HEALTH MJ

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NHS spending second lowest in G7, says ONS

Spending on health in the UK is the second lowest per head in the major industrialised countries but average compared to the world's 25 largest economies according to latest figures from the Office for National Statistics.

But contrary to public perception the NHS is efficiently administered compared to other countries mainly due to being free at the point of care.

The figures, which examine spending data from 2013/17 among the 25 members of the Organisation for Economic and Co-operation (OECD), show the UK spent £2,989 per head on healthcare compared to the average of £2,913.

However this compares poorly against major G7 economies like the US at £7,736, Germany at £4,432 and France at £3,737. It is also below the average of the so-called EU15, the earlier members of the European Union.

The UK's publicly funded NHS-based health system contributes to the UK having one of the highest shares of publicly funded healthcare (79%) in the OECD. Other countries like the US may spend more on health because of larger private sector systems.

In 2017, the UK spent £53 per person on healthcare governance and the costs associated with financing healthcare which was below the median average for OECD countries.

As a percentage of GDP, UK healthcare spending fell from 9.8% in 2013 to 9.6% in 2017, while healthcare spending as a percentage of GDP rose for four of the remaining six G7 countries (the G7 is the US, UK, France, Italy, Canada, Japan and Germany). This is partly because the UK's GDP rose at a faster rate.

As for long-term health care the UK compared favourably with France and Canada.

In 2017, the UK spent the equivalent of £560 per person on health-related long-term care, which was less than most other northern or western European countries, but a similar amount to France (£569) and Canada (£556).

The UK spent £197bn on healthcare in 2017, equating to £2,989 per person.

In the OECD, spending was lowest in Mexico at £837 per person and highest in the US at £7,736 per person. The US spend per person is more than two and a half times what is spent per person in the UK.

For the UK, health spending equated to 9.6% of GDP, which was ranked as the second-lowest of the G7 countries (the US, Canada, France, Germany, Italy, Japan and the UK).

See feature – p6-7

Capital funding welcome but staffing crisis 'needs addressing'

Government pledges to invest in new hospitals have been welcomed with a warning that maintenance and staffing shortages must also be addressed.

Richard Murray, chief executive of The King's Fund, said: 'A longer-term investment programme is also needed to tackle the £6bn NHS maintenance backlog, upgrade GP surgeries that are no longer fit for purpose, and modernise the NHS so it can take advantage of new technology, particularly given the ambitions of the NHS long-term plan to develop facilities in the community.'

He added: 'As well as shoring up buildings, urgent action is needed to shore up the NHS workforce. Severe staff shortages are the biggest challenge facing the health service, with nearly 100,000 vacancies in NHS trusts.

'If the Government really wants get the best value out of this new capital spending, it will need considering alongside a comprehensive plan to tackle staffing shortages in both the NHS and social care, future plans for public health spending and investment in social care, to help keep people well for as long as possible and out of hospital when they don't need to be there.'

INSIDE: Delays still block UK hospital beds. See p8

comment

By Michael Burton

One of the big public policy challenges for this Government is how to address the increasingly lopsided profile of the welfare state in which spending is geared towards older people because of health, pensions and care costs.

In fact, despite almost a decade of austerity, the size of the state is much as it was in the middle of the last Labour Government, mainly because NHS and pensions have taken a greater share of the spending cake.

This is not unusual for major industrialised countries and, as the latest Office for National Statistics figures show, the UK's health service is still way below the average for the G7 countries when it comes to spending, partly because they also have private insurance top-ups compared to the UK's mainly taxpayer-funded system.

The delay in the publication of the social care Green Paper shows how difficult a nettle this subject is for ministers to grasp.

The Conservative manifesto commitment on social care during the 2017 election pretty well scuppered Theresa May's chances of a majority.

Part of the problem is, as Institute for Fiscal Studies director Paul Johnson pointed out in a fringe at the October Conservative conference, that since the public is so unaware of the real costs of their social care, just bringing the subject up at all is guaranteed to lose votes.

However, there have been several previous attempts to deal with social care funding plus numerous studies from think-tanks.

The solutions are there – they just need leadership from politicians to deliver them.

Michael Burton is editorial director of Health MJ
m.burton@hgluk.com

IPPR calls for care home funding

By Paul Dinsdale

A think-tank has called for state provision and the building of more care homes to tackle the continuing crisis in the social care sector.

A report by the IPPR said the private sector now provides 84% of beds for people needing residential social care, an increase from 82% in 2015. A further 13% are provided by the voluntary sector and only 3% by local authorities and other public sector bodies, based on data collected by Future Care Capital (FCC).

In addition, almost one-fifth of all social care provision is provided by the five largest providers, of which four – one more than in 2016 – are owned by private equity firms. The IPPR said growing 'financialisation of the sector has seen these organisations rely on high borrowing, complex corporate structures and cost-cutting measures such as tax avoidance and low staff pay, which makes them potentially unstable, with two of the big five providers going into administration in recent years: Southern Cross in 2011 and Four Seasons in 2019.

The report identifies three factors that can lead to lower quality care from private providers, especially those backed by private equity *(see box)*.

