The Health and Social Care Economy in the North West

North West Regional Assembly's contribution to the North West Investment Plan for Health

March 2003

Researched and written by
Centre for Public Services

For further information, please contact Peter Hart, North West Regional Assembly, Coops Building, Dorning Street, Wigan WN1 1HJ. Telephone 01942 737 922 or email peter.hart@nwra.gov.uk. For more information about North West Regional Assembly, please see our website www.nwra.gov.uk

CONTENTS

Foreword 2

Executive Summary 3

Part 1
Introduction: Economic, employment and health gains from health and social care investment 7

Part 2
Methodology for public service sector analysis 14

Part 3
Importance of the health and social care sector in the North West regional economy 20

Part 4
Direct and indirect employment in health and social care sector 28

Part 5
Planned growth of the health and social care sector 41

Part 6
Targeting investment to meet social needs and reducing health inequalities 45

Part 7
Economic implications of restructuring and modernisation of the health and social care sectors 49

Part 8
Key issues for the North West regional economic and planning strategies 57

Part 9
Scope for action by the regional partners on economic and employment matters related to health investment 79

References 84

North West
Regional
Assembly

FOREWORD

Regional partners need to examine and develop appropriate policy responses to a range of key issues in the North West. Health merits such attention. Health is a cross cutting issue with many economic, social and environmental factors that impact on public health and health inequalities. The Assembly recognises that health and wellbeing are essential to quality of life in the region.

The Health and Social Care Economy in the North West report is the North West Regional Assembly's contribution to shaping the forthcoming Investment Plan for Health for the North West. Researched and written by the Centre for Public Services the report is intended to provide an economic analysis of health and social care expenditure and investment in the North West. It recognises the important contribution of the health and social care sector in terms of economic, employment and health gains from increased investment; the role of the sector, not just the NHS, as a major employer in the region; equalities and earnings; targeting of investment to social needs and reducing inequalities; as well as recognising the opportunity to maximise regional benefits of a growing health and social care economy. It also sets a series of challenges for further key action to be undertaken and developed by regional partners, for example through the review of the Regional Spatial Strategy and the Regional Economic Strategy and it's action planning process.

This is our contribution to the continuing health debate which is vital both for our public services and for our regions economy.

Derek Boden

Leader

North West
Regional
Assembly

EXECUTIVE SUMMARY

Economic, employment and health gains from health and social care investment

The health and social care sector contributes 7.3% GDP to the North West economy. It has an economic and employment role, extending beyond providing services, meeting health needs and reducing inequalities. The health sector spends over £6billion per annum, £4billion on labour costs and £2billion on goods and services with local authorities spending a further £2.2billion on social services. The NHS in the North West purchases £678m of clinical supplies and services and a further £114m of general supplies, mainly catering and laundry. Office related expenditure is £144m with a further £282m spending on utilities, maintenance and cleaning. However, the proportion of goods and services sourced and produced in the North West is unknown but clearly has a significant economic effect on jobs and the regional economy.

Major employer in the local and regional economy

The sector directly employs over 192,000 staff (6.8% of employment in the region). When indirect and induced employment is taken into account, the health and social care economy supports 418,000 or 14.8% of jobs in the region. It is therefore a significant sector in the regional economy.

It has strong links with manufacturing industry in the region, particularly the manufacture of medical and surgical equipment and pharmaceuticals. It also has a key role in medical research and training. Employment in health related manufacturing (pharmaceutical products, pharmaceutical preparations, medical and surgical equipment) accounted for 10,000 jobs, about 2% of manufacturing jobs in the region. In addition, the North West health sector (public and private) is estimated to employ about 6,900 construction workers.

Equalities dimension

Just over 75% of NHS staff nationally are female and nearly a third of medical and dental staff are black, Asian or other ethnic groups. Hence the employment impact of NHS expenditure and investment is a major equalities issue. Nearly a third of the female workforce in the North West, with the exception of Cumbria, works in the health

North West Regional Assembly

services, social work and education sectors. Health, social work and education employment accounts for a quarter of male and female jobs in Merseyside and Blackpool. Male employment in this sector is higher in Blackpool, Cumbria, Lancashire and Merseyside.

Health and social care earnings important for the regional economy

The earnings profile in the health sector is very significant for the regional economy. Firstly, average weekly earnings are considerably higher than for other public sector professional groups. Higher paid staff have a significant role in supporting additional employment in the regional economy. However, 80% of male and 95% of female staff in health and related occupations earn under £400 per week compared to 66% male and 93% of women in all manual occupations.

Secondly, there is a much wider differential between the highest and lowest average earnings for different occupations in the health service than for other public services. 73% of male health professionals earn over £800 per week compared to less than 10% in other professional groups.

Planned growth of the health and social care sector

Total health and social services expenditure (revenue and capital) in the North West is expected to increase in real terms from £8.2bn in 2000-01 to £12.5bn over a seven year period, assuming expenditure increases in line with the national plans. The 52% increase means that some £7.5bn will be spent on direct employment in the region by 2007-08 with a further £5bn per annum on goods and services.

The Wanless Review forecast a need for up to 300,000 additional staff in the NHS over the next two decades – about 43,500 additional health care staff in the North West by the year 2020. In the shorter term, the North West's share of the government's target of 80,000 additional consultants, nurses, midwives, health visitors, therapists and scientists could be about 12,000 jobs over the next six years. An indication of the scale of these new employment opportunities is reflected in the Health Service Plan for the Cheshire and Merseyside Strategic Health Authority which includes an additional 1,546 jobs by March 2003, a 6.4% increase on the March 2002 total workforce of 23,969. Additional jobs will also be created in the social care sector.

North West
Regional
Assembly

Importance of the health and social care sector in the North West regional economy

The report identifies twelve key reasons why health and social care expenditure and investment are important in the regional economy and hence for the Regional Economic Strategy:

- The level of direct employment;
- The income profile;
- Health and social care expenditure on goods and services;
- Supply chains to manufacturing and related industries and the potential role of Small and Medium Sized Enterprises (SMEs) and Ethnic Minority Businesses (EMBs);
- Capital investment and orders for the construction industry;
- Training and skills development;
- Level of indirect and induced employment;
- Health and social care research and development;
- Quality of employment in setting labour market standards;
- Public health – increasing productivity, reducing sickness absence and improving community well-being;
- Reducing social and economic inequalities;
- Increasing regional identity.

Targeting investment to social needs and reducing health inequalities

The economic and employment role of the health and social care economy can make a significant contribution to reducing health and social inequalities through targeting of employment and by increasing the regional share of expenditure on goods and services.

The health and social care sector employs a large percentage of women and black and ethnic minority staff, it has a wide ranging skills and earnings profile with significant career opportunities, and is highly committed to training.

North West
Regional
Assembly

Economic implications of restructuring and modernisation of the health and social care sectors

Regional benefits could be undermined by further privatisation in the health and social care sector, increased use of private finance for health and social care projects, the continued use of the Private Finance Initiative and the transfer of services and assets from the public to the private and voluntary sectors. These policies generally lead to increased sourcing of goods and services nationally thus reducing regional content, increased the export of capital from the region, reduce terms and conditions leading to lower earnings thus reducing indirect and induced employment in the local and regional economy.

Maximising the regional benefits of a growing health and social care economy

There are a number of key issues which the regional partners need to examine and develop policy responses. These range from focusing on regional and local procurement to countering the increasing centralisation of procurement; harnessing spin-offs within the region; integrating the expansion of health expenditure and investment with regeneration, urban and rural renaissance schemes; ensuring the modernisation agenda does not accelerate privatisation; examining the implications of existing health care employment, demographic change and the location of health care investment for spatial development under the Regional Planning Guidance.

Scope for action by the regional partners on economic and employment matters related to health investment

The report concludes with a series of proposals to be considered by the regional partners under the following headings:

- Strengthening links to regional manufacturing, research and development;
- Strengthening regional and local procurement;
- Training;
- Minimising further privatisation and marketisation;
- Scrutiny and monitoring;
- Research agenda.

North West
Regional
Assembly

PART 1

Introduction: Economic, employment and health gains from health and social care investment

The economic rationale of health and social care in the North West economy

The report identifies twelve key reasons why health and social care expenditure and investment are important in the regional economy and hence for the Regional Economic Strategy:

- The level of **direct employment**;
- The **income profile**;
- Health and social care **expenditure on goods and services**;
- **Supply chains to manufacturing and related industries** and the potential role of Small and Medium Sized Enterprises (SMEs) and Ethnic Minority Businesses (EMBs);
- Capital investment and **orders for the construction industry**;
- Training and skills development;
- Level of **indirect and induced employment**;
- Health and social care **research and development**;
- **Quality of employment** in setting labour market standards;
- **Public health** – increasing productivity, reducing sickness absence and improving community well-being;
- **Reducing social and economic inequalities**;
- **Increasing regional identity**.

Integrated health and social care not only means co-ordinating service delivery, encouraging joint organisational and operational approaches but also securing the integration of the health and social care economy into the local and regional economies.

Aims of this study are:

1. To examine the importance of health and social care in the regional economy.
2. To assess the employment impact of the health and social care sector.
3. To identify the linkages to manufacturing and other services in the regional economy.
4. To identify the threats and opportunities in maximising regional benefits and scope for action by the regional partners.
5. To identify the economic contribution which the health and social care sector can make to reducing health inequalities in the region.

North West Regional Assembly

The importance of health expenditure and investment to the regional economy

Health sector expenditure is planned to increase to £90bn by 2005/06, an average annual growth rate of 7.3% (2002 Spending Review and Department of Health Annual Report 2002/03). The national focus is on health policy, investment and modernisation – government is insistent on reform and increased productivity. But this is not the full story. A significant part of the health economy is missing. There are economic as well as medical/public health, social and environmental impacts or consequences of health and social care investment. It is a labour intensive sector with, on average, 60% of expenditure taken up by staffing costs. But how and where the other 40% is spent, some £2.5bn in the North West, is significant for the regional economy.

This report refers to expenditure as being the revenue budgets of health and social care bodies which is used for staff wages and the purchase of goods and services (it is also used to repay the cost of privately financed capital projects). Investment refers to capital expenditure on new buildings and facilities.

The success of the region will depend, in part, on how the regional partners take advantage of these economic linkages and how the region maximises the added value of the planned growth in health and social care expenditure in the regional economy. It must manage this economic activity for the benefit of the region rather than simply allowing other regions in the UK and abroad to gain the benefit of increased investment in the North West.

It could be claimed that since the government has already agreed to expand health and social care expenditure and investment, this sector will grow anyway, therefore resources should be focused on other sectors and clusters. However, there is evidence that the economic linkages in the health economy are poorly understood and much remains to be done if the advantages of increased health investment are to be harnessed within the region. The quality of employment will be a key factor. The debate about 'new localism', Foundation Hospitals or growth of the 'social economy' also needs to be addressed in terms of the health economy.

"Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood" (World Health Organisation, 2001).

North West Regional Assembly

Why it is important and what can be achieved

The approach and methodology promoted in this report could result in:

- Increased employment in the region;
- Strengthened related employment in manufacturing and service sectors;
- Eliminate or reduce the conditions under which a two-tier workforce develops;
- Reduce health inequalities in both urban and rural areas;
- Increased capacity of health and social care organisations in the region;
- Improve procurement processes to maximise benefits;
- Enhanced community well-being;
- Strengthened regional ability to negotiate deals in the interests of the North West.

Targeting localities

At the local level the economic benefits could include:

- Better quality and more secure jobs;
- Better quality, more nutritious and regionally produced food in hospitals and care facilities with benefits to local agriculture, health and recuperation;
- Development of new products and services within the region to maximise benefits;
- Improve skills and the widest possible range of career opportunities in the health and social care sector within the region;
- Support local suppliers of quality good and services.

Proposals to maximise economic benefits of the health and social care economy will need to be put into effect at both the regional and local levels. Education about the health economy and the mechanisms which can be used will be needed and the regional partners have an important role in cascading the regional perspective to the sub-regional and local level.

The analysis and proposals in this report will also help to strengthen the North West's regional identity. Local procurement, devolved institutions and increased regional capacity have a key role in this process.

North West
Regional
Assembly

The North West Investment Plan for Health

The Department of Health North (Public Health) have prepared a draft Investment Plan for Health for the North West based on the NHS Plan and 2002 Spending Review.

This Report contributes to the North West Regional Assembly's comments on the draft Investment for Health Plan. It sets out a methodology for an economic analysis of the health and social care economy in the North West. This can also be applied to other public services such as education/training and housing/regeneration.

The provision of health and social care is a key economic activity with linkages to the manufacturing and service sectors. It is a major employer in most local economies. It directly employs and supports 15% of employment in the regional economy.

The draft North West Investment Plan for Health report focuses on the health of the North West population, the consequences of poor health, the causes of health inequalities and the health policies required to increase community well-being in the home and workplace. However, the report does not assess the economic relationships between the health and social care sector and the regional economy.

The Investment Plan for Health should demonstrate how health investment can be used to maximise the economic benefits and reduce health inequalities in the region. The report requires the following additions:

- An analysis of health and social care investment needs in the North West in the 2002-2008 period;
- An indication of the scale of additional public investment planned for the North West;
- An economic understanding of the regional health and social care economy;
- Analysis of the role and impact of health investment in tackling health inequalities;
- Analysis of the current trends in the region which prevent the regional partners from maximising the economic gains of health investment for the manufacturing and service sectors;
- Proposed changes in the health and social care delivery mechanisms are likely to increase 'national' and international sourcing which will undermine the economic benefits gained from regional and 'localism' strategies.

North West Regional Assembly

The draft Investment Plan for Health refers to the need for the NHS to develop its role as *"a 'corporate citizen' contributing as a major regional organisation and stakeholder to wider regeneration and sustainability objectives"* (page 6). But the NHS is not a business in the normal sense of the word. The NHS, together with other public health and social care agencies, are a core part of the public sector with a fundamental democratic obligation to ensure policies, programmes and projects not only improve the health of the nation, reduce inequalities but also enhance community well-being and maximise the economic benefits.

The Department of Health North (Public Health) have commissioned a study of the NHS's 'economic footprint' in the North West. It will identify *"business development opportunities and links to other economic clusters and the potential contribution of the NHS to wider regeneration objectives and the links to the five themes of the Regional Economic Strategy"* (summary, page 13).

The concept of an 'economic footprint' is derived from an 'ecological footprint' developed to highlight the availability of natural resources and the extent to which production and consumption impacts on them. It includes estimating energy and material flows within a local economy and translating them into areas of land that would be needed if this consumption were met purely from renewable resources. In contrast the 'economic footprint' concept is used to describe economic analyses of varying scope.

Whilst the 'footprint' concept is very useful to demonstrate ecological impact it is not so appropriate for assessing the economic, social and environmental components of the health and social care economy. The reasons for this are fourfold.

Firstly, it is a 'negative' concept because it is associated with minimising an ecological footprint (the smaller the footprint the fewer resources required) whereas the larger the regional 'footprint' for the health and social care economy the more this indicates a high level of intra-regional production and economic sustainability. The objective is not to promote a deficit but the reverse.

Secondly, the 'footprint' concept is descriptive whereas economic analysis has to be dynamic in identifying the opportunities afforded by the expansion of the health and social economy in the region.

Thirdly, it does not cover employment which is fundamental to the regional economy and reducing health inequalities.

Finally, the 'footprint' concept refers to only one aspect of the regional economy.

North West
Regional
Assembly

Limited analysis

There has been very limited analysis of the macro/micro economics of health and social care expenditure and investment either in Britain or elsewhere. A study by the London School of Economics and Imperial College which examined the economic impact of the NHS on the London regional economy showed that health contributes 6% to the city's GDP and supports nearly 10% of London's jobs (NHS Executive London, 2000). A Kings Fund study examined NHS spending on buildings, food, energy, childcare, waste and procurement in general (Coote, 2002). A search of the web sites of health and public organisations in Britain and internationally revealed little comparable research.

This report substantially extends the scope of the London research by:

- Examining the key trends and consequences of modernisation of the health and social care sector and the implications for economic linkages and employment;
- Detailing the impact of changes in the planned level of expenditure and investment in the sector;
- Examining the earnings profile of the health and social care sector which is significantly different from other sectors and therefore has a particular impact on the regional economy;
- Examining procurement policies for the purchase of goods and services and capital investment and how this impacts on the economic linkages;
- Identifying key issues for the regional economic strategy, the policy agenda and makes a number of proposals for strengthening the regional economy;
- Identifying how a health economy perspective can make a significant contribution to reducing health inequalities in the region;
- Developing a model which can be applied for other public services and activities.

Education is another very important public service in the North West regional economy. The Higher Education sector alone has a regional turnover of £1.3bn, employs 26,000 staff and has 200,000 students, the highest number of students outside of London. The combined expenditure of Higher Education Institutions, staff and students has been estimated at about £2.1bn annually (NWUA, 2002).

North West
Regional
Assembly

Structure of the report

Part 2 of the report describes a methodology by which the economic and employment impact of public services can be assessed. Part 3 identifies the different economic dimensions to the health economy and the impact of health and social care expenditure and investment. It describes the importance of the health and social care sector in the regional economy in terms of GDP, the scale of expenditure on goods and services and the links to manufacturing and other services. Part 4 assesses the direct, indirect and induced employment supported by the health and social care sector and the significance of gender and earnings profile of the sector.

