



COVID-19

UK Political Analysis

By Tim Hames, Senior Adviser | 15th May 2020



Politics of Pain. Why the NHS needs “protecting” and the probable future of health policy.

“Protect the NHS” has been one of the most consistent messages of the coronavirus crisis. It also appears to have been extremely effective. The public has all but universally accepted its importance. In many ways, though, it is a strange slogan. Why should a health system require “protecting” from potential and prospective patients? Should not the “protection” element be the other way around?

Yet, protecting the NHS has been more than a set of words; it has been the central aspect of policy throughout the past several weeks and it has had a prominence that does not seem to be the case in other countries. This edition of the FTI UK Political Analysis will deploy a painstakingly compiled (by me) collection of data involving sixteen different countries, drawn almost entirely from various OECD publications, and segmented into three “control groups” to outline why the NHS has been especially exposed in this crisis compared with other systems internationally and from there will outline what is the likely long-term impact on health spending in the UK and how taxes might rise to finance this.

EXECUTIVE SUMMARY.

- Public and private health care spending is relatively low in the UK (but not extremely low).
- Where it is strikingly low is in terms of spending on key “frontline” resources such as the numbers of doctors and nurses, hospital beds and critical care beds and very sophisticated medical technology. This led to the real fear of the NHS being “overwhelmed” by COVID-19.
- These deficiencies can be largely explained by the structure of health spending in the UK, the overall level of public spending as a proportion of GDP and the political difficulties involved in contemplating fundamental systemic change. This produces the paradox that while the UK’s level of government health spending as a proportion of all spending is surprisingly high, this does not translate into the sort of clinical outcomes that one might expect that it would.
- In the aftermath of the coronavirus crisis, NHS spending is almost certain to increase (and by as much as 2-3% of GDP) but that expenditure will mainly be bolted on to the current model.
- An increase in taxation to fund this is highly likely. Reconstructing VAT might be appealing. There will be considerable political incentives to find a means of hypothecating or by some other means distinguishing health care expenditure from the rest of government spending.

INTRODUCTION.

The strengths and weaknesses of the NHS and health policy more broadly in the UK can be best assessed by a set of international comparisons. One (hopefully subtle) method to be utilised in this analysis compares the UK with three “control groups”. The first is other large (by their population) European nations: France (FRA); Germany (GER); Italy (ITA); Poland (POL) and Spain (SPA). The next is other northern European nations: Belgium (BEL); Denmark (DEN); Holland (HOL); Norway (NOR) and Sweden (SWE). The final set is the anglosphere, other

English-speaking countries with intense historical connections to the UK: Australia (AUS); Canada (CAN); Ireland (IRE); New Zealand (NZ) and the United States of America (USA). As will be demonstrated here, this leads to significant findings.

UK public and private health spending is relatively low but not really extremely low.

The first three tables set out where the UK stands in health spending compared with other nations.

Table 1: Overall Health Expenditure as a % of GDP, 2018.

LARGE EUROPE: GER 11.2% FRA 11.2% UK 9.8% SPA 8.9% ITA 8.8% POL 6.3%

NORTH EUROPE: SWE 11.0% DEN 10.5% BEL 10.4% NOR 10.2% HOL 9.9% UK 9.8%

ANGLOSPHERE: USA 16.9% CAN 10.7% AUS 10.3% UK 9.8% NZ 9.3% IRE 7.0%

The same broad themes can be seen if only government health care spending is examined.

Table 2: Government Health Expenditure as a % of GDP, 2018.

LARGE EUROPE: GER 8.7% FRA 8.7% UK 7.6% ITA 6.5% SPA 6.5% POL 4.5%

NORTH EUROPE: SWE 9.2% NOR 8.9% DEN 8.5% BEL 8.0% UK 7.6% HOL 6.5%

ANGLOSPHERE: USA 8.3% CAN 7.8% UK 7.6% NZ 6.9% AUS 6.3% IRE 5.3%

The shortfall that the UK faces is compounded by comparatively low personal spending on health.

Table 3: Personal annual spending on pharmaceuticals and medical non-durables, 2017 (US\$, PPP).

LARGE EUROPE: GER \$766 FRA \$667.6 ITA \$601 SPA \$572.3 UK \$497.4 POL \$357.2

NORTH EUROPE: BEL \$679 SWE \$572.3 UK \$497.4 NOR \$473.8 HOL \$416.6 DEN \$341.8

ANGLOSPHERE: USA \$1,162 CAN \$807.2 IRE \$684.3 AUS \$617 UK \$497.4 NZ \$263

Although the figures for UK are distinctive here, notably when compared with Germany and France and the northern European cohort, they are not so exceptional as to explain why the NHS may need a special form of protection or why the risk of complete collapse due to the virus was so credible. To understand that requires another set of tables relating to the availability of core health care assets.