The IPPR is calling on the Government to tackle the growing problems and ensure that the sector is properly overseen by taking a number of measures, including creating a powerful new care regulator, OfCare, to oversee the financial regulation of medium and large providers that are important to the stability of the system, compelling all state-funded care providers to maintain a minimum 'safe' level of reserves and show that they pay their fair share of corporation tax in the UK; and committing to building homes to provide up to 75,000 beds that will be needed by 2030 through borrowing worth £7.5bn.

The Government should also ensure that care within these homes is either provided directly by the state, or purchased from innovative not-for-profit local providers.

Harry Quilter-Pinner, lead author of the report, said:'The social care crisis is about more than just money. We need radical reform in who provides care and how they do this. Over the last few decades, the state has handed over the responsibility for care to the private sector. Too often these firms put profits before people.'

IPPR's findings on the care home crisis

- *Workforce* – previous IPPR research found strong evidence that private providers employ fewer staff, offer lower pay and less training and have higher turnover, driven by a business model that prioritises shareholder value over the quality of service provided to the taxpayer.
- *Instability*: three-quarters of local authorities reported they had experienced care providers shutting down during the past year, up from two-thirds the year before, according to the Association of Directors of Adult Social Services (ADASS). This is partly due to downward pressure on fees local authorities can afford to pay, but also reflects the growing reliance on debt within the sector.
- *Size*: the smaller the care home, the more likely it is to provide good care. Some 89% of small residential or nursing homes are rated as good or outstanding by the Care Quality Commission, compared with 65%of larger nursing homes and 72% of large residential homes.

Younger children 'at risk of depression'

Younger children in the UK school year may be more likely to be diagnosed with depression by the age of 16 than older children in the year, according to a study published in the journal *JAMA Pediatrics*.

Using the electronic GP records for a sample of one million school-aged children in the UK, the study by the London School of Hygiene & Tropical Medicine, found children born in the last quartile (youngest) of the school year were estimated to have a 30% increased risk of depression compared to the first quartile (oldest).

The authors say the total number of children diagnosed with depression remains low but that the findings should be a catalyst for more research into the causes of depression in school children and how to prevent it.

Putting the findings in context, each year around 800,000 children start primary school in the UK.

Based on the results of the study, the researchers predict that among these children, about 500 more of the youngest in the year might be diagnosed with depression compared with the oldest (2,200 vs 1,700), over the whole course of their schooling up to 16-years-old.

The findings also echo results from previous research with the youngest quartile, facing similar increases in risk for diagnoses of attention deficit hyperactivity disorder (ADHD) – 4,700 against 3,500 – and learning disability – 2,100 against 1,600.

Victims of domestic abuse 'more likely to become homeless'

A national domestic abuse charity says women who are victims are more likely to be homeless as a result of their situation.

A report by the Women's Aid charity, No Woman Turned Away, shows that it supported 309 women who were left with nowhere to turn as they fled domestic abuse. In the last year, 136 (44%) of these women 'sofa-surfed', 42 (14%) stayed in local authority emergency accommodation, 22 (7%) slept rough and 12 (4%) stayed in a B&B, hostel or hotel.

While waiting for a refuge space, 59 women (19%) experienced further abuse from their partner. The report describes the financial difficulties survivors face when escaping domestic abuse, with many women struggling to feed themselves and their children and to pay for the phone calls and transportation required to reach a safe place to stay.

The charity's annual audit found a shortfall of refuge bed spaces of 1,715 in England. The report also found 57% of domestic abuse service providers were running an area of their service with no dedicated funding, and 31% reported that, since 2014, they have had to make staff cuts due to reduced funding.

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For editorial inquiries contact Michael Burton at m.burton@hgluk.com. News editor. Paul Dinsdale
For display advertising inquiries contact Kasia Brzeska-Reffell at k.brzeska@hgluk.com and
for recruitment advertising contact Dave Lawrence at d.lawrence@spacehouse.co.uk. Tel: 01625 614000
Health MJ**: 32 Vauxhall Bridge Road, London SW1V 2SS**

Families unaware they qualify for social care payments

Many families may be eligible for direct payments for social care, but may not claim them when the need arises, said a charity.

Recent research by live-in care company, Elder, found that up to 83% of families are able to pay for care with some form of funding they had not necessarily expected they were entitled to.

The findings come from the 2,268 families who have used Elder's care funding calculator tool, which gives guidance to those looking to claim their entitlements.

Elder found that just under half (46%) of families are potentially entitled to direct payments from their local council, although it varied across the country.

Eligibility for direct payments – where families take control of local authority entitlements – was highest in North East England, where savings are lower, with Scotland coming second.

Due to high property values, London and the South East were the best places to fund care by unlocking the value of a home, with the capital coming out on top, where just under 70% of people are likely to be eligible.

The national picture showed that equity release could be an under-utilised way to fund care, being a potential option for 65% of respondents.

More elderly people have to sell homes to fund long-term care

By Paul Dinsdale

Pensioners are being forced to sell their homes to fund their care

Around 400 pensioners sell their homes each week to pay for social care, according to the latest research.

