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Chapter 9

Health care budgeting in the United Kingdom

by
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In this chapter, budgeting challenges in the United Kingdom health system are discussed. Health spending trends are presented, followed by a summary of the relevant institutional frameworks for budgeting. Government measures to reduce cost pressures are then assessed, in terms of their ability to make cost savings, their effect on the government's overall structural budget position and their impact on service standards. Evidence on the extent of future funding pressures are then discussed.

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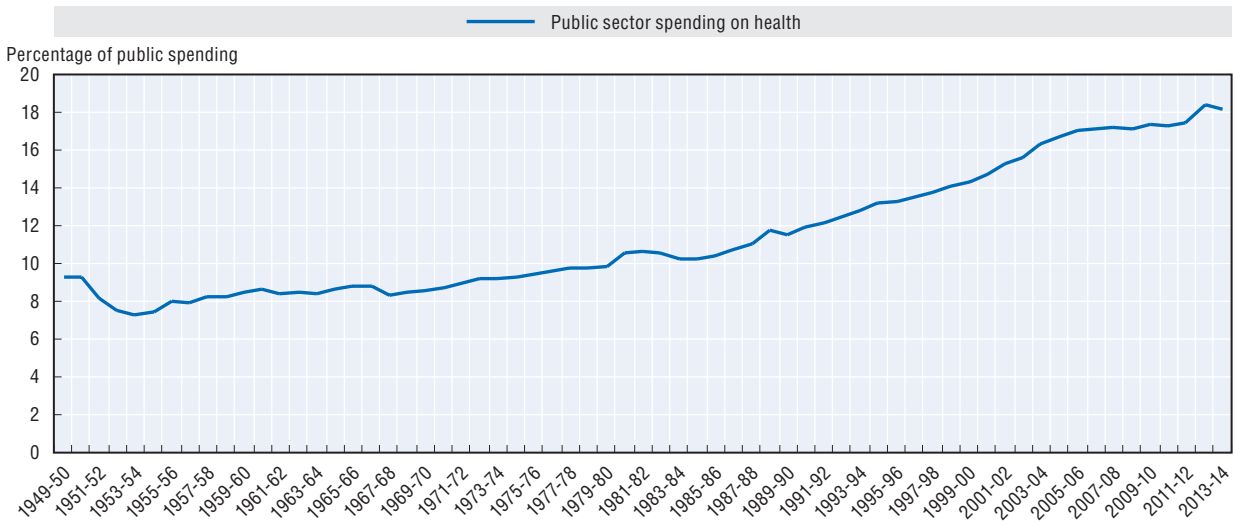
9.1. Overview of health in government expenditure

The United Kingdom spent 9.3% of GDP on health in 2012, in line with the OECD average. This is USD 3 289 per capita (adjusted for purchasing power parity), around 5% below the OECD average. Public health spending accounts for an above-average share of total health spending – 84% compared to the OECD average of 72.2% in 2012 (OECD, 2014).

The proportion of UK public spending allocated to the National Health Service (NHS) has risen steadily, from 9.3% in 1949-50 to 18.1% in 2013-14 (Figure 9.1). As a result, almost GBP 1 in every GBP 5 of UK government spending now goes to health care.

Figure 9.1. **NHS spending in the United Kingdom, as a proportion of total public spending**



Note: GDP deflators for years 1949/50 to 1954/55 were estimated by applying the same annual change in GDP deflator as for the GDP deflators by calendar year (ONS).

Source: Lloyd, T. (2015), *Funding Overview: Historical trends in the UK*, The Health Foundation, London.

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Table 9.1 demonstrates that the rapid growth in health spending has not been accompanied by an increased tax burden. Looking at the three decades preceding the economic crisis, public spending on health increased from 4.3% of GDP in 1978-79 to 6.7% in 2007-08; but over the same period receipts and total government spending both fell as a share of GDP. This was possible as the composition of public spending changed. There has been a significant reduction in the share of GDP spent on other public services and on welfare, and debt interest fell as a share of GDP.

Table 9.1. **Changes in public spending as a share of GDP and tax receipts**

Share of GDP	Total public spending	Health spending	Other public services	Welfare and debt interest	Receipts
1978-79	43.5%	4.3%	25.6%	13.6%	38.6%
2007-08	39.2%	6.7%	20.1%	12.3%	36.6%
Difference	-4.3	2.5	-5.5	-1.2	-2

Source: Author's calculation using data from IFS, OBR and HM Treasury.

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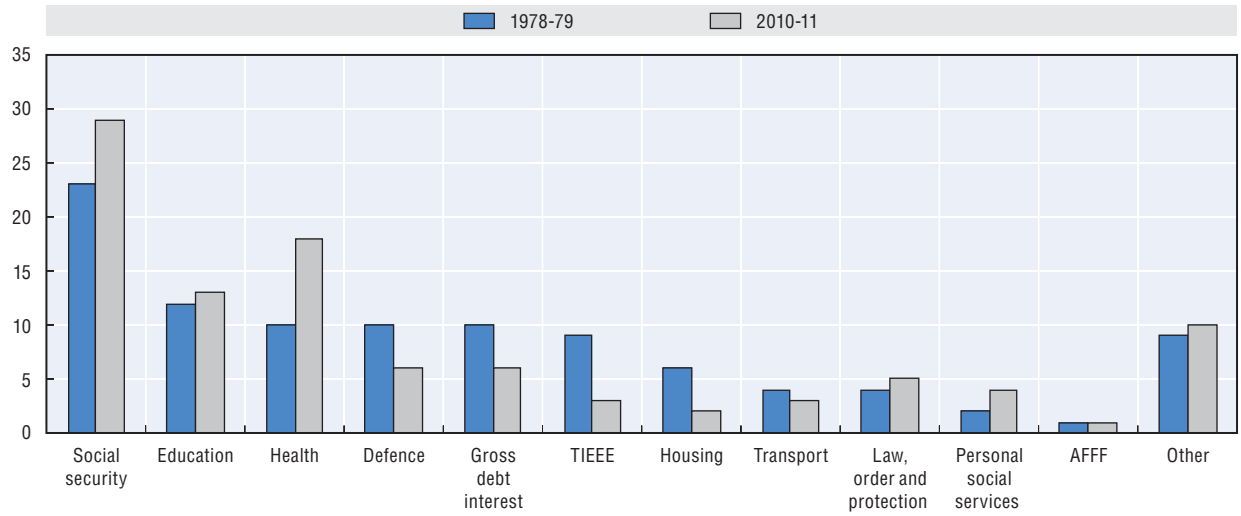
This compositional change is clear from a comparison of the main areas of public spending in 1978-79 and 2007-08 (Figure 9.2).

Figure 9.2. **Percentage of public spending in 1978-79 and 2010-11**



Note: AFFF is spending on agriculture, fisheries, food and forestry. TIEEE is spending on trade, industry, energy, employment and the environment. Other includes overseas spending (including overseas aid), national heritage, miscellaneous expenditure and other accounting adjustments.

Source: Author's calculations using data from Crawford, R. and P. Johnson (2011), "The Changing Composition of Public Spending", *IFS Briefing Note* No. 119, Institute for Fiscal Studies, London.