The UK has strikingly low comparative performance on a range of crucial health care assets.

The next six tables are the essence of the story. They start with the numbers of doctors and nurses.

Table 4: Doctors per 1,000 of the population, 2015.

LARGE EUROPE: GER 4.1 SPA 3.9 ITA 3.8 FRA 3.1 UK 2.8 POL 2.3

NORTH EUROPE: NOR 4.4 SWE 4.2 DEN 3.7 HOL 3.5 BEL 3.0 UK 2.8

ANGLOSPHERE: AUS 3.5 NZ 3.0 IRE 2.9 UK 2.8 CAN 2.7 USA 2.6

The picture is the same but in less exaggerated form for the number of nurses available as well.

Table 5: Nurses per 1,000 of the population, 2015.

LARGE EUROPE: GER 13.3 FRA 9.9 UK 7.9 ITA 5.4 SPA 5.3 POL 5.2

NORTH EUROPE: NOR 17.3 DEN 16.7 SWE 11.1 BEL 10.8 HOL 10.5 UK 7.9

ANGLOSPHERE: IRE 11.9 AUS 11.5 NZ 10.3 CAN 9.9 USA 8.6 UK 7.9

These numbers might seem to be counterintuitive. The NHS is the fifth largest employer in the world (and easily the largest single employer in Europe). It has around 1.6 million FTEs on the payroll. How can it, therefore, be so short of doctors and nurses? The main explanation is that the combination of a very large number of very small GP surgeries and a significant pool of smaller and older hospitals (where closing a unit is politically hard and shutting down the whole site unless a new facility is built on essentially the same spot, even if that location has ceased to make sense, is politically suicidal) means that the number of support staff required for administration, catering and clearing is high. Remember also that if it were not for a very unusually high number of doctors and nurses who were born overseas, these statistics would be even more stark. They also explain why just about the first move made when the virus appeared was to appeal for retired doctors and nurses to return to work.

The statistics for doctors and nurses are virtually echoed by hospital beds and ICU/critical care beds.

Table 6: Hospital Beds per 1,000 of the population, 2017.

LARGE EUROPE: GER 8.0 POL 6.62 FRA 5.98 ITA 3.18 SPA 2.97 UK 2.54

NORTH EUROPE: BEL 5.76 NOR 3.60 HOL 3.32 DEN 2.61 UK 2.54 SWE 2.22

ANGLOSPHERE: AUS 3.84 IRE 2.96 USA 2.77 NZ 2.71 UK 2.54 CAN 2.52

Table 7: Intensive Care Unit/Critical Care Beds per 100,000 people, 2017.

LARGE EUROPE: GER 33.9 ITA 12.5 FRA 11.6 SPA 9.7 POL 6.9 UK 6.6

NORTH EUROPE: BEL 9.7 NOR 8.0 DEN 6.7 UK 6.6 HOL 6.1 SWE 5.8

ANGLOSPHERE: US 34.7 CAN 13.5 AUS 9.1 UK 6.6 IRE 6.5 NZ 4.7

The above tables tell you why ministers rushed to create pop-up Nightingale Hospitals as they did.

There was much discussion about ventilators and whether the UK had enough of them in the early weeks of the coronavirus crisis. International comparisons on ventilator numbers are not

possible in that different sorts of ventilators do differently sorts of things and so are apples and pears in truth. There are alternative – and in many ways superior – proxies for sophisticated medical technology. The ones that tend to be used for comparative purposes are CT scanners and MRI scanners. Once you look at the next two tables, it becomes plain that it is a miracle that Matt Hancock sleeps a wink.

Table 8: CT Scanners per 1,000,000 of the population, 2017.

LARGE EUROPE: GER 35.1 ITA 33.3 SPA 18.0 POL 17.2 FRA 16.6 UK 9.5

NORTH EUROPE: DEN 37.7 BEL 22.9 NOR 22.0 SWE 20.5 HOL 13.8 UK 9.5

ANGLOSPHERE: AUS 59.6 USA 42.6 NZ 17.8 IRE 17.8 CAN 15.0 UK 9.5

Table 9: MRI Scanners per 1,000,000 of the population, 2017.

