

The welfare state after the crisis

Nicholas Barr

London School of Economics

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Summary

1. This note is not a blueprint but a strategy framework for developing the welfare state, which people with the necessary expertise will need to populate with implementable policies.
2. The note sets out two central analytical messages:
 - What is involved is *systemic uncertainty*, a much wider problem than risk, the crisis created by the pandemic being an example of a larger class of such problems.
 - Private insurance, for technical reasons, does not cope well with systemic uncertainty; thus the state has to be the major actor.
3. The central policy message is that addressing uncertainty points to the need for resilience, which in turn requires spare capacity. The right analogy is the need for sufficient bank reserves, not just-in-time delivery of BMW car parts to their plant in Swindon.
4. Achieving resilience requires two background ingredients:
 - A strategic plan; and
 - More resources; given the debt overhang after the crisis, additional resources inescapably will involve higher taxes and/or user charges.
5. Specific policy areas discussed are:
 - Putting food on the table;
 - Improving health, health care and social care;
 - Widening and deepening human capital;
 - Better use of resources, with particular emphasis on integrating the finance of health and social care.
6. The key to achieving policy goals is better governance. Two aspects stand out: an enhanced capacity to take a long-term view; and better understanding and greater respect for implementation.

1 The starting point

- 1 This note offers a set of strategic thoughts to frame discussion.
 - It is a note, not a fully-fleshed out paper: some parts of the strategy (e.g. mental health) lie outside my skill set and are labelled but not completed.
 - It is a strategy not a blueprint: filling in the details requires people with sector-specific expertise – both analytical skills *and* experience running things on the ground.
- 2 PROBLEMS EXPOSED BY THE STRESS TEST OF THE CRISIS.
 - Lack of preparedness, including lack of clarity at an early stage about how to respond.
 - Income support: inability to deal quickly with large spikes in applications for benefits.

¹ Professor of Public Economics, European Institute, London School of Economics; N.Barr@lse.ac.uk; <http://econ.lse.ac.uk/staff/nb>

- NHS: shortages of equipment and the need to devise a plan at short notice.
- Problems with food distribution.

3 THE STARTING POINT. Once the immediate crisis is over, the situation the country faces includes:

- Long-term under-resourced public services.
- A large debt hangover, both national debt and private debt.
- Pervasive uncertainty (as distinct from risk, discussed below).

4 ANALYTICAL FRAMING.

- The dividing line between market activity and state activity is mainly a microeconomic question rooted in issues of market failure.
- The scale of spending is a separate question – mainly macroeconomic – largely reflecting the fiscal situation.
- Market failures both explain and justify substantial government involvement in welfare-state activities.

Thus the analytical starting point is that the choice of policy instruments – crudely market or state – is more a technical matter than an ideological one. This is the central argument of Barr (2020, summarised on pp. 3-7, and for future-looking discussion, Ch. 12).

2 Core objectives

2.1 Addressing systemic uncertainty: A central area of state activity

5 A useful starting point is to ask the ‘So what?’ question – why does all this matter?

6 As Appendix 1 explains, insurance is based on (a) the size of the loss and (b) the probability that it will occur.

7 SIZE OF THE LOSS. The present crisis illustrates the scale of economic and human losses.

- Lost output, which will be a significant fraction of GDP in many countries.
- Lost lives, both direct and indirect (e.g. through postponed medical treatment): it need hardly be said that these are a huge loss to family and friends; this loss is additional to the lost output.
- Cost in terms of individual well-being: in addition to the loss of income for many people (partly included in lost output) are wider costs in well-being, such as having to stay at home for extended periods. People miss their family and friends and cultural and sporting activities; children miss their fellow students; and there has been increased domestic abuse.

8 These costs bear disproportionately on less well-off people. The over-representation of African Americans among coronavirus-related deaths in the USA illustrates the point.

