transformation: Lessons from mental health', 4 February.

take into account when implementing the shift of funding to primary and community care.

4.2.2 Investing in hospitals' technology and estates

The second big funding shift that should be prioritised is from hospitals' day-to-day spending to capital spending.

Capital spending is used to fund buildings and facilities, service equipment, IT infrastructure, and research and development in the NHS.[61] There is currently a shortfall in these investments, which has left estates 'crumbling' and the IT infrastructure severely underdeveloped (particularly in regard to administrative tasks).[62] The Darzi Report outlines that there is currently a backlog of maintenance for estates worth £11.6bn.[63] In addition, research by the BMA found that more than 13.5m working hours are lost yearly in England as a result of inadequate IT systems.[64]

Capital investment is not only insufficient due to the actual amount of funding available, but also due to the challenges in accessing it. There is a complicated and lengthy approval process that is described by the Nuffield Trust as 'so byzantine that it is hard to find an NHS senior manager who understands it.'[65] HM Treasury also strictly enforces its capital expenditure approvals, even if funding for such additional investments is available.[66] This effectively means that capital investment is not being used—in recent times, a large part of the capital budget has been diverted and used to cover day-to-day expenses. [67]

The Nuffield Trust identifies a number of actions to address this issue, including:

1 enable the development of strategic capital investment plans that allows for 'quasi-automatic' approval for schemes that meet pre-defined criteria;

[61] Nuffield Trust (2022), 'NHS capital and infrastructure: Delivering the manifesto and unlocking potential', November, p. 1.
[62] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, p. 101.
[63] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, p. 8.
[64] British Medical Association (2022), 'Building the Future. Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the UK's health services'.
[65] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, p. 101.
[66] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, pp. 101.
[67] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England', 12 September, pp. 101-102.

2 devolve approval responsibilities for smaller capital schemes to Integrated Care Boards (ICBs) which were set up in 2022 to join up health and care services in local areas, oversee how money is spent and ensure that high-quality care is delivered.[68]

In this context, we can learn lessons from local transport (see the box below) before devolving capital funding to ICBs. Crucially, each ICB needs the necessary capabilities to plan, design and deliver capital projects. This is because there is often an insufficient pipeline of 'shovel-ready' capital projects across the trusts that ICBs collaborate with. As a result, funding may be allocated to trusts with the most developed plans rather than those with the greatest need.

Box 4.1 Lessons from local transport

In local transport, local authorities are responsible for maintaining and improving the road network and supporting local bus services. Central government funding for these services has often been awarded to local authorities through competitive processes, resulting in a 'local transport lottery' that compounded pressures on local government finances.[69] This meant that local authorities with the most developed proposals received the funding, as opposed to those with the greatest needs.

In response, the Department for Transport (DfT) now requires local authorities to develop Local Transport Plans, Bus Service Improvement Plans, and Local Cycling and Walking Investment Strategies, with financial support provided for plan development.[70] With these plans in place, the government aims to streamline funding delivery and reduce the need for competitive funding applications.[71]

A similar approach for ICBs—requiring robust capital plans and providing dedicated support to develop and deliver them—

[68] Nuffield Trust (2022), 'NHS capital and infrastructure: Delivering the manifesto and unlocking potential', November.
[69] Urban Transport Group (2020), 'The Local Transport Lottery', February.
[70] Department for Transport (2024), 'National Bus Strategy: 2024 Bus Service Improvement Plans', January.
[71] Department for Levelling Up, Housing and Communities (2022), 'Levelling Up the United Kingdom, 2 February.

should reduce the need for extensive Treasury approval and help unlock necessary capital funding, aligning funding more closely with actual needs. Capital spending should then focus on technology and estates, since these parts of the NHS have some of the most urgent needs.[72] For example, the updates to the data infrastructure that were highlighted in section 4.1.1 will rely on a well-functioning capital funding model.

Source: Oxera.

4.3 Design principles for a new funding model

In addition to the recommendations made in the sections above, a more extensive approach to reforming NHS payment systems should be considered so that the funding structures are equipped to support the NHS in meeting the challenges it faces in the future.

The current NHS payment systems can broadly be put into five categories, as follows.

- **Block budget payments**: provide NHS services with a set amount of money over the year.
- **Capitation payments**: lump-sum payments to cover services for individuals over a certain period. They are usually annual per person payments, adjusted for patient complexity.
- **Activity payments**: fixed payments for an episode of care, meaning a specific service.
- **Fee for service**: retrospective payments for all units of a specific service provided.
- **Top-up or 'withhold' payments for quality**: provide rewards for high performance or quality.[73]

A specific NHS service normally does not rely on any one of these payment structures but combines several. For example, GPs typically receive a mix of money from capitation payments and payments for quality.[74] The exceptions to this are mental health and community

[72] Nuffield Trust (2022), 'NHS capital and infrastructure: Delivering the manifesto and unlocking potential', November.
[73] The Health Foundation (2021), 'The future of the NHS hospital payment system in England', July, p. 4.
[74] NHS Confederation (2024), 'Unlocking reform and financial sustainability: NHS payment mechanisms for the integrated care age', March.

services, where block payments predominate, and acute care, which mostly relies on activity payments.[75]

All of these different payment approaches have different strengths and weaknesses in isolation. However, the current mixture of providing case-based payments for acute care and block budgets for out-of-hospital services does not incentivise an integrated approach to healthcare that is focused on prevention.

Specifically, the reliance of hospitals on activity payments for acute care means that they have to complete of a full episode of care to receive the funding they need. Working together with other service providers—or supporting initiatives for preventative care—is thereby discouraged.[76] At the same time, the block contracts in community services do not incentivise treating complex patients whose prevalence will grow as the population ages.[77]

In light of the above, the NHS should take into account the principles highlighted in the figure below for updating its payment systems.