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Trends in health spending

In 2000, spending on health in the United Kingdom was 7% of GDP, below the OECD average of 7.8% (OECD, 2014). In the decade that followed, spending increased rapidly in real terms and as a share of GDP. By 2012, the UK's total spending on health care as a percentage of GDP was 9.3%. This is lower than the EU15 average (ten per cent), but is in line with the OECD average of 9.3%. The United Kingdom spends less than nine other EU15 countries, although that is considerably more than in 2000 when it spent less than 13 of the 15 countries. The increase in health spending as a share of GDP in the United Kingdom in recent years has been driven by increased public spending on health. Public spending on health grew as a share of GDP while private health care spending remained stable.

Government spending on health across the United Kingdom in 2013-14 was GBP 129.4 billion or 7.5% of GDP (HM Treasury, 2014c). Since the formation of the NHS in 1948, this figure has increased by an average of 3.7% in real terms with only seven financial years where there has been a real decrease (The Health Foundation, 2015). Two of these seven years were 2010-11 and 2011-12.

Table 9.2. **Government spending on health in the United Kingdom**

Share of GDP based on UK Office for National Statistics (ONS) GDP figures published on 6 October 2014

Billion GBP	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Cash terms	74.9	82.9	89.8	94.7	101.1	108.7	116.9	119.9	121.3	124.3	129.4
Share of GDP	6.20%	6.50%	6.70%	6.60%	6.70%	7.20%	7.80%	7.60%	7.40%	7.50%	7.50%
Real terms (2014-15)	97.6	104.8	110.4	113.4	117.6	123.3	129.3	129	128.2	129.2	132.1
Real terms % change		7.30%	5.40%	2.70%	3.70%	4.90%	4.80%	-0.20%	-0.60%	0.80%	2.20%

Source: UK Office for National Statistics (ONS) and HM Treasury, London.

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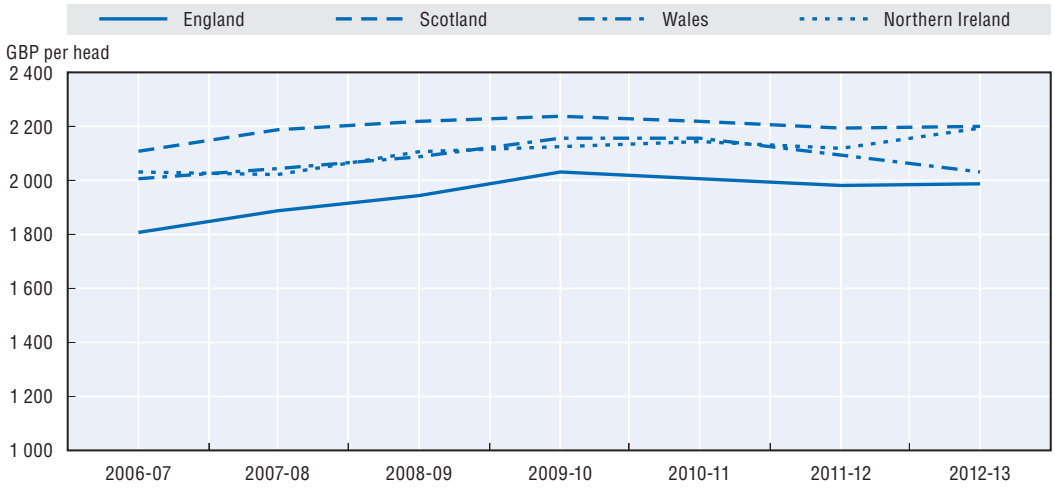
A total of 83% of UK government health spending was spent on the NHS in England. The remainder was spent by the devolved governments in Scotland, Wales and Northern Ireland on their health services. A small amount went to the Departments for Business, Innovation and Skills (BIS) and Culture, Media and Sport (DCMS). This was funding for the Medical Research Council and the National Lottery Distribution Fund (HM Treasury, 2014c).

Health spending in the United Kingdom forms part of the devolved budget of the administrations in Scotland, Wales and Northern Ireland. Figure 9.3 shows how levels of health spending vary between the four countries of the United Kingdom. Spending per person in Scotland, Wales and Northern Ireland has been above that for England and the UK average. But in recent years, spending per person in Wales has converged with England.

Figure 9.3. **The variation in public health spending per person in the four countries of the United Kingdom**

2014-15 prices



Source: Lloyd, T. (2015), *Funding Overview: Historical Trends in the UK*, The Health Foundation, London.

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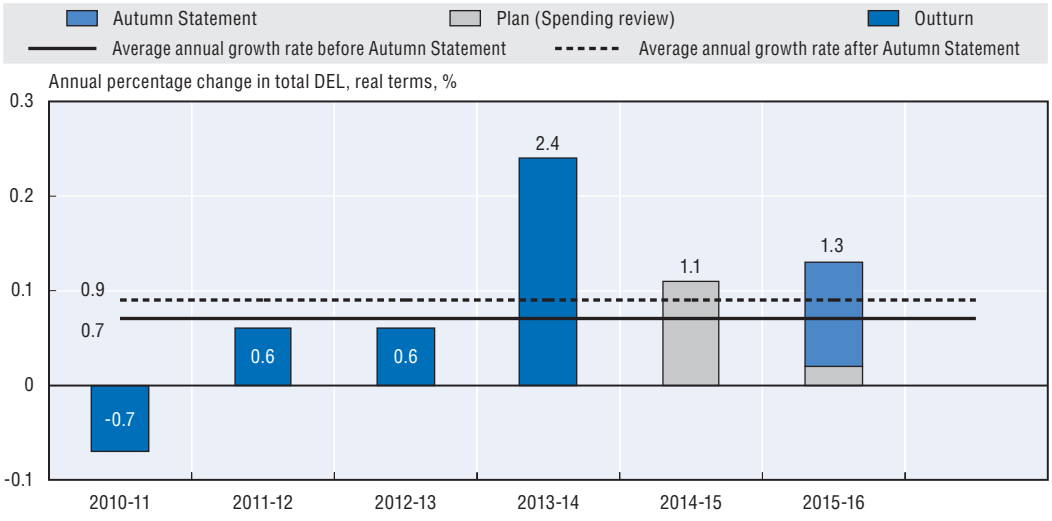
9.2. Institutional framework and budgeting practices

The NHS is funded by general taxation. General tax policy is the responsibility of Her Majesty's Treasury (HMT) on a UK basis. The administration of the NHS is the responsibility of the administrations of each of the four countries of the United Kingdom. For the English NHS, the budget is set by HMT as part of the periodic,

cross-government public spending reviews. This sets a revenue and capital budget for the Department of Health. For Scotland, Wales and Northern Ireland, the UK government sets a population-based allocation of total public spending, comparable to that in England. The UK government does not earmark funding for specific purposes. The devolved administrations determine the allocation of public expenditure between the services under their control, including health.

The current government has undertaken two reviews of public spending in 2010 and 2013 (HM Treasury, 2010, 2013). These set out the government's spending plans for 2011-12 to 2015-16 (Figure 9.4). The English publically funded health budget is currently fixed. However, current financial and service pressures in the NHS have led the government to allocate further funding to the NHS for 2015-16 above the totals planned in the 2013 spending round (HM Treasury, 2014).

Figure 9.4. **English health budget to 2015-16**



DEL: Departmental expenditure.

Source: LaFond, S. (2015), *Funding Overview: Current NHS Spending in England*, The Health Foundation, London.

