

Q&A 12

TIME FOR A PLAN C?

SLOW GROWTH
AND PUBLIC
SERVICE REFORM

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MAY 2012

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Time for a Plan C?

In October 2010 the Chancellor, George Osborne, presented what we might want to think of as ‘Plan A’; the government’s Spending Review, which fixed budgets for each government department up to 2014/15.¹

The review announced an £81 billion cut in public spending in the remaining years of this parliament, with average departmental cuts of 19%.

Since the start of the spending review period there have been numerous calls for a ‘Plan B’. This included a letter published in October 2011 and signed by 100 economists, which argued:

“It is now clear that plan A isn’t working... We urge the government to adopt emergency and commonsense measures for a Plan B that can quickly save jobs and create new ones. A recovery plan could include reversing cuts to protect jobs in the public sector, directing quantitative easing to a green new deal to create thousands of new jobs, increasing benefits to put money into the pockets of those on lower and middle incomes and thus increase aggregate demand.”²

Since then in its annual green budget, the IFS Green Budget warned that however painful cuts had been to date, they amount to less than a tenth of what is planned by the 2016/17 fiscal year and that 88% of the cuts to benefits and 94% of the cuts to current public spending are still to come.³

Most recently data from the Office for National Statistics (ONS) showed the economy shrank by 0.2% in the first quarter of 2012 putting the UK into recession.

With increasing commodity prices, an ageing population, and an on-going crisis across the Eurozone affecting exports many now believe the UK should not expect to return to an economy growing consistently at faster than 2% a year for the foreseeable future.

The Plan C challenge is for policy makers, opinions formers and ordinary citizens to examine how we would cope, and even thrive, with long term slow growth. How can we adapt to a period of low growth very different from the era of high growth that we have recently experienced? Is there any way in which we can plug this gap? What can we do differently and are there are new things we should be doing?

Time for a Plan C?

It is not difficult to list the problems arising from slow growth ranging from high unemployment to falling living standards and declining public service entitlements. Slow growth will mean more hard choices about public service and welfare entitlements. Faced with further retrenchment, will it be possible through public service reform to protect the most vulnerable and universal service standards and if so how?

Does slow growth require a more profound shift in policy, expectations and culture?

Might it even be possible for some things about our economy, society and culture to improve despite (or even because of) slow growth? This paper forms part of the RSA collection – Time for Plan C? – which will explore the implications of, and responses to, slow growth from the perspective of a highly respected and influential set of thinkers.

- **Paul Johnson**, Director of the Institute for Fiscal Studies on what will slow growth mean for fiscal policy.
- **Gavin Kelly**, Director of the Resolution Foundation on the implications of slow growth for living standards.
- Journalist **Deborah Orr** on the values that will get us through a sustained period of low growth.
- Economist **Vicky Pryce** on the implications of slow growth for the overall shape of the economy and particularly regional economies.
- **Nick Seddon**, Deputy Director of Reform on the implication of slow growth for public service reform.
- **Julian Thompson**, Director of Enterprise at the RSA on how we need to change the way we see the relationship between human capital and economic recovery.

Slow growth and public service reform

In Montana in 1949 a forest fire engulfed a parachute brigade of firefighters. Panicking, they ran, trying to make it up a steep slope to safety. But their commander, a man named Wag Dodge, saw that their plan was not going to work. So he stopped, took out some matches and set the tall grass ahead of him on fire. The new blaze caught and rapidly spread up the slope. He stepped into the middle of the burned-out area it left behind, lay down, and called out to his crew to join him.

Dodge had single-handedly and through quick thinking, invented what came to be known as an ‘escape fire’; this later became a standard part of forest service training. His men, however, either thought he was crazy or never heard his calls. They ran past him. All but two were caught by the inferno and perished while Dodge survived virtually unharmed. The firefighters’ organisation had unravelled because they lost their ability to think coherently, to act together, and to recognise that a lifesaving idea might be possible. This is what happens to all flawed organisations in a disaster, and it is what is happening to western states.