9 RISK AND UNCERTAINTY: A FUNDAMENTAL DISTINCTION. With risk, the probability of an event (e.g. breaking a leg or becoming unemployed) is known or, more realistically, the

probability distribution of outcomes has only a small variance. With uncertainty, in contrast, the relevant probability is not well known.

10 In a crisis like the present, insurance is important because

- Uncertainty is very present: Covid-19 is the fourth pandemic this century (SARS, swine flu, Ebola), with further outbreaks plausible (*Scientific American* , [11 March 2020](#)); *and*
- Tail-risk losses are very large.

11 But systemic uncertainties are much wider than pandemics. Examples include:

- Economic – a trade war or another economic crisis;
- Political – instability in the Middle East;
- Environmental – accelerating effects of climate change;
- Technical – artificial intelligence, robots, nuclear safety (Fukushima);
- Social – the multiple effects of a changing age structure.

For discussion of the huge implications of uncertainty, as distinct from risk, see Haldane (2012) and Kay and King (2020).

12 WHAT PRIVATE INSURANCE CAN AND CANNOT DO. It is a standard result in economics that insurance raises the well-being of a risk-averse person. To demonstrate the point, one need look no further than the long-term popularity of the NHS.

13 A second result (Barr 2020, Ch. 4) is that private, actuarial insurance operates well when certain technical conditions are met (e.g. automobile insurance and burglary insurance are rightly left to the market), but becomes inefficient (e.g. high cost) or non-existent (so-called missing markets) when one or more of the conditions fails. Private medical insurance in the USA offers a sad (but, alas, entirely predictable) example (Barr 2020, pp. 240-45). Particularly relevant in the present context, private insurance does not cope well with uncertainty. Thus, for technical reasons, quite separate from ideological views, private insurance cannot address systemic uncertainty. If insurance is to be provided, the state has to step in.

14 CENTRAL ANALYTICAL MESSAGES. What is involved is systemic uncertainty, which only the state has the capacity to address. The state can be involved either directly or in strategic conjunction with finance or services provided by private entities. Tackling the problem effectively is justified not only in human terms; given the scale of losses, it is likely also to be cheaper.

2.2 Strengthening resilience

15 CENTRAL POLICY MESSAGE. An implication of uncertainty, particularly ‘fat-tailed risks’ (Haldane 2012) is the need for resilience.

16 DIAGNOSIS: THE WRONG MODEL. ‘Just in time’ works well in a situation (a) of certainty and (b) where the costs of failure/delay are relatively small, but is the wrong model for complex products like health care. Thus the proud boast of 98% NHS bed usage is profoundly mistaken. A more apt analogy is the requirement that banks should hold sufficient reserves.

17 Short-run cost minimisation is mistaken in principle – a logical category error – given complexity and uncertainty.

‘Both [Covid-19 and climate change] feature emergence, path dependence, feedback loops, tipping points, and non-linearity. Both entail catastrophic fat-tailed risks ruled by radical uncertainty and call for eschewing traditional cost-benefit analysis – which relies on known probability distributions – in favor of drastic mitigation to reduce exposure. And, importantly, both highlight the need for much closer forward-looking international cooperation to manage global threats’ (Derviş and Strauss 2020).

18 In this context, the approach is also mistaken in practice. For areas like health care, a narrow accounting focus on short-term cost efficiency leads to false economy. And excessive decentralisation loses sight of interdependencies, e.g. insufficient spending on social care leads to (more expensive) NHS bed blocking. The resulting inefficiencies then rebound on the public purse.

19 **PRESCRIPTION: GREATER RESILIENCE.** The crisis illustrates the central role of the welfare state in protecting against uncertainty. Resilience has at least two elements.

20 *A flexible, adaptable plan* (outlined in section 3.1). It is generally not possible to reduce risk to zero; even staying at home at all times has some risk, and comes with economic and psychic costs. Thus a plan should seek to optimise exposure to risk.