The figures, compiled by the charity Independent Age, show that 21,120 owners had to sell their homes last year, compared with just 11,880 in 2000. The charity says the latest figures indicate the scale of a crisis in which people with more than £23,250 in savings, including their property value, is refused state support.

Thousands of pensioners have to sell their homes in order to fund their own care.

The report also found that only some councils offer 'deferred payment agreements' which save people having to sell a property before their death.

The charity estimates that 11,880 owners had to sell in 2000. Since then, the annual total has almost doubled, with 21,120 selling their homes in 2018.

The latest report reveals that since 1999, when a Royal Commission proposed making personal care free at the point of use, more than 330,000 elderly people have had to sell their homes to pay for care. The scale of the problem has grown as care costs have soared and the elderly population has increased, says the charity.

In a separate development, a report by the Ombudsman found that funding issues are increasing the incidence of poor social care.

Mistakes were made in 66% of adult social care complaints investigated by the local government and social care Ombudsman in the last year – up from 43% in 2010.

The report said the rise in upheld complaints reflected 'rationing' of funds and 'mounting pressures on those who work in the care system'.

Head of the service Michael King said: 'While I recognise the challenging environment both commissioners and providers are operating within, any attempts to reduce costs must also properly consider the impact on the rights and dignity of people who use services.'

The Ombudsman received 3,070 complaints about adult social care in the past year, with only 435 from people who fund their own care.

NHS performance slips on waiting times

Waiting times for treatment at NHS hospitals have continued to lengthen over the last year, according to figures from NHS England.

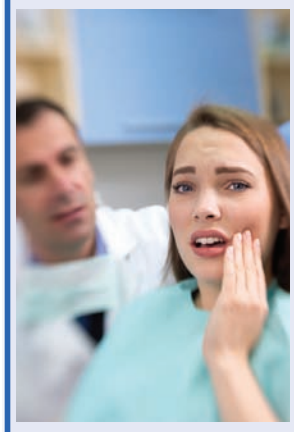
Commenting on the latest NHS performance figures, Professor John Appleby, chief economist at the Nuffield Trust said: 'These figures confirm that this year has seen an alarming slump in NHS performance against important targets. This summer was no exception, showing little sign of reprieve for staff and patients, with 6% more people turning up at A&E in August compared to last year.

'Over the last six months there has been on average over 60,000 more people waiting more than four hours in A&E per month compared to last year.

'In July, over 4.5 million people were on the waiting list for elective treatment, and one in seven of them had been waiting longer than 18 weeks. This is the largest the waiting list has ever been, and the worst performance since January 2009, Professor Appleby said.

'People must not get distracted by incoming new targets from the fact that NHS performance this year has seen a sharp decline. Changing measurements won't make a difference if things keep on worsening at this rate.'

briefs



■ A recent survey of 1,000 UK adults reveals that almost half of British patients have had a negative experience at the dentist.

The survey by the Dental Law Partnership found that 74% had experienced pain or discomfort during a dental procedure; 35% had experienced pain after leaving the practice; 23% didn't trust their dentist to know what they were doing and 7% had heard another patient screaming, shouting or crying while at the dentist.

The survey collected data on the anxieties patients feel when going to the dentist, as well as data on how many people have stopped going entirely due to their fears, or to increasing costs.

■ Construction contract awards in the medical and health sectors – hospital wings, GP surgeries – remained below the £100m threshold for the third consecutive month at £73m, based on a three-month rolling average. This was 5.7% lower than July and 21.3% lower than for August 2018.

In the three months to August 2019, total medical and health contract awards were valued at £220m, 54% lower than the previous quarter and 35% lower than for the comparable quarter ending August 2018.

Insight from construction industry analysts Barbour ABI highlights levels of construction contract values awarded across Great Britain in the medical and health sector.

briefs

■ A new study led by a research team from Queen's University Belfast, and the University of Southern California, has found social media messaging, such as Facebook posts and sponsored ads, have a significant positive effect on a range of teenage health behaviors.

The study found that educating popular teenagers to spread health messages to their peer groups can help other young people to address health issues such as substance abuse, an unhealthy diet and smoking.

Dr Ruth Hunter, lead author on the paper, said: 'Humans are embedded in social networks and these networks obey particular rules. They can give us new ways of intervening for the better.'

Among the positive behaviours noted were talking to pharmacists to quit smoking and/or cutting back on unhealthy foods.

■ Better financial support is needed to tackle one in four nursing students dropping out of their degrees before graduation, said a health think-tank. A quarter of all nursing students are still leaving their courses early or suspending their studies, said research by the Health Foundation.

It shows that despite political pledges to tackle the issue, students are still dropping out in worrying numbers. There are an estimated 40,000 vacant nursing posts in England alone. Figures show that of 19,566 UK nursing students who began three-year degree courses finishing in 2018, 4,695 had left their courses early or suspended their studies, a drop-out rate of 24%.

Doctors say vegan diet is 'safe' for youngsters

A study has concluded that a vegan diet can be beneficial for all age groups, including children, following a report earlier in the year that it could be damaging to young people.

