

NHS funding settlement

Is it enough and how
should it be spent?



NHS funding settlement

What was announced?

On 18 June 2018 the government announced plans for a long-term plan for the NHS including an increase in funding.

Additional funding

Under the plan, NHS funding will grow on average by 3.4% in real terms each year from 2019/20 to 2023/24, increasing the NHS England budget by £20.5 billion by 2023/24.

This additional funding will be applied to NHS England's budget rather than the overall health budget (Department of Health and Social Care expenditure). This means it excludes vital health expenditure areas such as public health, education and training and capital investment. It is crucial that there is also growth in these areas as they have a huge impact on patient care.

Factoring in a lack of growth in these areas, the overall increase will be closer to 3% (rather than the 3.4% announced). The funding increase, therefore, would have been more effective had it been provided to the Department for Health and Social Care's budget (TDEL).

It is important to note that the extra money will be matched by increases for Scotland, Wales and Northern Ireland through the Barnett formula.

A new 10-year plan for the NHS

The government has announced that a 10-year plan for the NHS in England will now be developed, with publication expected in November 2018. Although further details are yet to be published, the priority areas that have been announced include:

- Getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care
- Transforming cancer care so that patient outcomes move towards the very best in Europe
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- Better integration of health and social care, so that care does not suffer when patients are moved between systems
- Focusing on the prevention of ill-health, so people live longer, healthier lives

Potential legislative changes

As the 10-year plan is developed, the government has said it will consider proposals from the NHS on where legislation or current regulation may need to change to reduce barriers to integrated working. This could potentially signal an opportunity to move away from the internal market and free up the time and expense involved in contract negotiations between commissioners and providers.

This indicates that government is open to changes in the law that will support moves towards integrated care across England based on collaboration and not competition.¹

Is the funding enough?

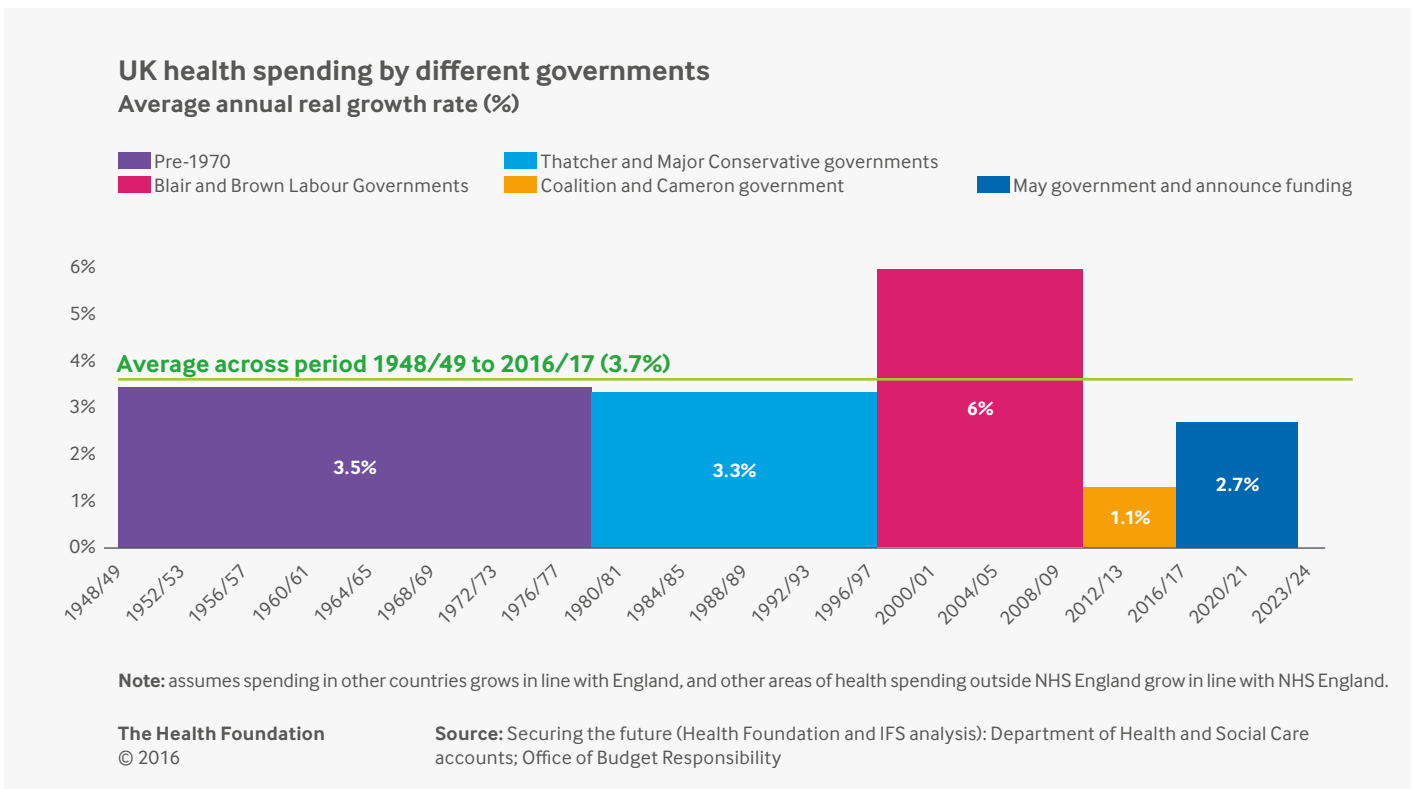
Although an increase in funding for the NHS is welcome, projected spending still remains below what the BMA and many policy experts believe is needed. The following sets out three examples of how this funding falls short of what is needed to ensure the NHS can keep up with rising patient need.

