House of Lords committee on the long-term sustainability of the NHS

Key points

- New OBR projections suggest that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% and 8.9% by 2030/31 – equivalent to a rise of just under £100 billion over the next 15 years, of which 60% would come from projected growth in GDP and the remainder from a combination of tax and reprioritisation of other public spending.
- **Choosing a specific spending path for health** (such as the OBR's 'declining cost pressures' projection) **would be a financially sustainable position** that would enable the quality and volume of health care to grow more or less in line with public expectations and medical technology.
- **Pressures to spend more on social care will inevitably also grow over time**, and other sustainability problems are inherent in this area given its funding sources and traditional separation from health.
- The OBR's 'declining cost pressures' projection for social care spending to 2030/31 would add a further 0.6% of GDP from the 2014/15 level. Around 30% of this increase would arise from projected growth in GDP, leaving around £16 billion to be found via a combination of tax and reprioritisation of public spending.
- **We will end up paying more for social care one way or another** – either through higher taxes for improved services; directly from the public's pocket; or through non-financial costs arising from reduced access to publicly funded services. The issue is **how to ensure extra spending delivers what we want** from social care, including, we argue, equal opportunity of access for equal needs.
- A **smoother, steadier spending path over the long term** would not only support the decisions health and social care need to take to be sustainable, but would increase the transparency for the public about the financial commitment they could be asked to make.
- The investigation into long-term health and social care spending and sustainability should not just be an ad hoc exercise. There is a need for **a wider-ranging independent review of the long-term future for care every three-to-five years to inform public and political debate**.

Consultation response

October 2016

This note sets out the Nuffield Trust's views on key questions concerning the Committee's investigation of the sustainability of the NHS over the next fifteen years. It updates oral evidence given to the Committee on 6 September 2016 by Prof John Appleby, Director of Research and Chief Economist, in the light of a new survey of the literature on spending projections and, in particular, new projections for health spending published by the Office for Budget Responsibility on 21 September 2016.

Introduction

Worries about the affordability of the NHS have a long history. Almost as soon as it opened its doors, concerns were expressed about its cost. Then, in 1953, health minister Iain Macleod announced an independent parliamentary committee to investigate the long-term costs of the NHS and to make recommendations about possible structural and funding changes. Three years later, Claude Guillebaud's committee reported that the NHS was not particularly inefficient, that costs were not as high or rising as fast as feared, and that little structural reform was needed (Chester, 1956).

At the time of the report, the UK was spending around 3 per cent of its GDP on the NHS – equivalent to nearly £13 billion at today's prices.

Over the sixty years since Guillebaud's report, spending on the NHS has risen (as it has in other countries). While the economy has grown over four-fold since 1956, NHS spending has increased eleven-fold – taking its share of GDP from 3% to 7.4% – equivalent to around £1 in every £14 in the economy. And on average, NHS spending rose in real terms by around 4% each year. Key drivers of this increase included increasing national wealth, population growth and the expansion in medical technology.

If NHS spending as a share of GDP continued to grow at the rate it has done since the 1950s, by 2191 it would consume 100% of GDP. Clearly, on this trajectory, at some point between now and 176 years in the future, spending on the NHS will need to stabilise for it to be financially sustainable. The question is, when?

How we – the public, taxpayers, politicians – make the decision that 'enough is enough' will, among other things, involve choices between competing areas of public spending, the balance between taxes and private disposable income and how we value what health care and medicine has to offer in the future.

A crucial starting point for these difficult decisions is how NHS spending might evolve in the future based on how it has changed in the past, and how we think the drivers of spending – population changes, national income and so on – will shape spending decisions in the future.

1. Public spending projections on health care in the UK

Estimates of future health spending can be carried out either on the basis of 'policy neutrality' – what spending would look like given forecasts of the path of key spending drivers (such as population size and age structure) but not those related to changes in policy (such as the introduction of seven-day working for example) – or on a more positive basis in terms of specifying what sort of health care should be available in future

and then estimating the cost of achieving such a vision. Most projections, both in the UK and in other countries and supra-regional organisations, are of the former kind. The estimates of future spending needs for the UK NHS carried out by, for example, Derek Wanless in 2002 was an example of the latter.