In May, the Royal Academy of Medicine of Belgium (RAMB) said that a vegan diet for children, adolescents, pregnant and lactating women should be prohibited or discouraged.

But a collective of Belgian doctors and scientists have now contradicted the earlier report, saying that the opinion of the RAMB is 'unfounded and constitutes misinformation'. The expert group says 'a well-planned and balanced vegan diet is beneficial for health at all stages of life'.

It analysed the studies on which the opinion of the RAMB was based in its two successive reports against vegan diets.

All the conclusions addressed to the academy are detailed in an 12-page report, drawn from a total of 83 sources. They said their conclusions have attracted international support and the report has been signed by more than 100 health professionals and doctors of science from 13 different countries.

This group also said it regrets 'the lack of education and knowledge on nutrition issues within the medical community, particularly on plant-based nutrition.' They point to an American study which highlights significant gaps in nutritional education for cardiologists.

For the full report, visit: www.reponseARMB.com

Tool predicts MRH after hospital discharge

PRIME tool measures the benefits and harms of medication to help guide intervention

By Paul Dinsdale

Researchers have a developed a new tool to assess the likelihood of an older adult suffering from medication-related harm (MRH) after discharge from hospital.

According to recent studies, more than a third of older patients experience MRH following hospital discharge. Apart from causing harm to patients and significant distress to their families and carers, MRH is also associated with a significant cost to the NHS of around £396m annually.

Researchers at Brighton and Sussex Medical School (BSMS), working in collaboration with King's College London, have now developed a new tool to assess the likelihood of an older adult suffering from MRH at the point of hospital discharge.

The PRIME tool includes eight routinely collected pieces of information relating to patients: age, gender, number of medicines taken, anti-platelet and diabetes medications, sodium level, previous adverse drug reaction, and living alone.

Using these eight determinants in a mathematical formula/tool provided predictive information on whether an individual patient was likely to suffer MRH in the eight week period after leaving hospital. It also predicts MRH in patients who may require additional NHS care.

Professor Chakravarthi Rajkumar, chair of geriatrics and stroke medicine at BSMS, and academic lead of the study, said: 'In our ageing population, the use of multiple medications is common. All too often patients can suffer harm from their medicines rather than benefit from them. By identifying those most at risk of MRH, the PRIME tool can help GPs, pharmacists and allied health professionals to implement interventions to help minimise the risk of such harm.'

The study involved more than 1,200 patients from five hospitals in the South of England. Of these, approximately one in six patients suffered MRH from adverse drug reactions. The study was published in *BMJ Quality & Safety.*

PFI costs 'damaging investment in NHS', says think-tank

Safety hazards, sewage leaks and falling ceilings are major risks at hospitals after decades of under-investment and the legacy of the Private Finance Initiative (PFI) in hospitals, researchers said.

The NHS is facing 'a PFI postcode lottery' as some trusts are forced to spend up to £1 in every £6 on PFI payments, with worrying consequences for patient safety, said the IPPR think-tank.

In a new report, IPPR outlines the 'capital crisis' facing the NHS and calls for the end of the 'toxic' legacy of PFI.

IPPR analysis of latest HMRC data found that for just £13bn of investment, the NHS will be spending £80bn over a number of years. It adds that NHS trusts will pay £2.1bn on PFI repayments this year, rising to over £2.5bn in 2030 and taking money away from vital patient services.

The impact of this is uneven, with some areas spending up to a fifth of their budget on PFI payments. The worst affected trusts are North West Anglia, Sherwood Forest, University Hospitals Coventry and St Helens and Knowsley.

PFI is compounding the damaging effects of austerity, which introduced regular cuts to NHS capital budgets.

The report says capital investment has 'fallen off a cliff' as trusts have been forced to re-allocate long-term capital funds to cover day-to-day running costs. In the last four years £4bn of capital funds have been reallocated.

The NHS has the lowest number of MRI and CT scanners per head among advanced Organisation for Economic Co-operation and Development (OECD) economies. Pagers, fax machines and paper filing systems are still commonplace, leaving it dangerously outdated, said the report.

Labour pledges to introduce free personal care in England

By Paul Dinsdale

Shadow chancellor John McDonnell has announced that a future Labour Government would introduce free personal care for people over 65, in a pledge that would cost around £6bn a year.

Personal care is already free in Scotland and the pledge comes on top of other costly Labour commitments made in the last few weeks.

The plan to make the 'care element' of social care free was proposed by the IPPR think-tank in two recent reports, which claimed it could save the NHS £4.5bn a year.

IPPR's research found that providing free personal care to all those over 65 who need it would create parity between cancer patients, who receive NHS care free at the point of need, and dementia patients, who currently have to pay for their own care.

It would also more than double the number of people who receive access to state-funded care, reaching many who currently do not have their needs met, and would help shift care out of hospital and into the community and at home.

John McDonnell: The Labour Party's pledge would cost around £6bn a year

The IPPR said the policy would also reduce hospital admissions, and its analysis showed this could deliver savings of £4.5bn a year to the NHS.

The policy appears to have public support, as a survey by *Independent Age* shows that three-quarters of respondents support it and two-thirds would be willing to pay more tax to get it.