LARGE EUROPE: GER 33.6 ITA 28.2 SPA 15.9 FRA 12.6 POL 7.6 UK 7.2

NORTH EUROPE: NOR 21.0 DEN 15.4 SWE 14.6 HOL 12.5 BEL 11.7 UK 7.2

ANGLOSPHERE: USA 37.5 AUS 14.5 IRE 14.1 NZ 13.3 CAN 9.5 UK 7.2

It should now be crystal clear why ministers, officials and advisers were genuinely terrified that the NHS would be “overwhelmed” by the coronavirus crisis and urged the public to protect it. It also makes sense that senior scientific figures might have thought about a herd immunity strategy until the Imperial College, London model published on March 16th contended that it would result in some 500,000 deaths. The NHS – with comparatively few doctors and nurses, overall beds and critical care beds, CT scanners and MRI Scanners – can hardly cope with a rush of alcohol-induced accidents on a hot Saturday night in summer or a more intense outbreak of the winter influenza than is customary. Asking it to take on a full-blown pandemic of a completely new kind is a very large request indeed. It has been an utterly staggering achievement that it has dealt with the crisis as well as it has done.

The challenges for UK health policy lie in the structure of the NHS and overall public spending.

There are a number of different means by which developed nations can choose to fund and to organise health systems. For comparative purposes, these are government spending (GS), via a compulsory health insurance system (CHI), voluntary (or private) health insurance (VHI), through personal out-of-pocket spending on health (OOP) and other, smaller, possibilities (OTH). The next three tables compare the UK with the three control groups utilised before on these structures.

Table 10 (a), (b) and (c): Health Expenditure by type of financing, 2017.

10 (a) LARGE EUROPE	GS	CHI	VHI	OOP	OTH
UK	79%	-	3%	16%	2%
ITA	74%	-	2%	25%	1%
SPA	66%	4%	5%	24%	1%
POL	10%	59%	6%	23%	2%
GER	6%	78%	1%	13%	2%
FRA	5%	78%	7%	9%	1%
10 (b) NORTH EUROPE					
NOR	85%	-	-	14%	1%
SWE	84%	-	1%	15%	1%
DEN	84%	-	2%	14%	-
UK	79%	-	3%	16%	2%

BEL	21%	56%	5%	18%	-
HOL	6%	75%	6%	11%	1%
10 (c) ANGLOSPHERE					
UK	79%	-	3%	16%	2%
IRE	74%	-	13%	12%	2%
AUS	69%	-	10%	18%	3%
NZ	69%	9%	5%	14%	3%
CAN	68%	1%	13%	15%	2%
USA	26%	58%	-	11%	4%

These tables, however, understate how different the UK model is from virtually anyone else. In the larger European category, Italy and Spain raise far more tax and make far more health spending decisions at the regional and local level than is the case in this country. In the northern European section, Norway, Sweden and Denmark have a higher proportion of government spending than in the UK but once again regional and local government are a much more significant actor. Further to that, in Norway health care is not free at the point of use at all. The first 2,040 Krona (£160) each year falls (with a few exceptions) to the individual citizen. Only after that are they entitled to any additional health care without charge. In the Anglosphere, Australia and Canada again raise health taxation at the State or Province level to an extent unknown in the UK. Ireland and New Zealand are the closest to the UK, but Ireland has more than four times the level of voluntary health insurance and New Zealand is more decentralised than the UK. Our “single payer, single provider” is unique.

It also has a simple consequence. Some 98.8% of NHS income is derived from central taxation and national insurance. It follows that the only plausible means of raising spending is by that route too. Nothing else will boost cash enough. So how much, comparatively, public spending is there about?

Table 11: All Government Spending as a % of GDP, 2018.

LARGE EUROPE: FRA 56.0% ITA 48.6% GER 44.6% POL 41.5% SPA 41.3% UK 38.5%

NORTH EUROPE: BEL 52.4% DEN 51.3% SWE 48.4% NOR 48.0% HOL 42.1% UK 38.5%

ANGLOSPHERE: CAN 40.7% UK 38.5% AUS 36.7% NZ 36.7% USA 35.1% IRE 25.3%

So, by the standards of larger European nations and northern European nations (but certainly not the Anglosphere), the UK has comparatively low public spending overall. This leads to the irony set out below that, in terms of government health spending as a proportion of all government spending, the UK is far from a spend-thrift nation. It is, in fact, on this metric, one of the very highest in Europe.

Table 12: Government health expenditure as a % of all government expenditure, 2017.

LARGE EUROPE: GER 19.9% UK 18.7% FRA 15.5% SPA 15.5% ITA 13.4% POL 10.9%

NORTHERN EUROPE: UK 18.7% SWE 18.7% NOR 18.0% DEN 16.6% BEL 15.5% HOL 15.5%

ANGLOSPHERE: USA 22.5% IRE 20.0% CAN 19.5% NZ 19.5% UK 18.7% AUS 17.8%

What does all this mean for the probable future of UK healthcare policy after the virus ends?