Historical comparison

The announcement is less than the long running average growth in health spending in the UK. For example, The Health Foundation has found that the average annual growth in the overall health budget between 1948/49 and 2016/17 was 3.7%.

For comparison, average funding growth in health spending under the Thatcher and Major governments was 3.3%. This increased to 6% under the Blair and Brown governments. This latest funding uplift means that NHS funding is growing at an average rate of 2.7% over this government, 1% below the long term average.

Figure 1: UK health spending by different governments – The Health Foundation, 2018²



Assessment of growing patient need

Leading health policy think tanks have reported that the NHS will need around a 4% real terms annual increase in order to be sustainable. For example, the Institute for Fiscal Studies and The Health Foundation³ have developed analysis that states that in order to maintain quality and access to care at current levels the overall health budget for England would need an extra 3.3% funding over the next 15 years. However, improving the quality and range of care provided would require an increase in spending at a faster rate – growing by 4.1% annually over the next 15 years.

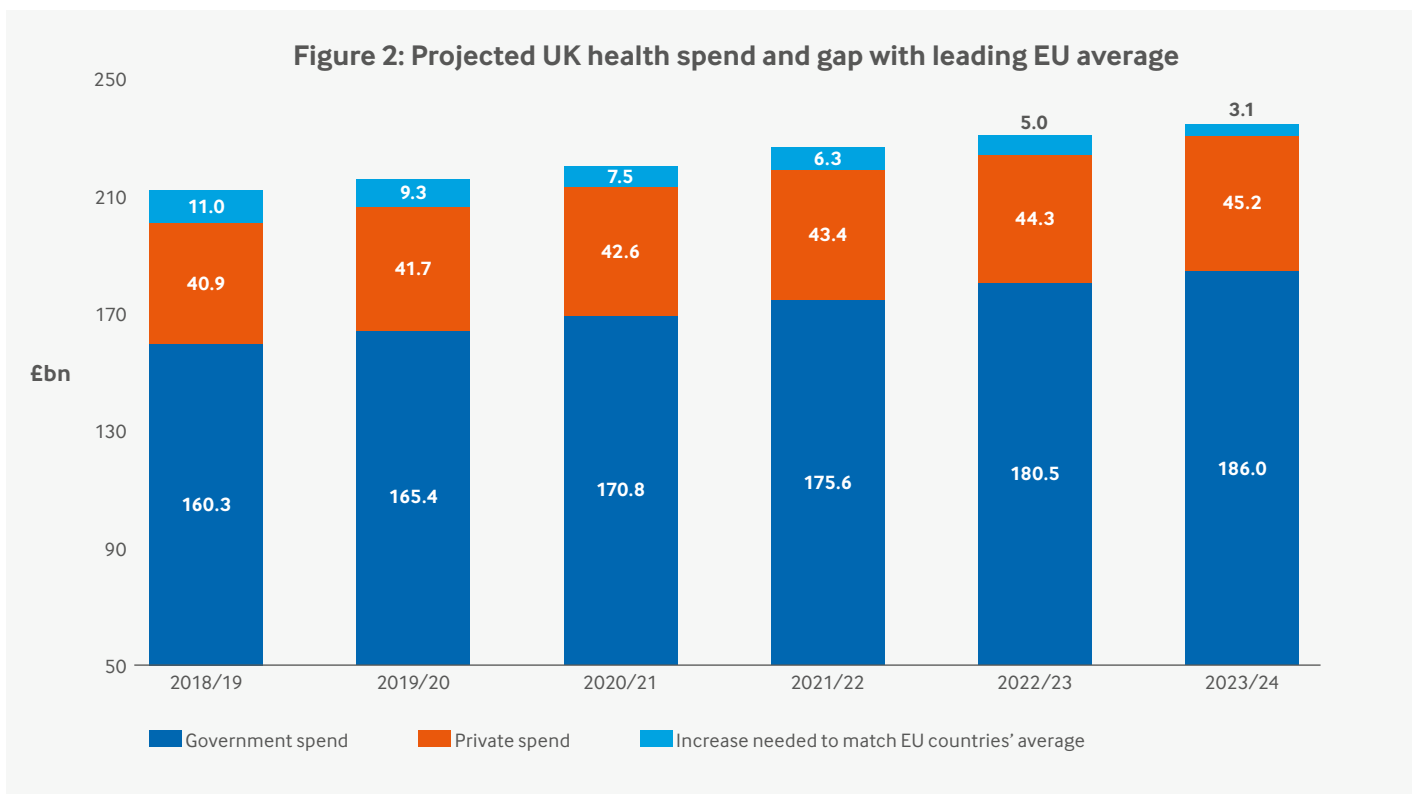
This is due to growing patient need and increased costs with, for example, the number of people living with one or more chronic conditions significantly rising.

Increasing total health funding by an annual 4.1% will help ensure the NHS in England is able to meet waiting times targets for A&E and inpatient care, deliver parity of esteem for mental health and invest in modern technology and facilities.

European comparison

The UK currently spends less on health as a proportion of GDP than many other leading EU countries. The latest OECD⁴ data shows that in 2017 the UK spent 9.7% GDP on health, whereas the leading EU countries^a spent an average of 10.1%. Although the new NHS funding will go some way to bridging this gap, the UK will still spend less than these leading EU countries.

Based on the new real terms funding for NHS England^{5, b} and assuming no growth in the rest of the health budget in England, we predict that total UK health spending will reach £231.2 billion by 2023/24. This includes government health spending of £186 billion and private health spending of £45.2 billion by 2023/24.^c However, to bring us in line with leading EU economies, the UK governments would have to spend an extra £3.1 billion by this time. This would bring total UK health spend to £234.3 billion by 2023/24.