Part 5 examines the planned growth of health and social care expenditure and the potential effects on the regional economy. The need for expenditure and investment to target health and social needs and the investment deficit is the subject of Part 6. It demonstrates how the growth of health and social care expenditure, given a regional economic perspective, could make a significant contribution to reducing social and health inequalities in the region.

Part 7 examines the economic implications of restructuring and modernisation of the health and social care sectors. Outsourcing and privatisation, the adoption of commissioning and other marketisation policies and changes to terms and conditions of staff have a material effect on the regional economic benefits of health and social care expenditure.

Part 8 examines a number of key issues for the North West which range from threats or challenges to maximising the regional economic benefits of public expenditure and also identifies many opportunities for the regional partners. The concluding Part 9 makes a number of proposals for further action by the regional partners.

North West
Regional
Assembly

PART 2

Methodology for public service sector analysis

Introduction

The economic impact of the public sector has been consistently understated in regional strategies and planning nationally and in the North West. However, the new Regional Economic Strategy 2003 for the North West recognises the important role of the public sector and includes healthcare as one of the planned clusters.

Relatively limited economic analysis has been carried out on the role of public services as economic drivers contributing to regional growth and competitiveness. Public services such as health and education are rarely classified as sectors or clusters, irrespective of the relative merits of such a classification. This section develops a methodology for assessing the economic structure of the health and social care economy.

The public sector model

The economic impact of a public service such as health or education could be the same or even have greater significance than the benefits which might be gained from other sectors or clusters. It is also significant that the regional partners have a greater degree of control and influence over the economic performance of public expenditure and investment than they could have over most clusters which generally rely heavily on private sector action.

Our recent review of the Regional Economic Strategy recommended that it should consider the impact of the government's modernisation agenda, particularly the focus on procurement; the planned level of capital and revenue public sector expenditure in the North West over the next three years for each sector (Centre for Public Services, 2002).

The review also recommended that the RES should examine the economic opportunities created by this expenditure, particularly for priority areas and clusters, but also for key sectors such as construction. It also recommended that the key developments in the interface between the public and private sectors and the social economy be more fully examined in the North West.

A similar economic analysis could be carried out for other sectors such as education, housing and regeneration. Each make a distinctive contribution to the regional economy which needs to be more fully understood for the RES to maximise the regional opportunities.

These other sectors are also undergoing major organisational and operational change as part of the government's modernisation

North West Regional Assembly

agenda. Outsourcing, partnerships, private finance, transfer of services and assets to the third sector or social economy are common across most public services. These changes may affect the regional economic linkages to the manufacturing, construction and service sectors. It will be necessary to examine the relative role of North West based international, national and regional firms in capital investment and the supply of goods and services.

This report provides a methodology which could be adopted for wider use by the regional partners – see the diagram on page 11. It has also identified a number of gaps in data availability. It should be regarded as work in progress. Where there are gaps in information, data and analysis, the report identifies a number of key questions and a possible research agenda.

Methodology

The methodology developed for the health sector can be applied to other public services such as:

- Education (primary, secondary, Further and Higher Education);
- Housing and regeneration;
- Environmental services (including waste management);
- Local government;
- Central government.

These are major areas of public expenditure and it is essential to identify and maximise the economic benefits of this spending. It is necessary to go beyond policy-making and the allocation of expenditure. The growth or decline of public expenditure and investment has direct economic consequences for the local, regional and national economies.

In an era of new models of financing and operating public services it is important to fully assess the economic and social consequences of different investment and service delivery models. This is more pertinent in the current debate over a 'new localism' and calls for the expansion of the 'social economy'.

Increased expenditure and investment per se may not have the same impact as previous equivalent expenditure and investment because of the role of the private sector and national sourcing of goods and services. It is also necessary to assess the percentage of expenditure which is used to provide new facilities and services rather than merely fund the additional cost of partnerships and private finance.

North West
Regional
Assembly

More investment is generally beneficial, particularly if it is improving access and the quality of service for North West residents. But this is only one part of the expenditure/investment system. How and where the money is spent will also determine the region's share of the economic benefits arising from the expenditure/investment, particularly in terms of what is sourced within the region compared to what is sourced nationally or internationally.

There are significant differences in the type of expenditure between public services, for example between health and education, which justify separate analyses of their economic impact. They include differences in:

- The economic impact on employment and earnings;
- The level and type of purchase of goods and services, procurement processes and supply chains;
- Role of the construction industry;
- Public/private responsibilities and degree of reliance on market economy;
- The modernisation agenda;
- Economic linkages to manufacturing and services sectors;
- The potential impact of liberalisation under GATS and other agreements at European and international level.

Sectors and clusters

Regional economic strategies have generally defined both sectors and clusters as comprising almost entirely of private firms. Sectors are usually defined by firms which make a common product or service whilst a cluster is usually defined as *"a geographic concentration of inter-connected companies, specialist suppliers, service providers, firms in related industries and associated institutions, in particular, that compete but also cooperate"* (Porter, 2001). Of course, this analysis or approach is not new. Various types of industrial and commercial clusters have formed for centuries.

Public services such as health and education are sectors which have some attributes of clusters such as a degree of co-operation and links to research and development organisations. They also have links to manufacturing and service sectors. Firms compete in a common market but there is often a low level of concentration at local or regional level.

There is also a distinct difference in the robustness of the potential outcomes, for example, clusters are often embryonic, vague and there is often an ambiguity over what outputs may emerge or

North West
Regional
Assembly

develop. In contrast, public services offer a much clearer set of targets and potential for a hands-on approach. To this extent the public sector has a distinctly different risk profile from a private sector focused cluster. The health and social care economy affords an opportunity to focus on the real as opposed to the marginal benefits of clusters by securing the substantive benefits of the production chain.

The economic case

Sectors and clusters should be selected according to a number of criteria which could include:

- Long term growth potential;
- Regional economic significance such as contribution to regional competitiveness and innovation;
- Significant employment and influence in regional labour market;
- Experiencing difficulties in maximising regional and local benefits;
- Potential to reduce social exclusion and inequalities;
- Value for money in the use of public economic development resources;
- Scope for public intervention and potential level of co-operation and co-ordination which can be achieved within and between public and private sectors;
- Links to other regional policies such as regeneration, urban and rural renaissance;
- Sub-regional dimension and impact across the region;
- The degree of risk.

It is evident that the health and social care economy scores highly under all these criteria, reinforcing its importance in the regional economy.

Supply chains

Sector analysis involves examination of the supply chain, the sourcing, delivery, distribution and supply of raw materials and support activities required for the manufacturing process or the delivery of services. But the 'service chain' is also significant, particularly where there is competition between public and private sectors.

All service organisations are concerned to maintain and expand the services they provide. This is their core function. However, the particular form of the current modernisation agenda means that

North West Regional Assembly

public sector providers are confronted by privatisation and pressures to adopt a 'mixed economy' of provision. These frequently mean a fracturing and loss of service delivery responsibilities for the public sector.

Changes in European and global policies also present a challenge to maintaining service chains. For example, under certain conditions new European Union regulations permit NHS patients to travel to other European countries for treatment, funded by the NHS. The introduction of GATS (see Part 8) will increase the marketisation of health and social care services.

The introduction of further competition in the NHS via Foundation Hospitals will have the same effect. More North West patients will be able to receive treatment in neighbouring regions, elsewhere in Britain or abroad. Whilst the actual numbers may initially be relatively small, they are likely to establish trends which will have a bigger impact. They effectively reduce or weaken the service chain of the NHS and public sector service providers. It fractures the chain between GP, PCT, health clinic, hospital, intermediate care, residential/home care. This continuum of care has traditionally been provided by the public sector. These changes could have negative repercussions on the regional economy.

Methodology for economic analysis of public expenditure and investment: Health and social care

North West Regional Assembly

PART 3

Importance of the health and social care sector in the North West regional economy

Introduction

This section identifies the total expenditure of the health and social care sector in the North West and examines the different types of public spending and the effect on the regional economy, in particular, the linkages with manufacturing, business services and construction sectors.

Significance of the health and social care economy

Health and social work Gross Domestic Product (GDP) was £5,461m or 7.3% of total GDP in the North West in 1998 compared to an UK average of 6.6%. Health and social work (public and private) is fifth in the North West region GDP rankings (1998 data). Manufacturing is expected to have declined further between 1998 and 2002. The planned expansion of health and social care is likely to consolidate health in the top third of sectors in terms of their contribution to the region's GDP.

Table 1: Contribution to Regional GDP

Sector	% Regional GDP
Manufacturing	25.1
Real estate, renting and business activities	18.4
Wholesale and retail trade (including motor trade)	13.2
Transport, storage and communication	8.2
Health and social work	7.3
Education	5.9
Construction	5.1
Financial intermediation	4.5
Public administration and defence	4.3
Hotels and restaurants	3.2
Electricity, gas and water supply	2.3
Agriculture, hunting, forestry and fishing	0.9
Other mining and quarrying	0.2
Other services	4.5
Financial services indirectly measured	-3.2
Total	**100.0**

Source: Region in Figures, ONS, 2002.

Type of expenditure

Health sector expenditure is basically divided between spending on wages and goods and services with a smaller proportion on capital investment. Significantly, it has one of the highest percentage expenditure on goods and services (96.8%) and differs from

North West Regional Assembly

housing and education because it does not include transfer payments to the personal or private sectors in the form of benefits and/or grants in its overall budget (see Table 2).

Table 2: Classification of general government expenditure by service, 2001.

Service	% of total final consumption expenditure as a % of total outlay
Health	96.8
Recreation and Culture	78.9
Education	75.8
Housing	54.0
Average all services	**47.9**

Source: UK National Accounts, Blue Book, Stationery Office, London.

Regional health expenditure

The North West region had the third largest health and personal social services public expenditure of the English regions in 2001. Total expenditure was £8.2bn with only London and the South East regions having higher expenditure levels. These three regions had substantially higher expenditure than the other English regions. Some £6bn of the £8.2bn total was health spending with the remainder being personal social services spending by local authorities (see Table 3). Expenditure per head was £1,190 per head in the North West, also the third highest for all the regions.

Table 3: Health and social services public expenditure by region, 2000-01

Region	Expenditure (£m)
London	10,206
South East	8,367
North West	8,200
West Midlands	5,747
Yorkshire & Humberside	5,759
Eastern	5,536
South West	5,376
East Midlands	4,309
North East	3,083
Total England	**56,583**

Source: Table 8.12a, Public Expenditure: Statistical Analyses 2002-03, Cm 5401, Stationery Office, London, May 2002.

A breakdown of health revenue expenditure by health authorities and NHS Trusts in England reveals that just over 60% of expenditure was taken up with wages in 2001, a decline from 64.6% in 1997 (see Table 4).

North West
Regional
Assembly

Table 4: Health authority and NHS Trust identifiable expenditure in England (31 March 2001)

Revenue expenditure	Amount (£m)	Percentage
Salaries and wages	20,532	60.4
Supplies and services	4,668	13.8
Establishment	1,079	3.2
Premises and fixed plant	1,780	5.2
Miscellaneous expenditure	3,107	9.1
Cost of use of capital assets	1,125	3.3
Purchase of health care from non-NHS bodies	1,549	4.6
External contract staff	149	0.4
Total	**34,009**	**100.0**

Source: Department of Health, Table E3.

Most NHS Trust Annual Reports state only the number and total amount of invoices and the percentage paid within 30 days. The focus is on the speed of payment to suppliers rather than analysis of the types of expenditure on goods and services. For example, Salford Royal Hospital NHS Trust issued 60,230 invoices to purchase £50.4m goods and services in 2000/01, an average invoice of £837. Central Manchester NHS Trust had 115,236 invoices for £107.2m goods and services, an average invoice of £930. A large majority of NHS trusts in the North West do not provide a breakdown of expenditure on different goods and services in their annual reports.

A detailed breakdown of expenditure by the Blackburn Hyndburn and Ribble Valley NHS Trust – provided a more detailed breakdown of expenditure than Table 3. Although staff costs were higher accounting for 66.7% in the trust compared to 60.4% for all health authorities and trusts in England, there is a high level of comparability in the other expenditure items as demonstrated in Table 5.

Table 5: Type of Expenditure by Blackburn, Hyndburn and Ribble Valley NHS Trust (2000/01)

Expenditure	£000	%
Staff costs	67.7	66.7
Directors costs	0.7	0.7
Supplies and services – clinical (drugs, medical and surgical)	11.4	11.3
Supplies and services – general (catering/laundry)	1.9	1.9
Service from other NHS bodies include ambulance costs	5.1	5.0
Establishment (postage, printing, stationery, telephones and transport costs)	1.9	1.9
Premises – maintenance, gas, electricity, rates, furniture and cleaning costs	4.8	4.7
Depreciation and amortisation	4.5	4.5
Transport	0.2	0.2
Bad debts	0.0	0.0
Audit fees/VFM	0.1	0.1
Clinical negligence	0.3	0.3
Other	2.7	2.7
Total	**101.5**	**100.0**

Source: Annual Report 2000/01, Blackburn, Hyndburn and Ribble Valley NHS Trust.

North West Regional Assembly

Using the data from Tables 1-3 it is possible to estimate NHS expenditure in the different categories in the North West. Of the £8,200m identifiable expenditure in the region in 2000-01, some £6,000m was health expenditure. Table 6 estimates the level of spending in the different categories of expenditure to give a clearer picture of the impact of health spending. More detailed analysis is required to determine what proportion of this expenditure is spent within the regional economy.

Some £4,000m of health expenditure in the region is staff costs. The NHS in the North West purchases £678m of clinical supplies and services and a further £114m of general supplies, mainly catering and laundry. Office related expenditure is £144m with a further £282m spent on utilities, maintenance and cleaning.

Table 6: Regional health sector spending based on £6bn annual expenditure (date)

Expenditure	%	Estimated North West Regional expenditure £m
Staff costs	66.7	4,002
Directors costs	0.7	42
Supplies and services – clinical (drugs, medical and surgical)	11.3	678
Supplies and services – general (catering/laundry)	1.9	114
Service from other NHS bodies include ambulance costs	5.0	300
Establishment (postage, printing, stationery, telephones and transport costs	1.9	114
Premises – maintenance, gas, electricity, rates, furniture and cleaning costs	4.7	282
Misc	7.8	468
Total	**100.0**	**6,000**

Source: Tables 1 – 4 above.

This table could be expanded based on table 14 but need social services element. What number of jobs could be supported by this increased spending.

Expenditure within the region

The question is what percentage of the expenditure occurs in the North West region. It appears that no analysis has been carried out, not even an average national/regional split.

The pattern of local government expenditure in one city was examined in the preparation of the Manchester Employment Plan (1987). The City Council spent £199.1m on goods and services with private firms in 1985-86, including £30m construction contracts. The research examined £95.5m or 50% of contracts. Contracts for £10,000 - £100,000 and over £100,000 were analysed separately to identify any variations.

North West
Regional
Assembly

The research revealed that 29.25% of invoices had Manchester addresses, 24% had Greater Manchester addresses with the remaining 46.75% in other locations. Manchester addresses accounted for 31.5% of the larger contracts but only 23% of those in the £10,000 – £100,000 category. Of course, invoice addresses do not always indicate the geographic production of goods and services. The supply of goods and services may have a local address but they may be produced in full or part elsewhere but warehoused and distributed locally. A similar analysis should be carried out by a small sample of NHS Trusts in the North West.

Links with other sectors in the regional economy

Health spending on goods and services and on capital projects for new buildings and equipment falls into a number of categories:

- Pharmaceuticals;
- Manufacturing of medical equipment (hospital and aids for patients);
- Manufacturing of medical and surgical supplies;
- Information and communications technology hardware, software and training;
- Management and technical consultants;
- Catering supplies;
- Office supplies and printing;
- Transport vehicles, maintenance;
- Construction, building repair, maintenance and FM/estate services including architectural services.

It appears that very little information is available on a regional level, either disaggregated from national statistics or collected on a regional basis. Further research and analysis is needed to identify the North West dimension in each of these sectors. A number of questions arise:

- What is the current regional content of goods and services supplied to NHS and social care trusts?
- Which firms in the North West manufacture medical equipment and surgical supplies, what is their capacity, the wider market for products, investment plans, staffing and recruitment/training needs?
- What are the barriers to increasing the regional content of goods and services – supply, access, price, quality and suitability?

North West Regional Assembly

- Are there specific skill shortages in these health related economic activities in the North West which constrain the expansion of regional provision?
- What are the supply chains in health and social care and how do they differ from other sectors?

Many of these issues could be further investigated by the regional partners.

Social services expenditure analysis

In 1999-2000 local authority gross expenditure on personal social services was £12,848m, of which about £2.2bn was spent in the North West. Residential care provision accounted for £5,904m (46%), day and domiciliary provision £5,035m (39.2%) and assessment and care management £1,909m (14.8%). Older people dominate the division of expenditure by client group, accounting for 45.9%, followed by children's and families services (22.3%), learning and disabled adults (13.6%), physically disabled adults (6.7%), mentally ill adults (5.3%) and asylum seekers (4.3%).

Labour costs in residential care account for between 70%-75% of budgets with home care labour costs being even higher.

Health care spending in the local economy

Table 7 shows the staffing levels and annual medical budget for the Central Manchester Healthcare/Children's Hospital NHS Trust in 2001-02. The annual budget of £222.7m in 2001-02 included wages and employer costs for 5,430 staff and £75m expenditure on goods and services. This is very significant for the local economy. Taking into account other NHS Trusts in Manchester, the education sector and Manchester City Council highlights the important role of the public sector in Manchester and North West regional economies.