There are three reasonable assumptions that can be made here. The first is that spending on the NHS will rise faster than was anticipated in the Budget on March 12 (which earmarked a notable increase by recent standards). This could be in the order of 2-3% of GDP as Germany and France become the unofficial targets to emulate in terms of overall spending levels. The second is that having experienced a serious near-miss that could easily have taken out the NHS due to its severe capacity shortages (which may still happen if there were to be a

substantial second spike of the virus), the extra resources will be directed overwhelmingly to the areas of greatest exposure: the numbers of doctors and nurses, the numbers of overall beds and critical care beds and the likes of CT Scanners and MRI Scanners. The third is that the status of the NHS when it emerges will be such that the additional money will be bolted on to the existing model rather than be part of radical change to that model. Sad policy wonks (like me) might well think there is much to be said for the French and German model of compulsory health insurance, that we need a smaller number of far bigger and better hospitals (slamming the doors on the old ones) and that GPs must be compelled at gun point to form a smaller number of far larger practices, but there are about as many votes in this blueprint as there would be in suggesting that the best means of reducing the strain on the NHS would be to sanction the slaughter of the first born to cut down the numbers that NHS staff have to deal with. The crisis may well act as a spur for further and welcome modernisation within the NHS (indeed it is almost certain that it will) but it is very unlikely to be the trigger for a re-evaluation of its principles. The public want it free at the point of use and prefer the familiar and convenient to the new and the efficient. That GPs spend much of their time engaged in duplicating the activities of pharmacists and social workers and that A&E is clogged up with people who should really be at a GPs is immaterial. The overwhelming politics of health in the UK means working with and around the present system.

That means, realistically, much more government spending on health henceforth. How will it be financed? By a mixture of spending restraint elsewhere, higher borrowing, and more tax money.

What device might appeal to ministers? Hypothecating tax revenue for the NHS has long had its advocates (even if the Treasury instinctively loathes the idea). This could be done by rebranding national insurance contributions (which are close to a fraud anyway) as NHS contributions but that would fall some way short of existing NHS expenditure, never mind more of it. But VAT reform...

Table 13: Standard rates of national sales taxes/VAT, 2018.

LARGE EUROPE: POL 23% ITA 22% SPA 21% FRA 20% UK 20% GER 19%

NORTH EUROPE: DEN 25% NOR 25% SWE 25% BEL 21% HOL 21% UK 20%

ANGLOSPHERE: IRE 23% UK 20% CAN 15% NZ 15% AUS 10% USA 0%*

(* There are state and local sales taxes in the USA, but these vary very considerably).

How much money are we discussing here? This is the most recent annual NHS expenditure.

Table 14: NHS Spending across the UK, 2018/2019.

England £127,032 billion, then Scotland £13,030 billion, Wales £7,538 billion and NI £4,585 billion. TOTAL £152,185 billion.

By happy coincidence, this is met by the combination of VAT receipts and the main “sin taxes”.

Table 15: UK Tax Revenue by source, 2018/2019.

VAT £132.18 billion, Alcohol Duties £12.11 billion, Tobacco Duties £9.29 billion, Betting and Gaming Duties £2.985 billion, Soft Drinks Sugar Levy, £0.24 billion. TOTAL £156,805 billion.

All of the above means that there is the option of rebranding VAT and Duties as the starting base for a (perhaps notional) hypothecated health tax along the lines of VAT4NHS or the NHS NST (National Spending Tax). The standard rate would rise to 25%. As a populist touch, some activities engaged in most by those on lower to average incomes (cinema tickets, for example) could stay at 20% while a higher levy could be put on luxury goods (memo to the private equity industry, buy that yacht now).

What would be the attraction of VAT reform to an astute Chancellor looking to fund much higher NHS spending? There are three somewhat interconnected reasons to consider the option plus the fact that for technical elements too tedious to outline leaving the EU makes it easier to undertake. The first is that VAT was raised to a significant extent in 1979 (to cross-subsidise income tax cuts), in 1991 (to cross-subsidise cuts to the new Community Charge/Poll Tax) and 2010 (deficit reduction). In none of these cases was substantial political damage done to the Government of the day. The next is that absolutely nobody has the faintest idea how much VAT they paid in the course of any year and it would be incredibly hard to find that figure out (unlike income tax and national insurance sums). Finally, politicians are aware that they can get away with almost anything if they can argue that the NHS will be the ultimate

beneficiary of an initiative (“Why do we need to spend all that money on Trident?”, “To deter envious foreigners from nuking our NHS hospitals”, “In that case, we should keep that missile system”). It would involve breaking a manifesto commitment but so would any change in taxation required to raise NHS spending this much. By the strictures of the Politics of Pain, overhauling and reclassifying taxes and duties on spending is probably the least painful politically.

We are some time from the point where these decisions have to be made. They will certainly come. The vulnerability of the NHS exposed by the coronavirus crisis will not want to be witnessed twice. The structure of health spending in the UK means there is but one means by which it will take place.

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