In practice, the distinction between these two perspectives can be blurred, and given uncertainties about the future, both approaches involve assumptions about the drivers of future spending (population changes, health system productivity and so on) with tests of the sensitivity of projections to variations in the underlying assumptions. So, where might spending on the NHS be headed over the next fifteen years?

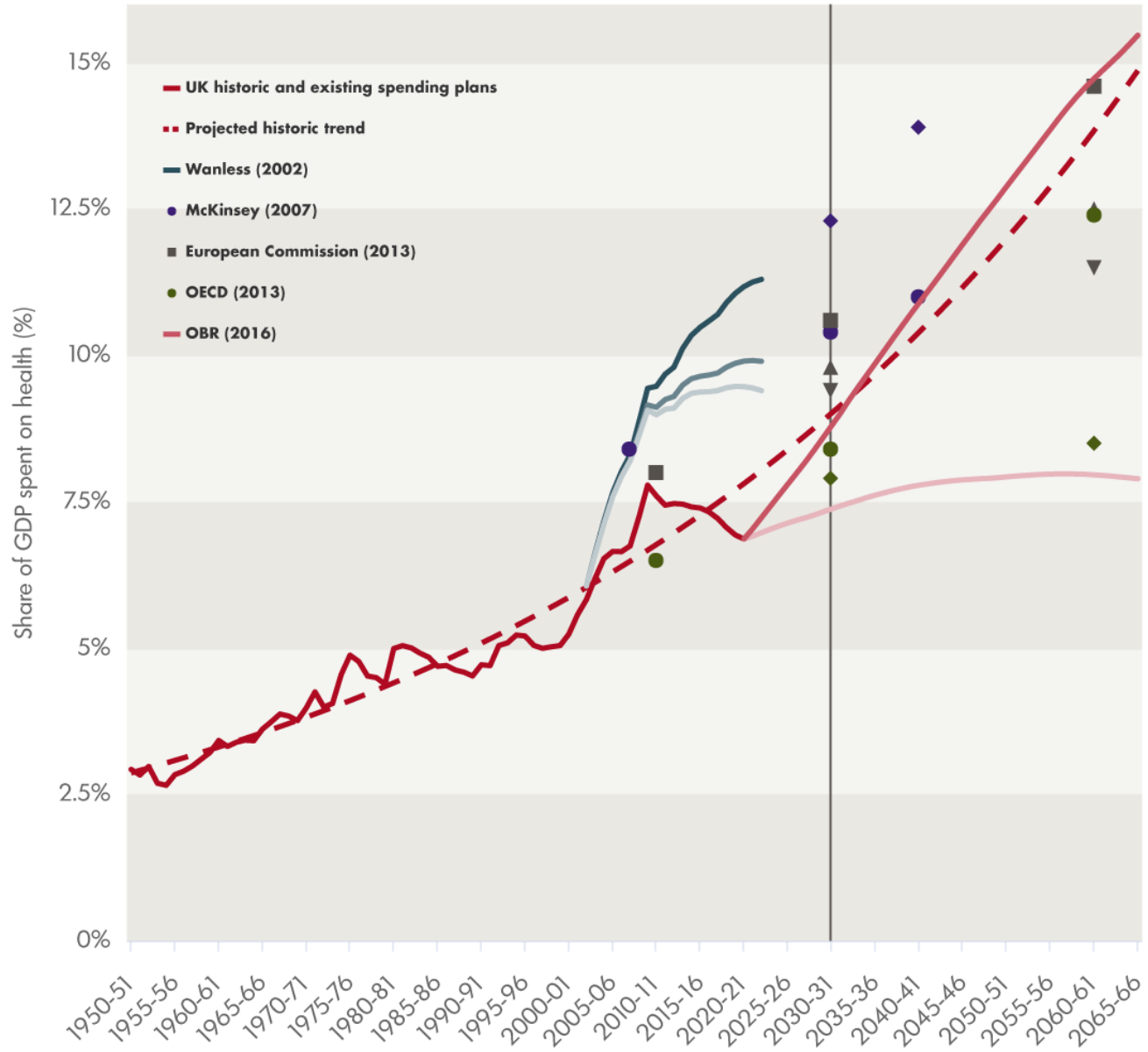
Table 1 shows the latest estimates of UK health care public spending to 2030/31 from four organisations – the Office for Budget Responsibility, McKinsey Consulting, the European Commission and the OECD. All are essentially policy neutral, take slightly different approaches to the assumptions underlying their projections and vary in the extent of the testing of these assumptions. Table 1 also includes Wanless's estimates of the costs of his 'vision' for the NHS up to 2022/23 for comparison. (Figure 1 shows more detail for these projections and provides the historical spending context. An interactive version of this chart is also available.)