The financial crisis exposed the unsustainability of governments across the western world. Yet, faced with the need to conduct a public finances rescue mission, the old instincts persist. Our leaders keep on trying to do the old things in the old ways. But imposing a lid on public spending and salami slicing budgets will not work. The problems we face are systemic: the public sector is too big and inefficient; high public spending levels cannot be sustained by high tax levels if the country wishes to be competitive; current transfers and entitlements present social and demographic time-bombs; and a culture of rights without responsibilities means that people do not do enough for themselves.

Some have argued that it is too ambitious to seek to eliminate the deficit, reform public services and change the individual’s relationship with the state. But these things are necessary and the crisis we now face requires us to do all three things. A strategic diagnosis must ask how we can meet citizens’ demands for better services and social support. Here lies the secret to the fire escape.

Reinventing social protection

In an essay written in the 1920s, John Maynard Keynes distinguished between the agenda and non-agenda of government.⁴ This could not be fixed for all eternity, he suggested, but would vary over time. Keynes devised the idea to separate himself from those 19th-century Liberals who saw little useful role for the state.

But his approach could equally be applied in reverse; to cordon off areas where the government has no business interfering with citizens or where it needs to restrain its influence. Over the years, governments' agenda has expanded, just as the annual budget has got thicker as the ambitions of the state have grown. Establishing what is agenda and non-agenda calls for a revaluation of the social protection model, especially in the politically explosive and bank-busting budgets of health, social care, welfare and pensions. Some things that have previously been provided should no longer be provided. Some things that have been provided at no cost to the user should be provided at a cost.

The principle of the original Beveridgean compact was always that the individual had high levels of responsibility. The very basis of the welfare state was 'something for something'. People contributed as well as received. If you were out of work you would do what you could to get ready for work and to get a job. Fast forward, and we have created a culture of entitlement that has celebrated rights without responsibility. We have become accustomed to the state providing services from a tax base that is shrinking relative to the demands made upon it. With the population ageing at a faster rate than at any time in history, the Beveridgean social contract is unravelling.

The welfare state was designed for a young and growing population with a life expectancy much lower than the average enjoyed today. Payments to retired and other families in need would be paid for by a younger generation of workers. This younger generation would, in turn, receive benefits in later life funded by the next generation. Population ageing turns this model on its head.

State spending needs to be high value. Yet spending on welfare increased even when the economy was growing; rather than reforming welfare to support enterprise and social mobility during the period of growth, entitlements were expanded to groups not in need. The cost of the Winter Fuel Allowance, free bus passes and free TV licenses runs into the billions, yet a parliamentary committee has shown that close to 90% of payments of the Winter Fuel Allowance go to pensioners not in fuel poverty. Research by the Institute for Fiscal Studies (IFS) has shown that around 60% of these payments are spent on things other than fuel.⁵ Benefits for the middle classes have been used to attract votes, creating a money-go-round, and higher income families have been encouraged to use the welfare state as an ATM while poor families were left with scraps. This has undermined the integrity of the welfare system.

The flipside of having a welfare system that provides an important safety net is that people should be expected to provide for themselves if they are able. Welfare reform must start with cutting benefits that have really become middle class boondoggles. In turn, ending universal provision of services and benefits will enable better targeting of support for those in need. Analysis of the British Social Attitudes Survey showed that as spending on welfare increased the number of people who believe that benefits are too low has fallen, even though benefits, including unemployment benefits have become less generous over time.⁶ Some have argued that targeting spending where it is most needed would weaken social solidarity. The opposite is true.

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Our sense of our own futures must change. We should expect to work longer, save more, and delay retirement: we should be better educated to prepare for our futures. The principal responsibility for retirement saving must rest with the individual and not the state, and we will need to foster a new way of thinking, where working longer and paying more into our pensions becomes hardwired into both individual behaviour and our approach to policy. The state can help support a culture of saving through fiscal measures and by ensuring the social security pension rewards, rather than penalises savings. The same goes for social care for the elderly. It is a rare politician who will acknowledge that families have to pay for care and, indeed, that for the future system of care to be affordable, contributions will have to increase. We will need to get used to the idea of spending more of our accumulated assets on our care – the obvious source for contributions is the equity in housing – rather than holding on to them for posterity.