Tom Kibasi, director of the IPPR, said: 'We are delighted the Labour Party has made this new commitment to making social care free at the point of need, just like the NHS.

'This was a central recommendation from an expert and cross-party group convened by IPPR and led by former Labour minister Lord Darzi and former Tory minister Lord Prior, now chairman of NHS England.

'With an ageing society, free social care, it is common sense and preferable to complex and unfair insurance schemes. It is right to end the care lottery and provide security and dignity in older age.'

Extending free personal care to all those who meet the current test of need would cost around £6bn in 2020/21 and £8bn in 2030/31, care experts said.

Very elderly people 'should move before a health crisis'

People in advanced old age would feel more in control of their lives if they considered a move to assisted accommodation or residential care before health problems forced them to, say researchers.

Most older people want to continue living at home for as long as they can, but in many cases, a health crisis means they need to make the transition to a new home closer to their families or to long-term residential care.

Researchers at the Universities of East Anglia (UEA) and Cambridge say that very elderly people are rarely involved in decisions about moving due to the urgency of their health crisis or cognitive decline.

They suggest that thinking about future moves earlier would help older people have more involvement in decision-making and could lead to better outcomes for all.

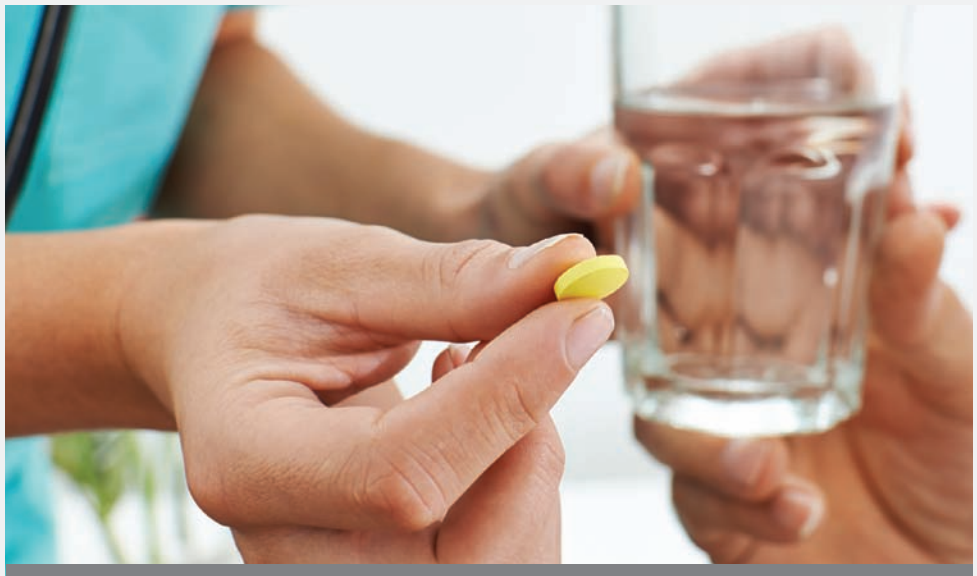
The research team studied interviews with a rare cohort of participants who were all aged over 95, most with some level of cognitive impairment, and their families.

Dr Morag Farquhar, from UEA's School of Health Sciences, said: 'A minority of older people choose to move to age friendly housing before the onset of disability, but the majority prefer to grow old in their own homes and put off moving until a health crisis forces them to.

'We know that in some cases the decision to move an elderly person is made by others who may override the older person's views and preferences, or even make it without their full consent. The likelihood of moving involuntarily increases with age and those over 80 are in the high risk bracket.

'Moves at this time of life are often driven by incidents like serious injury from a fall, hospitalisation, or the death of a spouse acting as a carer.'

Patients' Association launches care home 'charter'


The Care Home Charter will aid the administration of medication for those in care homes

The Patients' Association (PA) has launched a 'Care Home Charter' to improve medication practices for people living in care homes across the UK.

It has been developed in collaboration with care home residents and their families, experts in health and social care and is endorsed by the National Institute for Health and Care Excellence (NICE), among other organisations.

The charter aims to help support residents living in care homes to be actively involved in decisions about their care. It also provides a guideline for care home staff to follow in order to improve medication practices.

The PA says that of the 410,000 residents in care homes in the UK, many have complex needs including significant frailty, dementia and disability, and that research shows care home residents are prescribed an average of 7.2 medications and 7 in 10 residents were found to have been exposed to at least one medication error.

The charter emphasises the importance of residents being involved in regular monitoring and review of medications, and states that medicines should only be given with a resident's consent, unless they lack the capacity to provide it.

It also provides a guideline for care home staff to follow on administering medicines, and said staff should ensure that a care home plan is in place for the resident, and that good oral and dental care is provided.

Piloted in 22 care homes across England, Wales and Northern Ireland, the charter has received positive feedback from care home residents and staff.

How UK healthca

The UK's NHS performs better than it seems when compared with the health systems of other advanced countries, according to latest official figures

Despite claims that the NHS is on its knees, spending is about average compared to other developed countries, according to latest figures from the Office for National Statistics.