Table 1: UK health care public spend projections to 2030/31 as a percentage of GDP

	Scenario	Baseline	2015/16	2022/23	2030/31
	Actual		**7.4**		
OBR (2016)	Declining 'other pressures'		7.4	7.2	8.8
	Constant 'other pressures'		7.4	7.2	8.9
	Low health care productivity (1.2% p.a.)		7.4	7.1	8.3
	High income elasticity (1.2 converging to 1)		7.4	7.1	7.9
	Low income elasticity (0.8 converging to 1)		7.4	6.9	7.3
	Slower expansion of morbidity		7.4	7.0	7.5
	Compression of morbidity		7.4	7.0	7.4
Wanless (2002)	Slow uptake		10.5	11.3	
	Solid progress		9.6	9.9	
	Fully engaged		9.4	9.4	
McKinsey (2007)	Baseline	8.4 (2007)			10.4
	High				12.3
European Commission (2013)	Cost pressure	8.0 (2010)			10.6
	High cost containment				9.4
	Low cost containment				9.8
OECD (2013)	Cost pressure	6.5 (avg 2006–2010)			8.4
	Cost containment				7.9

Sources: Licchetta and Stelmach (2016), Kibasi and others (2012), Wanless (2002), EC (2013), OECD (2013).
NB: McKinsey and EC 2030/31 are linear interpolations inferred from these studies' longer-term projections (to 2040 and 2060 respectively) McKinsey analysis covers private as well as public spending.

Figure 1: Projections for UK health spending to 2065–66



Some data sources provide a high and low projection or high, central and low projections, so some plots diverge to show various outcomes.
Sources: Licchetta and Stelmach (2016), Kibasi and others (2012), Wanless (2002), EC (2013), OECD (2013).

Across the four policy neutral studies, spending is projected to change from around 7.4% of GDP in 2015/16 to between 7.3% and 12.3% by 2030/31.

However, these are the extremes based on alternative assumptions about, for example, the ability of the NHS to contain growing costs (through higher productivity for example) or how health care needs might change in the future.

2. New projections from the Office for Budget Responsibility

Of more note – not least because the projections are the most recent and involve a change in assumptions – are those by the Office for Budget Responsibility (OBR).

A key change in the OBR's assumptions about future spending is the inclusion (similar to the OECD) of a factor for 'other cost pressures'. These are, in essence, the extra growth in costs over and above demographic change and any effects of growing national income (and the desire to devote increasing wealth to health). This element of the growth in health spending is hard to pin down, but is generally recognised as an important driver of additional growth in health spending over time for all countries. The OBR's new 'cost pressures' growth projections suggest that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% or 8.9% by 2030/31, depending on the extent of any containment of this element of growth.

Based on the OBR's 2015 projections for growth in GDP (OBR, 2015), these shares of GDP are broadly equivalent to a real increase in health spending of just under £100 billion over the next fifteen years (from £139 billion in 2015/16 to £237 billion, in 2015/16 prices).

3. What do current spending projections tell us about the long-term sustainability of the NHS?

Bearing in mind the inevitable uncertainty of any projections of health spending, taking the OBR's new projection of around 8.8% of GDP by 2030 (and bearing in mind projections from the OECD and EC), is it possible to draw a conclusion about the financial sustainability of the NHS?

The short answer is, yes, but the OBR's new projections do have implications for taxation and spending priorities across government.

