

Institute for Public Policy Research



LIFTING THE CAP

THE FISCAL AND ECONOMIC
IMPACT OF LIFTING
THE NHS PAY CAP

**Joe Dromey and
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60-SECOND SUMMARY

Workers in the NHS have experienced a seven-year pay squeeze, with a two-year pay freeze from 2011/12, followed by pay capped at 1 per cent for the following five years. This has significantly eroded the value of pay in the NHS; pay for a band 5 nurse is £3,214 or 10.1 per cent lower today than pay for the same role in 2010/11.

The decline in real terms pay has contributed to a growing workforce crisis in the NHS. Net satisfaction with pay has fallen by 10 per cent since 2010 and the NHS is facing increasing challenges in recruiting and retaining staff. The number of nurses in the NHS is falling for the first time in four years and the number of vacancies for nurses has doubled in the last three years.

In response to growing recruitment and retention challenges, the NHS has increasingly come to rely on agency workers. The agency bill as a proportion of total pay in the NHS in England nearly doubled between 2011/12 and 2015/16, reaching £3.6 billion in that year, with a bill of around £250 million in the other nations of the UK. The cost of agency staff is far higher than the equivalent cost of directly employed staff, leaving the NHS facing an ‘agency premium’ of hundreds of millions of pounds as a result of not being able to secure sufficient permanent staff.

This growing workforce crisis may be exacerbated by Brexit, which may reduce the access to the EU migrants on which the NHS has increasingly relied. The scrapping of NHS bursaries, which led to a 23 per cent decline in applications for nursing degrees in England, is also likely to exacerbate work force pressures.

The Westminster government had planned to continue the pay cap until 2019/20, which would have led to further real terms pay cuts for NHS staff, and a deepening workforce crisis. However, in the face of growing opposition, they have recently followed the Scottish government in announcing that the NHS pay cap will be scrapped.

In this briefing, we examine the fiscal and economic impact of two alternative scenarios for NHS pay over the next two years; increasing pay in line with Consumer Price Index (CPI) inflation, and a ‘catch-up’ rate of increasing NHS pay in line with private sector earnings plus 1 per cent.

If pay in the NHS were to be uprated in line with CPI between now and 2019/20, rather than in line with the governments cap, then the additional annual cost of the pay bill for the whole of the UK would be £1.8 billion in 2019/20. However, when taking into account the fiscal impact of money immediately returned to the Treasury through higher tax receipts and lower welfare payments, the net cost falls to £1.1 billion. While the headline cost of our catch-up scenario would be £3.9 billion a year by 2019/20, the net cost would be far lower at £2.3 billion.

We find that lifting the pay cap and increasing pay in the NHS would also have a positive economic impact. Increasing pay in line with CPI would generate additional GDP of £250 million by 2019/20, with associated additional tax income of £100 million. Increasing pay in line with the catch-up scenario would generate an additional £550 million in GDP, with £150 additional tax income. Increasing NHS pay could help narrow regional inequalities as the impact would be higher in regions outside of London and the South East where pay

is lower; the impact in cash terms is nearly twice as high in Yorkshire and the Humber as in the South East.

Taking these fiscal and economic impacts into account, the **final cost to government of increasing NHS pay in line with CPI would be £950 million by 2019/20. The final cost of our 'catch-up' rate of increasing NHS pay in line with private sector earnings plus 1 per cent would cost £2.1 billion.**

If the government continued with the pay cap until 2019/20, NHS pay workers would have seen significant further real terms pay cuts. A nurse would have faced an additional cut of £845 by 2019/20, bringing the cumulative real terms cut to over £4,000 or 12.7 per cent. Under our catch-up scenario though, 41.1 per cent of the real terms pay cuts experienced by an estates officer or health care assistant since 2010/11 would be reversed by 2019/20, with 31.2 per cent of the cut to pay for a nurse reversed.

While the net cost of increasing NHS pay is far lower than the headline cost, any increase in pay must be funded. While the government has lifted the pay cap for police officers and prison officers, no new funding has been provided, with the additional cost having to be found from existing budgets. Such an approach would be unsustainable in the NHS, where trusts in England are on course for an underlying deficit of £5.9 billion this year – 12 times the deficit target. Trusts and boards in the rest of the UK are also reaching crisis point. Requiring NHS trusts and boards to fund an increase of above 1 per cent from existing budgets would escalate the financial crisis in the NHS and it would come at the expense of patient care.

We recommend the following.

- The UK government should lift the NHS pay cap. It should revise its guidance to the NHS Pay Review Body and ensure its independence and integrity going forward, by making clear that it will accept their recommendations for pay. This should include accepting significant real terms increases in pay for NHS workers in order to reverse some of the real-terms decline seen since 2010/11, as well as differential uprating to boost pay most for areas of the NHS facing particular challenges with recruitment and retention, and for those on lower pay scales.
- Government should provide additional funding at the Autumn Budget to cover this additional expenditure, rather than requiring NHS trusts and boards to meet the cost from already over-stretched budgets.
- In the light of the potential impact of Brexit, government should develop a national NHS Workforce Strategy, in conjunction with NHS Employers and the NHS trade unions to ensure sustainable workforce pipeline for the future.

1. OVERVIEW

1.1 THE PAY CAP IN THE NHS

Workers in the NHS – as with the rest of the public sector – have experienced a seven-year pay squeeze.

While recommendations on annual pay uplifts in the NHS are made by the NHS Pay Review Body (PRB), the UK government has issued guidance over the past seven years, effectively limiting the pay increase it could recommend.

The UK government introduced a two-year pay freeze in 2011/12, affecting all public sector workers earning £21,000 or more. Announcing the freeze, the Chancellor explained that public sector workers “did not cause this recession – but they must share the burden as we pay to clean it up” (Osborne 2010). Following the pay freeze, pay has been effectively capped for the past five years, with the government making it clear in its guidance to the PRB that it will only fund public sector workforces for a pay award up to this level. The government had intended to continue the NHS pay cap up to and including 2019/20 (HMT 2015). This would have represented an unprecedented nine-year public sector pay squeeze.