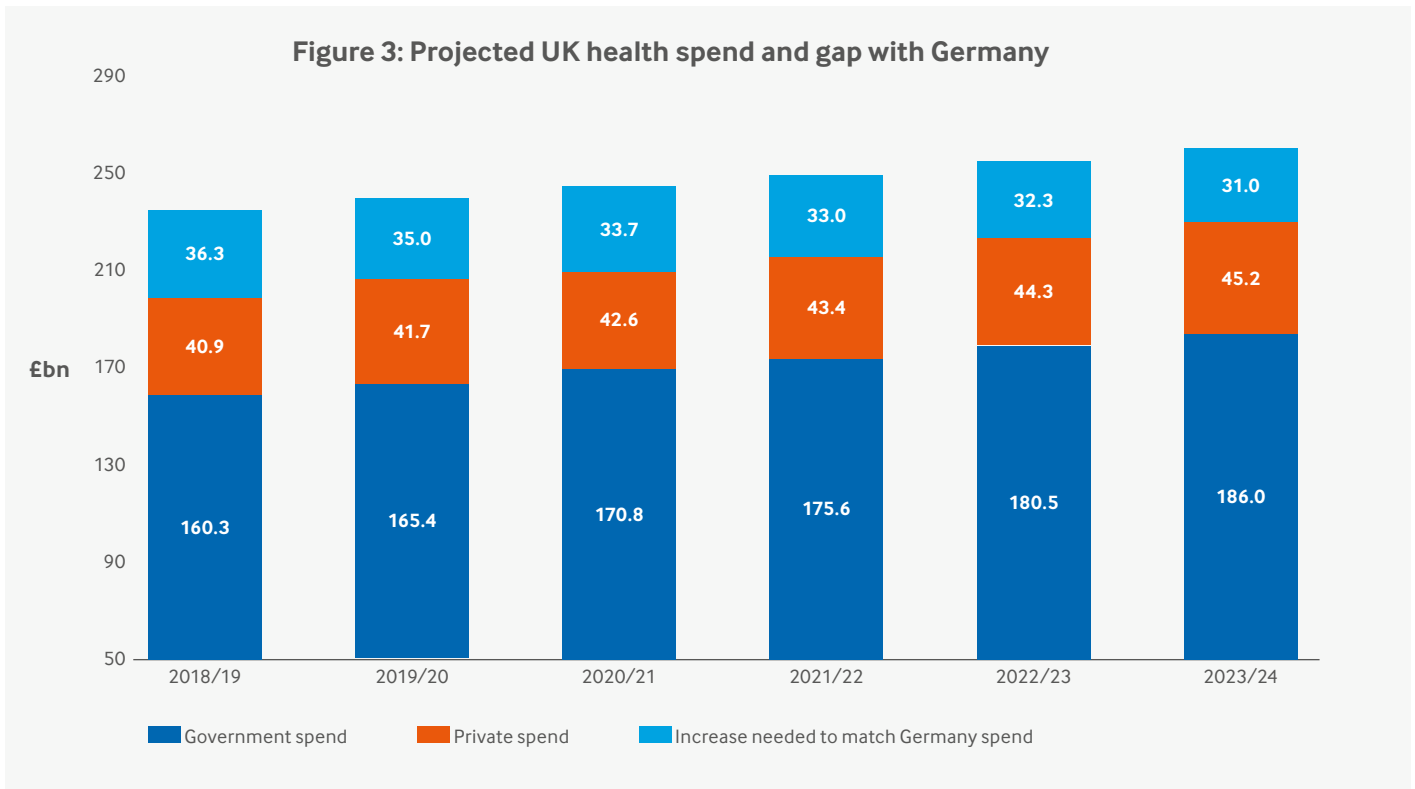


Individual leading EU countries such as France and Germany spend significantly more on health than the UK. For example, in 2017 Germany spent 11.3% GDP on health, compared to the UK's 9.7%. Assuming that Germany continues to spend this proportion of GDP on health, the gap between UK and Germany's health spend would reach £31 billion by 2023/24. However, as the proportion of GDP that Germany is spending on health has increased (e.g. 10.9% in 2013 to 11.3% in 2017), it is likely to continue to increase and therefore increase the gap with the UK even further.

a Leading EU countries measured by GDP per capita. Excluding the outliers of Luxembourg and Ireland the top 10 leading EU countries are Austria, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Sweden and Spain.

b This does not include the extra funding allocated for NHS pensions.

c Assuming no growth in the remaining DHSC budget, private health spend rising in line with GDP growth of 2% per year, and devolved nation's health budgets rise in line with England.



How will the money be raised?