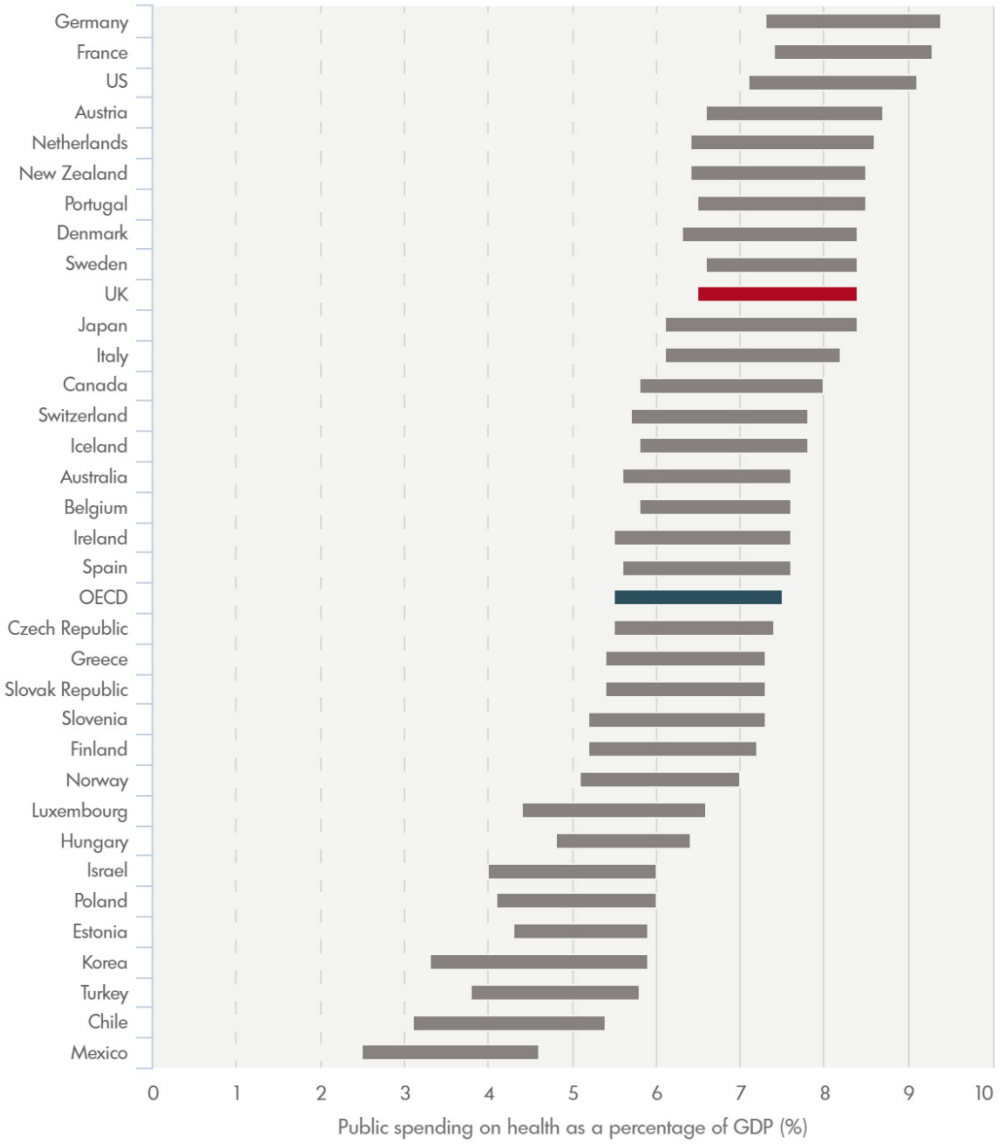
To put the projection in some historical context, the increase of around £100 billion in spending over the next fifteen years implied by the new cost pressures projection (and projections of GDP growth) represents an average annual real increase of around 3.5%. This is less than the long-term (1950–2015) increase of just over 4%. Further, the increase in share of GDP of 1.4% over 15 years is also the same as the increase over just five years between 1999/2000 and 2004/5.

From this perspective, then, the increase in projected spending does not seem out of line with history – and indeed, slightly lower than the long-term growth in spending.

From an international perspective (caveated with warnings about the difficulty of making comparisons in health spending between countries), a national public spend of 8.8% by 2030 would take the UK to the levels of public spending for France, the Netherlands, Denmark, Sweden, Germany and Japan (and a little above Norway and the US) – in 2015. And in terms of where other countries are likely to be in terms of public spending by 2030, the OECD projections suggest that all countries' spending is likely to increase (see Figure 2 – an interactive version of this chart is also available), leaving the UK's relative rank on public spending on health essentially unchanged between 2010 and 2030.

In themselves (and possibly taken together) these triangulations of the UK's possible spending on health by 2030 do not provide a conclusive answer to the financial sustainability of the NHS over the next fifteen years. However, they do provide a strong indication that – judged historically and across countries – spending increases are sustainable.