- Reducing risk: in a few years time we will have better data on the cost of the crisis in terms (a) of mortality rates per 1 million population and (b) as a per cent of GDP, and thus will be able to make at least a preliminary evaluation of how well strategies in different countries worked. Given what look to be the huge costs in most countries, the scale of the potential saving from reducing risk is clear.
- Mitigating risk: ‘smoothing the curve’, by spreading risk makes it easier to accommodate.

21 *Spare capacity* is a second aspect.

‘Designing robust systems requires building some redundancy and slack into them, at the expense of some efficiency in the short term. But if ... the tail risks materialize, the more robust systems will prove to have been more efficient from a long-run perspective’ (Derviş 2020).

22 Part of spare capacity is to stockpile some equipment, e.g. the beds and monitors that were available at short notice to set up the Nightingale Hospitals. But it is neither feasible nor desirable to try to stockpile everything. For a start, it is generally not possible to stockpile services. Thus another aspect of spare capacity is to plan how to ensure sufficient personnel and skills and how to manufacture or buy equipment in large quantities at short notice (for example, it is not necessary to have a large stockpile of ventilators if the plan contains a ventilator design that can be implemented at scale at short notice).

3 Underpinning elements

3.1 A strategic plan

23 Planning is well outside my expertise, so the following paragraphs are only indicative.

24 A strategic plan or series of interlinked plans is needed that can be adapted to whatever uncertain future emergency eventuates. The existence of a strategic plan improves the speed and quality of response, and hence outcomes, and reduces the need for emergency spending larger than would have been necessary with prior planning and preparation – spikes in demand raise prices!

25 SCOPE. Plans need to be set in an international context. On pandemics, which by definition are international, see the call in a [letter of 6 April 2020](#) for the creation of a Global Pandemic Emergency Co-ordination Council, led by the UN Secretary General, the head of the WHO, the President of the World Bank and Managing Director of the IMF.

26 Plans also need to address wider risks than a pandemic.

‘Unfortunately, the responses to particular disasters have tended to focus on preventing that exact kind of disaster from recurring, rather than mitigating risks more broadly. After the September 11, 2001, terrorist attacks in the US, for example, robustness was built into airport security – and not much else’ (Derviş 2020).

‘Thus what is needed is ‘a broader shift toward greater systemic robustness’ (*ibid.*).

27 Clearly a single plan cannot cover all the systemic uncertainties outlined in para. 11, pointing to plans for different types of contingency. Each plan should incorporate lessons from past experience, i.e. ‘knowing what we know now’.

28 SOME ELEMENTS. At least some elements in plans can be identified now. One is to ensure robust mechanisms to assist co-operation across departments. The excellent Royal Society paper on pandemics by Cunningham *et. al.* (2017) cites the example of rabies, responsibility for which often falls between the Ministry of Health and Ministry of Agriculture.

... [R]abies in humans transmitted through dog bites ... kills around 60 000 people annually The disease is easily preventable ... through repeated annual or biannual mass vaccination of dogs In many countries with a high burden of rabies in dogs, considerable sums are spent by the public and Ministries of Health annually on post-exposure prophylaxis (PEP—often given after dog bites whether or not the animal was known to be rabid). *The expense of this repeated treatment usually dictates that far more is spent on treatment than would be required to vaccinate all dogs in the same region* (pp. 4-5, emphasis added).

29 Another element that can at least to some extent be anticipated is to reduce red tape during an emergency, when the application of routine rules at routine speeds is counterproductive. The problem is not restricted to the UK, illustrated by two articles in the *New York Times* on 13 April 2020, ‘[The Coronavirus Stimulus Is Playing Hard to Get: Why do we make it so difficult for people to receive unemployment and other forms of relief?](#)’ and ‘[Foreign Doctors Could Help Fight Coronavirus. But U.S. Blocks Many,](#)’

3.2 More resources

30 Two aspects of resource mobilisation require discussion: the need for more resources, outlined here, and better use of resources, discussed in section 4.5 in the context of welfare-state activities.