Table 7: Number of staff and the annual budget of specialities at Central Manchester NHS Trust

Speciality	No. of staff	Annual budget 2001/02 (£m)
Acute Medicine and A & E	360	10.0
Acute Surgery	304	11.2
Anaesthesia, MRI Theatres and Sterile Services	320	15.0
Children's services	1,694	75.1
Clinical Radiology	125	6.5
Critical Care	120	5.0
Dental Hospital	197	7.2
Laboratory Medicine	267	7.8
Manchester Heart Centre	283	12.2
Medical Specialities	225	14.0
Ophmalmology	350	12.0
Renal medicine	225	12.9
St Mary's Hospital for women and children	762	25.6
Surgical Specialities	198	8.2
Total	**5,430**	**222.7**

Source: Central Manchester Healthcare NHS Trust Annual Report, 2002.

Health sectors contribution to construction industry

The health sector investment has a significant role in the construction industry. The public sector accounted for about 14% of non-housing new orders annually in the North West between 1999-2001. Public and private investment in the health sector has increased its share of new orders nationally, rising from 3.8% in 1997 to 4.3% in 2002 – see Table 8. Construction output in the health sector was £1,934m in 2002. The increase in public sector investment was more than matched by an increase in private sector investment in the health care sector resulting in the proportion of public sector investment decreasing from 73% to 69% of the total.

Table 8: Value of construction output new work in health sector (Great Britain, current prices)

Sector	1997	1998	1999	2000	2001	2002
Public (£m)	822	764	879	928	1,083	1,330
Private (£m)	307	389	474	622	545	604
Total (£m)	1,129	1,153	1,353	1,550	1,628	1,934
% of total new work	**3.8**	**3.6**	**3.8**	**4.1**	**4.1**	**4.3**

Source: Construction Output, First Quarter 2003, March, DTI.

Total construction sector employment was 1.6m in Great Britain in the final quarter of 2002. The North West health sector (public and private) is estimated to employ about 6,900 construction workers.

However, the number of jobs generated by different types of health sector construction (jobs per £m expenditure for different

types of facilities) is not available. A study of 26 housing contracts of over £100,000 and valued at £32m, contracted out by Doncaster MBC between 1991/92 to 1997/98 showed that the average contract consisted of labour 33%, materials 47% and overheads 20% (Sheffield Hallam University, 1998). The proportion of jobs taken by Doncaster residents was 35% with 42% resident in other parts of South Yorkshire and 23% from other areas. The investment created 459 job years in Doncaster and 1,043 job years in South Yorkshire over a six-year period.

A similar analysis of NHS capital investment for different types of facilities would enable more accurate forecasting of the employment and economic impact of the health and social care capital investment programme in the region, particularly since PFI and NHS LIFT projects are likely to increase the involvement of national firms and national sourcing.

The Construction Industry Training Board (CITB) estimate that the North West has average annual demand for 6,600 new recruits into the industry in the 2002-2006 period. Craft occupations are under pressure with skill shortages for carpenters and joiners, bricklayers, plumbers, painters and plasterers (CITB, 2002).

Conclusion

This section has demonstrated the important contribution of the health and social care sector in the North West regional economy. There are direct linkages with manufacturing industry and other services. The health and social care sector spends over £2 billion per annum on supplies, goods and services and the construction industry. The extent to which this is spent within the region is unknown. Clearly, the region could benefit significantly if a larger share of this expenditure is procured from regional firms.

PART 4

Direct and indirect employment in the health and social care sector

Introduction

Health and social care organisations are major employers in the local and regional economy. Spending by these employees, plus the NHS purchase of a wide range of goods and services, supports further jobs in the economy. This section quantifies the direct and indirect health and social care employment in the North West.

Recent employment change in the North West

The region had a 59,000 increase (+2%) in jobs in the period December 1998 to December 2001 with service sector jobs increasing 83,000 (+4%) and a 30,000 (19%) job increase in the 'other sector' including construction, energy and agriculture. These increases were accompanied by a loss of 55,000 (-10%) manufacturing jobs in the region reflecting a comparable decline across the UK. The increase in the total number of jobs and service sector jobs were below the UK average but the increase in the 'other sector' category was the highest for any region and nearly ten times larger than the UK average of 2%.

The planned growth in health and social care employment is not new. The health and social work sector created 28,000 new jobs in Lancashire between 1984-95, a 72% increase, which was *"nearly as many jobs as were lost throughout the whole of the manufacturing industry over the same period"* (Lancashire CC, 1997). So health and social care employment has an important role in the regional economy.

Categories of health and social care employment

Employment in the health and social care sector has been calculated using the following categories:

Public sector

- **Directly employed staff in NHS and local authority health and social care trusts and organisations** (NHS and local authority employment data, jobs rather than full-time equivalents);
- **Service contract staff** employed by contractors within the NHS (IT, catering, domestic services, repair and maintenance in PFI and outsourced contracts, current lack of data so only estimate);
- **Construction staff** (NHS and local authority building projects);

North West Regional Assembly

- **Staff employed in private sector companies and organisations** providing goods and services to health and social care trusts (indirect employment, estimate on basis of expenditure, avoid double-counting with contract staff).

Private health care sector

- **Directly employed staff in private health care**;
- **Service contract staff** employed by contractors in the private hospitals (IT, catering, domestic services, repair and maintenance);
- **Staff employed in the companies and organisations providing goods and services to private health care sector** (indirect employment);
- **Construction staff** (building private hospitals, nursing and residential care homes).

Voluntary sector

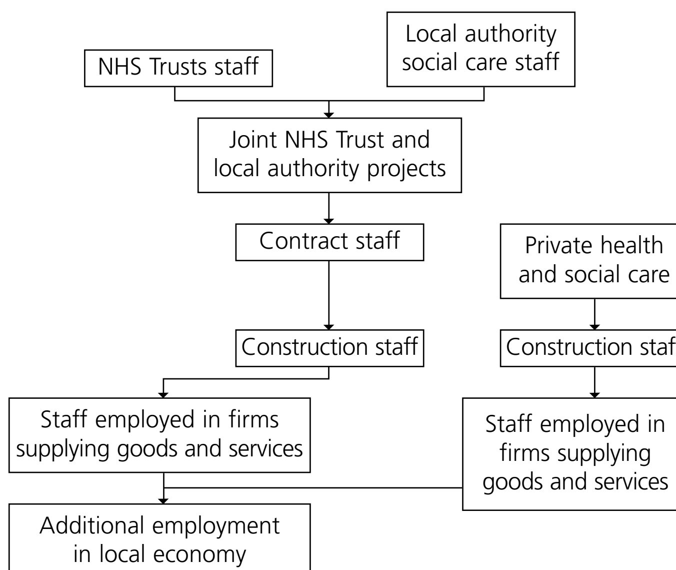
- **Directly employed staff in voluntary sector**;
- **Staff employed in the companies and organisations providing goods and services to private health care sector** (indirect employment).

Knock-on effect of public, private and voluntary sectors

- **Employment in the local economy** supported by public and private health and social care expenditure and investment (induced employment).

The approach is shown in Chart 1 below:

Chart 1: Employment in the health and social care sector in the North West



North West Regional Assembly

Employment in the health sector in the North West

NHS and Community Health Service employed 121,600 (WTE) staff in September 2001 (see Table 9). This included nearly 84,000 direct care staff, the bulk of whom are nurses, midwives and health visitors. The total number of jobs (headcount) is estimated to be 149,568 based on a national ratio of 1.23 WTE/headcount.

Table 9: NHS and Community Health Service staff in the NHS North West Regional Office area, 30 September 2001 (WTE)

Occupation	%	Number of staff (WTE)
Medical and dental	7.5	9,120
Nursing, midwifery and health visitors	47.7	58,003
Scientific, therapeutic and technical	13.8	16,780
All direct care staff	*68.9*	*83,903*
Administration and estates	21.7	26,387
Other	9.4	11,430
All management and support staff	*31.1*	*37,817*
Total	**100.0**	**121,600**

Source: Table 7.18, Regional Trends 37, Office for National Statistics, 2002.

Health services, social care and education sectors directly account for 20% of employment in the North West (see Tables 10 and 11). There is a significant gender divide with these sectors accounting for nearly 31% of female employment in contrast to only 10% of male employment.

Table 10: Employee jobs in the North West by industry, December 2000

Industry	% Female jobs	% Male jobs	% All people
Agriculture, hunting, forestry and fishing	0.3	0.8	0.6
Mining and quarrying	–	0.2	0.1
Manufacturing	9.7	25.3	17.6
Electricity, gas and water	0.2	0.2	0.2
Construction	1.4	8.0	4.7
Distribution, hotels and catering, repairs	27.7	21.6	24.6
Transport, storage and communication	3.2	8.2	5.7
Financial and business services	15.8	16.0	15.9
Public administration and defence	5.9	5.7	5.8
Education, social work and health services	30.9	9.6	20.1
Other	4.9	4.3	4.6
Whole economy (No)	**1,398,000**	**1,437,000**	**2,835,000**

Source: Table 5.4, Regional Trends 37, October 2002.

North West
Regional
Assembly

Table 11: Health and social care jobs in the North West region, December 2000.

	% Health services, social work and education jobs in region	Number of jobs
Female	30.9	569,835
Male	9.6	137,952
Total	**20.1**	**707,787**

Source: Regional Trends 37, Office for National Statistics, 2002.

Within the total of 707,787 health, social work and education jobs in the North West, some 43,210 are social services staff, representing 15.5% of the total social services staff in England see Table 12. Nearly two thirds are employed part-time and 30% remain engaged in care or special needs establishments despite the recent spate of privatisation or closure of local authority care homes.

Table 12: Local authority social services departments staff at 30 September 2001

Type of work	Full-time	Part-time	Total
Strategy/central staff	1,730	775	2,505
Staff in operational divisions	7,635	12,535	20,170
Day care provision	2,830	4,055	6,885
Care in residential establishments	3,475	7,995	11,470
Specialist needs establishments	255	1,495	1,750
Other staff	215	125	340
Total in North West	16,140	26,980	43,120
England	**125,735**	**158,710**	**284,445**

Source: Department of Health, 2002.

The total direct health and social care employment in the North West is thus 192,688 jobs (6.8% of employment in the North West).

Gender of the NHS workforce

Just over seventy five percent of all NHS staff nationally are female. The percentage of medical and dental staff was relatively low at 34.3% in 2001 compared to the very high percentages of women employed in nursing, midwifery, and health visiting (88.9%), scientific, therapeutic and technical staff (78.2%) and management and support staff (74.9%) see Table 13. Hence the employment impact of NHS expenditure and investment is a major gender issue.

Table 13: NHS Hospital and Community Health Services Directly Employed Staff and Gender, England, 30 September 2001

Occupation	Number of staff	% Female	No. of Female staff
Medical and dental staff	73,850	34.3	25,330
Nursing, midwifery and health visiting staff	458,580	88.9	407,677
Scientific, therapeutic and technical	139.050	78.2	108,700
All management and support staff	329,750	74.9	246,982
All directly employed staff	**1,036,370**	**76.1**	**788,689**

Source: NHS Medical and Non-Medical Workforce Census, 2001.

Nearly a third of the female workforce in the North West, with the exception of Cumbria, works in the health services, social work and education sectors – see Table 14. Health, social work and education employment accounts for a quarter of male and female jobs in Merseyside and Blackpool. Male employment in this sector is higher in Blackpool, Cumbria, Lancashire and Merseyside.

Table 14: Percentage employees in health services, social work and education in the North West

Local authority	Female	Male	Total
Blackburn with Darwen	32.3	7.5	19.8
Blackpool	35.1	12.5	25.5
Halton	31.1	5.3	16.9
Warrington	26.3	5.0	15.1
Cheshire	28.7	6.6	17.8
Cumbria	20.8	12.7	16.4
Greater Manchester	30.7	8.7	19.5
Lancashire County	30.4	10.2	19.6
Merseyside	36.5	13.1	25.4
North West	**30.9**	**9.6**	**20.1**

Source: Table 4.16, Region in Figures, Office for National Statistics, 2002.

The significance of health and social care employment

The health and social care sector requires a very wide range of training, skills and experience, hence earnings across the sector vary from the very high to the very low. The sector also has a wide range of economic activity ranging from research, professional, management, manufacturing, ICT, administration, construction, facilities management and personal services.

Health and social care and related employment accounted for nearly 12% of jobs in the region in 1997 (see Table 15) with higher than average levels in Merseyside/Halton and Cumbria. The total number of jobs in health related manufacturing (pharmaceutical products, pharmaceutical preparations, medical and surgical equipment), identified from the Annual Employment Survey, was 9,778, about 2% of manufacturing jobs in the region.

North West
Regional
Assembly

Table 15: Employment in health and social care and related industry sectors

Sector	Cheshire/ Warrington	Cumbria	Greater Manchester	Lancashire	Merseyside/ Halton	Total
Manufacture of pharmaceutical products	40	0	4	135	73	252
Manufacture of pharmaceutical preparations	1,087	1,250	1,342	1,610	1,238	6,527
Manufacture of medical and surgical equipment	285	37	1,077	922	678	2,999
Wholesale of pharmaceutical goods	1,084	47	1,038	1184	487	3,840
Retail sale of orthopaedic goods	162	0	59	35	165	421
Hospital activities	16,637	9,640	56,877	35,377	33,408	152,360
Medical practice activities	2,135	2,694	6,660	3,455	3,563	18,507
Dental practice activities	783	454	2,389	1,115	1,126	5,867
Other human health activities	1,754	665	12,529	1,590	3,843	20,381
Total health	**23,967**	**14,787**	**81,975**	**45,423**	**44,581**	**210,733**
Social work activities with accommodation	6,382	4,417	14,990	12,510	14,665	52,964
Social work activities without accommodation	5,886	3,818	24,428	8,177	13,497	55,806
Total social work	**12,268**	**8,235**	**39,418**	**20,687**	**28,162**	**108,770**
Grand total	**36,235**	**23,022**	**121,393**	**66,110**	**72,743**	**319,503**
Total employees in region	393,441	193,877	1,063,926	562,710	516,330	2,730,284
% health and social work	9.2	11.9	11.4	11.7	14.1	11.7

Source: Annual Survey of Employment, 1997.

Ethnic minorities in workforce

Nationally nearly a third of medical and dental staff are black, Asian or other ethnic groups (see Table 16). No data is available for the North West region.

Table 16: NHS Hospital and Community Health Services Directly Employed Staff by Ethnic Groups, 30 September 1999

Occupation	% Black, Asian and other	% Unknown
All directly employed staff	9.6	3.5
Nursing, midwifery and health visiting staff	8.4	5.9
(of which: qualified staff)	(8.6)	(4.6)
Medical and dental staff	31.6	2.0
Other direct care staff	6.5	1.6
Administration and estates staff	5.4	1.7
Other management and support staff	5.7	2.0

Source: Department of Health, Table D4.

North West Regional Assembly

Average weekly earnings relative to NW average

The average weekly earnings of female and male employees in the health, social work and education services sector was £460.2 and £372.6 respectively for males and females at April 2001. These earnings are higher than the North West regional averages of £451.1 and £337.2 for men and women respectively. The sector average was also slightly higher than the average earnings for women in England although the sector average for men was below the average male earnings in England.

If we take a more detailed look at the national earnings data, the health sector is significant for three reasons. Firstly, average weekly earnings are considerably higher than for other public sector professional groups. The average weekly earnings for male health professionals is £1,180.80 followed by £628.70 for teaching professionals (university, secondary and primary), £599.80 for architects and planners and £310.90 for health related workers (the respective figures for women were £832.20, £529.30, £494.30 and £248.90). The higher paid staff have a significant role in supporting additional employment in the regional economy.

However, 80% of male and 95% of female staff in health and related occupations earn under £400 per week compared to 66% male and 93% of women in all manual occupations.

Secondly, there is a much wider differential between the highest and lowest average earnings for different occupations in the health service than for other public services (see Table 17). Whilst just 26.7% of male health professionals earn less then £800 per week, over ninety percent of other professional groups earn less than £800 per week.

Thirdly, the largely female composition of the health sector workforce and the relatively high percentage of black and ethnic minority staff means that any changes in staffing levels and terms and conditions have equalities implications.

North West
Regional
Assembly

Table 17: Distribution of gross weekly earnings – an inter-sector comparison

Occupation		% with weekly earnings less than			
		£200	£400	£540	£800
Health professionals	Male	0.8	2.6	5.8	26.7
	Female	1.1	8.6	17.6	N/a
Health associate professionals	Male	0.7	27.8	72.4	95.4
	Female	1.1	34.6	79.0	N/a
Health and related occupations	Male	12.1	79.6	95.3	99.8
	Female	26.3	95.0	98.9	N/a
Hospital porters	Male	22.0	92.7	97.2	100.0
	Female	N/a	N/a	N/a	N/a
Teaching professionals	Male	0.2	9.9	34.7	85.2
	Female	1.0	18.2	52.9	N/a
Architects, planners & surveyors	Male	0.5	16.4	46.5	84.9
	Female	N/a	17.9	66.1	N/a
Social workers/probation	Male	N/a	30.0	79.3	100.0
	Female	0.5	38.0	85.9	N/a
Social welfare assoc profess	Male	3.8	66.5	94.0	100.0
	Female	4.3	67.7	93.6	N/a
Professional occupations	Male	0.7	13.4	37.4	76.9
	Female	1.0	20.4	53.0	N/a
All manual occupations	Male	6.0	66.4	89.7	98.8
	Female	33.1	93.4	98.5	N/a

Source: Office for National Statistics, New Earnings Survey, 2002.