StatLink http://dx.doi.org/10.1787/888933219286

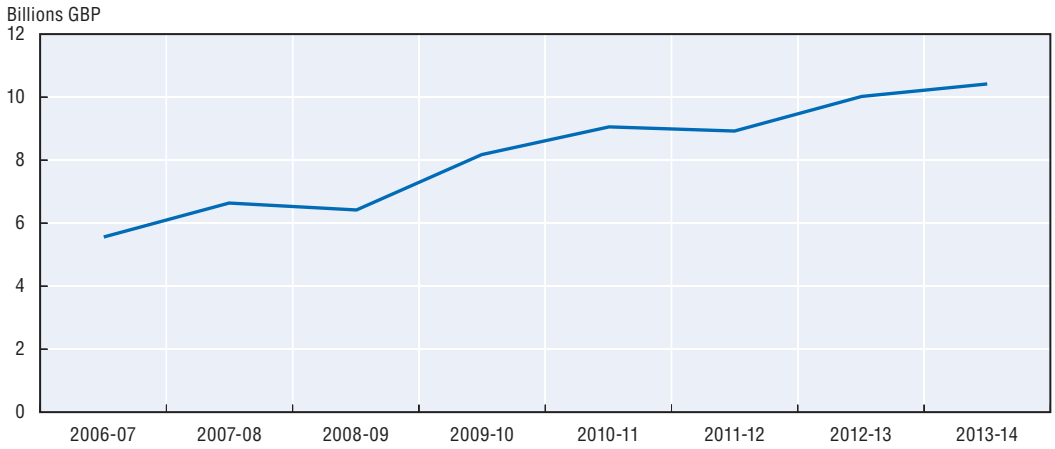
The vast majority of the English budget for health care is distributed by the Department of Health to NHS England, the body responsible for commissioning health care across England. NHS England commissions primary care and specialised care services across the country. It allocates around two-thirds of its funding to the local bodies responsible for commissioning routine health care for their local population [211 Clinical Commissioning Groups (CCGs), which largely replaced the functions of Primary Care Trusts following the Health and Social Care Act 2012].

NHS England and the CCGs purchase health care from a mix of NHS and private-sector providers: acute hospitals, mental health hospitals, community nursing services and independent primary care providers (GPs, dentists and pharmacies). Most hospital, mental health and community health services in England are provided by NHS-owned and NHS-managed providers; but there has been a growth in NHS-funded but privately provided care over the last decade (Kelly and Tetlow, 2012; Arora et al., 2013). Figure 9.5 shows the growth in spending on NHS-funded care provided by non-NHS providers over recent years. As a result, the NHS now spends 11% of the budget for commissioners of care on services

provided by non-NHS organisations. The use of non-NHS providers varies by health sector – a relatively small proportion of hospital services are delivered by non-NHS providers; but, in community nursing and mental health care, non-NHS providers are responsible for delivering a higher proportion of care (LaFond et al, 2014). In addition, most of the providers of primary care – GPs, dentists and pharmacists – are independent businesses.

Figure 9.5. **Purchase of NHS-funded health care from non-NHS bodies from 2006-07 to 2013-14**

2013-14 prices



Source: LaFond, S. (2015), *Funding Overview: Current NHS Spending in England*, The Health Foundation, London.

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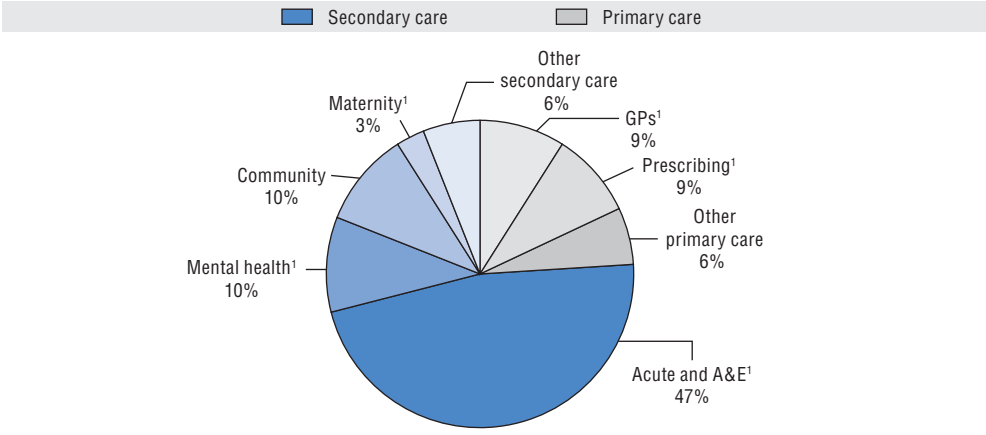
Around half of publicly funded health spending is for acute hospital services. Other key areas of spending are mental health care, community, GP services and prescription medications. Figure 9.6 shows spending by services before the fiscal tightening to address the growing budget deficit (2009-10).

Figure 9.6. **NHS primary care trust expenditures 2009-10 – GBP 97.5 billion**



A&E: Accident & emergency.

1. Included in model.

Source: Primary Care Trust (PCT) financial accounts 2009-10.

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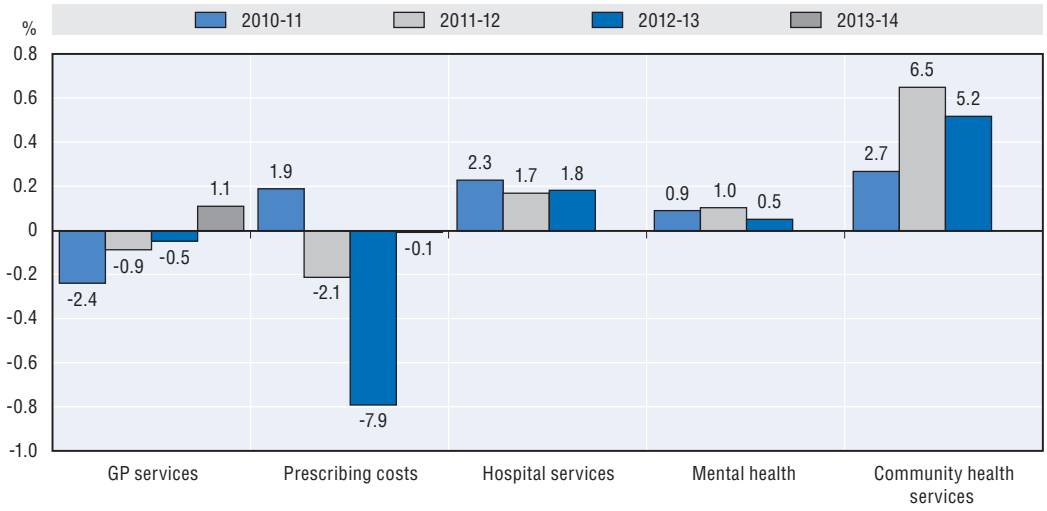
Figure 9.7. **Percentage change from previous year in English NHS spending by service area**



Source: LaFond, S. (2015), *Funding Overview: Current NHS spending in England*. The Health Foundation, London.

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Figure 9.7 shows how spending in different service areas has changed since 2010-11.