31 THE NEED FOR MORE RESOURCES. It is necessary to remedy past under-resourcing, and for forward looking reasons, to build resilience. Examples include:

- Benefit administration: greater capacity to deal quickly with large spikes in applications for Universal Credit and Job Seeker's Allowance.
- NHS: more hospital beds; increased hospital capacity to provide oxygen; greater stockpiles of key equipment and consumables such as ventilators and personal protective equipment, both within the NHS and for other front line workers, e.g. social care, bus drivers, etc.
- Greater elasticity in the distribution of food and similar household necessities.
- Other essential services, e.g. broadband (a particular problem in rural USA – [‘Coronavirus exposes America’s broadband problem’](#), *Financial Times*, 12 April 2020).

32 MORE RESOURCES WILL REQUIRE HIGHER TAXES.

- If the welfare state is to offer effective and equitable insurance against systemic uncertainty, more resources are essential.
- The large hangover of public debt constrains what can be financed from borrowing. An inescapable implication is that a more robust welfare state will require higher taxes and/or higher contributions and/or some user charges.
- To gather sufficient resources, higher taxes will have also to fall on the middle of the income distribution not just the best off.

33 POTENTIAL SOURCES OF ADDITIONAL REVENUE. Each of the following sources of additional requires detailed discussion.

34 Personal income tax: policies include action to widen the tax base (desirable on efficiency and equity grounds), and an increase in tax rates on middle and higher incomes.

35 VAT: the current 20 per cent rate has little scope for further increase. However, there may be some scope to widen the tax base. A radical idea (albeit politically not feasible) would be to charge VAT on food and use some of the additional revenue to increase cash benefits to protect people with low incomes. Such a move, properly designed, would (a) have a large yield and (b) could be progressive (champagne and caviar would no longer be tax free).

36 National Insurance Contributions: there is scope to widen the tax base, e.g. by raising the upper earnings limit. There is perhaps also scope to increase contribution rates, e.g. the charge above the upper earnings limit.

37 An NHS contribution? The economic argument is that hypothecated taxes are generally undesirable, but political economy arguments can point the other way. An NHS contribution is likely to be politically more palatable than an increase in income tax; and a dedicated contribution might offer the NHS more protection against budgetary crises than finance from general government revenues.

38 A dedicated long-term care tax or an addition to social insurance contributions: as discussed in section 4.3, the finance of long-term care faces major uncertainties, creating the case for mainly public finance.

- Illustrating the approach, in the Netherlands, an AOW premium (*Algemene Ouderdomswet*, or General Law for the Elderly) helps to finance a non-contributory pension. The tax is additional to, but integrated with, the income tax (i.e. the same tax base) but paid only by people under 65.
- Germany levies an add-on to social insurance contributions: while the main contribution stops at age 65, the add-on does not.

39 User charges are common in a number of well-regarded European health-care systems, and already occur in some areas in the UK, e.g. prescription charges, tuition fees.

4 Policy in more detail

40 As noted, this section offers a strategy not a blueprint. It includes some specific policies intended as illustrations. As discussed in section 5, the relevant expertise for detailed policy needs to include both analytical skills and operational experience.

4.1 Sequencing: What policies in what order

41 Short-term policies, as insurance against a recurrence of Covid-19, include putting food on the table and ensuring adequate supplies of medical consumables.

42 Alongside developing a strategic plan, outlined in section 3.1, medium term policies include:

- Wider re-resourcing of the NHS;
- Addressing constraints in the finance and delivery of social care;
- Action to strengthen human capital;
- Integrating the finance of health and social care; and
- Action to strengthen governance.