Figure 2: Public spending on health across OECD countries 2010 and projected to 2030



The left side of each bar represents public spending in 2010, and the right side the projected spend in 2030.
Data: OECD (2013). Projections based on OECD's highest cost pressures projection.

4. Higher health spending – but who pays?

Nevertheless, if the OBR's cost pressures projection became the chosen spending path, this choice has policy implications. Not least is the question of where the extra money would come from. The choice, crudely, is between (or rather, some combination of) extra taxation and/or shifting government spending away from some areas and towards health.

It is important to bear in mind that a big chunk of the £100 billion increase implied by the OBR projection arises because the economy – and its measure, GDP – is also projected to increase: even if the health spend share remained unchanged at its current rate of 7.4% (with all other government spend also staying the same as the 2015/16 shares), the NHS would grow by nearly £60 billion in real terms as GDP is projected to

grow by just over 40% in real terms by 2030[1]. This would leave around £40 billion (an extra £2.7 billion each year) to be funded through some combination of increased tax and reprioritisation of government spending.

Just for illustration, if the additional spending on health were split evenly between tax rises and reprioritisation of spending in non-health areas, given the sums involved and the time period for the increased spending, non-health spending could still increase in real terms (around 2.2% per year), even though reducing very slightly as a proportion of GDP (by 0.7 percentage points over 15 years – around one twentieth of a percentage point per year). The remaining additional health spending of around £1.4 billion each year is equivalent to a year-on-year increase across all income tax rates of around one fifth of a percentage point each year. We would emphasise that these are rough estimates only, but they give an idea of the scale of the opportunity costs involved in choosing the OBR's declining cost pressures spending path.

While the focus here has been on the costs (additional tax/reprioritisation) arising from pursuing a path to increase health spending, it should be noted that there is also an opportunity cost of not doing so. If, for example, health care spending only increased in line with GDP growth (that is, remained flat as a share of GDP), over time it is likely that the quality and volume of health care would increasingly diverge from the sorts of levels expected by the public, and with advances in medical technology becoming increasingly unaffordable within the global health care budget available.

Summary: Health care

On balance, and given the evidence of likely future cost pressures and the opportunity costs of meeting these, our main conclusion is that choosing a spending path (such as the OBR's 'declining cost pressures' projection) would be a financially sustainable position that would enable the quality and volume of health care to grow more or less in line with public expectations and medical technology.

[1] These estimates depend on the rate at which GDP will grow in the future. The full impact of the Brexit decision on GDP for example remains unknown, but most projections indicate a reduction in the rate of growth of GDP into the future. This will clearly limit the choices available to future governments in terms of their tax and spend decisions.

5. Public spending projections on social care in the UK

As with health, there are a number of studies that project spending on social care/long-term care. Some are 'policy neutral' (e.g. OECD and the OBR), and while others introduce an allowance for deliberate policy to, for example, improve quality (e.g. the Barker Commission, Wanless) or extend coverage (e.g. the European Commission in one of its scenarios).

Table 2 and Figure 3 summarise projections from five studies (an interactive version of Figure 3 is also available)