Direct patient charges make a small contribution to the cost of NHS care. The key areas of charging and co-payments are for prescriptions and services. The bulk of prescription medications are funded by the NHS although there is a small co-pay (GBP 8.05 for item as of April 2014) but with widespread exemptions including all children under age 16, everyone aged over 60 and pregnant women. This means that around 90% of all prescriptions in the NHS are dispensed free of charge (Barker et al., 2014). As a result, the prescription charge system raises a small amount, GBP 471 million in England in 2013-14 (Department of Health, 2014). The exemption regime for dentistry is more complex but also includes children, pregnant women and people on means-tested benefits. For older people, exemptions are more limited than for prescriptions and focused on those on low incomes. In 2013-14, dental charges raised GBP 684 million (Department of Health, 2014). In total across all services, patient fees and charges accounted for around 1.4% of public health spending in the English NHS.

NHS providers are a mix of directly managed hospitals and more autonomous foundation trusts which remain fully public sector bodies but have more freedom to manage their own affairs with risk-based oversight from a national health care regulator (Monitor). These bodies have some flexibility to borrow from the private sector and can earn private income (subject to a cap). The aggregate surplus or deficit of NHS providers forms part of the consolidated financial position of the Department of Health and the UK's government's overall fiscal position.

9.3. Controlling key elements of health expenditures

The government's policy to manage health expenditure since the economic crisis has the following key components:

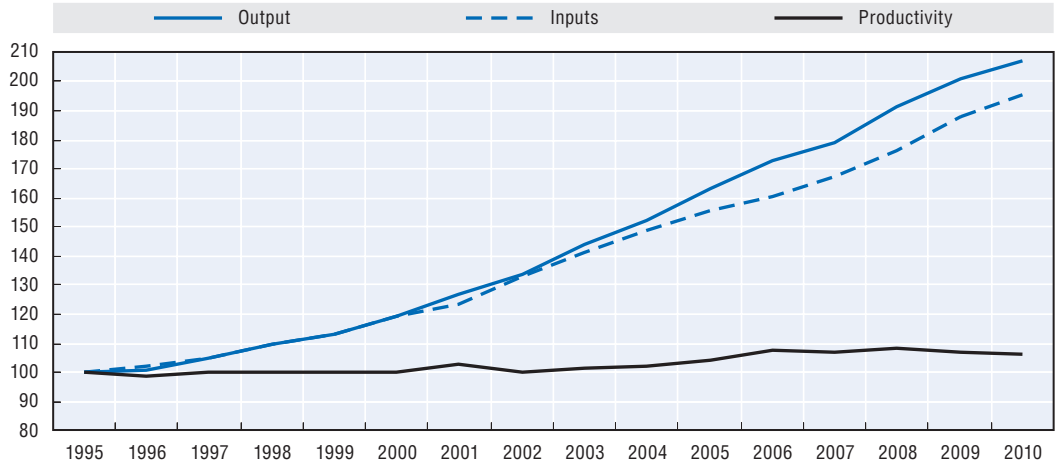
- a cap on total public health spending
- a reduction in input pressures
- a funding focus on front-line delivery
- improved productivity.

The cap on the health budget since 2010 is the tightest aggregate four-year budget set for the NHS since the 1950s (Crawford and Emmerson, 2012). There is a major focus on managing costs and improving productivity to ensure that the NHS can manage within the tougher fiscal climate whilst maintaining quality of care and access to services. The Department of Health estimated that, to meet rising demand in the face of constrained funding, the NHS will need to make recurrent efficiency savings of around 4% a year in real terms between 2011 and 2015 (Department of Health, 2012). This is a major challenge for the NHS as over recent years its productivity growth has been much lower.

The Office for National Statistics (ONS) publishes an annual report on productivity in health care in the United Kingdom. The latest report provides estimates of productivity for publicly funded health care between 1995 and 2010 (Massey, 2012). Measuring productivity is complex, and this is particularly true in health care. In health care, the challenge in estimating changes in productivity is being clear about the service provided. In particular, is it enough to measure the activity provided? There are two problems with focusing on activity: first, activity alone does not capture changes in quality, yet these are very important outputs of health services; and second, the link between activity and health outcomes is variable. The measurement of productivity of health services is therefore subject to much debate (Black, 2012; Grice, 2012). The ONS measurement attempts to capture quality-adjusted output. The choice and comprehensiveness of quality measures and the relative weight quality is given in the productivity measure will impact on the conclusions that can be drawn.

Figure 9.8. **Health care output, inputs and productivity estimates (nominal terms), 1995-2010, United Kingdom**

Index numbers 1995 = 100



Source: Massey, F. (2012), "Public Service Productivity Estimates: Health Care, 2010", Office for National Statistics, London.

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The ONS defines health care productivity as the ratio of quality-adjusted output to the volume of inputs. The outputs are measured as a cost-weighted activity index covering hospital and community health services (hospital inpatient and day cases, outpatient visits and community nursing activity) and primary care (GP and nurse visits, sight tests, prescriptions and dental treatments). These outputs are adjusted for quality, based on the extent to which services succeed in delivering their intended outcomes and the extent to which they were responsive to user needs. The inputs are measured as labour, spending on goods and services, and capital consumption. The ONS produces productivity estimates

on data from 1995 onwards for the United Kingdom.[1] Both outputs and inputs have grown continuously during this period, but there was a more rapid increase in outputs than in inputs between 2004 and 2006 (Figure 9.8). The ONS estimates that between 1995 and 2010 the output in the United Kingdom rose by 107% and the input by 95%. This results in an estimated UK productivity growth of 0.4% per year between 1995 and 2010.

Combining the ONS estimates with Cost-Weighted Activity Index (CWAI) estimates[2] for earlier years, it was estimated that productivity in the health care sector has risen on average by about 1% a year between 1979 and 2010 (OBR, 2014a).

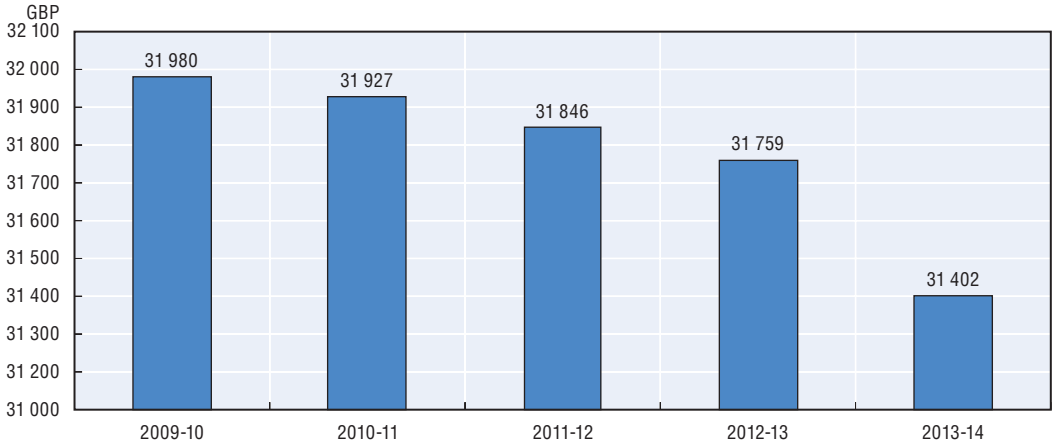
The ONS measures of productivity on a UK-wide basis only have data up to 2010, the start of the current period of austerity in the health service. A separate study measures productivity for England only but on a very similar basis to the ONS research. It finds that recent productivity growth has been higher, increasing at a rate of 1.5% a year between 2004-05 and 2011-12. (Bojke et al., 2014).