Charts 1 and 2 below dramatically illustrate the economic impact of the higher weekly earnings of health professionals in comparison to other professional groups.

Chart 1: The percentage of male workers earning over £800 per week in 2001

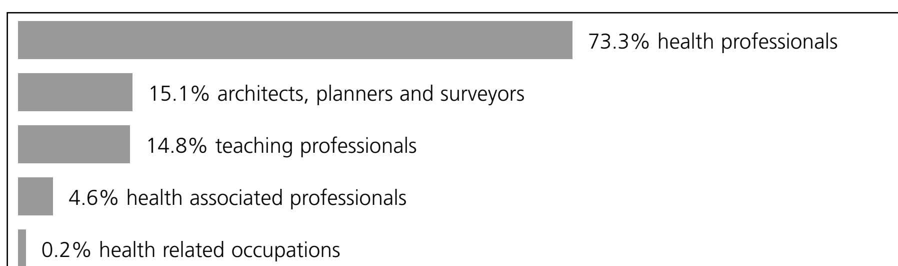
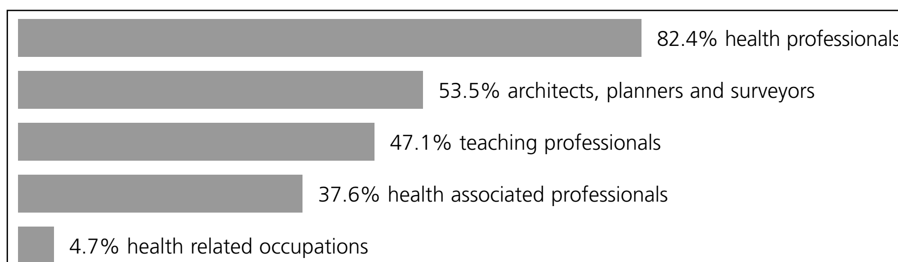


Chart 2: The percentage of female workers earning over £540 per week in 2001



North West Regional Assembly

The longer health care earnings profile means that the sector supports a larger number of indirect and induced jobs in the local and regional economy than an equivalent number of jobs in other public services. It also means a more significant contribution to regional GDP. The wide earnings differential should be taken into account in assessing the impact of increased NHS expenditure – clearly the provision of additional medical services will have a far greater economic impact than a construction project which retains the same level of medical staff and transfers NHS support staff to facilities management companies. Further widening of the differentials is likely to lead to major recruitment and retention problems and staff shortages. There is, of course, an optimum level after which increased earnings have less impact on the regional economy as a higher percentage of earnings are saved, spending on luxury items increases many of which are not produced in the region and more time is spent on holidays and visits outside of the region.

Living wage issues

The part-time and low-wage nature of many health and social care jobs results in staff having low earnings and being dependent on state income support. This in effect means that the government is subsidising both NHS and private sector employers. It is questionable whether these workers earn a 'living wage'.

The regional partners should consider developing a living wage level for different parts of the region taking account of urban and rural variations. They could go further and develop a 'livability index' which could take account of social needs, income (wages, benefits, pensions), cost of living variations and concessionary public services. The combination of increasing the minimum wage, living wage demands and benefit take-up campaigns could make a significant contribution to reducing health inequalities and social exclusion in the region.

Temporary staff

The use of bank and agency nursing staff increased by a third in 1999/2000. About 20,000 bank and agency staff work in NHS trusts daily, covering about 10% of shifts. Agency staff cost the NHS in England £360m in 1999/2000 with a further £430m for bank staff in the same period (Brief Encounters, Audit Commission, 2002). Research by the Audit Commission revealed that it costs NHS Trusts 5% more for shifts filled by agency nurses because of the higher rates of pay and commission charges. It also found evidence that the use of temporary staff undermines the quality of patient care.

North West
Regional
Assembly

Vacancies (37%) and sickness absence (28%) accounted for two thirds of shifts booked with peaks in workload and annual leave each accounting for 10% of shifts booked. Further investigation should determine the prevalence of the use of temporary staff in the North West although it is unlikely to be radically different from the pattern for England. There would appear to be significant opportunities for creating more permanent NHS employment in the North West.

Vacancies

The number and ratio of three month vacancies for different groups of NHS staff must also be taken into account by the North West Investment Plan for Health. Table 18 compares the number and rates for different occupational groups in England and the North West. There is a clear divide in the rates in England with the three month vacancy rate for medical and dental staff, qualified nursing and scientific, therapeutic and technical staff ranging between 3.1% – 3.7% compared the much lower rates for other staff groups. The North West has a similar profile although with generally lower rates except for medical and support staff.

Table 18: NHS three month vacancies in England and the North West

Occupation	England		North West	
	No	% Rate	No	% Rate
Medical and Dental staff	1,320	3.7	180	3.7
Qualified nursing, midwifery and health visiting staff	8,390	3.1	910	2.2
Scientific, therapeutic and technical staff	4,160	3.5	460	2.7
Health care assistants	680	2.1	40	0.9
Support staff	1,100	1.7	190	2.0
Administration and estates staff	1,630	0.9	120	0.5
Ambulance staff	90	0.5	0	0.1
Other staff	40	0.9	0	0.4
Total	**17,410**		**1,900**	

Source: Department of Health, Vacancy Survey, March 2002.

The pattern of three month vacancies in the North West region varied widely with an 8.1% vacancy rate for medical staff in Bury and Rochdale and 6.6% in Salford and Trafford. Five other health authorities had vacancy rates above the national average (Manchester, Morecombe Bay, North West Lancashire, North Cheshire and West Pennine).

Manchester, North West Lancashire and South Lancashire health authorities had higher vacancy rates for qualified nursing, midwifery and health visiting staff whilst the remaining health

North West
Regional
Assembly

authorities had vacancy rates below the national average. Five authorities, North Cheshire, South Lancashire, St Helens and Knowsley, West Pennine and Wirral had vacancy rates for scientific therapeutic and technical staff above the national average.

Analysis of indirect employment supported by health and social care sectors

The starting point for calculating the wider employment impact is the direct employment totals for health care and social work in the North West region:

Health care	149,568 jobs
Social work	43,120 jobs
Total	192,688 jobs

Health and social care services support additional employment effect in the region through the purchase of goods and services in the economy. The indirect employment effect has been calculated using the health care and social work employment multipliers from the Scottish Input-Output Tables (Input-Output Table and Multipliers for Scotland, 1998). These are 1.998 and 1.382 respectively and are likely to be very similar to equivalent multipliers for the North West.

149,568 x 1.998	=	298,836 jobs
43,120 x 1.382	=	59,592 jobs
Total	=	358,428 jobs

Thus the indirect employment is 358,428 – 192,688 = 165,740 jobs.

In addition, the direct and indirect employment of health and social care employment plus the employment supported by the expenditure of good and services, increases household expenditure which in turn supports additional employment. The induced employment effect is calculated using the specific health care and social work employment multipliers for induced employment from the Input-Output Tables, which are 2.345 and 1.567 respectively.

149,568 x 2.345	=	350,737 jobs
43,120 x 1.567	=	67,569 jobs
Total	=	418,306 jobs

Thus the induced employment is 418,306 – 358,428 = 59,878 jobs.

The total direct, indirect and induced employment in the North West region supported by the health and social care sectors is 418,306 jobs which accounts for 14.8% of jobs in the region.

North West
Regional
Assembly

Thus 192,688 jobs in the health and social care sector support an additional 225,618 jobs. The ratio of direct to indirect/induced employment is 2.17. Of course, not all of these jobs are in the North West. The actual number will depend on the percentage of goods and services produced within the region.

Purchasing in the North West

An analysis of the contribution of the NHS services to the London and south east economy for the NHS Executive, London Regional Office, estimated that 140,000 people were employed in health services with a total direct and indirect employment of between 350,000 and 400,000 jobs, a ratio of direct to indirect of between 2.5 and 2.8.

Mapping health and social care workforce and demographic change

Warrington has the lowest percentage of employees in the health, social work and education sectors yet has the highest projected increase in population between 1996-2021 and the second highest percentage change in the percentage of the population aged 65 and over (see Table 19). Merseyside and Blackpool have the highest percentage of employees in this sector, 25.4% and 25.5% respectively, yet the Merseyside population is forecast to decrease by 10.04% although it has the lowest projected change in the population aged 65 and over. In Halton the projected population decline is similar to that forecast for Merseyside, however, the projected change in the population aged 65 and over is one of the highest in the region in contrast to the low percentage change in Merseyside.

Table 19: Health, social work and education employment and projected demographic change

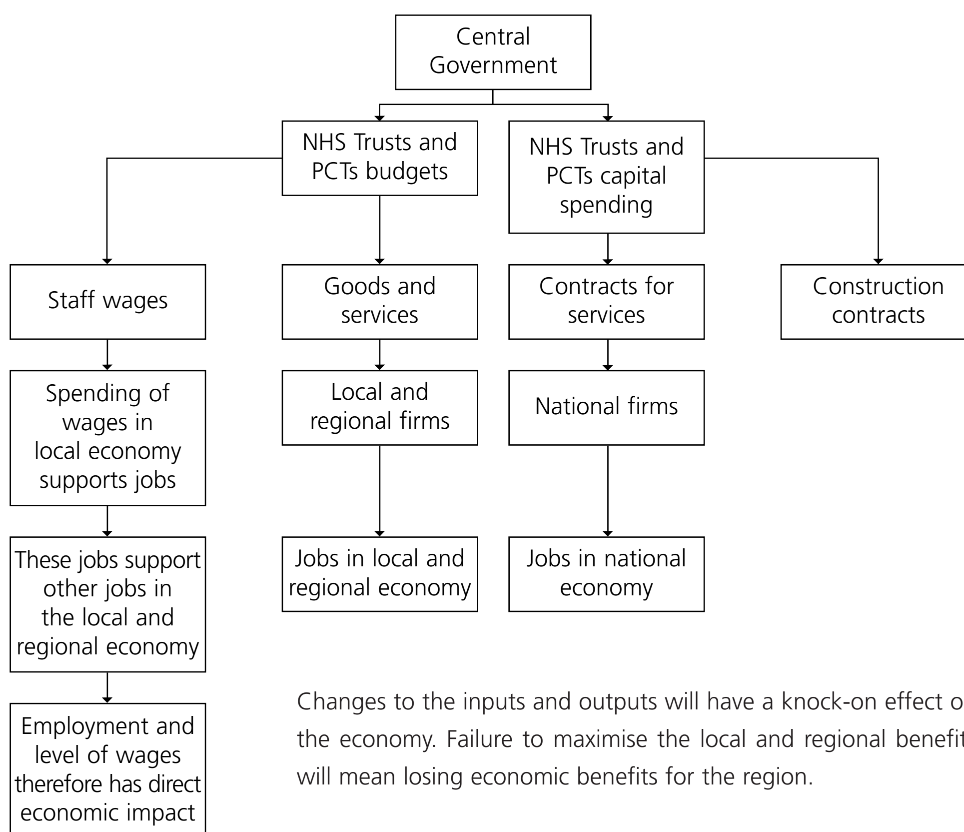
Local authority	% employees in health, social work and education	Projected % population change 1996-2021	Projected % change in population aged 65 and over 1996-2011
Blackburn with Darwen	19.8	2.58	22.1
Blackpool	25.5	2.40	10.3
Halton	16.9	-10.97	25.7
Warrington	15.1	9.98	30.9
Cheshire	17.8	6.53	41.4
Cumbria	16.4	3.62	26.1
Greater Manchester	19.5	-1.93	11.3
Lancashire County	19.6	2.93	19.9
Merseyside	25.4	-10.04	5.5
Total	**20.1**		

Source: An Ageing Population: Impacts for the North West, 1999.

Conclusion

Health and social care employers and employees have a very significant role in the North West regional economy. Direct and indirect employment accounts for nearly 15% of jobs in the region. It is also significant because of the long earnings profile in health care, the fact that four out of five health and social care workers are women, and the relatively high level of ethnic minorities in the medical profession.

Assessing economic and employment impact of health and social care sector



Changes to the inputs and outputs will have a knock-on effect on the economy. Failure to maximise the local and regional benefits will mean losing economic benefits for the region.

North West Regional Assembly

PART 5

Planned growth of the health and social care sector

Introduction

The planned level of expenditure in public services, whether it is set to increase, remain stable or decrease, will have an effect on the regional economy. This section maps out the broad plans for the significant growth of the health and social care economy nationally and the likely impact in the North West.

Planned growth in key public services

The 2002 Spending Review set the spending plans for three years from 2003/04 to 2005/06. It included substantial real growth increases in public spending for health, education, transport and other services. They are summarised in Table 20.

Table 20: Planned real growth: Departmental spending limits

Sector	2002-03 (£m)	2005-06 (£m)	Annual average average growth rate (%)
NHS (UK)	68,070	90,490	7.3
Education (UK)	53,520	68,430	5.7
Transport (UK)	11,960	16,410	8.4
Housing (England)	4,850	5,900	4.2
Criminal Justice (England & Wales	14,703	18,336	5.0
Total Departmental **Expenditure Limits**	**239,710**	**300,990**	**5.2**

Source: Table 1.3, Opportunity and Security for All, Spending Review 2002.

In England, the Spending Review provided details of NHS revenue and capital expenditure over a six year period from 2002-03 to 2007-08. In this period expenditure is planned to increase an average 7.4% per annum after inflation (7.3% on a full resource budgeting basis) with capital investment rising 179% in this period and revenue expenditure 57%. Personal Social Services expenditure in England will also increase by 28% in the four year period 2002-03 to 2005-06 (Table 7.1, 2002 Spending Review).

Planned growth of the health and social care economy

Total health and social services expenditure (revenue and capital) in the North West is expected to increase in real terms from £8.2bn in 2000-01 to £12.5bn over a seven year period (see Table 22). This is based on the planned national increases in expenditure detailed in the 2002 Spending Review and the Department of Health

North West
Regional
Assembly

Annual Report. It assumes that health and social care expenditure in the North West is increased in line with the national plans. The 52% increase means that not only will some £7.5bn be spent on supporting direct employment in the region by 2007-08 but the health and social care sector will be spending £5bn per annum on goods and services by 2007-08.

Table 21: Total estimated planned expenditure in health and social services in the North West region by 2007-08 in real terms

Year	% increase in Health spending	Health spending (£bn)	% increase in social services	Social service spending (£bn)	Total (£bn)
Level at March 2001		**6.0**		**2.2**	**8.2**
2001-02	5.0*	**6.3**	3.0*	**2.3**	**8.6**
2002-03	5.0*	**6.7**	6.2	**2.4**	**9.1**
2003-04	7.3	**7.2**	4.0*	**2.5**	**9.7**
2004-05	7.3	**7.7**	4.0*	**2.6**	**10.3**
2005-06	7.6	**8.3**	4.0*	**2.7**	**11.0**
2006-07	7.3	**8.9**	4.0*	**2.8**	**11.7**
2007-08	7.5	**9.6**	4.0*	**2.9**	**12.5**

Source: Department of Health Departmental Annual Report 2002-03, July 2002.
** Estimated percentage increase.*

Increased staff: The Wanless Review forecast a need for up to 300,000 additional staff in the NHS over the next two decades including 62,000 doctors, 108,000 nurses, 45,000 professional qualified therapists and scientists and 74,000 health care assistants. This could amount to about 43,500 additional health care staff in the North West by the year 2020.

In the shorter term, the government has set a national target of 15,000 consultants and GPs, 35,000 nurses, midwives and health visitors and 30,000 therapists and scientists by 2008. Training will be increased to address the issue of an ageing workforce and to meet the staffing targets.

The North West's share of the 80,000 additional consultants, nurses, midwives, health visitors, therapists and scientists could be about 12,000 jobs over the next six years. An indication of the scale of these new employment opportunities is reflected in the Health Service Plan for the new Cheshire and Merseyside Strategic Health Authority plans for an additional 1,546 jobs by March 2003, a 6.4% increase on the March 2002 total workforce of 23,969. Additional jobs will also be created in the social care sector.

Information and Communications Technology (ICT): The NHS currently spends about £1.1bn per annum on ICT which is expected to double to £2.2bn in 2003-04 rising to about £2.7bn by 2007-08 (Wanless Review). The health service has lagged behind other sectors in the application of ICT; however, the application of ICT in public services has been fraught with problems.

North West Regional Assembly

Expansion of personal social services expenditure: The impact of demographic and health status changes are expected to result in an increase in spending on services for adults, rising from £6.4bn in 2002-03 to between £10bn - £11bn in 2022-23. This would be an average increase in real terms of between 2.3% and 2.8% per annum.

Better quality services: The NHS currently spends about £500m per annum on catering, an about £2.50 per person per day, and almost half the cost at BUPA hospitals. The Wanless Review forecast that if the NHS increased the quality of food to £4.80 per person per day by 2022 (at 2002-03 prices), the NHS would be spending £1bn per annum on food. This could amount to an additional £72.5m expenditure in the North West.