Compared to the largest of the advanced economies, however, the picture is worse, with the UK being the second lowest.

In 2017, the UK spent £2,989 per person on healthcare, which was around the median for the 25 members of the Organisation for Economic Co-operation and Development (OECD) which was £2,913 per person.

However, of the G7 (the US, Canada, France, Germany, Italy, Japan and the UK) group of large, developed economies, UK healthcare spending per person was the second-lowest, with the highest spenders being France (£3,737), Germany (£4,432) and the US (£7,736).

As a percentage of GDP, UK healthcare spending fell from 9.8% in 2013 to 9.6% in 2017, while healthcare spending as a percentage of GDP rose for four of the remaining six G7 countries. This is partly because the UK's GDP rose at a faster rate.

The UK's publicly funded NHS-based health system contributes to the UK having one of the highest shares of publicly funded healthcare (79%) in the OECD.

In 2017, the UK spent the equivalent of £560 per person on health-related long-term care, which was less than most other northern or western European countries, but a similar amount to France (£569) and Canada (£556).

The UK spent £197bn on healthcare in 2017, equating to £2,989 per person. This was slightly above the median expenditure for OECD member states which was £2,913 per person, but below the median for the EU15 (the original EU member countries), which was £3,663 per person.

In the OECD, spending was lowest in Mexico at £837 per person and highest in the US at £7,736 per person. The US spend per person is considerably more than any other OECD country and more than 2.5 what is spent per person in the UK. While there are many reasons why countries spend different amounts on healthcare, the OECD reports that countries spending the most tend to be high income economies.

Research suggests that the high spending in the US, compared with other countries, is partly attributable to

How is healthcare funded?

Healthcare is funded either publicly or privately. These revenues are used to fund the different health financing schemes through which healthcare is accessed, such as Government schemes, health insurance schemes or household spending.

For the UK, around four-fifths (79%) of health expenditure is paid for through public revenues, mainly taxation.

This is one of the highest shares of publicly funded healthcare out of the 25 Organisation for Economic Co-operation and Development (OECD) countries with comparable data. Several Nordic countries (Norway, Denmark, Sweden and Iceland) have larger shares of publicly-funded healthcare and, like the UK, operate predominantly tax-funded healthcare systems. Japan and Luxembourg are the only countries with a higher share of public revenues that operate primarily insurance-based health systems.

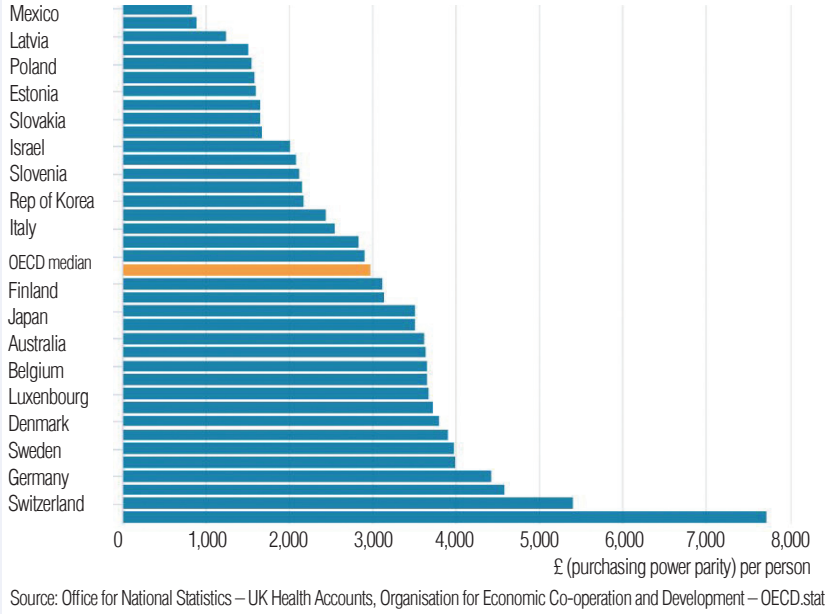
Public revenues cover the bulk of healthcare financing in most countries. Switzerland is the only OECD country for which data are available where the share of public healthcare funding is less than private funding. This is due to Switzerland operating a healthcare system where private health insurance is mandatory for citizens. Consequently, most healthcare funding comes from private insurance contributions.

Other countries that have a low share of public revenues funding healthcare include the US, where there is a high share of privately-funded healthcare insurance as well as Chile and Mexico, where a large share of health expenditure is financed through out-of-pocket payments.

Public funding for healthcare in the UK is almost exclusively spent on Government-financed healthcare, such as NHS services or certain elements of local authority-funded social care. However, a small amount of public revenues also funds healthcare services accessed through charities. This represents less than 1% of overall healthcare funding.

In all OECD countries, most healthcare is accessed through mandatory financing schemes, which take a variety of forms. Some countries, like the UK, have NHS-based healthcare systems, where most services are financed and accessed through Government schemes. Others have insurance-based systems, where many healthcare services are provided through either Government-run social health insurance schemes, or through the mandatory uptake of private health insurance. In many instances, countries operate a mixture of Government and mandatory insurance-based schemes.