There are two central government initiatives to help the NHS meet the productivity challenge presented by the tight fiscal settlement. The government introduced a public sector pay policy to reduce input costs. Workforce costs are the single largest element of NHS providers' expenditures. Pay per head for hospital and community health service staff rose by an average of around 2% a year in real terms over the 35 years to 2009-10 (authors' calculations, based on Department of Health, 2011). The government froze pay awards for all public sector workers, including NHS staff, earning basic salaries of more than GBP 21 000 a year in 2011-12 and 2012-13; staff earning less than GBP 21 000 were awarded GBP 250 a year cash uplifts in April 2011 and 2012 (NHS Employers, 2012a). For 2013-14 and 2014-15, the government has set public sector pay awards at an average of 1% a year in cash terms (HM Treasury, 2011).

Despite the two-year pay freeze, overall earnings and aggregate pay costs in the NHS have increased in cash terms due to staff moving up through incremental pay steps, the employment of additional staff and a growing reliance on temporary and agency staff who receive a pay premium. While earnings per head is still rising in cash terms (1.2% a year), in real terms there was a small reduction between 2010-11 and 2013-14 (0.6% a year) (Health Foundation, 2015; see Figure 9.9). Estimates by the Nuffield Trust suggest that the government's pay policy will deliver around 40% of the efficiency savings required between 2011 and 2015 (Roberts et al., 2012).

Figure 9.9. **NHS Staff annual average earnings per person 2010-11 to 2013-14**

2014-15 prices



Source: Authors' calculations based on data from the Health and Social Care Information Centre and HM Treasury.

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The second area of central government action to support improved productivity is a focus on reducing administrative costs. As part of the 2010 spending review, NHS administrative costs were ring-fenced and reduced in real terms by a third (HM Treasury, 2010). The NHS has been restructured to support this with the abolition of a tier of NHS management (the nine regional Strategic Health Authorities). Administrative costs have fallen from just over 5% at the start of the decade to 2.8% of health spending in England in 2013-14 (HM Treasury, 2014c).

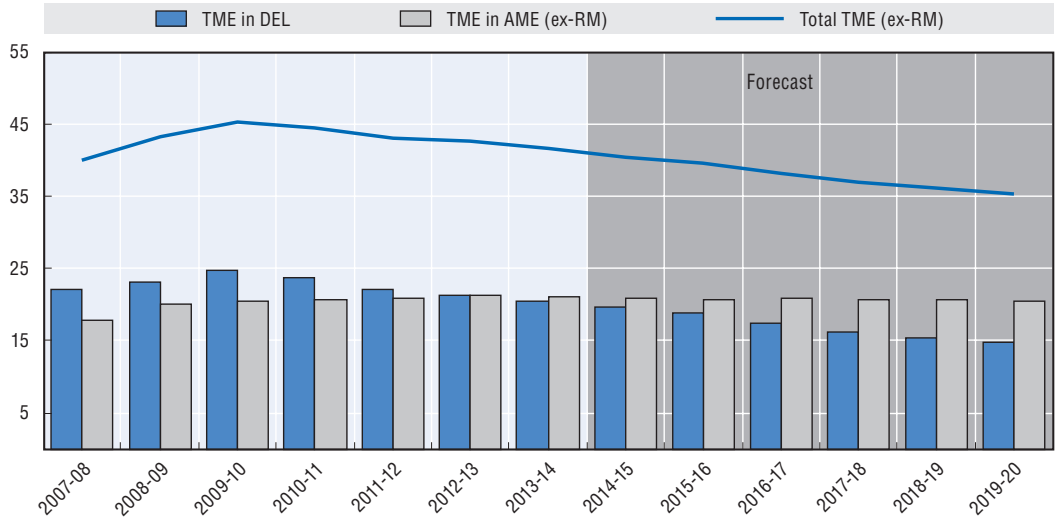
Alongside these national initiatives, the Department of Health and the NHS have a programme to deliver savings and improve efficiency across the NHS, the Quality, Innovation, Production and Prevention (QIPP) programme. Each local commissioning body (PCT/CCG) has a plan to deliver savings, including better medicines management and demand-management measures to reduce growth in the use of hospital care. But a significant component of the savings comes from reducing the price commissioners pay NHS and other providers for care. The national tariff (DRG prices) that commissioners pay NHS providers for care has been reduced by an average of 1.5% in cash terms between 2011-12 and 2014-15 (Marshall et al., 2014). Each NHS provider is then responsible for developing a cost-improvement plan to realise savings. Around 40% of the savings result from nationally-driven initiatives such as the pay policy and reducing the administrative costs of national bodies. A further 40% of the savings are being delivered by health care providers improving their efficiency and reducing cost (through better procurement, a reduction in back-office costs and medicine management). The final 20% is expected to come from more transformative changes in the way services are delivered: shifting care to community rather than hospital settings and more effective management of ambulatory care-sensitive conditions (NAO, 2012). NHS England estimates that over the last four years total savings of GBP 21 billion will have been delivered (2014-15 prices) (Charlesworth, 2015).

Despite the initiatives to reduce input costs and increase productivity, the NHS in England is finding it harder to maintain the quality of care and deliver financial balance. In 2013-14, the NHS had 66 providers in deficit, double the year before. Early indications of NHS financial performance suggest that NHS trust performance deteriorated in 2014-15. The problems are concentrated in acute hospitals. At September 2014, 80% of all NHS acute hospital providers in England were in deficit, amounting to a net deficit of just over GBP 700 million (Charlesworth, 2015).

9.4. The impact of health on the government's structural budget position

The government's macroeconomic target is to reduce the deficit from 10.2% of GDP in 2009-10 to a surplus of 1% of GDP by 2019-20 (OBR, 2014b). The government intends to achieve fiscal balance principally through reducing spending as a share of GDP rather than through increasing tax. This requires a reduction in total government spending from 45% of GDP in 2009-10 to 35.2% of GDP a decade later in 2019-20. Receipts are forecast to increase but by a relatively small amount from 35.1% of GDP in 2009-10 to 36.2% of GDP in 2019-20. With rising debt interest and spending on social protection, government spending on public services will continue to fall in real terms beyond 2014-15. Figure 9.10 shows the forecast reduction in public spending. Departmental expenditure (DEL) includes spending on public services such as health, education, policing and transport. It is forecast to fall sharply over the next five years. Annually managed expenditure (AME) includes spending on social protection and debt interest and is more stable.