Figure 4.2 Principles for updating the NHS's payment systems

Source: Oxera.

[75] NHS Confederation (2024), 'Unlocking reform and financial sustainability: NHS payment mechanisms for the integrated care age', March.
[76] The Health Foundation (2017), 'Towards an effective NHS payment system: eight principles', October, p. 9.
[77] The Health Foundation (2017), 'Towards an effective NHS payment system: eight principles', October, p. 10.

Of these principles, the first seems most obvious—funding should go where it is most needed. Across the NHS, the challenge is that all services are calling for extra funding. Hospitals need to continue to run on a day-to-day basis while GPs need to be able to cover their service costs. The NHS's future challenges suggest that any update to the NHS payment systems should focus on increasing funding for preventative and integrated care, provided by primary, community and mental health services.[78]

For this funding increase to take place, the second principle should be kept in mind. Funding can be distributed more flexibly across services if ICBs have a more central role in funding decisions. These local ICBs are made up of the NHS, local authorities and third-sector bodies, and are responsible for NHS services, funding, commissions and workforce planning across the ICS area.[79] They are therefore well positioned to judge local funding needs towards integrated and preventative care.

As set out above, NHS services currently rely on funding that is distributed locally based on nationally determined payment systems. To make sure that ICBs can respond to local needs, any update to the current payment system should give them more decision-making power over how to distribute funding. In this context, an increasing focus on capitation payments may be a way forward. Capitation relies on lump-sum payments made to local areas based on estimated needs.[80]

Already in place for GPs, this system could be implemented more widely as a payment system across services. ICBs would thereby be given more flexibility to spend money on services based on those which will deliver the best outcomes for patients, and provide an integrated, holistic provision around the different parts of healthcare. Importantly, the capitation system should also facilitate data sharing across services and enable the creation of a pathway intervention for people with long-term conditions. This would help to avoid unnecessary hospital admissions and could help ICSs to provide care to individuals earlier, enabling greater autonomy for people to manage their health.[81]

For ICBs to make payment decisions under the capitation or any other more local payment approach, they will need to have the necessary expertise. Recent experience has shown that simply increasing the ICBs'

[78] Department of Health and Social Care (2024), 'Independent Investigation of the National Health Service in England' , 12 September, p. 12.
[79] British Medical Association (2024), 'Integrated Care Systems (ICSs)', 28 June.
[80] British Medical Association (2024), 'Models for paying providers of NHS services', 28 June.
[81] The King's Fund (2010), 'Improving NHS productivity', July.

workload in taking on new functions means that they may be unprepared and can end up outsourcing these responsibilities for additional costs.[82]

Any updates towards a more locally focused NHS payment system should therefore be accompanied by investments in ICBs' capacity and capability. This is important to ensure that ICBs distribute money based on need rather than which service requests it the loudest. At the same time, national pressure on ICBs should be reduced, so that they can focus on a long-term approach to health rather than 'a small number of NHS driven, short-term political priorities – money, waiting lists, ambulances etc.'[83]

Finally, the third principle should also guide any decision making in terms of payment approaches: funding should be monitored nationally. While funding decisions should take place more locally, data collection on performance needs to take place both locally and nationally. This will enable NHS England to track performance and compare it against nationally set standards to ensure quality and appropriate funding throughout the system. It will also help to identify those ICBs that need more support in making their funding decisions and ensure that ICBs can share best practice and learn from each other.

In our view, the recent update of the commissioning of certain specialised services aligns with these principles. These were delegated to ICBs following the Health and Care Act 2022. ICBs will receive funding based on a weighted capitation approach, which gives them a considerable amount of flexibility in commissioning these services (as we outline above). At the same time, ICBs 'will be required to commission against nationally set specifications and clinical access policies'.[84] NHS England will also continue to be the ultimate accountable commissioner, so that it is assured that targets are being met.[85]

While this commissioning approach is still to be fully implemented, it will provide important feedback on the design principles set out above. In

[82] NHS Confederation (2023), 'The state of integrated care systems 2022/23: riding the storm', 17 August.
[83] NHS Confederation (2023), 'The state of integrated care systems 2022/23: riding the storm', 17 August.
[84] NHS England (2022), 'Roadmap for integrating specialised services within Integrated Care Systems', 31 May, para 1.11.
[85] NHS England (2022), 'Roadmap for integrating specialised services within Integrated Care Systems', 31 May, para 1.11.

particular, it will showcase what national support ICBs need to fully realise their potential. In the meantime, ensuring an efficient structure of the current funding system, and enabling a funding shift towards the community and capital remain areas that need to be prioritised by the NHS.

5 Conclusion

In this response, we have set out proposals in relation to how funding levers can help to address many of the challenges facing the NHS that the Darzi Report identified. Specifically, we have focused on proposals to make the current funding structure work more effectively, and to incentivise a shift towards care closer to home and long-term capital investment. We also recommend a comprehensive updating of the current NHS payment systems based on some general design principles set out in this response. These include allocating money to where it is most needed, giving ICBs more authority over funding decisions, and ensuring that performance targets are being met at a national level.

We are confident that these proposals will help to prepare NHS' funding for the years to come. Nevertheless, the problem is much bigger, and will need bold actions and system-wide thinking. For instance, our response does not examine the interaction of NHS funding with the funding to the life science sector, which, as we move towards personalised medication, will put additional demand on the public purse and is worth a further discussion. Other suggestions presented in the Darzi Report to address the challenges faced by the NHS also need to be implemented, for the healthcare system to remain functioning in the long term.

We therefore look forward to hearing the details of the forthcoming 10-Year Health Plan for the NHS, and hope that our proposals will provide a helpful roadmap to make the NHS's funding structure resilient to its future challenges.

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