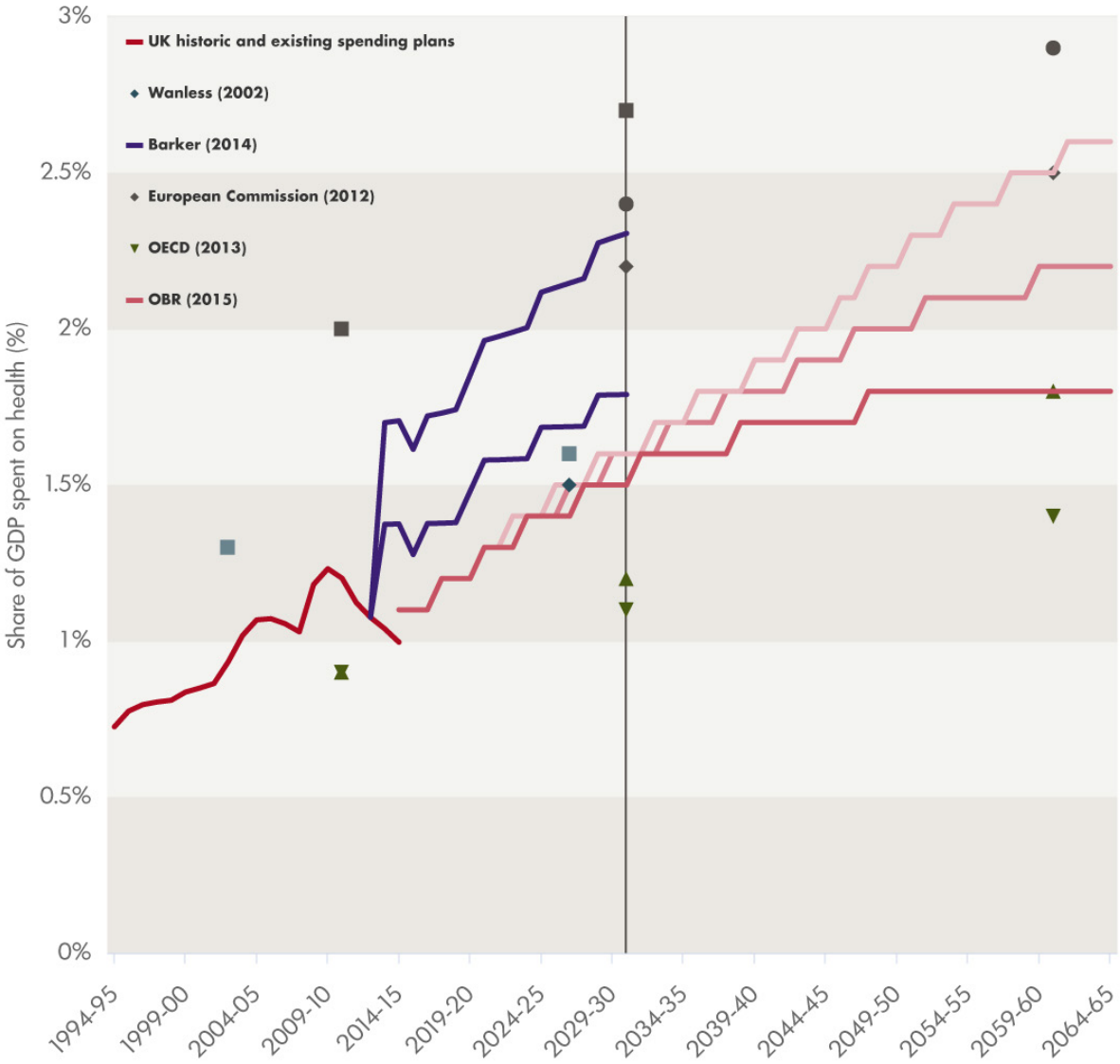
Table 2: UK long-term care/social care projections to 2030/31 as a percentage of GDP

	Scenario	Baseline	2014/15	2015/16	2022/23	2030/31
	Actual		**1.0**			
OBR (2015)	Central projection		1.1	1.3	1.5	1.6
	Old age variant		1.1	1.4	1.5	1.6
	Young age variant		1.1	1.3	1.4	1.5
	High migration variant		1.1	1.3	1.5	1.6
	Low migration variant		1.1	1.3	1.5	1.6
	FSR14 restated (low migration variant)		1.1	1.3	1.4	1.5
	Higher initial health and education spending		1.1	1.3	1.5	1.6
	Lower health productivity growth		1.1	1.3	1.5	1.6
Barker (2014)	Critical and substantial needs eligibility only		1.4			1.8
	Moderate eligibility		1.7			2.3
Wanless (2002)	Core business	1.3 (2002)			1.5	
	Wellbeing				1.6	
OECD (2013)	Cost pressure	0.9 (avg 2006-2010) 2.0 (2010)				1.2
	Cost containment					1.1
European Commission (2012)	Base case					2.4
	Delayed dependency					2.2
	Cost convergence					2.4
	High life expectancy					2.4
	Shift to formal care					2.7
	Coverage convergence					2.7

Sources: OBR (2015), Wanless (2002), Lipszyc and others (2012), OECD (2013).
NB: OECD and EC 2030/31 are linear interpolations inferred from these studies' longer term projections (to 2060)

Depending on the study and the scenario, spending projections to 2030 range from 1.1% (OECD) to 2.7% (European Commission) of GDP. The OBR's projections were published in its 2015 Fiscal Sustainability Report and, unlike health, have not yet been updated this year.