Figure 9.10. **DEL and AME components**

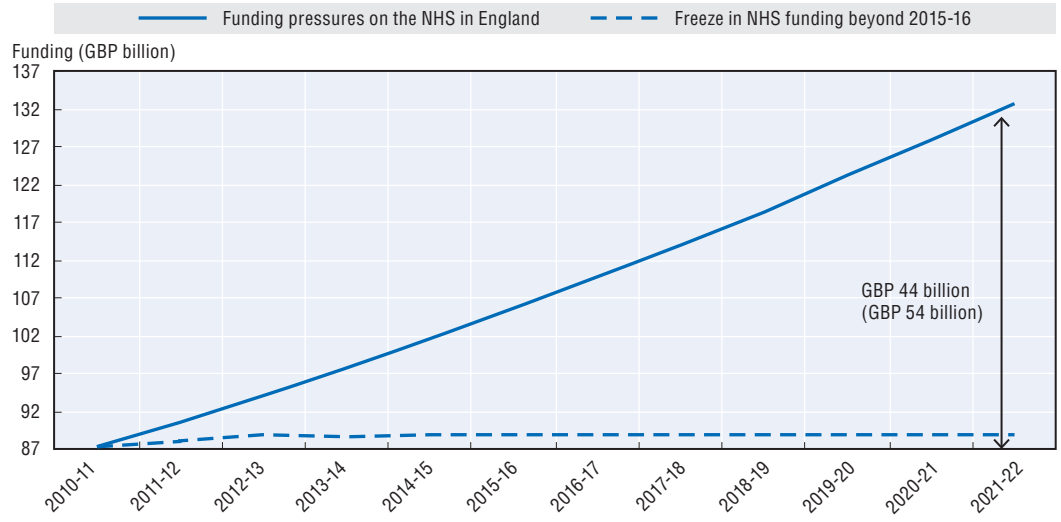


AME: Annually managed expenditure; DEL: Departmental expenditure; RM: Royal Mail; TME: Total Managed Expenditure.

Source: OBR (2014), *Economic and Fiscal Outlook*, Office of Budget Responsibility, The Stationery Office, London.

This puts pressure on the health budget. Work by the Nuffield Trust has examined the impact of demographic changes, rising chronic disease and input costs on health spending pressures. This research shows aggregate funding pressures on the NHS in England continuing to increase by around 4% a year up to 2021-22. If health service funding is held constant in real terms throughout this decade, this would result in a gap between the pressure on the health budget and funding available of around GBP 44 billion in 2010-11 prices (Roberts et al., 2012, see Figure 9.11).

Figure 9.11. **The financial gap by 2021-22, assuming English NHS funding rises as set out in the 2010 Spending Review to 2014-15 and is frozen in real terms**



Source: Roberts, A., L. Marshall L and A. Charlesworth (2012), "A Decade of Austerity? The Funding Pressures Facing the NHS from 2011-12 to 2021-22", Nuffield Trust, London.

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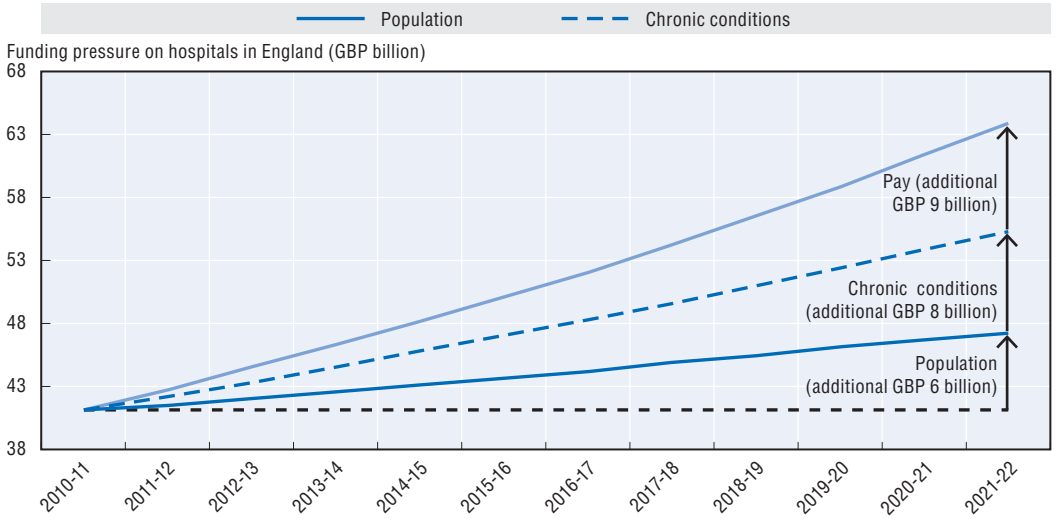
Within the acute sector we can examine the relative contribution of demography, chronic disease and input costs. The next decade will see significant demographic change. The population of England is projected to increase by 4 million from 52.1 million in 2010 to 56.4 million 2021. In addition, England is expected to have an ageing population over the same period; the percentage of the population over working age will rise from 16% to 19%. Although these changes are significant, during the next decade they are expected to result in funding pressures of just over 1% a year for hospital care. If recent trends in the treatment and management of chronic disease continue, there would be additional pressures of a further 1% a year for hospital care. The combined effect of population change and rising admission for chronic conditions produces demand pressures on the acute services in England of 3% a year in real terms. If pay pressures return to their historic trend before the economic crisis (2% per year in real terms) this would add a further 1% a year to hospital costs (Figure 9.12).

Figure 9.12. **Funding pressures on acute services in England attributable to population change and to the rising probability of admission for chronic conditions**



Source: Roberts, A., L. Marshall L and A. Charlesworth (2012), *A Decade of Austerity? The Funding Pressures Facing the NHS from 2011-12 to 2021-22*, Nuffield Trust, London.

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These estimates assume no underlying productivity growth in the NHS. In 2002, HMT published a review of the funding pressures on the health service in England commissioned from Sir Derek Wanless (Wanless, 2002). The review examined funding pressures up to 2022-23. It developed three scenarios which covered health seeking behaviour, the prevalence of risk factors for chronic disease and productivity. The "fully engaged" scenario assumed productivity growth between 2012-13 and 2022-23 of 3% a year compared to productivity growth of 1.75% a year in the "slow uptake" scenario. These different assumptions about productivity combined with different demand-side assumptions produce significant differences in the pressures on health funding. Table 9.3 compares the funding pressure projections for the three scenarios from the Wanless Review. The low-productivity, high-demand scenario (slow uptake) results in pressure on health funding which are 2 percentage points of GDP higher in 2022-23 than the high-productivity, low-demand scenario (fully engaged).

Table 9.3. **The 2002 Wanless Review projections of English NHS funding pressures**

	Projections				
	2002-03[1]	2007-08	2012-13	2017-18	2022-23
Total health spending (percent of money GDP)[2]					
Solid progress	7.7	9.4	10.5	10.9	11.1
Slow uptake	7.7	9.5	11	11.9	12.5
Fully engaged	7.7	9.4	10.3	10.6	10.6
Total NHS spending (GBP billion, 2002-03 prices)					
Solid progress	68	96	121	141	161
Slow uptake	68	97	127	155	184
Fully engaged	68	96	119	137	154
Average annual real growth in NHS spending (%)[3]					
Solid progress	6.8	7.1	4.7	3.1	2.7
Slow uptake	6.8	7.3	5.6	4	3.5
Fully engaged	6.8	7.1	4.4	2.8	2.4

1. Estimates.

2. All figures include 1.2% for private sector health spending.

3. Growth figures are annual averages for the five years up to date shown (four years for the period to 2002-03).

Source: Wanless, D. (2002), *Securing our Future Health: Taking a Long-Term View, Final Report*, HM Treasury, London.

StatLink http://dx.doi.org/10.1787/888933219547

NHS England recently published updated estimates of the funding pressures facing the NHS in England for the next five years (2015-16 to 2020-21). They estimate that funding pressures on the NHS will be GBP 30 billion higher at the end of the decade (NHS England, 2014). They then estimate the additional funding requirement above inflation under three scenarios for productivity. These are shown in Table 9.4.