Exact details of how the funding will be raised are expected to be announced by the Chancellor ahead of the spending review later this year.

Unless there is a clear plan on how this new funding for the NHS will be raised, it is likely to be unsustainable. The government has announced some options for raising the funding, such as raising taxes. There is a reported⁶ willingness by the public to pay more tax for the NHS. In addition, the BMA recently voted to support an increase in tax to fund the NHS.^d However, it is crucial that any proposals are communicated clearly by government in order to gain sufficient public and political backing.

Brexit dividend

It was announced that some of the extra funding will come from using the money the UK no longer spends on the annual membership subscription to the European Union after we have left. However, there is no guarantee that the extra money to pay for increased NHS funding will come from stopping our payments to the EU budget. In addition, other costs associated with Brexit are expected to outweigh the savings.⁷ For example, the UK is yet to leave the EU, so payments are still being made into the EU budget, which is currently expected to continue until 2021. The UK is also likely to have to pay a 'divorce bill' for leaving, which is estimated to be around £37 billion.⁸

The impact on the NHS workforce could also outweigh any predicted savings. The proportion of EU workers in both the NHS and the social care sector has been growing over time. Nearly 10% of doctors working in the UK are from the EEA. However, the decision to leave appears to be having a negative impact on the workforce. There is a very real risk that some EU nationals, including highly skilled doctors and medical researchers, will choose to leave the UK because of ongoing uncertainty in the Brexit negotiations. Nearly half (45%) of EEA doctors surveyed by the BMA in November 2017 said they are considering leaving the UK following the referendum vote. Of those considering leaving, more than a third (39%) have made plans to leave, meaning almost one in five EU doctors (18%) have made plans to leave the UK.⁹

^d ARM 2018 – That this meeting believes that in order to provide the necessary funding for the NHS taxation should be increased.

Any reduction in the number of doctors migrating to the UK will undoubtedly exacerbate workforce shortages and have an impact on staffing levels on hospital wards, in GP practices and in community settings across the UK. The quality of patient care and patient safety will be put at risk if the UK health services are restricted from recruiting highly skilled staff.

How should the new money be spent?

How the new funding is spent will be key to its effectiveness. It is crucial that doctors are at the heart of decisions about how the money will be used, to ensure investment reaches frontline services as quickly as possible.

The BMA will be calling for a number of priorities to be central to the decisions in how to spend the funding. The following sets out just a few examples of these priorities that carry equal importance to helping to sustain the NHS^e:

Workforce

There is a need to invest in the workforce to help put the NHS on a more sustainable footing. With workloads rising and doctors' pay having fallen by 22% over the last decade, staff morale is low and recruitment and retention is a key challenge for the NHS. There are at least 92,000 staff vacancies in the NHS.

Expanding training places to build up the future workforce must be a priority for government. However, with a lack of investment in the Health Education England budget (which is not included in the funding announcement), training and education is likely to suffer.

Bed capacity

Funding must increase bed capacity in line with rising demands on hospitals. The number of beds in the NHS in England has fallen (6,000 less beds since 2014/15), leaving secondary care staff to try and cope during the worst winter on record – bed occupancy levels have been left averaging 95% or over, and overwhelming system pressures have meant millions of patients are left awaiting treatment for an unacceptable period of time.¹⁰

The problem is not contained to seasonal spikes in demand; BMA analysis¹¹ has highlighted that the pressures are now year-round. We do not believe the situation is sustainable or safe – cuts to bed numbers mean that the UK now has one of the lowest numbers of hospital beds per patient in the OECD.

Primary care

General practice has faced a decade of underinvestment at a time when patient consultations are increasing, the population continues to grow, and patients are living longer with more complex health needs. A significant boost to general practice funding is an essential step towards making the NHS more sustainable in the longer term.

The commitments set out in the General Practice Forward View, to invest in general practice over the coming four years by at least £2.4 billion, remain wholly insufficient to either restore the share of NHS funding allocated to general practice to 2005/06 levels, or reach the BMA's target of 11%.

