

# How can the NHS maximise its role as an anchor institution to boost local economies and reduce socioeconomic and health inequalities?



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# Collaborating ARCs and Co-Investigators

- **Collaborating ARCs:**

- 7/15 ARCs: **Greater Manchester (GM), North East and North Cumbria (NENC), East of England (EoE), Yorkshire and the Humber (Y&H), North West Coast (NWC), Kent, Surry and Sussex (KSS), North Thames (NT)**

- **Academic co-investigators:**

- Professor **Matt Sutton** (Professor of Health Economics), **Paul Wilson** (Senior Lecturer in Implementation Science) – both University of Manchester, ARC-GM; Professor **Clare Bamba** (Professor of Public Health), Dr **Jo Wildman** (Research Fellow NIHR ARC NENC Health Inequalities and Marginalised Communities), Professor **John Wildman** (Professor of Health Economics), Dr **Heather Brown** (Senior Lecturer in Health Economics) – all Newcastle University, ARC-NENC; Professor **Kate Pickett** (Professor of Epidemiology) – University of York, ARC-YH; Professor **Ben Barr** (Professor of Applied Public Health Research) – University of Liverpool, ARC-NWC; Dr **John Ford** (Clinical Lecturer in Public Health) – University of Cambridge, ARC-EoE; Professor **Lindsay Forbes** (Professor of Public Health) – University of Kent, ARC-KSS; Professor **Paula Lorgelly** (Professor of Health Economics) – UCL, ARC-NT

- **Policy and practice partner co-investigators:**

- **NHS Confederation – Michael Wood** (Director of Health Economic Partnerships); **Northern Health Science Alliance – Hannah Davies** (Head of External and Public Affairs); **Newcastle Upon Tyne Hospitals NHS Foundation Trust – Dr Balsam Ahmad** (Consultant in Public Health); **Centre for Local Economic Strategies – Tom Lloyd Goodwin** (Associate Director of Policy)

# What is an “anchor institution”?



- NHS = a healthcare provider
- But the NHS is also a
  - Major employer
  - Major owner of land and buildings
  - Major purchaser of equipment, food, services, other resources
    - **Creates job opportunities and supports local economies**
- So, **like an anchor steadies a ship**, the NHS could steady local economies and bring benefits for local communities
- But is the extent to which an NHS institute acting as an anchor equal between differing local economies and local communities?

# Potentials of NHS as anchors

- ~1.5 million people work for the NHS in England, making it the 5th biggest employer in the world
- £114bn spent on the National Health Service in 2018/19
- This money is used to employ staff, purchase equipment, rent land and maintain buildings
- Within local areas the economic activity of the NHS and associated employers can be substantial
- Under current rules, providers in weak economic areas receive less funding

# Our aims and objectives

- **Overarching Research Question:** How can NHS organisations boost local economies and reduce socioeconomic and health inequalities?
- **Specific Objectives:**
  1. **Analyse relationships** between **provider expenditure on staff and other related anchor activities** and the **social, economic and health outcomes of the areas where they are located**. Explore **variations in the strengths of these relationships**
  2. **Identify local NHS areas with different trends in economic performance and different current practices** (interventions) for 3-4 in-depth **case studies** to explore the **underlying mechanisms** (using a realist framework) by **which providers can support local economies and identify barriers/facilitators**
  3. **Create a predictive model** of how providers can intervene to positively affect their local economy, presented as an interactive dashboard (a **'model anchor-hospital'**).

# Resource allocation in England

- The Resource Allocation Working Party 1976 gave a structure for the English funding formula
- Target shares for each organisation are based on population shares
  - adjusted for expected utilisation rates (based on demographic composition and additional need factors) to generate an expected volume of services
  - and for area variations in the costs of securing the inputs required

- At its simplest:

***Target share = Population share \* (Age Index) \* (Additional Needs Index) \* (Additional Cost Index)***

- each of the index adjustments taking a mean value of one

Market Forces Factors

# Market Forces Factors in brief

## WHO

CCGs, hospitals, GP practices

## WHAT

Transfers of substantial sums of money between CCGs and providers

## WHEN

Continuously, since 1977

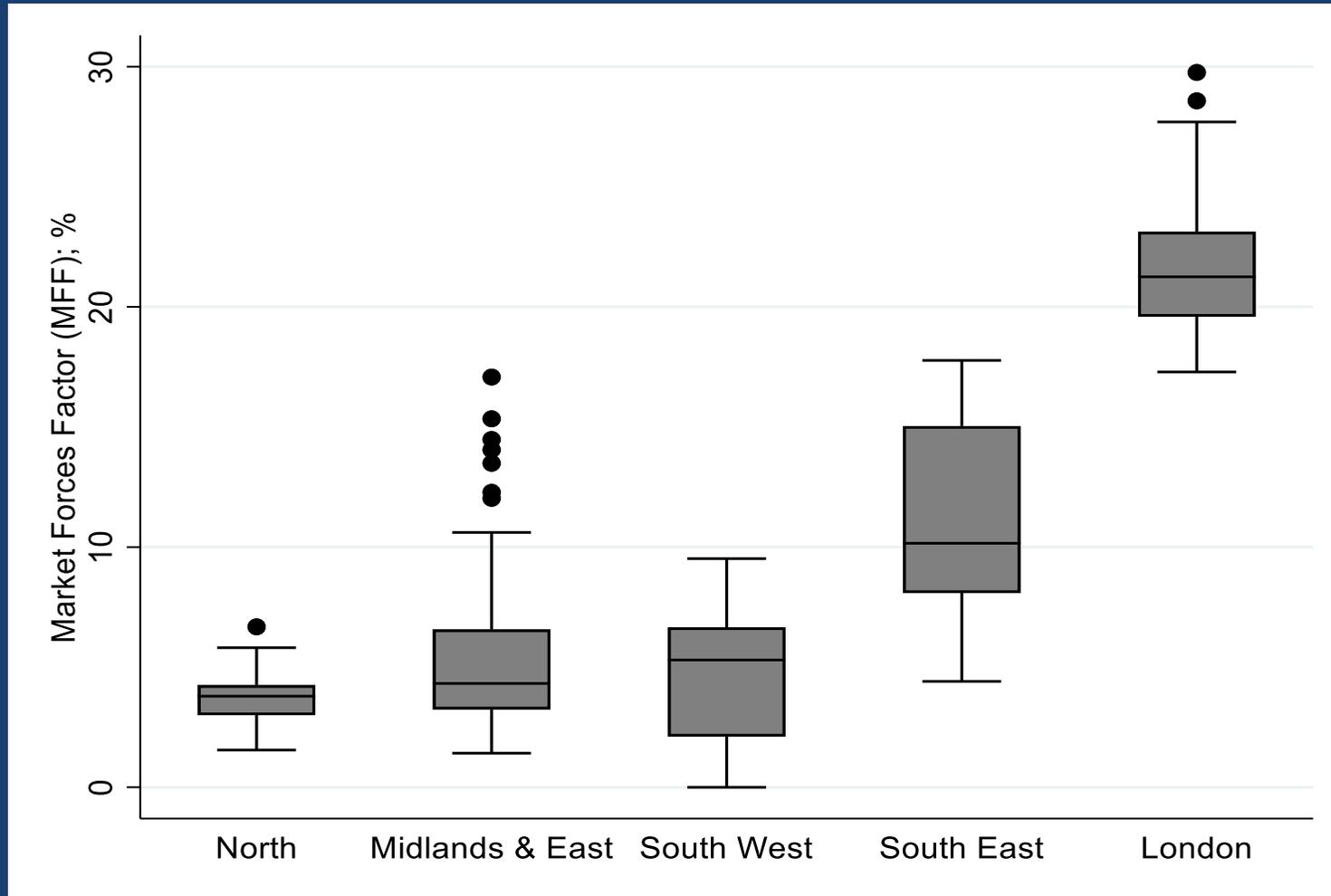
## WHERE

From low-price to high-price areas

## WHY

It costs more to provide care there

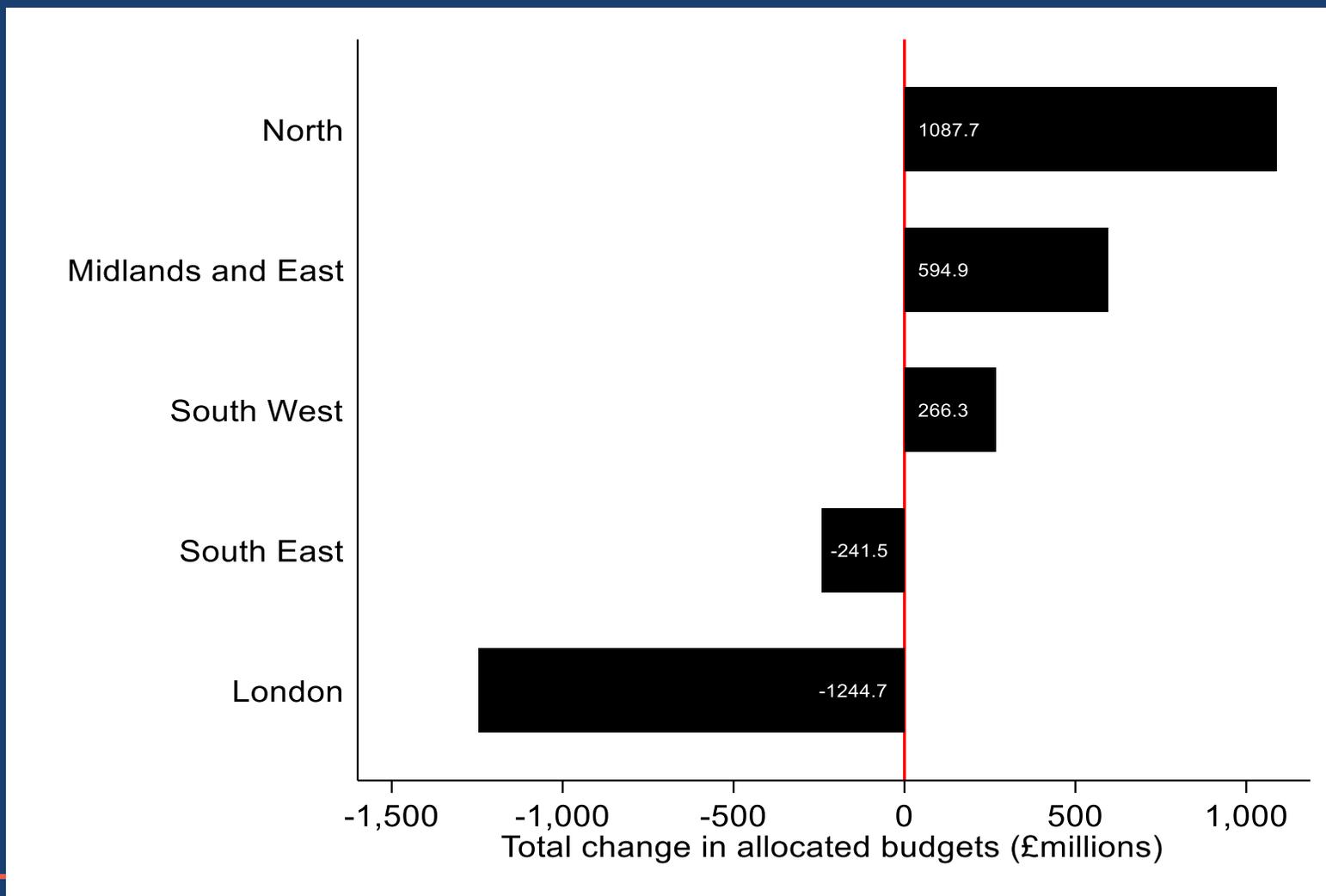
# Market Forces Factors by NHS region



# Effects of MFF on prices paid to hospitals

- For every £100 that Manchester University NHS Foundation Trust received in 2018/19:
  - University College London Hospitals NHS Foundation Trust received £123
  - Cornwall Partnership NHS Foundation Trust received £95
- University College London Hospitals received £890m for Patient Care in 2018/19
  - without the MFF, they would have £148m (17%) less
  - This is more than the combined amount that 40 Trusts received in total for patient care

# Changes in CCG allocation if MFF was removed completely



# Tensions between current policies

- The NHS makes an important contribution to local economies by employing local people, attracting more skilled workers into areas, and by increasing spending in the local service sector
- This mission is promoted by policymakers, but another national policy which pays hospitals less in areas where the economy is weak acts in direct contradiction of this mission
- The total effect of this discriminatory pricing policy was to reduce NHS spending in the North by £1.1bn in 2018/19
- The tension between these two national policies needs resolving and the NHS contribution to ailing economies should be prioritised to contribute to the levelling-up agenda

# Thank you!

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