Table 9.4. **NHS England funding pressures facing the NHS by the end of the decade**

Productivity growth assumption	Funding requirement above inflation
0.8% a year	GBP 21 billion
1.5% a year	GBP 16 billion
2-3% a year	GBP 8 billion

Note: NHS England's projections of total spending are in cash terms, allowing them to explore the impact of cost pressures (such as pay) separately to assumptions for GDP deflators. The budget for NHS England is then assumed to rise with inflation.

Source: Charlesworth, A. (2015), "Briefing: NHS Finances – The Challenge All Political Parties Need to Face", The Health Foundation, London.

StatLink http://dx.doi.org/10.1787/888933219557

Recent work by the Health Foundation has used the methodology developed in the Nuffield Trust work to extend the funding projections to 2030. Under the central projection, the NHS in England will continue to achieve productivity close to 1.5% a year, in line with recent trends. Therefore, if a high-quality, comprehensive service is to be maintained, funding will need to rise by around 3% a year, slightly above the expected rate of economic growth of 2.4% a year. If NHS productivity matches the estimate of whole economy trend rate of productivity growth (2.2% a year), public health spending as a share of GDP could remain broadly constant and meet projected pressures. But there is no evidence that productivity at this rate could be sustained in the medium term. Health care provision is relatively labour intensive and it is therefore likely that productivity growth will be slower in this sector than in the economy as a whole. But over the medium term, wages in the

sector would still need to rise in line with those in the whole economy. This would lead to what is known as "Baumol's disease" where the cost of the health service rises relative to other sectors of the economy. To maintain an increase in the level of service provided in line with increases in real output across the rest of the economy, government expenditure would have to increase more rapidly than GDP growth.

Table 9.5. **Health Foundation projected funding gap for English NHS in 2030-31 under three assumptions for productivity**

Annual rate of productivity growth	Average annual increase in NHS spending	NHS England estimate 2020/21	Funding gap in 2030-31:		
			Budget stays flat in real terms	Budget rises by 1.6% a year in real terms	Budget rises by 2.4% a year in real terms
0.0%	4.3%	GBP 30 billion	GBP 108 billion	GBP 78 billion	GBP 58 billion
1.5%	2.9%	GBP 16 billion	GBP 65 billion	GBP 34 billion	GBP 15 billion
2.2%	2.2%	GBP 8 billion	GBP 48 billion	GBP 17 billion	GBP 2 billion surplus

Source: The Health Foundation 2015.

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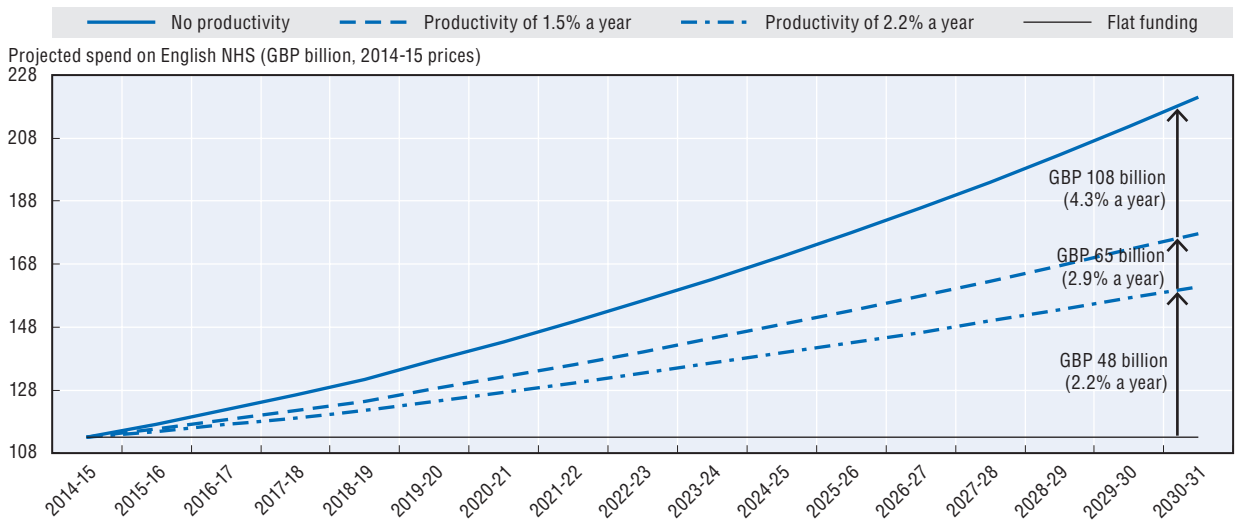
Figure 9.13. **Funding pressures on English NHS in 2030-31**



Source: The Health Foundation, 2015.

StatLink http://dx.doi.org/10.1787/888933219376

The work by NHS England, the Nuffield Trust and the Health Foundation looks at the medium-term funding pressures and funding outlook for health (Figure 9.13). For fiscal sustainability we also need to examine the long term. The UK's Office of Budget Responsibility produces long-term fiscal projections over a 50-year horizon (OBR, 2014a). The OBR latest assessment concludes that:

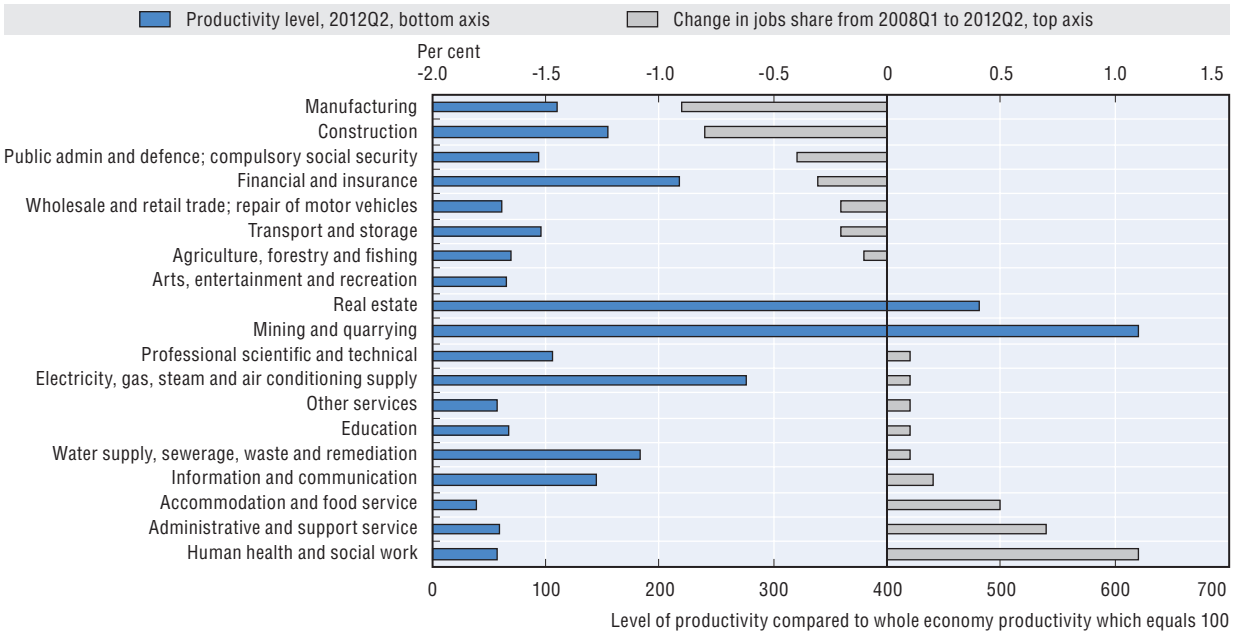
- Public spending other than on debt interest is projected to increase from 34.3% of GDP in 2018-19 to 39.1% of GDP in 2063-64.
- Public health spending is a key contributor to rising spending pressures. It is expected to increase by at least 2.1% of GDP by 2063-64, but this is very sensitive to assumptions about productivity. Long-term care costs are also projected to rise, with public spending increasing by 1.1% of GDP over the projection period.