Some answers were provided in the report of last year’s Commission on Funding of Care and Support chaired by Andrew Dilnot, which emphasised that people should make provision for their own long-term care.⁷ Perhaps the best idea generated by the commission was to cap how much people are required to pay towards the costs of their care. Although the proposed level (£35,000, but up to £50,000) was too low, a cap would provide greater clarity over entitlements and expectations. It would mean that people could pay for the bulk of the costs of their care but would be protected if these costs rise to catastrophic levels to prevent financial ruin. The certainty that a contributory cap provides would encourage people to look to vehicles like insurance, annuities and equity release to help manage these costs and make the market more attractive for private providers. In this way, public policy would seek to change the behaviour of citizens.

Many are calling for health and social care to be integrated, but once we have established a principle for individuals’ contribution to their social care, the only way the two ‘services’ can be integrated would be by accepting that the same goes for healthcare: the NHS. This is tantamount to heresy when talking about what Nigel Lawson called the closest thing the English have to a national religion. Yet the challenge will be to meet consumers’ demands without increasing the burden on the state. All countries struggle with this, but some define the package of care that will be provided by the state and allow greater private spending on top.

In 2000 the then Prime Minister Tony Blair set a target to increase UK health spending to the European average. In 2011, the UK reached this threshold. With the government’s current spending plan, we will again slip behind, so the UK now needs a new target: to increase private health spending to the OECD average, or 2.4% of GDP. Even if private spending in the UK increased just to the level of Italy – from 1.5% to 2.0% – health funding would be boosted by over £7 billion this year. Our approach should be to define the package of care that will be provided by the state – the ‘benefits basket’ – and allow greater private spending in the form of direct GP payments, top-ups and supplementary insurance. This would give patients skin in the game, and drive pressure on the demand side, while regulation can ensure that the system is equitable.

In time, we will have to go a lot further than this, as the Dutch realised in the 1980s when they set about reforming their health

So the UK now needs a new target: to increase private health spending to the OECD average, or

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insurance system. Over 20 years, from 1986 to 2006, they moved towards a universal private health insurance system. The NHS funding model is fundamentally unsustainable. Public services can still be funded equitably and in a way that consolidates social solidarity if they are not entirely funded through taxation.

We need a genuinely game-changing vision, like the one set out by David Laws in the *Orange Book*: healthcare largely funded by government, to guarantee access, but organised outside of government by insurance companies and other organisations, answering only to patients.⁸ A massive study by the OECD, recently reminded us just how good these systems are: it identified Australia, Korea, Japan and Switzerland – all insurance systems – as those that “perform best in transforming money into health outcomes”.⁹

The UK was way off the pace. According to the OECD, the fairest health systems are the insurance systems of the Netherlands, Germany and Switzerland; that is, the countries where the poorest get the most similar standards of care to the richest. Insurance-based systems can deliver higher quality and greater equality in outcomes.

Moving towards a mixed funding model is possible: the £80 billion commissioning budget could be allocated to insurers in professional alliances with commissioning groups, which would bring together clinical expertise with commercial intelligence. Everyone would be covered and those who can afford to would be encouraged to contribute more towards their care packages. This will achieve two things that governments have been questing after for three decades, without admitting what they really have to do to achieve them. Firstly, it will give patients power: because money talks and preference walks, the service will become properly accountable to patients, who in other countries have a greater understanding of what they are getting for their money. Secondly, it will dramatically reduce government intervention, so that the public demands more from clinicians, not politicians.

The citizen must do more

Alongside more private contributions, we need more private participation or action. Everyone knows that prevention is better than cure. Since the most powerful determinant of health is lifestyle and behaviour, the game-changer is to change behaviours. As William Beveridge put it: “the individual should recognise the duty to be well”. If the strategic planning exercise of the 21st century is to keep people out of hospital, we all have to play our part.