Renewal of the primary care estate: The condition of the primary care estate is poor with 80% of premises being below the current recommended size and only 5% are co-located with a pharmacy or social services. The most deprived areas tend to have the poorest primary care facilities. The government is using private finance under the NHS LIFT project to renew or replace two thirds of the primary care estate by 2006. The Wanless Review suggested that the entire estate will need to be renewed by 2010-11 which would increase annual expenditure from about £320m to £550m per annum.

Public – private investment analysis: The level of regional economic benefits from health investment will partially depend on the public-private division of investment. The type of funding has a major influence on the supply chain for goods and services and on the quality of employment. It is also influences organisational structures and local democratic accountability and control over health and social care policies and service delivery.

The Investment Plan for Health will need to identify the distribution of the additional resources across the region highlighting the spatial implications of the:

- Allocation to particular regional medical specialities, centres and services;
- Major construction sites;
- Additional volume of general NHS services;
- Expansion of community health services and improvements to the primary care infrastructure;
- Workforce plan demonstrating how skills, training and staffing needs will be met within the region, by migration from elsewhere in Britain or by recruiting in other countries.

North West
Regional
Assembly

Public sector capital investment

The three Strategic Health Authorities in the region, Cheshire and Merseyside, Greater Manchester, and Cumbria and Lancashire, have prepared health plans which provide some information of the planned level of capital expenditure. The £745.5m capital schemes planned in the Greater Manchester Strategic Health Authority area are listed in Table 23. Similar information has not been available for the other StHAs. About 90% of the planned expenditure comes under the PFI.

Table 22: Planned capital expenditure in Greater Manchester Strategic Health Authority

NHS Trust	Scheme	Capital cost £m	Funding
Bury Healthcare	Pathology	10.0	Pos PPP
Central Manchester & Childrens Univ. Hospital	SOC	250.0	PFI
Christie Hospital	IM&T	–	PFI
	Boiler House	–	PFI
Manchester Mental Health	Health scheme	15.0	–
North Manchester	Adults and paediatrics	14.0	–
Rochdale Healthcare	Phase 2	20.0	–
Salford Royal	Childrens & IM&T	126.0	PFI
Mental Health Salford	Secure services	6.0	–
South Manchester PCT	ACAD	19.4	–
Stockport NHS Trust	DTC	19.9	Pos PFI
	SOC	150.0	PFI
	Older people	2.3	PFI/DoH
Tameside & Glossop Acute Services	SOC	76.0	PFI
Wrightington, Wigan & Leigh NHS Trust	Phase 4	16.9	–
	Redevelopment	20.0	Pos PFI
Total		**745.5**	

Conclusion

The health care sector is expected to create about 12,000 additional jobs in the region in the next six years. This will generate an additional 14,160 jobs in the region through indirect and induced employment (see Part 4) giving a total of 26,160 additional jobs.

North West
Regional
Assembly

PART 6

Targeting investment to social needs and reducing health inequalities

Introduction

The previous section identified the overall planned growth of the health and social care economy nationally and within the region. There are three basic questions in the next stage of the analysis:

- Is there a regional Investment Plan for Health which identifies what, where and how the planned expenditure and investment will be implemented in the North West region?
- Is the planned growth of the health and social care economy linked into the Regional Economic Strategy and other regional policies, and is it targeted at meeting social needs and reducing health inequalities?
- Have the economic benefits of the planned growth in expenditure and investment been fully identified, particularly its direct employment and economic impact in reducing health and social inequalities and are mechanisms in place to maximise the regional benefits?

Lack of detail

The Cross-Cutting Review *"Tackling Health Inequalities"* (October, 2002) has only a passing reference to the health and social care economy. It contains one sentence in the strategy summary (page 150 under strengthening disadvantaged communities – "*assisting with the regeneration of disadvantaged areas through the location of public facilities there, the promotion of local employment policies and local purchasing of goods and services"*. But the report failed to develop this statement.

Another section in the Review draws on US evidence which showed that *"comprehensive, multi-disciplinary interventions targeted at low income mothers of young children appeared to demonstrate significant benefits"* (page 41). The opportunity to expand this statement to include the employment contribution of the health and social care sector with childcare provision as part of a multi-disciplinary approach was missed. The rest of the report, including a long-term strategy and key findings on successful intervention, did not recognise the potential contribution of the planned growth in health and social care expenditure and investment in reducing health inequalities and social exclusion.

The draft Investment for Health report does not set out the region's social needs in terms of health and social care with an investment plan targeted at meetings these needs, improving the quality of care and reducing health inequalities. This must be the starting

North West
Regional
Assembly

point for any investment plan. It would therefore appear that there is a lack of evidence of:

- A regional social needs analysis for health and social care sector. This could be formed by combining the analyses of the three new Strategic Health Authorities in the region although since they are new organisations, their initial analyses may only be a summation of existing local needs. It will also be important to forecast social needs arising from different economic scenarios. Furthermore, additional work will be necessary in drawing together the three sub-regional analyses, because summation of three into one does not always address priorities;
- Is the planned multi-billion expenditure and investment on health targeted to meeting needs and reducing inequalities?
- What are the regional priorities?
- Identifying the existing mechanisms for ensuring maximum regional economic benefit from health and social care expenditure and investment?

The February 2003 draft of the Investment for Health Plan includes a section on the Health of the North West and a section on national and regional priorities. The summary document section on *"Tackling the Wider Determinants"* identifies a wide range of key activities and policy initiatives. The questions above remain pertinent.

Health needs in the region

The North West ranks only second to the North East for the highest level of mortality rates for respiratory diseases and cancer and has the same rate for circulatory diseases (see Table 21).

Table 22: The North West's high level of age-standardised mortality rates, 2000

Region	All circulatory diseases	All respiratory diseases	Cancer	All injuries and poisonings	All other causes
North West	406	176	265	36	152
North East	406	183	278	32	161
Yorkshire & Humberside	376	166	247	28	155
East Midlands	359	161	237	34	157
West Midlands	383	164	244	34	161
East	344	151	228	30	146
London	339	176	235	28	146
South East	336	152	227	29	141
South West	342	133	227	30	145

Source: Table 7.3, Regional trends 37, Office for National Statistics, 2002.

North West
Regional
Assembly

Reducing health inequalities and social exclusion

There are many references to health inequalities in the draft Investment for Health Plan but they relate primarily to policy. There is no reference to how health and social care expenditure can be used to drive a reduction in economic inequalities in the region. Every NHS Trust, Primary Care Trust, health agency and local authority can take action to strengthen the regional economy by being proactive in the way in which they procure goods and services.

The growth in health and social care sector employment could, assuming this growth is primarily in the public sector where the quality of employment is better, have a bigger and/or more direct effect in reducing health inequalities than many health policy initiatives designed to reduce inequalities.

Reliance solely on national procurement mechanisms to achieve the implementation of equalities policies and good practice is unlikely to satisfy local and regional demands for more rapid mainstreaming of equalities or to meet the specific local needs and community demands. Regional and local mechanisms are required to achieve additional commitment to an equalities agenda in maximising the local benefits of health and social care expenditure and investment.

Gender, race and other equality issues

The combination of the high percentage of women and black and ethnic minority representation in the health and social care workforce, the negative impact of modernisation with respect to the transfer of services to the private and voluntary sectors where this reduces terms and conditions, and the potential contribution increased health expenditure and investment in reducing health and social inequalities makes it essential to address equality issues. It is essential that equalities is mainstreamed throughout the entire approach to the health and social care economy, with special emphasis on training, impact assessment, procurement and workforce planning.

Multiple deprivation in the North West

North West
Regional
Assembly

The North West has 12 local authorities with an average Indices of Multiple Deprivation (IMD) ward rank in the worst 100 in the country. They are Liverpool (5), Knowsley (6), Manchester (7), Halton (18),

Barrow-in-Furness (23), Blackburn (26), Blackpool (32), Hyndburn (45), Burnley (49), Oldham (61), Copeland (72) and Bolton (78).

The Claimant Count Rate in October 2002 varied across the region from 1.7% and 1.8% in Cheshire and Warrington respectively to 5.0% and 5.8% in Halton and Merseyside compared to the regional average of 3.3%.

Part 4 noted the local impact of projected changes in population and the population aged 65 and over. This showed that, generally speaking, those areas with the highest percentage of employees in health, social care and education had a largest projected decline in population between 1996-2021 and the smallest change in the population aged 65 and over.

Need for further research

The Investment Plan for Health should be based on an analysis of the planned distribution of health and social care expenditure and investment mapped with the following:

- Health needs;
- Current health inequalities;
- Areas of multiple deprivation;
- Forecast of changes in health needs and inequalities;
- Health and social care infrastructure deficit;
- Existing pattern of health sector employment and staff shortages.

However, there is currently a lack of NHS, local authority and ward level data to carry out this analysis.

Conclusion

The mapping of the planned increase in health and social care expenditure and investment with health needs, health inequalities and areas of multiple deprivation is a fundamental weakness of an Investment Plan for Health. It will be very important for the regional partners to ensure that expenditure and investment is targeted **and** that the economic and employment benefits are retained within these communities.

North West Regional Assembly

PART 7

Economic implications of restructuring and modernisation of the health and social care sectors

Introduction

Levels of public expenditure and investment are a crude economic indicator. How the money is spent is vitally important too. This section examines competition between the public and private health sectors and the employment and economic implications of restructuring and modernisation of the health and social care sector in the North West. It is important to note at this stage that the transfer and privatisation of public services to the private or voluntary sectors cannot be considered to be economic growth, they merely transfer assets from one sector to another. In many cases, transfers are initiated to achieve 'cost reductions' which often result in cuts in jobs, pay and conditions which inevitably may reduce an organisation's budget but also has a knock-on effect on the regional economy.

Private health market in the North West

The revenues of UK private hospitals and clinics have increased 11% in 2001 following a 9% increase the previous year (Laing's Healthcare Market Review, October 2002). Revenues reached £2,255m, excluding NHS pay beds. The 2000 'concordat' between the NHS and private hospitals to use spare capacity to treat NHS patients has encouraged further growth. There are 12 private hospitals in the North West operated by BUPA, BMI and Nuffield together with private units in a number of NHS hospitals. There were 93 dedicated NHS pay beds in the North West (concentrated in Blackpool, Manchester, Oldham and Wirral) out of a UK total of 1,365 last year. 12% of the North West population has personal medical insurance, similar to the national average, compared to 19% in the South East and 6% in the North East.

Mental health services are the fastest growing part of the private sector – NHS and local authorities now fund two thirds of patients in private psychiatric hospitals. Revenues were up 17% to £336m in 2001. Private sector capacity in residential homes fell by 15,000 to 511,000 places by April 2002 with a 3% loss of capacity in the North West compared to a 2.2% loss nationally (Care of the Elderly People Market Survey 2002, Laing & Buisson). Revenues were £7.7bn compared to £1.8bn in the public sector.

Use of private and voluntary sectors for home and residential care: Although a high proportion of residential care is purchased by North West local authorities from the private and voluntary sectors, the provision of home care is very varied. The percentage of home care contact hours purchased from these

North West Regional Assembly

sectors remained at under 50% in thirteen of the nineteen local authorities. The percentage of care provided by the private and voluntary sectors is substantially higher in London and the south of England. Nationally, local authorities directly provide less than half of the volume of home care (Domiciliary Home Care Market, 2000).

Table 23: Proportion of Social Services for Adults Purchased by North West Local Authorities from the Private and Voluntary Sectors

Local authority	% contact hours of home care provided by private and voluntary sectors	% supported residents in private and voluntary sector residential care
Shire Counties		
Cheshire	36	80
Cumbria	39	58
Lancashire	82	75
Unitary Authorities		
Blackburn	53	72
Blackpool	45	78
Metropolitan Districts		
Bolton	23	73
Bury	44	58
Manchester	52	97
Oldham	39	79
Rochdale	34	74
Salford	49	68
Stockport	34	99
Tameside	54	93
Trafford	35	68
Wigan	6	90
Merseyside Met Districts		
Knowsley	69	93
Liverpool	43	78
St Helens	41	58
Sefton	76	78
Wirral	61	70

Source: Department of Health, Public Expenditure Questions 2001, Memorandum to Health Select Committee, House of Commons, 2001.

A number of questions require further research and analysis:

- What is the planned role of private hospitals in the investment strategy? The use of private health care capacity outside of the region by North West NHS patients has a direct impact on the region. Patient fees are transferred from North West PCTs to private health companies elsewhere in Britain or overseas;
- How will the investment strategy change the structure of the market?
- Will it create new opportunities for private sector penetration of health services?
- What is the extent of the current NHS use of private sector spare capacity in the North West?

North West Regional Assembly

Export of capital from the region

Staffing costs, capital costs and other operating costs (provisions, utilities, maintenance) account for between 45%-50%, 18%-27% and 12%-16% respectively of private residential care home fees (Calculating a Fair Price for Care, 2002, JRF). The remaining cost is profit. The Joseph Rowntree Foundation report claimed that a target rate of 16% return on capital was *"reasonable"*. By the end of 1999, companies owned 31.4% of UK for-profit nursing, residential and dual registered beds in homes for the elderly and physically disabled people. By June 2001, 16 companies owned 1,394 homes with 74,300 beds.

Private sector revenues in the North West are estimated to be £980m in 2001. With profit margins between 8%-16% profits are between £78m - £157m per annum, a large part of which will be exported from the region.

Restructuring of health and social care sector

The health and social care sector is under going major change and reorganisation. Three new Strategic Health Authorities have been established, mergers between trusts and new care and children's trusts are impending. There are economic consequences of switching specialities between hospitals even within the same city (Social and Economic Audit of Royal Hospital Trust, Belfast, 1993). The audit demonstrated that the planned transfer/merger of specialities between two hospitals in the city had an employment impact on the community with consequences for social inclusion and equalities.

Private finance of health and social care

The increasing use of the Private Finance Initiative (PFI) for NHS capital investment and improvement of the primary care infrastructure has an impact on the regional economy and has longer term implications. Continued use of PFI in the North West could reduce the beneficial effect of the health and social care economy for the following reasons:

- Increased national and international sourcing of the Design, Building, Finance and Operation of projects. National facilities management firms such as Interserve and Haden generally have national purchasing arrangements for the supply of goods and services. Food supplies are usually sourced nationally;

North West
Regional
Assembly

- The loss of public sector intellectual capital in the region;
- North West based spin-offs are likely to have more difficulty developing without a regional health care economy to support the early stages of their formation;
- Despite improved TUPE transfer policies, most PFI contractors engage new staff on different terms and conditions which creates a two-tier workforce.

The current list of approved NHS major capital projects includes 64 PFI schemes and 4 publicly funded projects (including the Rochdale Healthcare Trust – £24m capital value). NHS PFI projects in the North West are shown in Table 21. There are many smaller PFI schemes nationally, including the North West, in the minor capital works and equipment category.

Table 24: Major NHS PFI projects in the North West

Project	Capital Value (£m)*
North Cumbria Acute Hospitals NHS Trust	67
South Manchester University Hospitals NHS Trust	66
Central Manchester Healthcare/Manchester Childrens Hospital	199
Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust	73
Salford Royal Hospital NHS Trust	102
St Helens & Knowsley Hospital NHS Trust	211
Tameside & Glossop Acute Services NHS Trust	47
Regional Total	**765**

Source: Department of Health, Department Annual Report 2002/03, July 2002.

(Note the revenue cost of these projects is approximately £3,190m because the capital costs exclude the cost of financing the project and facilities management and other PFI costs over the contract period of up to 35 years).*

The seven North West projects account for 11% of the national total of PFI projects and 10% of the national capital value. National firms dominate, for example:

Central Manchester: Catalyst Healthcare - Bovis Lend Lease (main contractor), Sodexho Services (FM services), HSBC Infrastructure Ltd (finance), Anshen Dyer (architects) and Pricewaterhouse Coopers advising the Trust.

Blackburn, Hyndburn and Ribble Valley: Balfour Beatty Capital Projects and Charterhouse Project Finance Ltd 50/50 joint venture, Balfour Beatty Construction (main contractor) with Haden Young (building services) and Haden Building Management (facilities management), both Balfour Beatty subsidiaries.

North Cumbria: Health Management Group – AMEC and Building & Property Group (now part of Interserve FM (Tilbury Douglas Group).

North West
Regional
Assembly

A recent national study of 26 major health PFI projects found that although most projects included fixed equipment, only 11% of

projects included moveable equipment such as medical equipment and furniture (Ernst & Young, 2002). Soft FM services (catering, cleaning and security) are included in over 80% of projects. However, the survey also revealed that only 55% of clients believe that these services deliver value for money compared to pre-PFI arrangements, with a majority of trusts incurring higher costs for service delivery. The government's Retention of Employment model in which staff are seconded from the NHS to the FM provider, is still being tested by three trusts. This model would only address the problem of the two-tier workforce and even this is limited to certain staff groups and does not cover the majority of staff.

The current model of PFI mainly affects maintenance, works, clerical and administrative staff and managers, although this may change as future PFI/PPP are likely to include nursing and medical staff. The NHS nationally employs 224,030 staff in these occupations in 2001 with an estimated 33,500 employed in the North West (NHS Non-Medical Workforce Census, 2002). The number will be higher when contract staff are included.

Private finance for primary health care facilities

The Department of Health established NHS Local Improvement Finance Trust (LIFT), a joint venture with Partnerships UK PLC, to fund investment in the primary care infrastructure. The DoH will invest £175m in the company over the next four years with matching equity from Partnerships UK. NHS LIFT will own and lease local health facilities, premises for GPs, dentists and chemists and will initially concentrate in inner city areas. It will extend the principle of PFI/PPP to community facilities.