The UK government has come under increasing pressure to abandon the pay cap, particularly following the 2017 general election. In October, following pay offers of above 1 per cent to police officers and prison officers, the Secretary of State confirmed the government has abandoned the cap in the NHS. However, he has yet to set out what level of pay increase would be acceptable, and whether the cost of the increase over and above the planned 1 per cent would be funded (Hunt 2017). Public sector pay policy has been applied differently across the four UK countries, and the Scottish Government indicated in September that the public sector cap will be scrapped.

In this briefing, we examine the growing evidence of the workforce impact of the NHS pay cap and the fiscal and economic impact of lifting the cap. We make the case for lifting the NHS pay cap and giving NHS workers a real terms pay rise, in order to reverse some of the significant real terms cuts that staff have experienced, and to ease the growing workforce crisis. We show that the net cost of lifting the cap is far less than the headline cost, and that it could have a positive impact on the economy.

1.2 REAL TERMS PAY CUTS IN THE NHS

The long period of pay restraint has led to a significant real-term fall in the value of wages for NHS staff. Table 1.1 sets out the impact of the seven-year pay squeeze on real terms pay in the NHS using England pay points as an illustration.¹ It shows that pay for a band 5 nurse is £3,214 or 10.1 per cent lower in real terms in 2017/18 than for the same role in 2010/11. The equivalent real terms decline is £1,688 for an estates officer or health care assistant (HCA) and £4,107 for a band 6 midwife or health visitor.

¹ Although all non-medical staff are employed on Agenda for Change – there are effectively different pay scales across UK countries.

If the pay cap had continued as planned until 2019/20, a band 5 nurse would have been £4,059 – or 12.7 per cent – worse off than in 2010/11, with a band 3 estates officer or HCA being £2,271 worse off in real terms and a band 6 midwife or health visitor being £5,153 worse off.

TABLE 1.1

Pay points for illustrative NHS workers, 2010/11, 2017/18 and 2019/20 (£, 2017/18 prices)

	2010/11	2017/18	2019/20 (assuming continuation of cap)
HCA or Estates officer (band 3)	21,540	-1,688	-2,271
Nurse (band 5)	31,960	-3,214	-4,059
Midwife or health visitor (band 6)	39,684	-4,107	-5,153

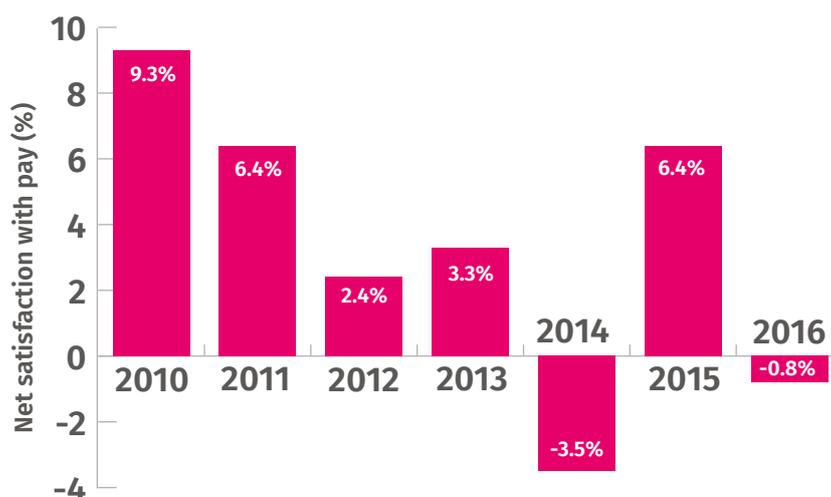
Source: IPPR analysis of NHS Employers 2017, NHS Employers 2010 and OBR 2017

1.3 SATISFACTION WITH PAY IN THE NHS

The deterioration in real terms pay since 2010/11 has coincided with a marked decline in job satisfaction in the NHS. Using the England NHS Staff Survey as an indication, in 2010, net satisfaction with pay was 9.3 per cent. By 2016, net satisfaction had fallen to -0.8 per cent – a fall of 10.1 percentage points. Satisfaction with pay is lowest among occupations in lower pay bands, including ambulance staff (-6.9 per cent) and nursing or healthcare assistants (-21.9 per cent) (IPPR analysis of NHS Staff Survey for England).