Other key proposals for primary care, outlined in the BMA's recent Saving General Practice report¹², include proper investment in premises, IT infrastructure and administrative support; a sustainable indemnity package; and a workforce strategy that fosters collaborative multi-disciplinary general practice and community care.

Primary care must be one of the government's key priorities for the 10-year plan for the NHS.

^e This is not an exhaustive list of BMA priorities. All future BMA lobbying will be based on cross-branch of practice priorities.

Mental health services

We do not believe commitments to embed parity of esteem have been realised, with funding too often not reaching frontline mental health services. Although mental ill-health accounts for 28% of the total burden of diseases in England¹³, it only accounts for approximately 13% of CCG spending.¹⁴ There must be increased funding for mental health services to more closely match disease burden.

Public health

A lack of growth in public health could have a costly impact on the NHS in the longer-term. Public health spending fell by a fifth in real terms between 2013/14 and 2018/19.¹⁵ A lack of investment and protection of public health services will ultimately lead to service reduction. For example, only 61% of local authorities now offer universal access to specialist smoking cessation services. This includes areas with high smoking prevalence.¹⁶

There is a need to move away from short-term or annual budgets towards long-term sustained funding for prevention. The creation of a 10-year plan for the NHS could be an opportunity to address this, but it is disappointing that the funding increase announced does not include public health because this falls outside the remit of NHS England.

Capital investment

Funding for capital investment has been reallocated to prioritise day-to-day running costs over recent years. For example, DHSC transferred £1.2 billion in capital funding to its revenue budgets in 2016/17, and these transfers will continue until 2020/21.¹⁷ Worryingly, the announced funding increase does not cover capital investment. Reducing the capital budget in real terms would mean investing less in buildings and equipment for the NHS, and this comes with a financial and human cost.

Social care

This is an area of increasing concern for the BMA due to the impact it has on the ability of the NHS to cope in the future. The current crisis in social care is a direct result of inadequate funding. For example, at least 400,000 fewer older people are now able to access publicly funded social care than in 2010.¹⁸ An underfunded social care system will impact negatively on an already stretched, overworked and underfunded NHS due to a lack of appropriate social care facilities for patients and delays in transfer of care.

The need for social care reform remains urgent. The BMA welcomes the government's commitment to publish a green paper on social care this year. However, it is crucial that this includes a long-term funding settlement, and ensures proposals are fully aligned with the plan for the NHS. It has been predicted that to keep up with the ageing of the population and growth in young adults living with disabilities social care will require public funding to increase by 3.9% a year across the UK over the next 15 years.¹⁹ This is just to maintain the current system of eligibility and means-testing for social care across the UK. Significantly more funding will be needed to improve access to and quality of social care services. Good integration and collaboration between health and social care systems is crucial to delivering a joined-up service for patients.

BMA view and next steps

The BMA will continue to call for funding to be brought in line with comparable European countries. As outlined above, this funding increase is welcome but remains insufficient to ensure the NHS can meet the growing needs of patients in the future. Government rhetoric around achieving “world class” care raises expectations that this funding announcement will not be able to match.

In the meantime, the BMA will seek to ensure that the views of frontline clinicians are central to discussions around how the new funding will be spent over the coming months. It is vital that there is transparency around how the funding is allocated, and we believe the emphasis should be on ensuring resources reach the front line where they are needed most as quickly as possible.

The BMA will also be pushing for the government to consider changes to the legislative structure of the NHS in England that will remove the competition and procurement regulations that currently waste vital resources and act as a barrier to integrated care. The BMA’s new ‘[Caring, supportive, collaborative](#)’ project will inform our thinking. This aims to create space for an honest conversation about the sort of NHS we need to meet changing health needs, to deliver the high quality and safe patient care we want to deliver and to be the kind of health service that doctors want to work in. It is an opportunity for the profession to set out a forward-looking vision and identify priorities for how the new investment should be used. The project will explore three main areas: how to move to a culture of openness and learning, how to best use skills mix and new clinical roles to support doctors, and how to organise health systems in a way which empower doctors to work collaboratively.

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