NHS LIFT has 42 approved projects nationally of which 7 are in the North West. There are approved NHS LIFT projects in Manchester; Salford and Trafford; Liverpool and Sefton; Ashton, Leigh and Wigan; Oldham; and St Helens, Knowsley, Halton and Warrington.

The East Lancashire project covers a mixture of new build and refurbished serviced community-based health and social care facilities such as intermediate care facilities, health centre, resource centres, walk-in centres, drop-in centres, outpatient and diagnostic facilities, GP and dentists accommodation, pharmacies and *"facilities for professions allied to medicine"*. The recent Official Journal of the European Community (OJEC) notice refers to a capital value of the initial scheme is £15m but this could rise to £65m (between £60 and £250m in total costs).

The longer term consequences of the continued and expanded role of PFI and NHS LIFT in the region should be fully examined by the regional partners. Whilst renewing the health infrastructure is important, it is also vital that the maximum economic benefits of health investment accrue to the region.

NHS Trusts naturally concentrate on meeting their local building needs but the cumulative impact of PFI and NHS LIFT projects in the region should be examined, particularly the potential effect of a two-tier workforce and national sourcing of goods and services. It may be possible to encourage bidders to voluntarily adopt local sourcing promoted by the region in addition to the TUPE Plus employment agreements negotiated by trade unions.

Employment and employment consequences of transfers and privatisation

The transfer of assets and services from the public to the private sector does not constitute economic growth. It only moves the delivery of a service and employees from one sector to another. However, transfer may have negative economic consequences if the new employer cuts jobs, reduces terms and conditions and/or changes the provision of goods and services to sources outside of the region. Reduced earnings impact in the local economy because staff have less earnings to spend in shops, leisure and local services. Privatisation also creates market opportunities which are frequently developed by national rather than local firms.

Some local authorities have avoided TUPE transfers by using their commissioning strategy to offer spot rather than block contracts to private and voluntary sector home care agencies. Local authority staff who leave through early retirement and for other reasons are not replaced and the public sector workforce is gradually reduced at the same time as increasing the outsourcing of work on a drip feed basis. Because there is no 'economic entity' there is no TUPE transfer. In these cases there is only a single tier low wage workforce.

The employment impact of residential care privatisation and closures and the outsourcing of home care to the private sector have been assessed in various studies by the Centre for Public Services (reports for Tameside, Sefton, St Helens, Rochdale and Lancashire UNISON branches in the last four years).

Changes in terms and conditions from local authority rates include cuts of up to £1 an hour, the loss of enhanced rates for unsocial hours, fewer holidays, reduced sick pay and lower pension

North West Regional Assembly

contributions by employers in to money purchase rather than final salary schemes. Claims that money saved is used elsewhere thus reducing or eliminating the negative economic impacts must be contested because:

- Reduced terms and conditions lead to recruitment and retention problems which can result in quality and service delivery problems;
- Reduced spending power of NHS or contractors staff has a knock-on effect on the local economy with fewer jobs supported in the local economy;
- Drives some workers into obtaining second and third jobs with a consequent impact on family life;
- Reduced earnings result in less government income from taxation and National Insurance contributions and increased government expenditure through tax credits and other benefits paid to those on low earnings (EOC, 1995);
- Increased health inequalities. There is a large body of evidence which has identified the links between (un)employment and health (summarised in East London and the City Health Action Zone, 2001). This includes the effects of low grade employment, for example low pay, lack of job security, and low levels of job control and involvement for employees. Improving the quality of employment has a positive effect. *"If employment strategies aim to change key attributes of work then they also have the potential to change the material and psychosocial effects of employment for workers, families and communities. Allowing for a number of mediating factors, employment strategies may therefore change determinants of health, and thus produce health change in the populations affected"* (ibid).

The consequences of the above trends are:

- Increased reliance on national procurement systems which will favour larger national and international firms rather than local and regional firms;
- More large multi-service facilities management contracts and large single contracts for goods such as food also favour large national suppliers;
- Long term contracts thus reducing flexibility for NHS bodies and local authorities;
- Cost-cutting which drives the greater use of cook-chill making use of local suppliers more difficult;
- Further privatisation of the health infrastructure with management and operation increasingly provided by the private sector;
- Loss of democratic accountability;

North West Regional Assembly

- Difficulty in establishing local contracts because national purchasing agencies focus almost solely on financial benefits from economies of scale;
- Government subsidy of low wage employment through income support and family credit (see comparable evidence in Calculation of the National Costs and Savings of CCT, Centre for Public Services, 1995 and EOC, 1995).

The government's new Code of Practice on Workforce Matters in Local Authority Service Contracts will increase the protection of both transferred and new staff (ODPM, 2003). However, the Code is currently confined to local authorities and other Best Value authorities but not the NHS.

Conclusion

So long as differences in the quality of employment between the public and private sectors remain, then it does matter who delivers services. The quality of terms and conditions have a direct knock-on effect on the local and regional economy. Similarly, increased private finance of health and social care means that many of the economic and employment benefits generated by increased expenditure and investment will be lost to other regions or internationally.

North West
Regional
Assembly

PART 8

Key issues for the North West regional economic and planning strategies

Introduction

The Report has demonstrated the importance of health and social care expenditure and investment for the North West regional economy and the opportunities created by the planned growth of this sector. But gaining the wider benefits of this growth beyond improved health care services requires specific action by the regional partners. Furthermore, some global and national policies threaten the region's ability to maximise the economic and employment benefits of this growth.

The regional framework

Threats and opportunities are examined using the Action for Sustainability (AfS) and the draft Regional Planning Guidance (RPG) as a framework. The *"Live"*, *"Grow"* and *"Action Plan"* sections of the AfS are particularly relevant. The Live section emphasized the need for healthy communities and reducing health inequalities. The Grow section highlighted the importance of land use planning, an integrated transport strategy, a stable and competitive economy, and improving the skills, productivity and creativity of the region to create employment. The health and social care economy could make a significant contribution to meeting several of the Action Plan objectives and targets.

A Health Task Group North West produced the report Health – A Regional Development Agenda in 2000. It noted that *"health services can contribute to regeneration not only through their efforts to maintain and improve the population's health, but as major employers and purchasers of services throughout the North West"*. However, it did not develop this approach.

The 1999 Regional Economic Strategy (RES) was organised in four themes – investing in business and ideas, investing in people and communities, investing in infrastructure and investing in image and environment. Investing in business and ideas had three objectives – develop world-class clusters of businesses which offers outstanding employment and growth potential; pursue business excellence in existing businesses; and accelerate new business development.

The role of public services has been consistently understated in regional economic planning despite their significant economic and employment role in the region. A narrow approach is evident in numerous NHS and Audit Commission studies – see procurement section below. A recent Audit Commission study into the performance of the NHS in England noted that the NHS was the

North West
Regional
Assembly

biggest employer in Europe but proceeded to refer only to the targets for increasing the number of doctors and nurses, ignoring other economic, employment and procurement aspects of performance to focus on the *"redesign of the system around the patient"* (The performance of the NHS in England, Audit Commission, 2002). Performance was defined in terms of resources and costs, waiting for care, the patient's experience, and outcomes such as stopping smoking, preventing suicides and surviving cancer.

The 1999 RES identified seven targeted growth clusters for regional support and action:

- Life science industries (biotechnology and pharmaceuticals);
- Medical equipment and technology;
- Environmental technologies;
- Financial and professional services;
- Tourism;
- Computer software and services/internet-based services;
- Creative industries, media, advertising and public relations.

The first two are clearly directly connected with health and social care services, although this was not recognised in the RES. Furthermore, the RES identified a *"core portfolio"* of seven established sectors *"which must contribute very significantly to the North West's future"*:

- chemicals;
- textiles;
- aerospace;
- mechanical and other engineering (including marine);
- energy;
- automotive;
- food and drink.

The revised Regional Economic Strategy 2003, launched in late March after this report was presented to the NWRA, has expanded the cluster concept which now includes healthcare. The NWDA is currently coordinating development work prior to forming a regional cluster network.

Health and education have a key role in regional strategies such as the AfS, RES and RPG as improving the well-being and skills of the North West. The draft Regional Planning Guidance provides a spatial framework for development in the region including specific policies to achieve:

- Economic competitiveness with social progress;
- Urban renaissance;

North West
Regional
Assembly

- Improving rural and coastal communities;
- Prudent management of environmental resources;
- Improved environmental quality;
- An accessible region.

It is essential that the revised RES recognises health and social care as a growth sector in the regional economy. Furthermore, this should not only recognise the contribution to healthy communities, the major employer and purchaser of good and services but also:

- The key role health and social care facilities, services and projects can have in making regeneration schemes more effective;
- The economic development role in creating new services, spin-offs from research and development and the role of related services such as child care provision;
- The contribution of the sector to reducing social and health inequalities through better services, employment and new opportunities for socially excluded groups;
- The important role of the public sector in maintaining standards in the local and regional labour market.

The rest of this section examines a number of key issues using the following framework:

Expansion of health and social care sector

- The scope for new services;
- Spin-offs in health and social care and economic development;
- Impact on small and medium sized enterprises and ethnic minority businesses;
- ICT in health and social care;
- The implications of European Directives and WTO General Agreement of Trade in Services (GATS) for the region.

Employment

- Structural change already underway in the social care sector and its implication for the region;
- Training, recruitment and workforce planning;
- Childcare provision;
- Trade union organisation and representation.

Regeneration

- Health and social care role in regeneration programmes.

North West
Regional
Assembly

Urban and rural renaissance

- Health and social care needs analysis;
- Implications for spatial development in the Regional Planning Guidance;
- Community well-being and public health.

NHS health economy issues

- NHS centralised purchasing;
- Capacity of health organisations;
- Enhancing regional intellectual capital.

Monitoring and evaluation

- Tier 2 Targets;
- Social and Economic Audit for the Regional Review.

Expansion of health and social care sector

The health and social care economy can deliver economic growth for the regional economy as well as enhancing services and making a significant contribution to the broader regional objectives.

The scope for new services

The scope for the development of new services should be assessed, for example, personal services in health and social care and childcare, which could create economic activity and employment in the region. There is likely to be scope for widening the range of options between home care provision and nursing home for the elderly, in addition to various types of intermediate care. However, this will need to recognise the increasing affluence of some elderly whilst others are likely to rely heavily on public services as a result of the substantial percentage of people who do not have an occupational pension and the shortfalls and declining value of those with occupational pensions.

The Audit Commission promotes integrated services for older people included whole systems working and a *"virtuous circle of services"*. However, this falls short of developing a genuine comprehensive and integrated continuum of care (Audit Commission, 2002). A continuum of care for older people should include a broad range of home-based services and new intermediate care services in which there is considerable scope for both enhanced/improved and new services (South Tyneside UNISON/Centre for Public Services, 2002).

North West Regional Assembly

A continuum of care

Public health

- Health Promotion;
- Health education and prevention.
- Occupational health and health and safety in the home and at work;
- Therapeutic care.

Home and related care services

- Home care – variety of levels of care and out-of-hours care;
- Support for carers;
- 'One-stop-shops' for information and advice;
- District nursing;
- Day care;
- Sheltered accommodation;
- Warden-aided sheltered accommodation;
- Rapid response – short term support at home;
- Hospital at home schemes.

Hospital

- Rehabilitation – discharge/transfer schemes;
- Transitional care units;
- Intermediate care units accessed from hospital/community.

Residential care

- Respite care;
- Residential care;
- Specialist residential care – EMI;
- Nursing care.

Hospice

The added economic value of new services will largely depend on the quality of employment created as many of these services are labour intensive with up to 70%-80% labour costs compared to the overall health sector average of a 60% staffing cost.

Spin-offs in health and social care research and development

Public and private expenditure on medical research is estimated to be £3.5 billion per annum in the UK. A study of NHS research outputs between 1990-1997 showed that the North West region contributed 14,490 NHS papers (13.3%) in this period. London

accounted for half of all outputs followed by the South East and North West. A similar pattern emerged for Wellcome Trust-acknowledged papers in the NHS. The study also examined the economic returns from research. These were not quantified but included benefits to future research, political and administrative benefits, health sector benefits and broader economic benefits, for example, from commercial exploitation of innovation arising from research and development. Miniaturisation, biotechnology, electronic communications of medical records, prescriptions and telephone medicine could provide much needed opportunities.

The North West trains more than 4,500 doctors and dentists per annum with a further 17,000 in training to be nurses and other health care professionals (North West Universities Association, 2002). The region has nationally and internationally rated research in community-based and hospital-based clinical subjects, clinical dentistry, pre-clinical studies, anatomy, physiology, pharmacology, pharmacy, nursing, professions allied to medicine, psychology and biological sciences.

A regional strategy is needed to ensure that potential spin-offs arising from NHS research development and service delivery are adequately supported through start-up capital, incubator and nursery economic development programmes which maximise community benefits and public sector interest.

An audit of NHS and public/private health and social care research being carried out in the North West region should be carried out. This should not only map the type, timetable and scope of research but equally focus on the potential for the development of new products and services within the region.

Impact on Small and Medium Enterprises and Ethnic Minority Businesses

Small and Medium Enterprises (SMEs) and Ethnic Minority Businesses (EMBs) in the region could be effected by the health and social care economy in four ways:

- Either the gain or loss of potential contracts as a result of the failure to develop local/regional procurement procedures and NHS/health organisation involvement in regeneration projects;
- The loss of existing contracts as national procurement systems replace local practice and force SMEs and EMBs to compete nationally;
- The potential loss of markets for locally produced/designed products and services which address community needs, for example, organic and multi-cultural foods, as procurement is increasingly based primarily on price rather than other criteria such as employment and social inclusion;

- A degree of instability in SMEs and EMBs as they are forced to spend additional resources in trying to obtain NHS contracts through national purchasing and supplies systems.

The role of SMEs and EMBs in the growth and health and social care services is discussed below.

ICT in health and social care

Poor track record of private sector ICT contracts: lessons from central and local government ICT projects – a poor track record (summarise and reference Select Committee, National Audit Office, Centre for Public Services) and previous health sector record is not good either. A survey of 134 organisations in UK,US, Europe, Australia and Africa revealed that two thirds had suffered from failed IT projects in the last year at an average cost of £8m (Computer Weekly, 27 November 2002). However, these sums are small beer compared to the wasted investment in many public ICT projects which have had to be abandoned or severely restricted.

Increased ICT expenditure in the NHS: only recently the key NHS Integrated Care Records Service (ICRS) IT project was subjected to a Office of Government Commerce gateway review in November 2002 which revealed significant problems relating to management, budgeting and timetable (Computer Weekly, 28 November 2002).

Scope for joint public-public partnerships: avoidance of Regional Business Centre Model:

- groups of Trusts and PCTs, hence StHA initiatives but need regional co-ordination;
- common systems hence exchange of data;
- co-ordinate use of consultants;
- joint projects with Las;
- establish centres of excellence.

Threat of local authority strategic partnership approach in the NHS: Potential of Strategic Service-Delivery Project model being extended to or encompassing health and social care services. Hyder and Capita? Already joint local authority-NHS ICT co-operation implemented or planned. Role of Strategic Health Authorities in co-ordinating ICT projects

North West
Regional
Assembly

The implications of European Directives and the General Agreement of Trade in Services (GATS) for the region

The European Union intends to fully liberalise and integrate markets for goods, capital, labour and services within its borders. Liberalisation of public services means the opening up of competition between a variety of suppliers for the provision of public sector contracts, which creates a market for public services.

Trade liberalisation is being advanced through negotiations in the World Trade Organisation (WTO) on the General Agreement on Trade in Services (GATS). Public services such as health and education could potentially be liberalised with the effect of creating public sector markets for private companies.

There are four aspects of trade in the GATS agreement:

Mode One: *Cross Border Supply* – this is the provision of public services from one country to another. For instance some medical records could be outsourced to a call centre in India and provided across borders back to the UK.

Mode Two: *Consumption Abroad* – this is where consumers or their property travel to another country to obtain a service. For example, UK nationals travelling abroad to have an operation paid for by the NHS.

Mode Three: *Commercial Presence* – this is where a service provider (public or private) would set up in another country. US and foreign health companies could expand their ownership and operation of private health and social care facilities in Britain.

Mode Four: *Presence of Natural Persons* – This consists of doctors, nurses, care workers and other professionals travelling to another country to 'supply' a service (WTO: 1995).

Article 1.4 of the agreement appears to exempt public services from liberalisation. However, this only applies if services are *"supplied neither on a commercial basis, nor in competition with one or more service providers"* (WTO: 1995). Most public services already involve a mix of public and private provision and often an element of competition, it is unlikely that this clause will provide much protection from liberalisation (Ministry of Employment and Investment, BC: 2001; Shybman: 2001).

The WTO and some national governments (including the UK) have claimed that public services can be exempted from liberalisation under the agreement. However, this requires each member state to explicitly exclude each separate public service, using a specially

North West
Regional
Assembly

designated code, in its 'schedule' of commitments. To do this would be extremely time consuming, expensive and would require a great deal of political commitment to protecting public services from the global market. It also ignores the fact that exemptions are temporary and the purpose of the agreement is to engage in progressive liberalisation in ever more sectors. It would also require governments to ignore the demands of transnational companies and business lobby groups.