FIGURE 1.1: NET SATISFACTION WITH PAY HAS FALLEN BY 10 PERCENTAGE POINTS SINCE 2010

Net satisfaction with pay 2010–2016, all NHS Trusts in England



Source: IPPR analysis of NHS Staff Survey for England

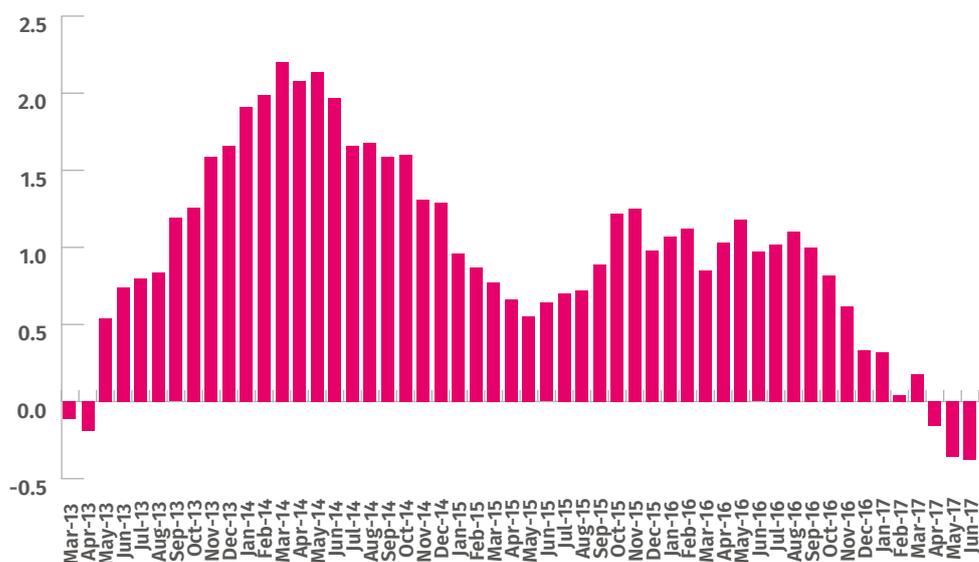
1.4 RECRUITMENT, RETENTION AND VACANCIES IN THE NHS

The Five Year Forward View, published in October 2014, argued that: “as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff” (NHS England 2014). However, since that point, pay in the NHS has continued to fall in real terms, while pay in the private sector has increased (see section 2.1). The decline in pay in the NHS – in real terms and relative to the private sector – has contributed to growing challenges in recruitment and retention, and to growing staff shortages in the NHS.

Last year, the number of nurses leaving the Nursing and Midwifery Council (NMC) register in the UK exceeded the number joining, with 20 per cent more leavers than joiners (NMC 2017). The number of nurses has started to fall in the NHS too. As figure 1.2 shows, the number of nurses compared to the same period 12 months earlier has declined in each of the last three months – the first time we have seen a year-on-year decline in the number of nurses in the NHS in four years.

FIGURE 1.2: THE NUMBER OF NURSES IN THE NHS IS DECLINING FOR THE FIRST TIME IN FOUR YEARS

Change in number of nurses and health visitors in the NHS compared with 12 months previously (per cent)



Source: IPPR analysis of NHS Digital based on Murray 2017

Workforce growth has slowed in Scotland, with the number of whole-time equivalent (WTE) staff increasing by just 0.6 per cent and the number of WTE nurses increasing by 0.3 per cent (NHS Scotland 2017). While the number of staff in the NHS increased by 3.2 per cent between 2015 and 2016, it has increased by only 5.2 per cent since 2010 (Welsh Government 2017). Workforce growth in Northern Ireland has also been slow by historic trends (Department for Health NI 2017).

While data is not collected centrally for NHS vacancies in England, figures compiled by RCN show a growing challenge with unfilled vacancies. In

December 2016, there were an estimated 40,000 nursing vacancies in England – a vacancy rate of 11.1 per cent – and 12,000 vacancies for healthcare support workers. This was nearly double the vacancy rate in 2013 (RCN 2017). Again, while data is not reported for Wales there are signs of significant staff shortages and high levels of agency staffing (RCN 2017). In Scotland, 8.5 per cent of consultant posts and 5.2 per cent of nursing and midwifery posts were vacant in June 2017. The rate of vacancies and long-term vacancies has increased in the last year for consultants and nurses (NHS Scotland 2017b).

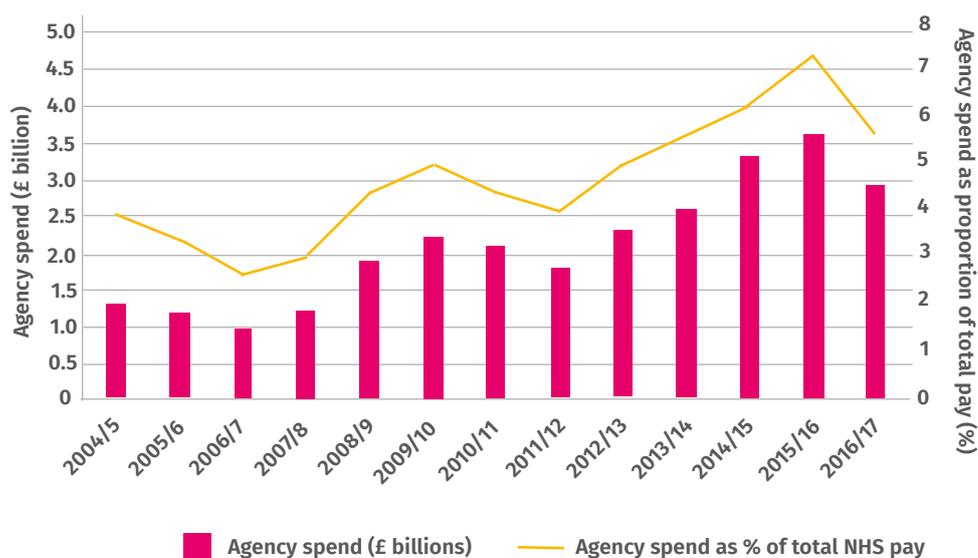
Rising staff shortages appear to be causing growing concern in the NHS. A recent survey of Directors and Deputy Directors of Nursing found that 87 per cent were concerned about overall vacancy rates in their organisation (RCN 2017). The NHS Staff Survey has shown an increase in concern over staffing levels. Between 2010 and 2016, net agreement among NHS staff that there were enough staff at their trust for them to do their job properly fell by 6 per cent (IPPR analysis of NHS Staff Survey for England).

1.5 AGENCY SPEND

NHS trusts and boards have faced both rapidly rising demand from a growing and ageing population, and a growing challenge in recruiting and retaining staff. In this context, NHS organisations have increasingly relied on agencies to maintain safe levels of staffing. As figure 1.3 below shows, the bill for agency staff in England rose from just over 4 per cent (£1.8 billion) of total pay in 2011/12 to 7.5 per cent (£3.6 billion) of total pay in 2015/16. This has contributed to rapidly growing deficits in NHS trusts; the National Audit Office has found a statistically significant link between high agency spend as a proportion of total pay, and trust deficits as a share of trust income (NAO 2016).