- Non-interest revenues are projected to be broadly stable. They are projected to rise from 37.3% of GDP in 2018-19 to 37.4% of GDP in 2063-64.
- With spending pressures increasing above projected revenue growth, the overall fiscal position would deteriorate. The primary budget balance is projected to be in deficit of 1.7% of GDP by 2063-64. Public sector net debt is projected to be 74% of GDP in 2015-16. This is projected to fall to 53% of GDP in the mid-2030s but rise rapidly again to reach 84% of GDP in 2063-64.

If productivity growth in the health sector grew in line with recent trends rather than at the rate of the whole economy, real health spending per person would need to rise by 3.4% a year to increase health output by 2.2% a year, in line with real earnings growth. This would see health spending in 2063-64 rise by around 5.9% of GDP and result in a significantly higher path for net debt.

Figure 9.14 shows the difference in productivity estimates between different sectors of the economy. Health and social work productivity is estimated to be around 59% of whole economy productivity.

Figure 9.14. **Change in sectoral job share and level of productivity**



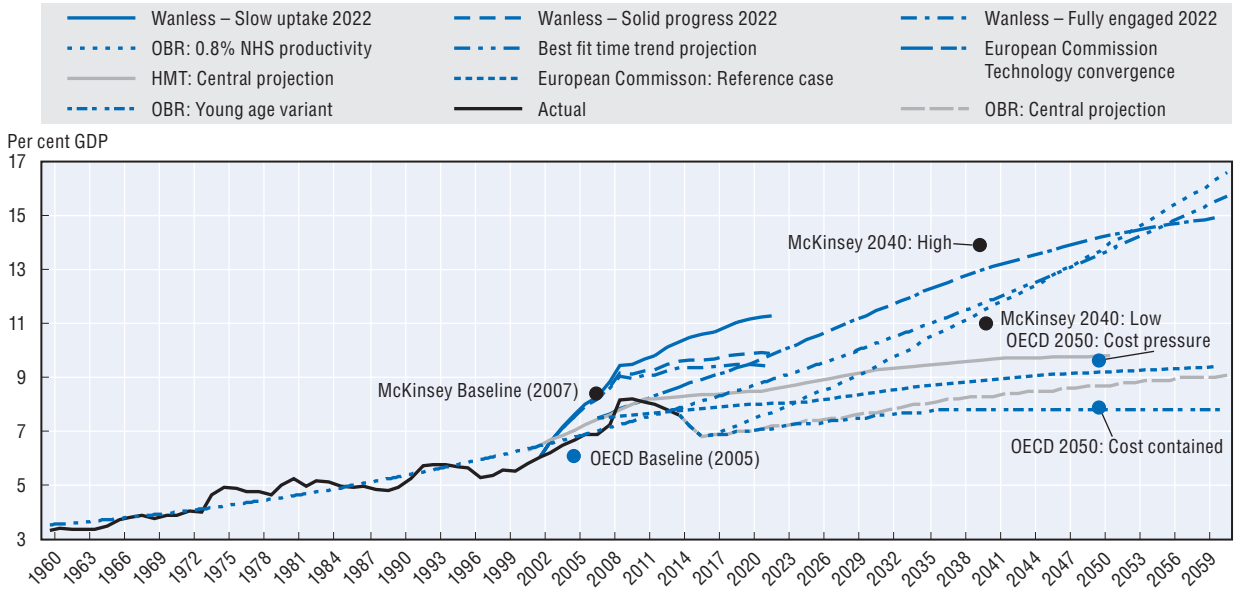
Source: Office for Budget Responsibility (2012), *Fiscal Sustainability Report*, Office of Budget Responsibility, The Stationery Office, London, *http://budgetresponsibility.org.uk/pubs/FSR2012WEB.pdf*.

StatLink *http://dx.doi.org/10.1787/888933219387*

Research by the Kings Fund has examined the factors which influence health and social care demand over a 50-year period. It reviewed a range of medium-term projections for health (Appleby, 2013). Figure 9.15 from the report compares some of the key projections.

This highlights the uncertainty about the path of spending in the long term. As Appleby notes, for health spending as a share of GDP the OBR's 2012 highest scenario for spending projection suggests that it will have reached 16.6% of GDP by 2061-62. Although this is much higher than current spending it is still lower than US health care spending was in 2010.

Figure 9.15. **A century of health spending: Projections of UK health care expenditure, 1960-2059**



Note: HMT: Her Majesty's Treasury; OBR: Office for Budget Responsibility. All projections are for public health care spending except McKinsey & Co's, which includes private health care expenditure.

Source: Appleby, J. (2013), *Spending on Health and Social Care over the Next 50 Years: Why Think Long Term?*, The King's Fund, London.

9.5. Conclusion

Spending on health in the United Kingdom is in line with the OECD average. In response to the economic crisis, the rate of growth in health spending has been sharply reduced. Health spending per person fell for two years at the beginning of this decade. The United Kingdom has robust measures in place to contain health spending in the short term, including a budget cap on public spending on health which allows health spending to grow at a much lower rate than historic trends. The government has also put in place measures to reduce cost pressures, including limits on administrative spending and a national public sector pay policy limit. It is seeking to protect access to care and quality of services through a programme to improve the productivity of the NHS. Although headline savings are being achieved and there is evidence of improved productivity, over the last year there are signs of pressure on both the budget and service standards. A significant number of NHS acute hospitals are in deficit and national targets for accident and emergency, elective surgery waiting times and cancer care are not being delivered. In December 2014, the government responded by increasing funding for the financial year 2015-16.

Beyond the current economic crisis, however, the United Kingdom faces a fiscal sustainability challenge. Health is an increasing share of total public spending. Health spending (along with pensions) is a major driver of the long-term growth in public spending. At present, health is projected to increase at a faster rate than government receipts. The scale of the potential fiscal gap is very dependent on assumptions about the long-run trend rate of growth in health service productivity.

Notes

1. A change in methodology in 2011 by the ONS means that services provided by non-NHS organisations now count as both an input and an output, while previously these were only counted as an input. This means that estimates produced after 2011 using ONS data are inconsistent with later estimates.
2. Cost-Weighted Activity Index (CWAI) for Hospital and Community Services in England from 1979 to 2000-01 (Oliver, 2005), The English National Health Service: 1979-2005, *Health Economics*, Vol. 14 pp. S75-S99. These estimates do not cover all hospital activities and are not adjusted for quality.

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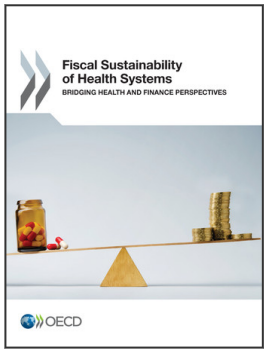

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