4.2 Putting food on the table

43 A better benefit system, as well as helping the direct beneficiaries, has wider advantages. Since benefit payments are generally higher during a downturn, more generous systems act as automatic stabilisers. In the context of the present crisis, better benefits will act to reduce the transmission rate of infection by reducing the pressure on people to work even when they have symptoms, because otherwise they have no source of income. The importance of food banks and the numbers of rough sleepers in one of the richest countries in the world buttress the argument that the UK benefit system is parsimonious

44 FIX THE PROBLEMS OF UNIVERSAL CREDIT.

- Address design problems, e.g. by increasing the level of benefits, and by offering regular payments more often than monthly.
- Address implementation problems, e.g. by increasing the capacity to disburse benefits rapidly even in the face of a large spike in applications.

45 WIDEN THE SCOPE OF CASH BENEFITS.

- General: should self-employed people be able to make voluntary national insurance contributions to qualify for unemployment and sickness insurance, with suitable safeguards against moral hazard?
- Crisis response: develop a wider system of crisis cash support to individuals, building on lessons from the current emergency packages.

46 UNIVERSAL BANK ACCOUNTS, or an electronic equivalent. These would allow benefits to be paid electronically and, if necessary, instantly. The simplest accounts could be debit only, i.e. an electronic jar of cash. Countries like Kenya offer good examples of financial transfers via mobile phones.

47 ENSURING RESILIENCE IN FOOD SUPPLIES. During the current crisis, food banks were overwhelmed; some foodstuffs – pasta, bread flour, much tinned food – were initially in short supply; and so were slots for deliveries of online orders from supermarkets. Planning should consider how to ameliorate such problems.

48 PENSION REFORM. Though outside the remit of this note, hence mentioned only briefly, the policy directions above should be accompanied by longer-term work on improving the design and operation of the pension system. The underlying analytics are set out in Barr (2020, Ch. 7), with some evaluation of current policy in Barr (2019).

4.3 Improving health, health care and social care

49 This section discusses the NHS, public health, mental health and social care separately since there are beneficial reform directions for each separately. However, it is necessary also to look at those areas holistically. In particular the current arrangement with separate funding streams creates a series of adverse incentives. The need to integrate funding is discussed in section 4.5.

50 There are two strategic pathways to improved health resilience: better health care and better health (and hence less need for health care).

51 THE NHS. A first step is to address historic under-resourcing. Acute shortages should be addressed with a rapid increase in finance. In other areas, however, it may be better to put in place credible pre-announced growth in resources, e.g. an increase of $x\%$ per year above excess medical inflation, rather than a big upfront splurge. The phasing of additional resources should be the subject of discussion with a wide range of stakeholders.

52 A second element is to add sufficient capacity to the system. As Appendix 2 explains, the extra funding necessary to increase capacity should take account of three sets of cost drivers: excess medical inflation, technical advance, and significant demographic change.

53 ‘Sufficient capacity’ has several dimensions. It refers to equipment, consumables and personnel. And it means that capacity should be optimised in the face of a wide range of stochastic outcomes. The core argument of this note is that ‘stochastic’ refers to uncertainty, not risk (Haldane 2012; Kay and King 2020). This argument is not invalidated by the inevitability of some redundancy during ‘normal’ times. In the present context, the case of Germany (‘Oversupply of hospital beds helps Germany to fight virus’, *Financial Times*, [13](#)

[April 2020](#)) is a graphic illustration that spare capacity (a better term than excess capacity) should be optimised not minimised. Nobody should pretend that optimising in the face of uncertainty is easy, but being approximately right by trying to do so is better than being exactly wrong by trying to minimise short-run cost.

54 A third element is to invest in technical advances: the examples below need to be reinforced by medical experts:

- Clinical, e.g. operations by remote control; greater use of AI in screening;
- Service delivery, e.g. online medical consultations;
- More use of apps for continuous monitoring.

55 PUBLIC HEALTH. Though only part of the picture, a robust emphasis on diet and lifestyle is an essential component. Such action should go considerably beyond counselling individuals to change their lifestyles; it needs also to address the structural causes. The sugar tax is an important start and should be extended to a wider range of unhealthy foods, perhaps with subsidies for healthy foods. The design of such interventions needs expert input.