FIGURE 1.3: AGENCY SPENDING AS A PROPORTION OF TOTAL PAY NEARLY DOUBLED BETWEEN 2011/12 AND 2015/16

Agency spend in NHS trusts (£ millions) and share of agency in the total staffing spend



Source: Grasic 2016 and IPPR analysis of NHS Improvement 2017

There has been a similar increase in the other UK countries. In Scotland, the bill for agency staff stood at £23.5 million in 2015/16, rising to £24.5 million in 2016/17, the fifth consecutive year that the bill for agency staff has increased (NHS National Services Scotland 2017). In 2015/16, the bill for agency and locum staff in Wales was £135 million, an increase of 54 per cent on the previous year. In Northern Ireland, the agency bill reached £92 million in 2015/16 – more than double the rate of 2010/11 (PRB 2017).

In response to rising costs, the NHS in England introduced measures to reduce agency spend in October 2015, including a cap on total agency spend by trust and a cap on the hourly rate trusts can pay for different staff groups. This appears to have had some impact in reducing agency spend. Between April and September 2016 – the six months before the introduction of the cap – the NHS spent £1.8 billion on agency staff. Between April and September 2017, agency spend fell to £1.5 billion (IPPR analysis of NHS Improvement 2017).² Other initiatives have been put in place across other UK countries, such as moves to stop the use of off-contract agencies in Wales. The Managed Agency Staffing Network was set up in 2015 to review temporary staffing across Scotland. It aims to reduce spending, improve the quality and governance of temporary staffing, and roll out good practice.

Agency spend is one of the largest inefficiencies in the NHS. NHS Improvement estimated that, of the £3.3 billion spent on agency staff in 2014/15, around £0.7 billion of this spend represented a ‘premium paid for agency staff’ over the equivalent cost of directly employed staff, including on-costs (NHS Improvement 2016). Even after the introduction of the cap, this ‘agency premium’ will still run into hundreds of millions of pounds.

There is a widespread consensus that ongoing pay squeeze has contributed to the growing agency bill. The NHS Pay Review Body has highlighted these concerns, and called for ‘an improved understanding of how pay and the employment offer affect supply and overall costs’ (PRB 2017). Dr Dan Poulter, the former health minister has even argued that lifting the NHS pay cap is ‘broadly fiscally neutral as [it] will improve staff recruitment and retention, and reduce use of expensive agencies [and] locums’ (Poulter 2017).

1.6 FUTURE WORKFORCE CHALLENGES

In addition to the potential impact of continuing the NHS pay cap, there are other potential factors which may aggravate the growing workforce challenge facing the NHS.

The impact of Brexit

As the NHS has struggled to recruit and retain the staff that it needs to meet growing demand, it has become increasingly reliant both on agency staff, and on migrant workers, particularly EU-nationals.

In 2009/10, just one in 10 new nurses registered by the Nursing and Midwifery Council (NMC) in the UK were trained abroad. By 2015/16 this had trebled to nearly four in 10 (Health Foundation 2017). The number of nurses who initially registered in the rest of the EU doubled between 2013 and 2016; had it not been for this increase, the number of registered nurses in the UK would have fallen by 5,800 between 2013 and 2017 (IPPR analysis of NMC 2017)

Brexit may significantly exacerbate the growing workforce crisis. There has already been a sharp decline in the number of new registrations from the rest

² We do not account for inflation here, and report the cash sum spent over the same period in each year.

of the EU; the number of nurses from the EU registering in the UK fell by 96 per cent between July 2016 and April 2017 (Health Foundation 2017). Changes in migration policy post-Brexit might restrict the ability of the NHS to recruit EU nationals, with significant consequences for the NHS workforce.

Given Brexit may significantly reduce access to EU workers the need to address recruitment and retention issues domestically is even more pressing.

The impact of training reforms

From August 2017, new nursing, midwifery and allied health students in England will no longer be entitled to receive bursaries and instead will have to rely on student loans. This will require students who want to enter these professions to take on substantial debt, and it will have a significant impact on their living standards.³

Under the current system, a band 6 midwife would face an annual student loan repayment of £1,312, equivalent to 4.8 per cent of take-home pay. Even if the government lifted the repayment threshold to £25,000 as planned, the same midwife would still be paying back £952 annually, equivalent to 3.5 per cent of take-home pay.⁴

These changes appear to have depressed learner demand. In 2017, the first year after the scrapping of bursaries and the introduction of loans, the number of applicants for nursing degrees in 2017 in England declined by 23 per cent (UCAS 2017). Again, these changes could further aggravate the growing workforce crisis in the NHS, by reducing the supply of NHS staff trained in the UK.

3 Nursing bursaries have been protected in Scotland, Northern Ireland and Wales, though students in Wales must commit to working for the NHS in Wales for at least two years after graduating.

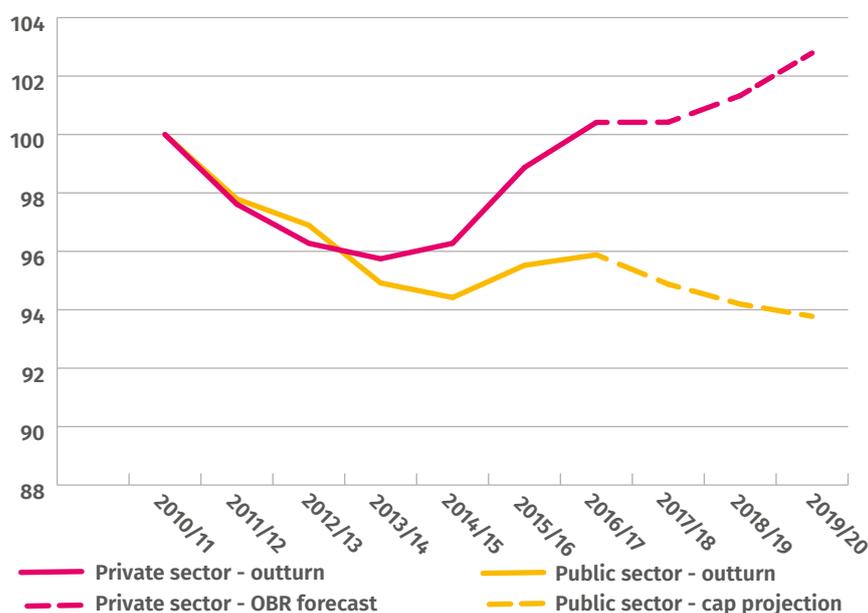
4 Author's calculations based on RCN 2017 and SLC 2017

2. LIFTING THE CAP?

There is a strong case for lifting the NHS pay cap. The long squeeze on pay in the NHS has led to significant real terms cuts to NHS pay, and to a substantial decline in satisfaction with pay. As pay has fallen behind both inflation and private sector earnings, so the NHS has seen growing challenges with recruitment and retention, which have contributed to a soaring bill for agency pay. Had the government continued the pay cap until 2019/20 as planned, this would have led to a greater real terms decline in pay, and an escalating workforce crisis.