The UK government has constantly maintained its commitment to trade liberalisation. The latest Government GATS consultation paper merely states that *"the main issues are likely to concern the establishment of foreign hospitals and the movement of doctors, nurses and other professional medical personnel, including from developing countries"* (page 43, DTI, 2002). The paper also states that *"the government has repeatedly stated that it does not intend to make commitments that could call into question the continued provision of public services through the National Health Service of the state education system"* (para 6.26, ibid).

The government has already made certain commitments under GATS for most sectors. In health and related social services it has made the following commitments:

- Hospital Services (full commitment in Modes 2 and 3 whilst keeping Mode 1 closed. Mode 4 is closed except for the horizontal commitment made by the EU relating to *"services considered as public utilities at a national or local level may be subject to public monopolies or to exclusive rights granted to private operators"*. The commitment does not apply to the supply of hospital services);
- Convalescent, Old Peoples Homes, Rest homes (full commitment in Modes 2 and 3 whilst keeping Mode 1 and 4 closed as above).

Under business Services, it has made commitments in two health-related sub-sectors:

- Medical, Dental and Midwifery (full commitment to Modes 2 and 3 except for limitation on Mode 3 relating to market access for doctors under the NHS being subject to medical manpower planning, whilst keeping Mode 1 and 4 closed as above);
- Nurses, Physiotherapists and Paramedical personnel (as above but no limitation placed on Mode 3 market access).

The plan to create Foundation Hospitals from the best performing NHS hospitals will create free-standing hospitals which are likely to own and manage their own assets and to borrow from financial markets. They will be privately-run but required to meet public

North West Regional Assembly

service obligations and receive state subsidies. The creation of Foundation hospitals and the extension of subsidies to the private sector are likely to ensure that GATS rules are applied to the NHS.

"If a WTO Dispute Panel took the same view as the WTO Secretariat – that the NHS is competing with private hospitals – then the UK Government would either have to extend any subsidies to the NHS to the private sector, or remove NHS subsidies completely in order to 'level' the commercial and competitive playing field. Clearly, this would have disastrous effects on the NHS" (World Development Movement, 2002).

The effects of liberalisation and privatisation could be to:

- Reduce and weaken regulatory regimes which restrict the operation of markets and market forces and business values;
- Increase national and international procurement in the health and social care sector;
- Encourage some users/patients to use health and social care services nationally and in other European countries which would reduce the demand for services unless it was replaced by users/patients from other regions seeking health and social care services in the North West;
- Increase privatisation;
- Make it harder to return assets and services to public ownership.

Company strategies in the private health and social care sector

The private sector is seeking to expand, consolidate and/or diversify in:

- Private hospital health care provision and managing NHS facilities;
- Capital projects for new hospitals, health centres and surgeries – ie PFI/PPP consortia;
- Support services and facilities management;
- ICT and related services such as payroll and medical records;
- Home care services;
- Intermediate and residential care.

Employment

Structural change in the social care sector and its implication for the region

There have been a number of significant consequences of government modernisation and reform programmes over the last decade since the introduction of the Health and Community Care Act 1990. They have led to:

- Residential home closures;
- Establishment of a commissioning role and the creation of care markets;
- Transfer of homes to private and voluntary sectors and trusts (Rochdale, Lancashire, Sefton, Manchester, Tameside, St Helens);
- Outsourcing of home care services resulting in cuts in terms and conditions;
- Fragmentation of services, growth in non-unionised workplaces;
- The growth of intermediate care initiatives.

There are a number of key trends which impose constraints on the public sectors capacity to implement a regional strategy. These include:

- The re-imposition of competition for all local government services (Audit Commission, 2002);
- The growth of trusts and other third sector organisations together with arms length companies, for example, health and social care trusts, children's trusts;
- The establishment of framework agreements or strategic partnerships for professional services such as financial services, personnel and payroll services, construction related services and engineering;
- The growth of Strategic Service Delivery-Partnerships for ICT and related services in local government (Liverpool, Blackburn, Cumbria) and their potential expansion or copy in the NHS; and
- The extension of PFI in health, education and other capital projects.

These aspects of the modernisation agenda could have a significant impact on the regional economy because the scale of potential outsourcing far exceeds the level reached in the 1990s. Contracts cover a much wider range of services and employment than they did previously, are usually substantially larger in value and long term, 10-15 years for ICT and equipment contracts, and up to 35 years for PFI building projects.

North West
Regional
Assembly

Training, recruitment and workforce planning

There are a number of aspects to training:

- The role of teaching hospitals in the region – the percentage of doctors and other health and social care specialists trained in the North West;
- What is the profile of medical specialities in the North West – what contribution does the region make, is it over or under-represented in different specialities?
- What are the training needs of the sector as a result of the NW Investment Plan – what is the skills base in the region to meet these demands?
- Potential to fulfil needs from indigenous population by focusing on improving training and care career opportunities rather than rely on migration into the region;
- Programme to meet investment requirements, for example, to staff new hospitals/services.

The regional partners will need to ensure that training programmes, recruitment and retention strategies, the link to regeneration projects, childcare provision and the provision of affordable housing are integrated into a coherent regional strategy in order to tackle existing vacancies and to create a supply of new health and social care staff to meet growth targets. Otherwise the expansion of health and social care will continue to be hampered by staff shortages and the region will not be able to maximise the economic and employment benefits of the planned growth.

Childcare provision

The provision of additional childcare in the health and social care sector will play a crucial role not only in creating additional employment but also assisting the implementation of training, recruitment and the retention of staff. Additional finance is also available by combining the health and social care sector needs with community needs in regeneration areas.

Trade union organisation and representation

There is a significant difference between the level of trade union organisation and representation in the NHS and local government compared with that in the private and voluntary sector workplaces in health and social care. Research has shown that trade union recognised and organised workplaces have, on average, ten percent higher wages and better terms and conditions compared to non-unionised workplaces. The difference between public and private employers in the social care sector is often frequently

North West
Regional
Assembly

greater. Hence the regional public sector trade union partners have a keen interest in maintaining quality public employment. On this basis alone, it does matter who delivers health and social care services.

Regeneration

Health and social care role in regeneration programmes

The Regeneration Priority Areas in the North West afford an opportunity to develop the health and social care economy and to obtain significant benefits for the community, health services and the regional economy. Close working between health and social care organisations, community and trade union organisations and regeneration agencies could achieve:

- Better targeting of policies, projects and services to meet social needs:
- Better integration and coordination of services, particularly for young people and the elderly, where a range of organisations are working co-operatively;
- The procurement of locally produced goods and services can be directly linked to economic and employment strategies in regeneration areas;
- Training opportunities can be more clearly identified and programmes developed in close co-operation with Higher Education, Further Education and other providers. The NHS Workforce Development Confederations have a key role to play;
- Health and social care organisations will be able to reduce or eliminate staff shortages and increase staff retention. Qualified staff are more likely to remain in the region if there are innovative policies and projects tackling health inequalities, public health and health promotion, integrating health, social care with other policies such as housing and education;
- The provision of childcare can be developed based on the joint needs of health and social care organisations and community needs;
- The modernisation of health and social care can be designed and adapted to meet local needs and priorities and local democratic accountability;
- Creates opportunities for wider community involvement in the design and planning of health and social care policies and services as part of the wider regeneration of an area, new opportunities for health promotion and education and to promote the democratisation of the health and social care sector.

North West
Regional
Assembly

Regeneration areas provide an opportunity to ensure that the planned growth in health and social care is targeted in areas of greatest need and that the economic and employment benefits generated by an expanding health and social care sector are concentrated in regeneration areas.

Urban and rural renaissance

Health and social care needs analysis

A 'state of the region' analysis is needed which sets out the investment needs in the North West taking account of health needs and inequalities and the health infrastructure deficit in the North West. The health plans produced in 2002 by the Strategic Health Authorities begin to establish spending and investment plans for different parts of the region. However, they need to be more comprehensive at both the regional and sub-regional levels.

Implications for Regional Planning Guidance

Health and social care investment in the North West will impact on Regional Planning Guidance in a number of ways:

- The location of new NHS facilities and community health services, including renewal of the primary care infrastructure, will require the integration of health service and local/regional planning;
- Maximising economic development opportunities arising from the health and social care sector including new business formation and new jobs;
- Managing possible nil growth in some areas where a population decline is forecast coupled with a relatively small change in the proportion of people aged 65 and over in the population in contrast to other areas where there is likely to be substantial net growth in health provision;
- Assessing the impact of dislocation between the location of new investment, regional health needs and the residential location of existing health staff which could lead to relocation pressures and increased commuting/traffic flows/demand for public transport. Much will depend on the level of intra and inter regional migration. The quality and diversity of the housing stock, house prices and the quality of schools are other relevant factors. A spatial analysis of health sector employment, demographic change and expenditure and investment strategies will be needed;

- Need to integrate the economic benefits which could be achieved in the health sector with regional-wide strategies to reduce social exclusion and inequalities. It is essential that the benefits are not constrained by a health sector perspective;
- Infrastructure investment and expanded health care training programmes should be linked to regeneration programmes so that urban and rural areas maximise their benefits.

Community well-being and public health

The expansion of the health and social care economy could make a significant contribution to improving community well-being and public health. However, in order to make this a reality the following measures will be necessary:

- A commitment to maximising the local and regional economic and employment benefits of increased expenditure and investment;
- Targeting employment and training opportunities in areas of multiple deprivation;
- Integrating health planning and regeneration proposals;
- Community involvement in the design and planning of health and social care services;
- Ensuring the employment policies and quality of jobs in spin-offs and new services are at least comparable to public terms and conditions in order to avoid creating additional low paid jobs requiring working tax credit subsidy;
- Use of the new health scrutiny powers of local authorities to ensure that the above policies are implemented and to assess whether the benefits of increased health and social care expenditure and investment are being obtained at the local and regional level.

There is also a debate emerging over 'new localism', mutualism and the 'social economy' or the role of social enterprises in the health and social economy. This requires a separate discussion. There is considerable scope for a wide variety of new community based health and social care projects. However, the extent to which the social economy seeks to expand the transfer or opting out of NHS and local authority health and social care services requires detailed attention by the regional partners. In addition, transfers which reduce the quality of employment, which has been a significant factor in the North West, have a negative impact of the regional economy.

The government's modernisation strategy focuses on creating 'diversity of provision' but this comes at a high price in establishing the competitive tendering and procurement structures across the public sector. To date, there has been little debate over these and other issues such as democratic accountability. There are also

contradictory policies, for example, primary and secondary schools have been given delegated budgets and freedom to purchase goods and services whilst national procurement systems hare being promoted for NHS hospitals thus reducing their ability to buy locally and regionally.

NHS health economy issues

NHS centralised purchasing

There is a degree of overlap between NHS organisations responsible for purchasing goods and services for health trusts and authorities. The region partners will need to negotiate regional policies with three NHS purchasing bodies, the NHS Shared Service Initiative, NHS Purchasing and Supply Agency and the NHS Information Authority. Each have different role but some overlap.

NHS Shared Service Initiative: launched in 1999 with the objective of improving the quality and value for money of non-clinical services, in particular streamlining back office functions across the NHS. Projects include shared financial services, electronic staff records and a finance and e-commerce project.

NHS Purchasing and Supply Agency: established as an executive agency of the Department of Health in April 2000 replacing 'NHS Supplies'. Most NHS purchases will be made or administered locally by purchasers working for individual NHS organisations such as Trusts and health authorities.

NHS Information Authority: its objectives include supporting national electronic care records, providing information services and secure information infrastructure services.

NHS procurement has been subjected to a number of reviews and research studies over the last few years by the Audit Commission, the Cabinet Office and NHS Procurement Agencies. A Cabinet Office Procurement Review (1998) following the first Comprehensive Spending Review sought to strengthen the NHS central procurement function and led to a DoH Circular (HSC 1999/143) implementing its organisational proposals and setting targets. An earlier Audit Commission report found that *"significant savings"* could be made from better supply management (Goods for Your Health, 1996).

The Audit Commission, in co-operation with the NHS Purchasing and Supply Agency, recently surveyed NHS Trusts on how they obtained £11billion of goods and services. They concluded, *"there*

North West Regional Assembly

is currently no consensus on which goods and services should be bought nationally, by inter-trust consortia or locally". However, government policy is that trusts should support the national buying power of the NHS and achieve savings (Audit Commission, Procurement and Supply, 2002). The same organisations have produced a series of performance indicators by which to assess NHS Trusts procurement processes. They focus on the effectiveness of the procurement strategy, the efficiency of its procurement process and the trusts use and storage of goods and services. A macro-economic, employment and/or regional perspective is non-existent (Audit Commission, Supplies & Procurement: Guide to the Indicators, 2002).

The Audit Commission has also reported twice since 2000 on the provision of equipment for 4m older people to assist their independence (Audit Commission, Fully Equipped, 2000 and Fully Equipped: Assisting Independence, 2002). Neither of these reports examined the production of equipment or employment issues and choose to focus entirely on service provision and the commissioning of equipment.

These procurement reviews and proposals are flawed because they have:

- Focused exclusively on service delivery and failed to examine the production of goods and services;
- Concentrated on costs and economies of scale with recommendations solely on means of bulk purchasing to achieve savings;
- Failed to take account of the needs of local and regional economies;
- The creation and maintenance of employment was never examined;
- Focus on local commissioning (p13 of fully equipped);
- Made no attempt to examine innovative approaches which would enhance a local and regional dimension and preferences within the framework of the European and UK procurement legislation;
- Failed to take account of the scope for reducing health and social inequalities through the procurement of goods and services;
- Concentrated on promoting national procurement organisations.

An analysis of the NHS Purchasing and Supply Agency's current database of NHS suppliers revealed 197 firms in the North West (12%). However, no information is available from this source on the type and size of contracts. Cheshire and Merseyside each had 36 firms, Manchester 43, Warrington 8, Cumbria 4, and most of the remainder had Lancashire addresses.

It will be difficult to change the procurement and supplies ideology being embedded in the NHS. The lack of a regional perspective is

North West
Regional
Assembly

all too apparent. However, the economic and employment benefits for the regional economy of a targeted procurement strategy could be considerable. If all regions adopted a similar strategy they may be no net gain although must will depend on the current contribution of the region to national NHS procurement. There is a need to redefine ‘good procurement practice’ in the context of regional planning and to develop local and regional indicators by which to assess progress.

Supply chains – the process of ordering, supplying, delivering, storing, invoicing goods and services – in effect the chain between the supplier and the end user, is vitally important to Trusts and the NHS as a whole. Taking advantage of bulk purchasing is essential. However, this appears to be the only agenda with local/regional economic and employment issues being excluded. It is more than just what the Welsh Assembly have termed *“winning business”* for the private sector from public service contracts. There is considerable scope to maximise other economic benefits which are likely to outweigh those gained from national procurement and also influencing what is produced and the supply process itself. There are direct links between procurement, economic development, local employment, reducing social and health inequalities and providing quality services.

European procurement regulations allow for ‘social considerations’ and local labour clauses covering a wide range of issues. It includes measures to ensure compliance with fundamental rights, equality of treatment and non-discrimination, preferential clauses for reintegration of disadvantaged or unemployed persons and positive action to combat unemployment and social exclusion (EU COM(2001) 566. For example, local labour clauses in construction projects and local sourcing of goods and services to increase the regional share of these contracts thus helping to support regional businesses and employment.

Capacity of health organisations

The strategies outlined above to maximise the benefits of the health and social care economy through employment, regeneration, procurement and so on will require increased capacity of health authorities and NHS trusts to design and deliver regional strategies. This should include the capacity for regional procurement, establishing links with regional manufacturers and service providers and implementing local labour schemes within the EU procurement regulations. This will mean developing core competencies within health and social care organisations. These increased demands cannot be met simply by increased use of consultants, partnerships and outsourcing. Reinforcing state institutions and social policies and strengthening the capacity of

North West Regional Assembly

the public sector are essential for national and local governments in a global economy (United Nations, 2001).

Enhancing regional intellectual capital

Intellectual capital is the knowledge and information about how the health care system is organised and operates in the North West and an understanding of regional and local health needs. This is built up over years, and although it is not something which can be easily learnt, it can be readily sold or transferred to other organisations.

Intellectual knowledge or capital takes several forms:

- Knowledge of public needs which could be in danger of being 'sold' or 'lost' to the private sector or could become very fragmented as a result of commissioning because much of the local knowledge is obtained through service delivery;
- Knowledge of local/regional health and social care systems and how they are organised and operated in the North West taking account of local patterns, geography, culture and politics;
- Knowledge of the history of health and social care decisions and the underlying reasons for those decisions.

Retention of the region's intellectual capital is an important means of enhancing regional identity.

Monitoring and evaluation

Tier 2 targets

The regional partners will need to establish methods to the continued monitoring and assessment of regional policies which are addressed at maximising the economic benefits of the health and social care economy in the region. The evaluation of performance in meeting the Tier 2 targets will provide one level of analysis but more detailed monitoring of the type of initiatives outlined in section 9 will need to be established. Some may be included within the Tier 3 targets. The targets date is 2005 unless otherwise stated.