Figure 1: UK health spending per person was around the median for OECD member states (2017)



Source: Office for National Statistics – UK Health Accounts, Organisation for Economic Co-operation and Development – OECD.stat

re compares

Spending on chronic healthcare was £560 per person

Of the £197bn the UK spent on healthcare in 2017, £37bn was spent on health-related long-term care.

This equated to £560 per person and concerns the medical or personal care services for people with chronic health conditions (including old-age and disability-related conditions) where an improvement in health is not expected.

For the UK this includes residential and nursing care or home-based care financed privately or through local authorities, care costs reimbursed through the Carer's Allowance, as well as palliative care and other long-term care delivered through the NHS.

This figure does not include social long-term care spending where the primary concern is to provide assistive-based services that help people with long-term care conditions to live independently, for example, meals-on-wheels, supported living and day care services.

The UK's spending on health-related long-term care was similar to that of France (£569 per person) and Canada (£556 per person). Northern European countries such as Norway, the Netherlands and Sweden tended to spend the most, while many eastern, central and southern European countries, in which informal care has a greater role, tended to spend less.

In the UK, spending on in-patient long-term care represented two-thirds (66%) of overall health-related long-term care spending, with the remaining expenditure mostly attributed to home-based care. In-patient long-term care spending tends to be higher than home-based care in most European countries.

higher prices and partly because of the consumption of a greater volumes of goods and services.

For the UK, health spending equated to 9.6% of GDP, which was ranked as the second-lowest of the G7 countries.

Since 2013, the percentage of UK GDP spent on healthcare has fallen slightly, from 9.8% in 2013 to 9.6% in 2017.

Despite health spending increasing every year during this period by an average annual rate of 3.5%, in current price terms, the rate of growth in the wider economy was faster, at an average annual rate of 3.9% in current price terms. Italy and France were the only other G7 countries for which health spending as a percentage of GDP was lower in 2017 than in 2013.

The share of the economy attributed to healthcare increased slightly in Germany, Canada and Japan, between 2013 and 2017, bringing it closer to the share in France.

The largest increase in healthcare spending as a percentage of GDP over the period was in the US, where it rose from 16.3% to 17.1%. This was because of health spending increasing at a faster rate than growth in the overall economy.

Taking an international perspective, average life expectancy tends to be longer in countries that spend more on healthcare, with the notable exception being the US.

However, while the association between more expenditure on healthcare and longer life expectancy is observable for countries that spent less than £2,500 per person on healthcare, it is harder to discern an association between these factors for higher-spending countries

The findings show the largest gains in life expectancy appeared to be associated with health spending and higher educational attainment, where better education encourages healthier lifestyles, with individuals more informed about potential health risks, such as the effects of smoking.

Overhead costs are lower in the UK's health system

In 2017, the UK spent the equivalent of £53 per person on healthcare governance and the costs associated with financing healthcare. This was below the median for Organisation for Economic Co-operation and Development (OECD) countries with comparable data.

For the UK, this spending covers central departmental governance, the regulatory activities of bodies such as the Care Quality Commission, as well as the operating of voluntary health insurance schemes, which include policy management, administrative costs, such as marketing, and profits earned.

Governance and financing costs exclude overhead expenses associated with the administration or functioning of healthcare providers, for example hospital management or payroll and procurement administration, which are instead included in other healthcare expenditure categories.

The relatively low UK spending on governance and financing costs is partly due to the type of health system the UK operates.

The NHS and other tax-based healthcare systems do not tend to have the financing costs typically incurred in health insurance schemes, such as revenues collection (the equivalent of which would be managed centrally in tax-based systems), risk-management, and profits in the case of mandatory private health insurance schemes.

The OECD reports that in countries with predominantly insurance-based health systems, these financing costs are expected to be much higher, which helps explain why governance and financing costs are greater in high income countries with insurance-based systems, such as France and Germany.

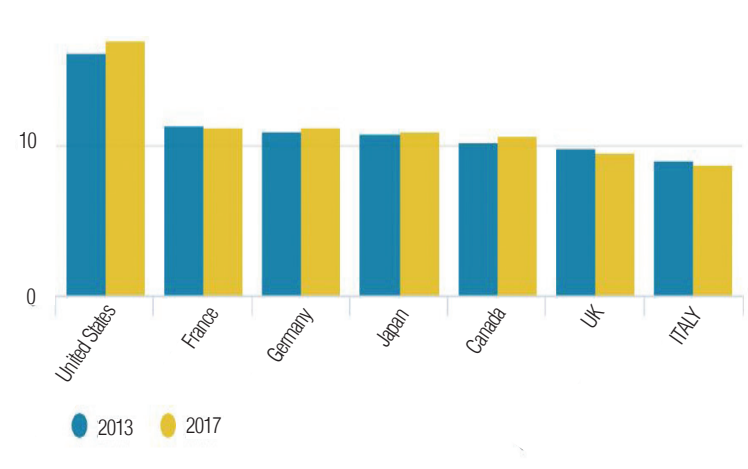
Spending on governance and financing is highest in the US, the equivalent of £639 per person. This is three times as much as the second-highest spender and 12 times the amount spent in the UK.