However, following the announcement that the government has scrapped the NHS pay cap, in the following section we examine the fiscal and economic impact of lifting the cap, including for different pay scenarios over the next two years.

FIGURE 2.1: TREND GROWTH IN REAL AVERAGE WEEKLY EARNINGS FOR THE PRIVATE AND PUBLIC SECTORS RESPECTIVELY, OUTTURN AND FORECASTS



Source: Authors' calculation based on ONS 2017a, OBR 2017a and OBR 2017b

Note: Rates of change in average weekly pay will not be exactly the same as the rate of change of pay scales due to compositional factors

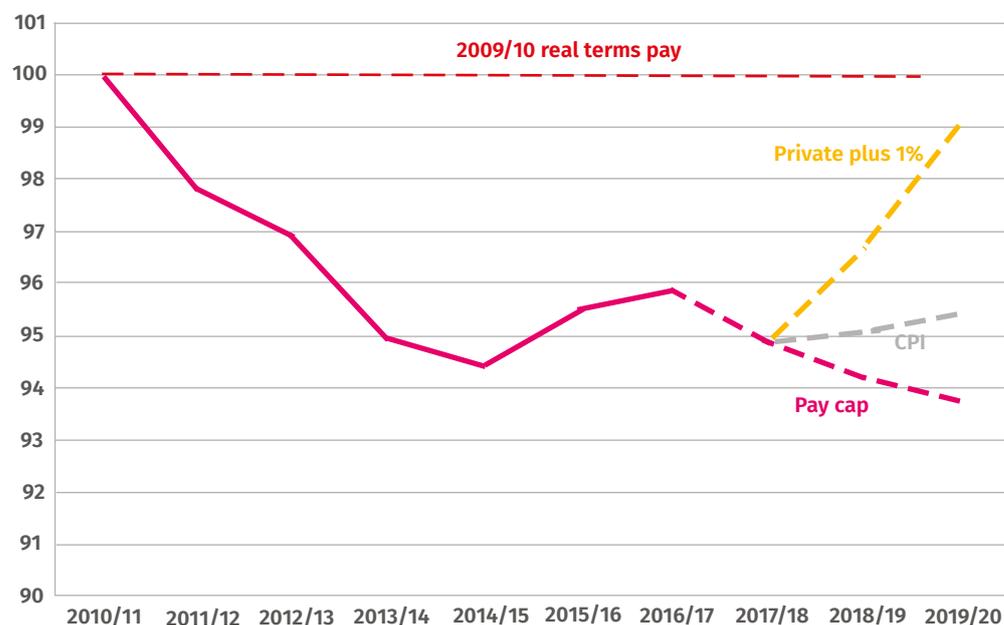
2.1 TRENDS IN PUBLIC SECTOR PAY

Since the introduction of the public sector pay freeze in 2011/12, which was then followed by the public sector pay cap, the rate of growth in real public sector pay

has fallen significantly behind private earnings (see figure 2.1).⁵ Real earnings in both the private sector and the public sector fell significantly between 2010/11 and 2013/14, partly as a result of high inflation driven by a weak pound. Private earnings fell fastest, largely due to compositional effects such as low skill workers starting to come back into the jobs market on below average salaries. Since 2013/14, however, private sector earnings have grown consistently and this trend is forecast to continue for the next few years, with pay rising in real terms (IPPR analysis of OBR 2017). However, in the public sector, the pay cap has stifled average pay growth since 2013/14. While a 1 per cent increase in pay scales was enough to deliver a small real terms increase during years of low inflation, any gains since 2014/15 could be lost as early as 2018/19 if pay scales continue to rise by just 1 per cent and inflation stays above the Bank of England’s 2 per cent target as is currently expected.

Below, IPPR set out three projected scenarios for public sector pay up to 2019/20 (see figure 2.2). In 2016/17 – the final year for which outturn data is available – weekly earnings were on average 4.1 per cent below their level in 2010/11, the year before the cap came into effect. This is expected to fall to 5.1 per cent below 2010/11 levels in 2017/18. In our forecast baseline scenario, which provides an estimate for weekly earnings if the pay cap is not lifted, real public sector pay will have fallen to a level 6.2 per cent below that of 2010/11 by 2019/20.

FIGURE 2.2: TREND GROWTH IN REAL AVERAGE WEEKLY EARNINGS FOR THE PUBLIC SECTOR, OUTTURN AND COUNTERFACTUAL SCENARIOS



Source: Authors’ calculation based on ONS 2017a, OBR 2017a and OBR 2017b

Note: The projection for CPI shows a small real terms increase because we assume that pay is uprated at the beginning of a given financial year in line with the average for the previous September. Because inflation is forecast to fall over the period, this means that pay is uprated slightly faster than the average rate expected for the forthcoming year. Our uprating scenarios are illustrative only. They assume that all workers see pay increase in line with the uprating policy and do not take account of compositional effects in the workforce.

5 This report uses the CPI index for inflation from the ONS, and forecasts for CPI from the OBR, to measure all ‘real terms’ effects across time. Other inflation metrics are available, such as CPIH – which includes housing costs – and RPI which uses a different methodology to calculate the average rate of price change across consumer items. While the direction of trend in real pay is similar for all metrics of inflation for the period in question, our findings will not be exactly the same as those estimated using alternative inflation indices.