Figure 3: Projections for UK long-term social care spending to 2064–65



Some data sources provide a highest and lowest projection or highest, central and lowest projections, so some plots diverge to show various outcomes. Sources: Wanless (2002), The King's Fund (2014), EC (2013), OECD (2013), OBR (2015)

From a baseline spend in 2014/15 of around 1% of GDP (equivalent to £18.4 billion in 2015/16 prices), the OBR's central projection suggests that population and other pressures would increase spending to 1.6% by 2030 – equivalent to around £42.5 billion at 2015/16 prices (a real increase of around 130%).

On the assumption of a need to boost quality and coverage of social/long-term care, however, the Barker Commission, for example, suggests spending by 2030 should range between 1.8% and 2.3% of GDP – equivalent to spending of around £48–£61 billion.

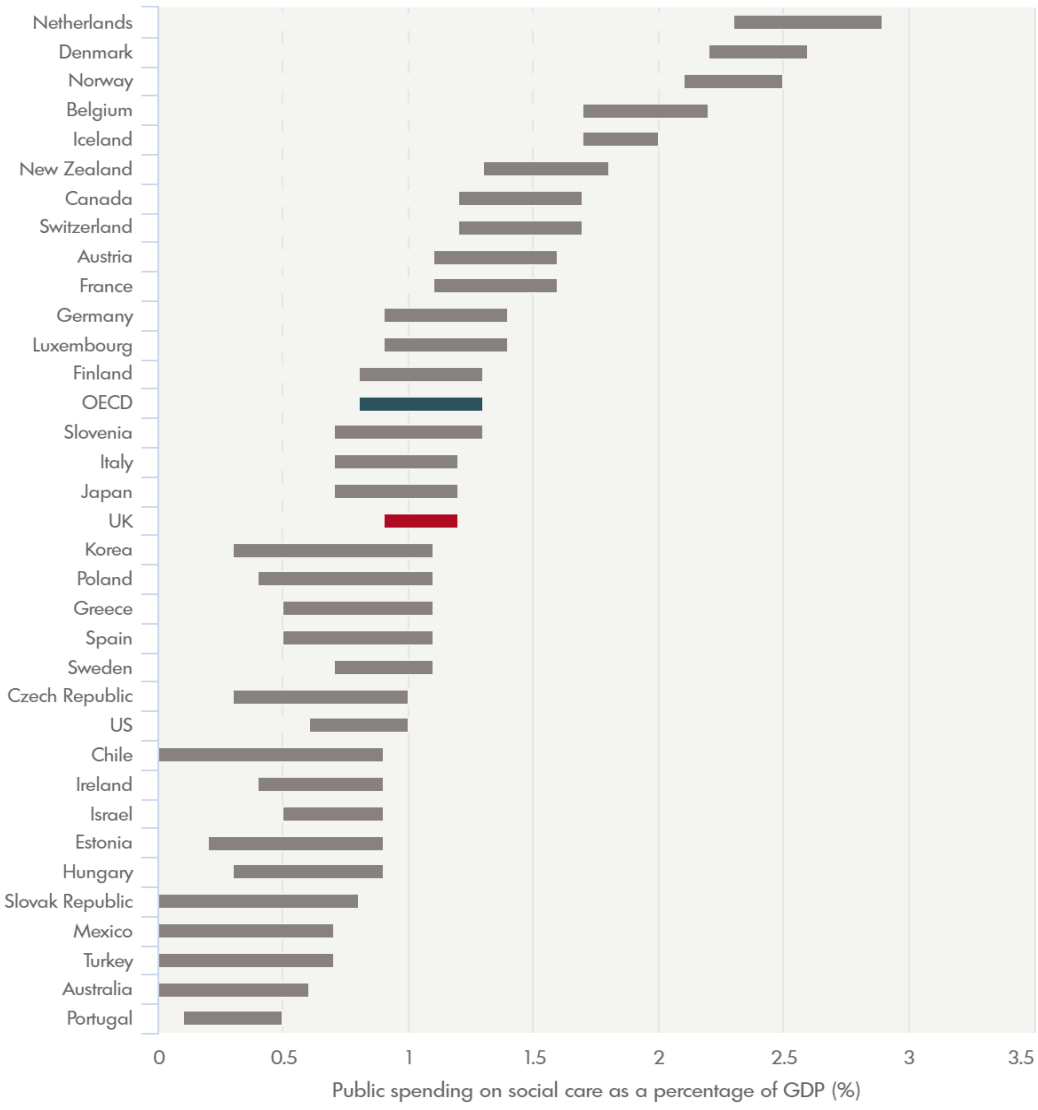
6. What do current spending projections tell us about the long-term sustainability of social care?