The importance of private health insurance in the US is an important factor in explaining the high level of spending, in particular the associated purchasing, contracting and provider negotiations.

The OECD cites other possible reasons, including the 'litigious environment' in the US and 'scrutiny from regulatory bodies and efforts devoted to utilisation management and quality improvement.'

Overhead costs excluded from the healthcare governance and financing costs measure include the £4.3bn of spending estimated by the Carter Review (2016) on staff employed in corporate and administration roles in NHS acute trusts in England.

Figure 2: UK healthcare expenditure as a share of gross domestic product was the second-lowest of the G7 countries (2013 and 2017)



Source: Office for National Statistics – UK Health Accounts, Organisation for Economic Co-operation and Development – OECD.stat

Delays still block UK hospital beds

Latest NHS England figures show continuing relentless pressure on emergency admissions and too many beds still occupied by elderly patients who are better off with community care

There were 139,903 delayed discharge days in July 2019, compared with 140,938 in July 2018, a decrease of 0.7%, but still a daily average of 4,513 beds occupied by delayed transfers of care (DTOC) patients in July 2019 and 4,546 in July 2018, according to the latest figures.

The proportion of delays attributable to the NHS in July 2019 was 60.6% – down from 61.9% in July 2018. The remaining delays were attributed as follows: 29.8% social care (down from 30.1% in July 2018) and 9.6% both (up from 7.9% in July 2018).

The main reason for delays in July 2019 was patients awaiting care package in own home, which accounted for 29,889 delayed days or 21.4% of all delays.

While 47.4% of delays for this reason are attributable to social care, 30.2% are to NHS and 22.3% to both.

The summer's figures show a relentless increase in A &E attendances say other figures from NHS England with 2.13 million attendances in August 2019.

There were 529,231 emergency admissions in August 2019, 2.3% more than in August 2018. Admissions in the last 12-month period were up 5.0% on the preceding 12-month period.

Estimates are for a 4.5% July 2019 year to date growth in emergency admissions. This is composed of 8.1% growth for those with zero length of stay and 2.6% growth with patients staying one or more days.

The number of attendances admitted, transferred or discharged within four hours was 1.65 million or 86.3% of the total. This is a 2.3% increase on the equivalent figure for August 2018 – 1.62 million seen within four hours.

Of these, 919,017 were Type 1 attendances *(see box)*, a decrease of 1.4% from August 2018 and 693,597 Type 3 attendances, an increase of 8.0% from August 2018.

The number of patients seen in over four hours was 262,896 compared with 182,950 in August 2018, an increase of 43.7%.

There were 56,499 patients waiting more than four hours from the decision to admit to admission (40.5% higher than August 2018). Of these, 372 patients waited more than 12 hours (129.6% higher than in August 2018).

Professor John Appleby, chief economist at the Nuffield Trust, said: 'These figures confirm that this year has seen an alarming slump in NHS performance against important targets. This summer was no exception, showing little sign of reprieve for staff and patients, with 6% more people turning up at A&E in August compared to last year.

'Over the last six months there have been on average more than 60,000 people waiting more than four hours in A&E per month compared to last year.

'In July, over 4.5 million people were on the waiting list for elective treatment, and one in seven of them had been waiting longer than 18 weeks. This is the largest the waiting list has ever been, and the worst performance since January 2009.

'People must not get distracted by incoming new targets from the fact that NHS performance this year has seen a sharp decline. Changing measurements won't make a difference if things keep on worsening at this rate.'

Of patients on the waiting list at the end of July 2019, 85.8% had been waiting less than 18 weeks, thus not meeting the 92% standard. This compares to 87.8% at the end of July 2018.

The number of referral to treatment patients waiting to start treatment at the end of July 2019 was 4.4 million. Taking account of trusts not submitting data, the waiting list increased by 4.6% over July 2018.

The number of patients on the waiting list who were waiting under 18 weeks increased between July 2018 and July 2019 from 3.6 million to 3.8 million, and the number of patients waiting over 18 weeks rose from 504,000 to 620,000. This comparison will be affected by differences in the trusts not submitting data in each period.

A total of 1,032 patients were waiting more than 52 weeks. This compares to 3,464 in July 2018, and 532 patients five years ago (July 2014). This comparison will be affected by differences in the trusts not submitting information in each period.

Still waiting: Over the last six months there have been more than 60,000 people waiting more than four hours in A&E

The A&E categories:

- *Type 1 A&E department*: A consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
- *Type 2 A&E department*: A consultant-led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
- *Type 3 A&E department/Type 4 A&E department/urgent care centre, other types of A&E/minor injury units/walk-in centres*, primarily designed for the receiving of accident and emergency patients. A Type 3 department may be doctor or nurse-led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a Type 3 department is that it treats at least minor injuries and illnesses (sprains, for example) and can be routinely accessed without appointment.

An appointment-based service (for example, an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example, most out-of-hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a Type 3 A&E service, even though it may treat a number of patients with minor illness or injury.