Long-term conditions like diabetes, heart disease, obesity and lung disease are a big deal: some 15 million Britons suffer from them and they take up 70% of ‘bed days’ in hospitals. The problem is hardly home grown; these conditions are very common in America and booming in the emerging economies like China and India. If the NHS was set up to deal with infectious diseases, it is now facing the challenges of lifestyle diseases. Nor are these just diseases of the old: the Facebook generation is picking them up rapidly. But they are still largely diseases of the poor, who live less healthy lives, smoking more, drinking more and consuming more salt and bad fats. These diseases also hit the working age population, damaging productivity.

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We can learn some lessons from insurers, who have strong incentives to achieve value for money. These incentives reflect the liability from people becoming unwell and, if they do become unwell, becoming expensive: for instance, ensuring rapid access to treatment for conditions where delay would make things worse, such as surgery, or better management of long-term conditions. Insurers in Germany and the US are investing in schemes to keep people well and help the ill manage their conditions.

A recent evaluation of the South African health programme, Vitality, has found that highly engaged beneficiaries of the programme experienced lower costs per patient, shorter stays in hospital and fewer admissions than all other comparative groups. GPs could trial discounted gym membership or healthy eating rewards, such as ‘NHS Nectar’ points or what Sir John Oldham has called ‘care miles’.

As well as limiting demand by promoting healthy living, we need to screen citizens and, when they have chronic illnesses, support them to manage their conditions. Singapore spends 4% of its GDP on healthcare, yet has an average life expectancy over 80 years. The World Health Organisation ranks it sixth in the world. That’s half as much as we spend, for better results. This has created its own problems: the country has an ageing population and a heavy burden of chronic diseases such as diabetes, asthma and coronary heart disease. If Singapore tried to treat all of these people in hospitals, the system would soon go bust. So the government introduced a national programme with regular screening and monitoring, encouraging patients to seek medical care regularly before things go wrong and educating them to live more healthily. By the end of the second year, half of those targeted had got their disease under control and were using the best treatments.

Likewise, Kaiser Permanente, a not-for-profit company with almost 9 million members across the US, has spent years pioneering outbound medicine for patients with chronic conditions. They make sure that if you have a condition like diabetes your GP will be a specialist in that condition. At any time of the day or night, you can go into any pharmacy and have a test done. The computer will analyse the data against a statistical sample, and if there’s a problem a red risk flag comes up. Your doctor will immediately get an email and give you a call to check if, for instance, you are still taking your drugs. This real-time tracking has made Kaiser a world leader in preventing unnecessary and expensive visits to hospital, consistently performing better than the NHS on value for money. Hippocrates was right: the patient can be the best doctor (with a little help from the system). Clearly, what this means is that we do not need the 19th century hospital infrastructure, or its staff.

We have to engage the public with the simple truth: that public services and the welfare state in general cannot succeed in the future unless users and citizens recognise their own role in helping those services and their communities do more with less. Citizens have to make their own efforts, whether it is sensible crime prevention measures, looking after their health, or making sure their children get to school on time. Services have to be designed in ways that encourage this transition: change will not just happen.

The scale of the challenge ahead is evident in the long-term forecasts of the Office for Budget Responsibility

The workers must do more

So far, so hard: we must spread the cost and improve allocative efficiencies. The next challenge is to achieve radical technical efficiency. Many services are still provided as state-run monopolies, which means they have weak incentives for better management and lower costs. This is reflected in high procurement costs and wage inflation. Consequently the increases in spending over recent years have not been reflected in a proportionate improvement in outcomes. Government should limit its role to funding public services, rather than both funding and providing them. Supply should be liberalised and consumers should be given greater control over where funds are allocated. A rapidly growing body of economics research – including influential recent reports from the LSE, Imperial College London, the OECD and IMF – is finding that competition in healthcare drives up quality and drives down costs.¹⁰ The OECD has urged “reinforcing competitive pressures on providers” in the NHS.¹¹