Our first counterfactual scenario sees public sector pay rising in line with CPI inflation. In this scenario, weekly earnings in 2019/20 are likely to be 1.7 per cent higher than they would otherwise be if the cap were not lifted. But pay would remain 4.6 per cent below 2010/11 levels. Our final counterfactual represents an illustrative ‘catch-up’ scenario. Here, average weekly pay rises in line with private sector earnings, plus an additional percentage point of growth each year. In this scenario, levels of average pay in 2019/20 would be 5.6 per cent higher compared with if the cap remained in place, and only 1 per cent lower than average pay in 2010/11.

2.2 THE INDIVIDUAL IMPACT OF LIFTING THE NHS PAY CAP

Because of the importance of compositional effects on average pay across time, the effects of the freeze and cap since 2010/11 are even more significant for individual pay bands (see table 2.1 below).⁶

As we set out in section 1.2, pay for a nurse at the top of the band 5 pay scale is £3,200 or 10.1 per cent less in real terms in 2017/18, compared with the same role in 2010/11. Were the cap to remain in effect until 2019/20, a nurse at the same level would be over £4,000 or 12.7 per cent worse off.

Increasing NHS pay with CPI would mean real pay remains flat between now and 2019/20. While this would mean no further real terms cuts in pay, it would not eliminate any of the decline in real terms pay since 2010/11.

However, taking our ‘catch-up’ scenario of increasing NHS pay in line with private sector earnings plus 1 per cent over the next two years, this would be equivalent to a pay rise of almost £700 a year for an estates officer or HCA by 2019/20, over £1,000 for a nurse and over £1,200 for a midwife or health visitor compared with 2017/18 (all 2017/18 prices).

This catch-up scenario would reverse 41.1 per cent of the real terms cut in pay for an estates officer or HCA since 2010/11 and 2017/18, with the equivalent figure for a nurse being 31.2 per cent and 30.3 per cent for a midwife or health visitor.

TABLE 2.1

Pay points for illustrative NHS workers, 2010/11, 2017/18 and 2019/20 (£, 2017/18 prices)

	Change in pay compared with 2010/11				2019/20 (Private plus 1%)
	2010/11	2017/18	2019/20 (Cap)	2019/20 (CPI)	
Estates officer or HCA (band 3)	21,540	-1,688	-2,271	-1,688	-993
Nurse (band 5)	31,960	-3,214	-4,059	-3,214	-2,208
Midwife or Health Visitor (band 6)	39,684	-4,107	-5,153	-4,107	-2,863

Source: IPPR analysis of NHS Employers 2017, NHS Employers 2010 and OBR 2017

⁶ This includes variation in the proportions of employees on different levels of pay across time due to people moving in and out of work or progressing through the pay scales.

2.3 THE ECONOMIC AND FISCAL IMPACTS OF LIFTING THE NHS PAY CAP

For this briefing, IPPR have modelled the three scenarios set out above in order to compare and assess their impacts on the public purse and economy as a whole. The analysis was conducted using IPPR's microsimulation tax-benefit model based on the latest sample of 19,000 households from the Family Resources Survey (for further information see DWP 2017).⁷ The model is capable of projecting forward different rates of earnings for individuals in the economy, estimating the interactive effects on personal tax and benefits, and then rebuilding an aggregate picture from the bottom up. By analysing the new data created, we are then able to present estimates of the fiscal and distributional effects of different rates of pay increase in the NHS.

2.4 THE FISCAL IMPACT OF LIFTING THE CAP

In the first instance, we model the static – before behavioural or multiplier effects – impact of an increase in pay on the government's fiscal position (see table 2.2).⁸ This means our results do not take account of any 'feedback' effects on staff costs, such as through the number of people recruited or retained on the NHS pay bill as a consequence of uprating pay bands at different rates.

TABLE 2.2

Annual fiscal effects of lifting the pay cap, relative to keeping the cap in place, £ million, 2019/20

	CPI	Private sector plus 1%
Change in NHS pay bill	1,800	3,900
<i>of which:</i>		
Employer pension contributions	250	600
Tax receipts generated	650	1,450
<i>of which:</i>		
Income tax	350	800
Employee NICs	100	300
Employer NICs	200	400
Net pay	850	1,900
Take home pay	800	1,800
Savings from means tested benefits	50	100
Immediate net cost	1,050	2,300

Source: Authors' analysis using the IPPR tax-benefit model based on data from the Family Resources Survey 2015/16, OBR 2017a, OBR 2017b, ONS 2017a, ONS 2017b and Cribb 2017.

Note: Counterfactual scenarios assume that the cap is lifted from 2018/19 onwards and pay scales are uprated by either CPI or private sector earnings plus 1 per cent (respectively) for two years to 2019/20. All affects are compared with a baseline line scenario where public sector pay goes up with the OBR's forecasts for 2018/19 and 2019/20. Columns may not sum due to rounding.

⁷ For the purposes of our modelling, we strip out all compositional effects from a changing labour market across time and assume that changes in average earnings are exactly equal to the change in each individual's pay.

⁸ This means our results do not take account of any 'feedback' effects on staff costs, such as through the number of people recruited or retained on the NHS pay bill as a consequence of uprating pay bands at different rates.