Historically, social care spending increased its share of GDP from 0.7% in 1994/5 to 1.2% in 2009/10 – equivalent to an annual real increase of 5.8%. Following real cuts to local authority budgets over the last six years, and despite their best efforts to maintain

publicly funded social care, current spending on care has now fallen to a 1% share of GDP – back to the levels of over a decade ago – and equivalent to a real cut of round 0.6% every year from 2009/10 to 2014/15. It is also clear that funding cuts and tightening eligibility criteria to access social care has reduced the numbers of people with publicly funded care packages by over a quarter between 2009 and 2014 (Humphries and others, 2016).

In this context, the OBR's central projection would, over fifteen years, add a further 0.4% of GDP to the peak level in 2009/10 (and 0.6% over the level in 2014/15 – that is, taking 0.2% of GDP to catch up with the fall in share over the previous five years). On average, from 2015/16, this represents an annual real increase of 4.8% – between £0.5 billion in the early years to around £1 billion in the latter years (at current prices). Internationally – and with a strong caveat concerning the comparability of data – the increase in social care spending projected by the OECD for the UK by 2030 would take it to just below the levels of spend averaged across 2006 to 2010 for Canada, Switzerland, New Zealand, Belgium, Iceland, Norway, Denmark and the Netherlands (which spent twice the proportion of GDP on long-term care in 2006/2010 that the UK is projected to spend over two decades later. And as Figure 4 shows, based on the OECD's upper projection, all OECD countries are expected to face increased spending pressures, leaving the UK's relative rank spending slightly lower by 2030 than in 2006/2010.

Figure 4: Public spending on long-term/social care across OECD countries 2010 and projected to 2030



As in the case of health spending, these historical and international comparisons provide an indication that additional funding for social care would be sustainable to 2030. And we would point out that around 30% of the increase in funding under the OBR's central projection will simply arise from a growing GDP, leaving around 70% (~ £16 billion at today's prices)[2] to be found via a combination of tax and reprioritisation of public spending.

Again, on balance, while there will be opportunity costs associated with higher public spending on care, these do not seem to be unreasonable or particularly unaffordable over the period to 2030.

7. Higher social care spending – but who pays?

Given reductions in funding over the last six years (and, as with health, a further four years of further cuts) and the direct reduction as a result in numbers of people eligible to access publicly funded care (at a time of rising demand), it is hard to see social care as a sustainable quality service available to those in need on current – let alone declining – levels of funding.

While the decline in publicly funded care services are likely to have been filled to some extent through greater levels of self-funding and ad hoc provision (from friends, relatives and voluntary organisations), the exact extent of this is unclear – and there will be equity implications due to variations in income and access to support. There are some indications of knock-on effects to the NHS, however, with a significant increase in the number of patients delayed in hospitals for reasons attributable to social care and access to care packages at home (Humphries and others, 2016).

We would agree with Kate Barker's conclusion that, one way or another, as a nation and as individuals, we will need to pay more for social care in future (The King's Fund, 2014) and that this will inevitably mean higher public spending. However, it might also mean higher private contributions in one form or another. We also note that, over the last decade, there have been a number of significant reports on how we might pay for social care in the future (cf Commission on Funding of Care and Support, 2011; The King's Fund, 2006) – but to date there seems to have been a political reluctance to grasp the nettle on this issue.

Summary: Social care

It is inevitable that the pressures to spend more on social care will grow over time. Social care also presents other problems in terms of future sustainability due to its funding sources and traditional separation from health. But, as with health, one way or another we will end up paying more; financially, either through higher taxes (for better services) or out of pocket, or the non-financial costs arising from reduced access to publicly funded services of declining quality and for some, exclusion from privately funded care rationed on the basis of ability to pay.

The choice, therefore, is not whether to devote more of the UK's growing wealth to social care, but how to ensure extra spending delivers what we want from social care – including, we would argue, as with health, equal opportunity of access for equal needs.

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