56 It was said of the banks during the 2008 crisis that they privatised the profit and socialised the losses. It is not unfair to level a similar charge at parts of the food industry. If policy fails to tackle this part of the problem other public health measures risk being largely a waste of time.

57 The main resource required for this part of the strategy is political will. Note that effective public health reduces the overall cost of maintaining and improving health, and to that extent public health is partly self-supporting.

58 MENTAL HEALTH. Specifics need input from people with the relevant expertise and detailed knowledge of the situation on the ground.

59 SOCIAL CARE. Financing social care faces major problems of uncertainty about (a) the probability that someone will need long-term care in the future and (b) what such care would cost. In both cases there is uncertainty not only about the level of the relevant probabilities but also about whether they will be higher or lower than today – thus even the direction of change is uncertain. For example, a medical advance that keeps people alive for longer in a dependent state increases costs, cheap and effective robots would lower them.

60 Uncertainty points to reliance mainly on publicly-organised insurance. Two approaches have been suggested. The Dilnot Report (UK Commission on Funding of Care Support 2011) proposed a mixture of tax finance and self-insurance. Barr (2010) sets out a proposal to fold the finance of social care into national insurance. Section 4.5 argues that it is necessary to integrate the funding of health and social care. Either of the two proposals can fit into an integrated framework. My preference for the national-insurance approach is not on analytical grounds but because, as with the NHS, a dedicated contribution may offer better protection against short-term fiscal stringency. For fuller discussion of the funding of adult social care, see House of Commons Health and Social Care and Housing, Communities and Local Government Committees (2018).

61 Reform is needed also on delivery, addressing quality assurance and the effectiveness, or otherwise, of outsourcing some aspects – again, issues that require expert input.

4.4 Widening and deepening human capital

62 THE NEED FOR MORE AND BETTER HUMAN CAPITAL. Skill-biased technical change implies a need for:

- More education and training;
- More diverse education and training, i.e. technical apprenticeships as well as degrees in theoretical physics;
- Repeated education and training, since knowledge goes out of date more quickly.

63 Improved human capital has two roles. It is part of investment in skills. It also offers insurance against technological obsolescence. The latter aspect has an uncertainty dimension (what technological change? how fast?) and is thus also part of the resilience agenda.

64 EARLY CHILD DEVELOPMENT. There is now overwhelming evidence on the centrality of early child development (Barr 2020, pp. 276-7).

65 THOUGHTFUL ADJUSTMENT OF THE SCHOOL CURRICULUM. Clearly this requires expert input, so what follows are only examples. The current crisis has added emphasis to a problem that was known before, namely the need to improve the ability of people in all walks of life to assess the quality of information. The time when information was (mostly) mediated by (mostly) responsible entities such as the BBC and newspapers has been supplanted by a 24-hour news cycle and the internet. Some training in school to help students distinguish between credible sources and fake news is important; so, too, is developing some understanding (another manifestation of uncertainty) that genuine experts may disagree, hence the need for such institutions as the Scientific Advisory Group for Emergencies on which the government is currently (rightly) relying heavily.

66 REFORMING THE FINANCE AND DELIVERY OF TERTIARY EDUCATION. The strategy set out in Barr (2018) (my evidence to the Augar Review) has four building blocks.

67 *A holistic view of tertiary education* that considers finance, delivery and distribution across tertiary education as a whole, not higher education in isolation.

68 *Granular finance*. A common funding framework for all tertiary education should include, *inter alia*,

- A lifetime entitlement (grant plus loan entitlement) to cover any mix of higher education, non-degree tertiary education, apprenticeships and degree apprenticeships;
- A well-designed income-contingent loan to cover costs higher than the grant element.