Competition drives innovation that can transform services for patients. What pioneers abroad are showing is that we can harness radical techniques to make healthcare better, safer and cheaper. Polarising debates which claim that public or private is better are unhelpful, since what is needed is an open system that allows the best of any sector to deliver the best care possible to patients. That said, according to international research by the LSE and McKinsey and Co, private hospitals achieve higher management scores than public hospitals, which matters because better management is associated with better care and stronger accounts.¹² They can do so because of their management of talent: private hospitals can escape some of the restrictions in the recruitment of staff and performance management, and they are freer to reward high performers, getting incentives in place for the best results. In Germany, private hospitals operate with lower staff costs, mainly because they have their own collective labour agreements with lower wages, which drives productivity.

At Narayana Hrudayalaya Cardiac Hospital in Bangalore, a team of elite surgeons is re-engineering the hospital. They measure and publish data about clinical and financial performance: of every department and doctor, charting every error and complication, some shared with staff in real time in the form of a daily text message (at midday every consultant gets an SMS with the profit and loss of the previous day). They have made a science of performance.

The result is that on clinical measures the doctors do better than most hospitals in developed countries, their infection rates are up there with the best in the world, and patients are five times less likely to suffer from post-surgical complications than they would be in the NHS. Narayana’s track record has a lot to do with its specialist focus – the doctors only deal with hearts – and its scale. In 2008, the 42 surgeons performed over 8,000 operations, a volume unheard of in developed countries. As volume and quality increase, costs also come down. Narayana performs heart surgeries at a fraction – a tenth – of the UK price.

To open the NHS up to these cutting-edge practices will mean doing things very differently and it will mean shaking up the workforce. To achieve scale in the NHS, for instance, we would need to grasp the nettle and close down under-performing hospital units so that operations can be concentrated in centres of clinical excellence like Narayana. Narayana

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is also interesting because they get the most out of their very productive surgeons by ‘task shifting’; involving lower skilled staff and junior surgeons in opening and closing operations.

At the centre of the health system – and all public services – is the work force. For any given hospital 70% of the costs are in the workforce. Our doctors and nurses are uncommonly expensive and inflexible, yet their clinical quality and financial performance are variable. Workforce reform will unlock the service redesign that is needed to integrate care and move services into more cost effective settings. Without workforce reform, innovation will stay on the public policy wish-list while the rest of the world gets on with it.

Shifting the paradigms

How can we put this together? Another fire fighting story may help. The Merseyside fire service has achieved more for less by reevaluating its purpose. Reforms were prompted by the death of a child in 1999 that the fire service could have anticipated: in a poor family, who smoked, used a chip pan and had no fire alarm. Until then, the service had not been interested in social issues. Its job was to get an engine to a fire within minutes. And it did a good job in those terms: for 88% of fire fatalities, a crew arrived within five minutes of the emergency call. Then the head of the service, Tony McGuirk, realised that speed was not enough: prevention was the key. At the time, no fire service in the country concentrated on preventing fires in the home. With the backing of the local political authorities, McGuirk and his team resolved to evangelise, providing basic fire-safety advice, checking 350,000 homes and fitting 700,000 smoke alarms. They liaised with social services and recruited new kinds of staff, such as ‘advocates’ who took the safety message into communities.

All this involved cutting the number of fire officers, who, McGuirk realised, were under-employed for long periods during their shifts. Anyway, fewer fires required fewer rescuers. Over the 10 years from 1999/2000 to 2009/10 the number of fires and fire-related deaths each year was reduced by roughly a half. Meanwhile, the number of traditional fire officers has fallen from 1,400 to 850, saving money. According to an Audit Commission report of 2008, Merseyside is now the country’s most efficient fire service, relative to population.¹³

Savings can be made in the most intransigent public services – by preventing problems rather than merely coping with them. Everything has to change: the supply-side, the demand-side, and indeed the whole business model. The same goes for the state and public services. People assume they are entitled to jobs or services or benefits or pensions: ending entitlement will not be easy. Change is hard and it is hardest for those who do not want to change, but change is necessary and it will bring opportunities as well as pain.

Endnotes

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