Table 25: Tier 2 targets – integrating macro/micro economics of health and social care

	Tier 2 Targets for 2005
Regeneration	• Reduce by 37,408 the number of adults in income support households (10%) • Reduce by 8,604 the number of adults in income based Job Seekers Allowance households (10%) • Reduce by 10,892 the number of unemployment claimant counts (10%) ***Comment:*** *direct health and social care employment growth alone could make significant contribution to meetings these targets.*
Urban	• Net increase in population • Reduce the disparity in house/ land prices relative to regional/ national averages • Increase the number of people living in city centres • Increase the volume of retail trade • Increase the value of commercial property rentals • Increase the number of visitors ***Comment:*** *contribute to net increase in population and increasing volume of retail trade. Could increase house price disparity depending on location of expenditure and investment.*
Physical development	• 65% of new housing to be provided on previously developed land and conversion of existing buildings • Reclaim brownfield land at a rate of 714ha per annum by 2004/05 ***Comment:*** *uncertain impact – will depend on where growth in health care expenditure and investment is located.*
Rural	• Progress the regeneration of 20 market towns, as measured by an increase in employment, skills levels and business formation rates • In priority rural areas (including wards in the bottom 20% of the IMD), secure an increase in employment, skills levels and business formation rates ***Comment:*** *increased health and social care employment can play an important role in helping to create new employment opportunities in rural areas.*
Employment	• Increase the regional employment rate from 73.1% (2001) to 74% ***Comment:*** *sector has important role, particularly if there is a strong focus on the linkages with other sectors of the regional economy and mechanisms are put in place to maximise the regional benefits.*
Skills	• Increase proportion of: – 19 year olds with level 2 qualifications to 86% – adults with level 3 qualifications to 52% – employees undertaking work related training over past 13 weeks to 30.5% – working population having undertaken training in past 4 weeks to 14.9% • Reduce adult population with poor or very poor levels of literacy to 15.5% and numeracy to 35% • Progress towards national learning targets for 16 year olds – 51% with higher grade GCSEs • Progress towards national learning target for 21 year olds – 61% qualified to NVQ level 3 ***Comment:*** *the NHS offers important training, skills development and career opportunities for young and older people.*
Investment	• Over the Corporate Plan period, achieve a total of 30 FDI projects ***Comment:*** *health and social care sector will not contribute to FDI investment but need to have a broader definition and targets for investment.*
Sustainable economic performance	• GDP to be 90.7% of the UK average and 90% of the EU average (i.e. maintain 1996 baseline) in 2003 • GDP to be 92% of the UK average (£15,665 GVA per head) in 2006 ***Comment:*** *sector can make a significant contribution to meeting this target.*
Productivity	• An average annual increase of 2% in productivity in real terms as measured by GVA per total hours worked ***Comment:*** *sector can make a significant contribution to meeting this target.*
Enterprise	• As a minimum, match the national average for the number of people considering going into business (target to be reviewed when baseline data is available) • An average annual increase of 2% in the productivity of SMEs, as measured by GVA per total hours worked • Increase by at least 1% p.a. the number of VAT registrations in those wards falling within the bottom 20% of the IMD ***Comment:*** *the health and social care sector could contribute additional enterprise formation as a result of spin-offs from medical research and development.*
Innovation	• Achieve the national average for the proportion of enterprises which are novel innovators (subject to the results of the Community Innovation Survey when the target will be reviewed) ***Comment:*** *there is scope to harness research and development spin-offs in the manufacturing sector and new services in both public and private sectors.*

Source: NWDA Tier 2 Targets, 2002.

Social and Economic Audit for the Regional Review

The audit is assessing the performance of Tier 2 targets over the next three years leading to the production of a social and economic audit of the North West in 2004/05. The audit will assess progress and determine the effectiveness of expenditure and investment in meeting the policy objectives. The model developed in this report can be used to assess regional progress in meeting the Tier 2 targets.

The Social and Economic Audit has six main objectives:

1. To assist the North West Regional Assembly (NWRA), North West Development Agency (NWDA) and Go North West (GONW) with the delivery of Tier 2 targets and objectives.
2. To assess the impact of regional performance at the sub-regional and community level to identify benefits and/or adverse impact on particular social groups and sectors in the North West economy.
3. To contribute to the development of appropriate performance measures, data collection, monitoring and assessment.
4. To identify ways in which social and economic assessment can be integrated into the planning process to improve policy and decision making.
5. To build capacity, understanding and support for regional targets at sub-regional and community level and to provide a mechanism for involvement in the assessment process.
6. To produce a Social and Economic Audit of the North West.

The project examines the Tier 2 targets in the following groups:

Year 1	Regeneration Urban Physical development
Year 2	Rural development Employment Skills Investment
Year 3	Sustainable economic performance Productivity Enterprise Innovation

(See North West Social and Economic Audit: Year One: Interim Report, May 2002.

The impact and contribution of the health and social care economy will be assessed under each of the Tier 2 targets as the audit progresses and providing more detailed evidence for each of the targets in Table 25.

North West
Regional
Assembly

Integrated impact assessment

Regional and local policies, programmes and projects in the health and social care sector will need to be assessed for their economic, social and environmental impact. This should be an integrated assessment covering community well-being, the type and quality of employment, supply chain linkages in the regional economy, social and environmental sustainability and the health impact. A social justice perspective should mainstream equality, equalities and social inclusion in all impact assessments.

Impact assessments should be an integral part of the planning and development stages of all policies, programmes and projects to ensure the region gains the maximum benefits from health and social care investment.

Conclusion

This section has highlighted the opportunities to maximise the regional benefits of increased health and social care expenditure and investment. Earlier parts of the report noted the high level of leakage from the regional economy. There are powers for the regional partners to take appropriate action. Impending changes in global regulations leading to further liberalisation of public services make regional action more imperative.

PART 9

Scope for action by the regional partners on economic and employment matters related to health investment

Introduction

This report has identified a number of key issues which need to be addressed for the North West region to be able to maximise the benefits of the planned growth in the health and social care economy. These benefits range from improving the quality of health care, reducing health inequalities and maximising the regional economic gains from increased public expenditure and investment.

This section identifies a series of proposals to be considered by the regional partners under the following headings:

- Strengthening links to regional manufacturing, research and development;
- Strengthening regional and local procurement;
- Training;
- Minimising further privatisation and marketisation;
- Scrutiny and monitoring;
- Research agenda.

Strengthening links to regional manufacturing, research and development

Audit of manufacturing and service sector companies supplying and operating in the health and social care sector. This would identify:

- The current manufacture of medical equipment, surgical supplies, pharmaceuticals and other health and social care products in the North West;
- The North West and national/international markets;
- A profile of the companies, financial status, ownership;
- The supply chains of these products;
- ICT hardware and software suppliers in the region;
- The range of specialist health and social care expertise provided by consultants, for example technical advice, change management and financial advice;
- The food chain and role/potential for local agriculture – for example, are the chickens from Cumbria, Norfolk or Thailand?

A health research and innovation audit should be carried out leading to a digest to link up research and development of new products and services with economic development and support to maximise regional manufacturing sector. This may require a survey

North West Regional Assembly

of economic development agencies to identify current projects and recent requests for support:

- If necessary, launch innovation grants, technical support, incubator and nursery facilities to encourage new health and social care products and services.

Strengthening regional and local procurement

- Procurement guidance for all health and social care organisations in the North West demonstrating how the process can be used to maximise economic and employment benefits to the North West. Development and 'regionalisation' of Procure 21;
- Draw up a PFI supplies charter to maximise regional content and accountability in health and social care projects;
- Operate approved lists of contractors which promote good practice and encourages, on a voluntary basis, a North West regional perspective;
- Propose that the NHS Procure 21 be expanded to include a regional dimension;
- Negotiate with NHS Purchasing, NHS SIA and NHS Information to persuade these agencies to adopt regional criteria in procurement;
- Local labour clauses: what is possible within European legislation;
- Separating food supply contracts to facilitate the supply of locally grown organic food to hospitals, care homes and other facilities. East Anglia Food Link (EAFL) is working with some Regional Development Agencies to increase access to locally produced fruit and vegetables from co-operatives and sustainable initiatives in agriculture. EAFL and SUSTAIN are producing a manual for public institutions on this issue in 2003 (Changing Places, Good Food for All, BBC Radio 4, 15 November 2002.). This approach is also dependent on retaining local kitchens rather than cook-chill systems.

Training

The regional partners will need to ensure that training programmes are designed to address the jobs and skills requirements of the North West, particularly the health and social care sector. The partners will need to:

- Determine the overall employment requirements of the health and social care sector, not just its constituent parts;

North West
Regional
Assembly

- The levels of sub-regional employment as a result of demographic change;
- An assessment of current and planned health and social care skills training programmes to assess their capacity to deliver;
- Determine trends in the private health and social care sector and to try to minimise the loss of NHS trained staff.

Minimising further privatisation and marketisation

Examine the implications of the General Agreement on Trade in Services for the North West region, particularly the potential impact on public services.

Encourage public bodies in the region to subject all proposed transfer and privatisation proposals to full integrated impact assessment to identify the local and regional economic and employment implications.

Scrutiny and monitoring

Targets: None of the current Tier 2 and 3 targets address the issues raised in this report with regard to the health and social care economy. It would be appropriate for some targets to be developed at Tier 3.

Health and social care scrutiny

No specific mention of macro/micro economics of health provision, however, the Consultation Paper notes that *"Councils will be scrutinising a health system or economy, not just services provided, commissioned or managed by the NHS"*.

The Consultation Paper on the draft regulations for health and social care scrutiny include, under *"matter to be reviewed and scrutinised"*, *"the planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population"* (section 7f).

Provision of information to determine macro/micro economic analysis of health economics – Section 18 states that it *"shall be the duty of each local NHS body to provide the local committee(s) with such information about the planning, provision and operation of*

North West
Regional
Assembly

health services within the area of the committee(s) as they may reasonably require in order to discharge their health functions under the legislation". A scrutiny committee will also be able to *"require any officer of a local NHS body to attend before the committee to answer questions that the committee, or authorised person consider necessary for the review or scrutiny"* (Section 20).

The quarterly Performance Monitoring Report published by the NWDA should be extended to cover progress in the public sector, in particular, progress in the implementation of the recommendations made above if they are adopted by the regional partners.

Research agenda

This report has identified a number of gaps in the availability if data and information and the need for further research and analysis, the most important of which are:

- Analysis of NHS/PCT expenditure on goods and services – expenditure, type, location;
- Analysis of private and voluntary health and social care provision in the region – type of services, trends, expenditure, employment, outsourcing;
- Health and social care employment (public and private) by ward and local authority;
- An audit of the procurement policies examining policies and measures for local sourcing of goods and local labour schemes;
- Detailed assessment of the location, spatial pattern and scale of planned health and social care investment in the region up to 2007/08;
- Analysis of the potential growth of the social care sector in parallel with the planned expansion of the health sector;
- Which firms in the North West manufacture medical equipment and surgical supplies, what is their capacity, the wider market for products, investment plans, staffing and recruitment/training needs?
- What are the barriers to increasing the regional content of goods and services – supply, access, price, quality and suitability?
- Are there specific skill shortages in these health related economic activities in the North West which constrain the expansion of regional provision?
- What are the supply chains in health and social care and how do they differ from other sectors?

North West
Regional
Assembly

This report has demonstrated that there significant benefits to be gained from increasing local and regional leverage in the health and social care economy in the North West. Further research should be designed to maximise these benefits.

Investment for health and social care should also be addressed as part of the preparation of a 'blueprint' for the future of public services in the new regional governance and the reorganisation of local government.

North West
Regional
Assembly

REFERENCES

Audit Commission (2002) Competitive Procurement, London.

Audit Commission (2002) Procurement and Supply:
Review of National Findings, May.

Audit Commission (2002) Brief Encounters:
Getting the Best from Temporary Nursing Staff.

Audit Commission (2002) Guide to the Indicators –
Supplies and Procurement.

Audit Commission (2002) Fully Equipped 2002:
Assisting Independence, London.

Audit Commission (2002) The Performance of the NHS in England:
Developing an Independent Commentary, London.

Audit Commission (2002) Integrated Services for Older People:
Building a whole system approach in England, London.

BBC (2002) Changing Places:
Good Food for All, 15 November, Radio 4, 15.00hrs.

Cabinet Office (2002) NHS Procurement Review.

Centre for Public Services (1995) Calculation of the National
Costs & Savings of CCT, Sheffield.

Centre for Public Services (2002) North West Social and Economic Audit:
Year One: Interim Report.

Centre for Public Services (2002) Critique of North West Regional
Economic Strategy Review Consultation Document, Sheffield.

Cheshire and Merseyside Strategic Health Authority (2002)
Health Service Plan.

Construction Industry Training Board (2002) North West:
Construction Workforce Development Plan 2002, London.

Coote, A. (2002) Claiming the Health Dividend, Kingsfund, London.

Department of Health (2001) Public Expenditure Questionnaire 2001,
Memorandum to the Health Select Committee, House of Commons, London.

Department of Health (2002) Delivering the NHS Plan, Cm 5503,
Stationery Office, London.

Department of Health (2002) Departmental Annual Report 2002/03, July.

Department of Health (2002) The Local Authority
(Overview and Scrutiny Committees Health Scrutiny Functions)
Regulations 2003, Consultation Paper, London.

Department of Health (2002) HR Directors Bulletin, 24 April, London.

Department of Health and others (2002) Tackling Health Inequalities:
2002 Cross-Cutting Review, London.

Department of Health (2002) Health and Neighbourhood Renewal:
Guidance from the Department of Health and Neighbourhood
Renewal Unit, London.

Department of Trade and Industry (2002) Liberalising Trade in Services:
A new consultation on the World Trade Organisations GATS
negotiations, London.

North West
Regional
Assembly

East London and the City Health Action Zone (2001) Health Impact Assessments for Regeneration Projects, Volume 2: Selected Evidence Base, London.

Ernst & Young (2002) Progress and Prospects: Healthcare PFI – A Survey, London.

Health Task Group North West (2000) Health – A Regional Development Agenda.

HM Treasury (2002) Public Expenditure: Statistical Analyses 2002-03, Cm 5401, Stationery Office, London, May.

HM Treasury (2002) Securing Our Future Health: Taking A Long-Term View, Derek Wanless.

HM Treasury (2002) 2002 Spending Review, Stationery Office, London.

House of Commons Select Committee on Health (2002) First report, Session 2002-03, London.

Joseph Rowntree Foundation (2002) calculating a Fair Price for Care, York.

Lancashire County Council (1997) Lancashire 1998: An Economic Situation Report, Preston.

Laing and Buisson (2001) Domiciliary Home Care Market, 2000, London.

Laing and Buisson (2002) Care of the Elderly People Market Survey 2002, London.

Laing and Buisson (2002) Laing's Healthcare Market Review 2002, London.

Manchester City Council (1987) Manchester Employment Plan.

NHS Executive (2001) Putting NHS Research on the Map, NHS Research and Development, London.

NHS Executive (2002) The Economic Impact of the NHS on the London Regional Economy, London Regional Office.

NHS Executive (1999) Review of NHS Procurement, June.

NHS London Regional Office (2002) Employment Improves Your Health: Regeneration and employment in health and social care, London.

NHS Purchasing and Supply Agency (2002) Annual Report and Accounts 2001/02.

NHS Purchasing and Supply Agency and Audit Commission (2002) Supplies and Procurement: Guide to the Indicators.

NWDA (2000) Regional Economic Strategy.

NWDA (2002) Investment Plan for Health (Draft).

NWDA (2002) Performance Monitoring Report, April – June 2002.

NWRA (1999) An Ageing Population: Impact for the North West.

NWRA (2000) Draft regional Planning Guidance for the North West.

NWRA (2000) Action for Sustainability: North West England's Framework for a Better Quality of Life.

North West
Regional
Assembly

NWRA (2002) Regional Review: Select Committee Style Hearing on Clusters and Business Development, Report, Regeneris Consulting, October.

NWRA (2002) Regional Review: Cluster Hearing: Key Conclusions, Regeneris Consulting.

North West Universities Association (2002) The Contribution of Higher Education to the North West Economy: A background paper for the Regional Strategy Review Consultation, September edition, Manchester.

ODPM (2003)Code of Practice on Workforce Matters in Local Authority Service Contracts, London.

Official Journal of the European Communities (2001) Interpretative Communication of the Commission on the Community as applicable to public procurement and the possibilities for integrating social considerations into public procurement, 28 November.

Office for National Statistics (2002) UK National Accounts, Blue Book, Stationery Office, London.

Office for National Statistics (2002) Regional Trends 37, Stationery Office, London.

Office for National Statistics (2002) Region in Figures: North West, London.

Office for National Statistics (2002) New Earnings Survey 2002, London.

North West Development Agency (1999) Health: A Regional Development Agenda, Health Task Group.

Scottish Executive (2002) Input-Output Table and Multipliers for Scotland.

Sheffield Hallam University (1998) Homes and Jobs in Doncaster, Centre for Regional Economic and Social Research.

South Tyneside UNISON/Centre for Public Services (2002) Social and Community Care for Older People in South Tyneside.

The Economist (2002) The Health Service's IT Problem, 19 October.

TUC (2002) Half the World Away: Making regional development work, London.

UNISON Northern Ireland (1993) Social & Economic Audit, Royal Hospitals Trust, Belfast, by Centre for Public Services.

World Development Movement (2002) Serving (up) the Nation: A guide to the UK's commitments under the WTO General Agreement on Trade in Services, London.

World Health Organisation (2001) Macroeconomics and Health: Investing in Health for Economic Development, Geneva.

North West
Regional
Assembly