69 *Granular delivery* involves flexible pathways concerning:

- The mix of higher, further and technical education in an individual's accumulation of skills, i.e. getting away from the executive lift that goes straight from level 3 (A levels) to level 6 (degree) without stopping at intermediate levels 4 and 5;
- The time path of accumulation of academic credit;
- Modes of delivery.

70 *Access.* Greater emphasis in pro-access policies earlier in the system, such as nursery education, and interventions such as the literacy hours and numeracy hour.

71 In Minouche Shafik's felicitous term, what results is a system of 'stackable credentials'.

- Someone who uses his/her grant and loan entitlement initially to acquire a plumbing qualification could then or later convert the qualification into a degree by adding units, e.g. in business studies or accounting (or some other subject);
- A person could start to accumulate credit in further education and finish in higher education;
- Faster degrees (e.g. 2 year) or slower degrees (part-time);
- The option to start part time and then move to full time (or vice versa).

4.5 Better use of resources

72 Complementing more resources, discussed in section 3.2, are reforms to make better use of resources.

73 POSSIBLE AREAS OF SAVING. Examples include:

- Continued action on state pension age, tying state pension age in some sensible way to life expectancy. There are sound principles on which to base such policy (Barr and Diamond 2010, Box 5.4).
- Improving procurement in the NHS.
- Action to reduce the loss on student loans (Barr 2018, paras 37-40).

74 A HOLISTIC APPROACH TO FINANCING EDUCATION. Resource use can be improved by rebalancing the finance of education holistically. Examples discussed above include some rebalancing between higher and further education (Barr 2018, paras. 42-44) and towards nursery and primary education.

75 THE BIG TICKET ITEM: INTEGRATING THE FINANCE OF HEALTH AND SOCIAL CARE. Given the scale of spending on these activities this is the area with the greatest scope for improving resource use.

76 *Diagnosis.* The present arrangement has three separate funding streams:

- Hospitals, where funding broadly follows patient numbers; more specifically payment is for admitted patient episodes, i.e. a tariff for each admitted patient given the diagnosis.
- Social care, where finance is mainly the responsibility of local authorities; funding cuts mean that resources are concentrated on very high need cases rather than on early prevention which would reduce long-term pressure on the costs both of social care and hospital care.
- GPs are funded largely on the basis of capitation payments weighted by age and deprivation.

77 Separate funding streams, especially when resources are scarce, create the well-known incentive to try to move costs onto someone else's budget. Thus shortages in social care cause bed blocking in the NHS – not the local authority's problem. And inability to get a GP appointment quickly has increased numbers going to Accident and Emergency.

78 There are some experiments that try to improve collaboration. Though desirable, these initiatives are all hampered by the fundamental structural problem of separate funding streams (see House of Lords (2013, Annex 12, in particular 'The fundamental problem: the split between healthcare and social care', paras. 200-207).

79 *Prescription.* A full solution requires that funding streams are integrated. That does not mean that they should necessarily be unified. The essay question for experts is: What structure for the finance of health and social care does the best job in terms of efficiency and equity, while recognising budget constraints?

80 An integrated funding system would make joined-up care considerably more plausible, for example the return of convalescent homes, simultaneously improving outcomes and reducing cost. Without integration, piecemeal reform will not address the underlying structural problems.

5 Better governance: The key to all of the above

5.1 Capacity to take a long-term view

81 Better governance is a prerequisite for the effective design and implementation of the policy directions just discussed. The issue, of course, is much wider than the welfare state. Bluntly, if my fairy godperson allowed me only one wish about the way economic and social policy is done, this would be it.

82 THE PROBLEM.

'Every junior minister wants eye-catching initiatives that will generate positive media coverage – how else will No. 10 know what they're doing? (Rachel Wolf, 2017, p. 23; see also Philip Collins in the same publication)

Nifty wheezes by ministers are a bad way to run policy areas such as health and pensions that require a long-term view.