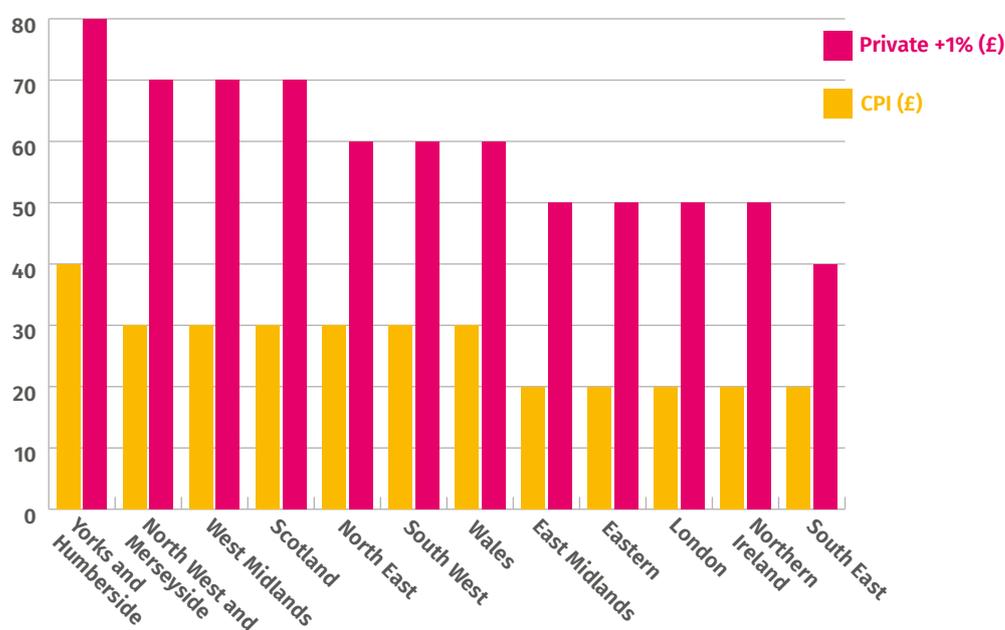
Our findings show that a significant portion of funding required to lift the public sector pay cap is in fact returned to the Treasury almost immediately in the form of higher tax receipts and lower welfare payments. The initial cost per year in 2019/20 of uprating the NHS pay bill in line with CPI from 2018/19 is £1.8 billion compared with the cost had the cap remained in place. However, this drops to just over £1 billion once higher receipts from income tax and national insurance, and lower welfare payments from means tested benefits, are taken into account.

Uprating pay scales in line with public sector earnings plus 1 per cent a year – our ‘catch-up’ scenario – has an initial annual cost of £3.9 billion in 2019/20, which falls to £2.3 billion after higher taxes and lower welfare payments are taken into account.

2.5 THE REGIONAL IMPACT OF LIFTING THE CAP

Our analysis also provides an estimate for the regional impact of raising the NHS pay bill above the cap in respect to our two counterfactual scenarios. Figure 2.3 suggests that lifting the cap would reduce regional inequalities. The effects are largest outside of London and the South East, where average levels of pay overall are highest. In cash terms, the impact on average incomes in Yorkshire and the Humber are around twice as large as in the South East. It is likely this reflects the fact that NHS employees make up a lower proportion of the overall workforce in London and the south east compared with the rest of the country.

FIGURE 2.3: AVERAGE CHANGE IN DISPOSABLE FAMILY INCOMES BY REGION OF RESIDENCE, 2019/20



Source: Authors' analysis using the IPPR tax-benefit model based on data from the Family Resources Survey 2015/16, OBR 2017a, OBR 2017b, ONS 2017a and ONS 2017b. See source for table 2.2 above for further information.

Note: averages taken across all households in the economy, including the majority who do not work on the NHS and who's pay remains constant across all scenarios. The average change for NHS workers only would be significantly higher.

2.6 THE ECONOMIC IMPACT OF LIFTING THE CAP

In addition to the static analysis presented above, there is also likely to be a positive stimulus in the economy through increased household consumer spending. This is likely to increase GDP and tax receipts, reducing the overall cost to government still further. We estimate these effects using the methodology set out by the economist Howard Reed (2014).

TABLE 2.3

Annual effect on GDP and final fiscal cost, £ million, 2019/20

	CPI	Private sector plus 1%
Change in take home pay for NHS employees	800	1,800
Additional GDP	250	550
<i>of which:</i>		
Consumption and labour taxes	100	150
Non-tax components of GDP	150	350
Final cost to government	950	2,100

Source: 'Change in take home pay for NHS employees' taken from table 2.2 above. Additional GDP estimated using the OBR 2015 multiplier for income tax (see Reed 2014). Additional receipts from consumption taxes were estimated by applying an estimate for the marginal propensity for additional consumption following a positive income shock (Bank of England 2017) and an estimate for the value of consumption taxes in additional consumer spending (Reed 2014). Additional receipts from increased labour in the economy are estimated using ONS 2017c, OBR 2017a projections for the share of labour costs in GDP and an estimate for the proportion of wages recouped in taxes (Reed 2014). The final cost to government is estimated by subtracting additional tax receipts from the immediate net cost in Table 2.2. Counterfactual scenarios assume that the cap is lifted from 2018/19 onwards and pay scales are uprated by either CPI or private sector earnings plus 1 per cent (respectively) for two years up to 2019/20. All affects are compared with a baseline line scenario where public sector pay goes up with the OBR's forecasts for 2018/19 and 2019/20. Columns may not sum due to rounding.

Using the IPPR tax and benefit model, Reed has shown that the distributional effect of increased public sector pay is similar to that of a decrease in income tax. This means that the Office for Budget Responsibility's estimated multiplier effect on GDP, following a change in income tax, provides an approximate estimate of the likely effect on GDP following a change in public sector pay.⁹

The additional GDP generated from higher spending will also include new tax revenue from VAT, as well as further labour tax receipts due to the jobs created to meet new demand in the economy. We estimate that uprating NHS pay in line with CPI will result in additional GDP growth worth £250 million,¹⁰ including

⁹ The distributional effect of lifting pay in the NHS is slightly different to the public sector as a whole, with a larger positive effect for higher income deciles. The effect of this would be a slight overestimate for additional GDP growth since higher income households are less likely to spend following a positive income shock than lower income households. However, overall our estimates for GDP are likely to be an underestimate (see footnote 10)

¹⁰ Our calculations of additional GDP in 2018/19 are likely to represent an underestimate since they exclude the cumulative and compound effects of higher GDP in 2018/19, as well as any multiplier effects from higher investment in the economy as a result of increased employer pension contributions. They also exclude any upward pressure that may come to bare on private sector earnings as a result of higher pay settlements in the public sector, which could also boost tax receipts and economic activity.

additional tax receipts worth just under £100 million, in 2019/20 compared to a baseline where the cap remains in effect. Uprating in line with private sector earnings plus one per cent a year, would see GDP £550 million higher and tax receipts up £150 million.¹¹

2.7 PAYING FOR THE NHS PAY RISE

The government has recently offered pay increases of above the 1 per cent cap to police officers (2 per cent, with 1 per cent as a bonus) and to prison officers (1.7 per cent). However, these increases remain well below CPI inflation, which currently stands at 3.0 per cent (ONS 2017b). So, while the cap has been lifted, this would represent another year of real terms cuts for these workers. The offer also does not come with additional funding; police forces and the Ministry of Justice will be expected to find the additional funding from reserves and existing budgets.