83 EXAMPLES OF GETTING IT RIGHT.

- In the 1990s the Swedish authorities established a Pensions Group comprising all the then major parties in parliament to design a pension reform that would have cross-party support. Once the reform legislation was passed, the Pensions Group was kept in place as guardians of the reform. Thus the pension system has remained stable, with reform over the years, limited, thoughtfully designed and with a long-term perspective (for details, see Barr 2013).
- In Canada, the law that establishes the rules by which the Canada Pension Plan adjusts to maintain long-run sustainability has legal protection similar to that of the Canadian constitution.
- A UK example is the Bank of England Monetary Policy Committee, which has operational independence in pursuing a policy whose strategic objective was set by Parliament, i.e. with democratic legitimacy.

84 I have a wistful dream of an NHS Board and a Pensions Board established on similar lines to the MPC.

5.2 Showing more respect for implementation

85 Implementation is as important as policy design. A besetting problem of all UK governments (plural) is a tendency to give excessive weight to policy announcements without due regard for and understanding of what is necessary to implement the policy successfully.

86 One of the roots of the problem is the profoundly mistaken tendency to design policy first and then hand it on to others to implement. It is necessary for policy design and implementation to take place together with both sets of experts in the same room.

87 Political speeches often promise to fix problems quickly. As a tiny example of the sort of detail that can be provided only by someone on the ground, and which speechwriters ignore, is that the current shortage of bread flour is not because there is too little flour, but because only about 4% of bread flour is sold in small bags through shops, the great bulk being in 16kg bags to bakeries and other food manufactures. The shortage in the shops is the limited capacity of flour mills to pack in small bags and the fact that 'existing packing lines can't easily be adapted to produce smaller retail bags' (BBC news, [9 April 2020](#)). Benefit officers, benefit recipients, organisations like Citizen's Advice and others could multiply such examples many times when explaining the inability quickly to increase processing of applications for Universal Credit. Medical practitioners, chemical engineers, pharmaceutical experts and others could offer multiple examples to explain the slow rollout of testing against Covid-19.

Appendix 1: The simple operation of actuarial insurance (Barr, 2020, Box 4.1)

Suppose that 100 people are flying to a football match in Barcelona, that each person has a suitcase whose contents are worth £1,000, and that on average 1 per cent of suitcases get lost in transit. The expected loss of the insurer is the value of the suitcase and its contents, L , multiplied by the probability, p , that the loss will occur. In those circumstances, the insurer could collect $1\% \times £1,000 = £10$ from each of the 100 people. When the group arrives in Barcelona the insurer would pay £1,000 to the person whose suitcase was lost.

Since the mechanism is based on an average, it works best with large numbers of people.

More formally, the actuarial premium for the i th individual, π_i , is defined as

$$\pi_i = (1 + \alpha)p_iL$$

where p_iL is the individual's expected loss, and α is the loading that the insurer adds to cover administrative costs and competitive profit. π is the price at which insurance will be supplied in a competitive market.

Appendix 2: Cost drivers facing health care systems (Barr, 2020, Box 9.4)

Health-care systems face a series of cost pressures.

The 'Baumol cost disease' (often referred to in this context as excess medical inflation) measures the extent to which the prices of services rise faster than prices generally (see 'An incurable disease', *Economist*, [29 September 2012](#)). That outcome has two roots. First, labour productivity in manufacturing generally rises over time as capital equipment improves; thus wages in manufacturing rise, driving up wages throughout the economy. However, productivity in services rises more slowly (Baumol uses the example of a Beethoven string quartet, which requires as many musicians today as in the 19th century), so rising wages are not offset by rising productivity. Reinforcing that effect, health care and education have a higher than average direct labour content.

Technical advance increases the possibilities for medical intervention and, connected, raises expectations.

Demographic factors. The increasing number of older people intensifies demand, since health spending per person by age is generally U-shaped, being high around birth and in old age. In addition, medical advances mean that more elderly people have multiple medical problems.

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