While the government should lift the cap in the NHS, requiring NHS trusts and boards to fund the additional increase from existing budgets would be unsustainable. NHS trusts and boards have seen a rapid rise in deficits in recent years. NHS Improvement figures put the reported financial deficit at £791 million in 2016/17 in England (NHS Improvement). However, this includes an emergency injection of £1.8 billion of funding through the emergency sustainability fund, and estimates from the Nuffield Trust have suggested that NHS trusts are on course for a deficit of £5.9 billion this year, 12 times the deficit target for this year of £500 million (Nuffield Trust 2017). Audit Scotland warned in 2016 that: “NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many had to use short-term measures to break even.” NHS Trust deficits have also risen very significantly in recent years (BBC 2017).

NHS Providers has argued that any lifting of the pay cap must be fully funded, and that failure to do so would “erode quality of care further at a point when the NHS is already missing all of its key performance targets” (NHS Providers). Simon Stevens, the Chief Executive of NHS England recently said that while NHS staff deserve a pay rise, any additional rise beyond the planned 1 per cent would require an increase in NHS budgets (Hansard 2017).

11 The end effect of higher nominal pay need not be inflationary. To some extent it is contingent on where the money to fund a pay rise comes from. But in the round, the Bank of England will always work to offset labour market drivers of inflation through monetary policy. As things stand, nominal pay growth is below both the UK's long-term trend, and what the Bank of England thinks the economy should be aiming to afford (given the room for productivity growth, see Haldane 2017), before any adverse effects on inflation.

3.

CONCLUSION: LIFTING THE CAP IN THE NHS

The long pay squeeze in the NHS has had a significant impact on the real terms value of pay in the NHS. The two-year pay freeze followed by five years of pay capped at 1 per cent has left the pay of a band 5 nurse over £3,200 lower in real terms than it was in 2010/11. Had the government continued with its pay cap, a nurse would have been over £4,000 worse off in 2019/20 than nine years previously.

As real terms pay in the NHS has been cut, so satisfaction with pay has declined. In the context of falling pay, the NHS has increasingly struggled to recruit and retain the staff that it needs to meet rapidly growing demand. This has led to a rapid rise in both vacancies and in agency spend. It is increasingly clear that this growing workforce crisis in the NHS is related to the ongoing pay squeeze. NHS Providers recently highlighted the impact of the pay cap on the workforce, and claimed that: “workforce issues are now the most pressing concern for NHS trusts across the country, surpassing the financial challenge facing the provider sector” (NHS Providers).

Following the general election, in the face of growing pressure and a growing workforce crisis, the government has abandoned its previous plan to continue the NHS pay cap for another two years.

While the headline cost of lifting the NHS pay cap is not insignificant, the net cost, taking into account the fiscal impact of higher tax revenue and lower in-work benefit spending, is far smaller. Increasing NHS pay across the UK in line with CPI over the next two years would cost £1.8 billion by 2019/20 relative to the government’s previous plan of continuing the pay cap. However, taking into account the fiscal impact, the immediate net cost would be only £1.1 billion. Our ‘catch-up’ scenario of increasing NHS pay at the forecast rate of private sector pay plus 1 per cent would have a headline cost of £3.9 billion, but a net cost of £2.3 billion, taking into account the immediate returns to the Treasury.

Lifting the pay cap and increasing pay in the NHS would also have a positive economic impact. Increasing pay with CPI would generate additional GDP of £250 million by 2019/20, with additional tax income of £100 million. Increasing pay in line with our ‘catch-up’ scenario of private sector earnings plus 1 per cent would generate an additional £550 million in GDP, with £150 additional tax income.

Taking these fiscal and economic impacts into account, the final cost to government of increasing NHS pay in line with CPI would be £950 million by 2019/20. The final cost of our ‘catch-up’ rate of increasing NHS pay in line with private sector earnings plus 1 per cent would cost £2.1 billion.

The first scenario – increasing pay in line with CPI – would prevent further real terms cuts to pay in the NHS, but it would not reverse any of the significant real terms cuts that NHS workers have seen since 2010/11. Our second ‘catch-up’ scenario would see 41.1 per cent of the real terms cut estates officers and

health care assistants have experienced since 2010/11 reversed by 2019/20, and 31.2 per cent of the cut to a nurses pay reversed.

Both scenarios would help reduce regional inequalities, as the impact on earnings would be higher in regions outside of London and the south east, where pay is lower.

RECOMMENDATIONS

- In the short term, the UK government should lift the NHS pay cap. It should revise its guidance to the NHS Pay Review Body and ensure its independence and integrity going forward by making clear that it will accept their recommendations for pay. This includes accepting significant real terms increases for NHS workers in 2018/19 and 2019/20 in order to reverse some of the real terms loss in incomes experienced since 2010/11, as well as differential uprating to boost pay areas of the NHS facing particular challenges with recruitment and retention and for those on lower pay-scales.
- The UK government should provide additional funding in Autumn Budget to cover this additional expenditure, rather than requiring NHS Trusts to meet the cost from already over-stretched existing budgets.
- The UK government should develop a national NHS Workforce Strategy, in conjunction with NHS employers and the NHS trade unions. This should review the potential impact of Brexit on the workforce, and it should review the impact of scrapping NHS bursaries on recruitment.

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