

Targeting Better Health

NIGEL KEOHANE

December 2016

SUMMARY

The funding of the UK's healthcare is at a crucial juncture. Compared to other domestic spending departments, the NHS has been protected from fiscal consolidation since 2010. Nevertheless, in historical terms the health budget has risen only slowly. Increases of around 1% in real terms per year (based on economy-wide inflation) compare to an average of around 4% per year since 1950. On a second measure – the proportion of GDP spent on healthcare – the UK's spending is receding this decade. Social care has fared even worse in funding terms. Despite having world class quality in some areas of care, outcomes on some measures are poor relative to comparator countries and there are signs that the system is under strain.

Much commentary has focused on immediate funding shortages. However, the Autumn Statement was silent on healthcare funding, and the Prime Minister has directed NHS England to focus more intensely on the £22bn efficiencies that were set out in 2015.¹ This decision shifts the focus to the more daunting medium- to long-term funding challenge, with the NHS facing future pressures from many sources including a growing population, older residents, new treatments and technologies that present fresh ways to improve health (and to spend money) and higher disposable incomes. Many of these changes are to be welcomed as they reflect and enable substantial health gains, extended lives, improve well-being and longer working lives, but they also drive up healthcare spending.

Given the UK's economic and fiscal position, it is not plausible to demand a one-off surge in expenditure. However, we can realistically expect to set healthcare funding on a more sustainable trajectory for the long-term. This report describes how this could be done by introducing a healthcare funding target.

The report identifies potential benefits that could be achieved were the Government to introduce a long-term funding target. These include:

- ensuring that future spending levels better reflect the underlying cost changes in healthcare;
- instilling public confidence; providing greater license to commissioners to make strategic decisions; and,
- delivering greater certainty for investors in the UK's health economy and life sciences.

The report assesses a number of potential approaches. It identifies particular benefits that would come from introducing a ‘Dual Target’ under which the Government would:

- Establish a long-term ‘**NHS Funding Rule**’ to increase healthcare spending levels by a minimum of the rate of GDP growth each year. Based on the OBR’s growth forecasts from November 2016, we estimate that this would increase health spending by an additional £7 billion by 2020/21. We envisage that this would be a rolling commitment, would act as an expenditure ‘floor’ rather than a ‘ceiling’ and would apply to spending across both health and social care.
- Set out a small number of ‘**Priority Care Commitments**’. These would comprise commitments to improve specific care outcomes over a five-year period, for instance in areas where the UK performs comparatively poorly, such as survival rates for cancer. The Government would be obliged to estimate the potential costs associated with meeting these goals at the outset of the period. Outcomes in these areas would then be reviewed annually, and the Government would be obligated to increase funding levels by the predetermined amount if necessary improvements on these objectives were not met after three years.

To provide accountability, the Government should ask the OBR to monitor healthcare spending to ensure that commitments are fulfilled. As the SMF has argued in a separate paper, the Government should also establish an Office for Patient Outcomes to oversee care outcomes and ensure that the necessary data is collected to track performance. We propose that the Dual Target should be enacted through legislation to establish a rolling commitment to ensure that healthcare funding is maintained on a sustainable course.

ABOUT THIS PAPER

AstraZeneca has funded development of the report, whose purpose was to assess the potential benefits and design of a health funding target. The Social Market Foundation retains full editorial control.

ABOUT THE AUTHOR

Nigel Keohane oversees the Social Market Foundation's research programme as research director and leads the work on public service reform, health and social care, and pensions and savings. He is also deputy director of the SMF.

Prior to the SMF, Nigel was head of research at the New Local Government Network think tank, worked in local government and taught history at Queen Mary, University of London. He has a BA and MA in history from Exeter University, and a PhD in political history from Queen Mary.

ABOUT THE SOCIAL MARKET FOUNDATION

The Social Market Foundation (SMF) is an independent, non-partisan think tank. We believe that fair markets, complemented by open public services, increase prosperity and help people to live well. We conduct research and run events looking at a wide range of economic and social policy areas, focusing on economic prosperity, public services and consumer markets.

ACKNOWLEDGEMENTS

The author is grateful to Hannah Copeland for her assistance during the project and also to Emran Mian and Nida Broughton for their input.

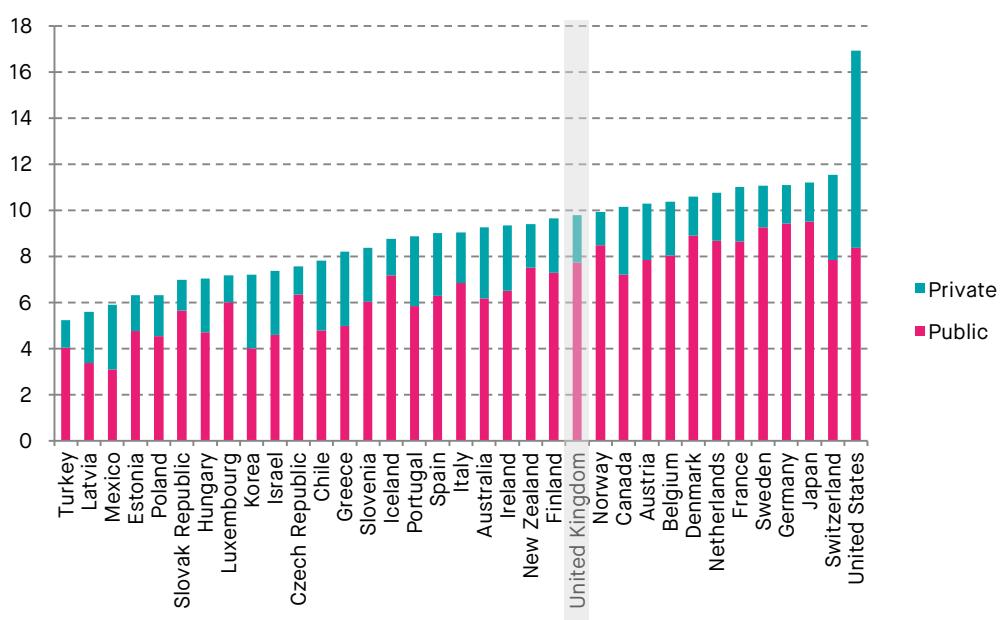
1. THE PROBLEM

This section describes the funding constraint in UK healthcare, including its position comparative to other countries, the funding prospects for the NHS during this decade compared to the preceding sixty years of the NHS, and care outcomes in the UK.

International comparison of health spending

The UK has for many years featured some distance from the top on healthcare spending in international indexes. Cross-country comparison is notoriously difficult given different interpretations of what constitutes healthcare expenditure. This has been complicated further by the introduction of new classifications by the OECD since 2013. Notwithstanding these complexities, on both the old and the new measures the UK has a modest record. In 2015, the UK (at 9.8%) ranked second from bottom among G7 countries in terms of healthcare spending as a proportion of GDP. As can be seen in Figure 1, the UK's expenditure is substantially below other G7 countries such as Japan, Germany, France, and the USA, each of which spends 11% or more of GDP on healthcare. Within the EU 15, the UK stands in the middle.

Figure 1: Proportion of GDP (%) spent on healthcare by OECD countries, 2015



Source: OECD data. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT. Note this data uses the new accounting method.²

A significant proportion (79%) of UK healthcare expenditure is publicly funded. However, it is a misconception that the differences between the UK and higher spenders lie simply in levels of private spending. In fact, with the exception of Canada, all countries that spend a higher proportion of their GDP on healthcare than the UK also spend a higher proportion of GDP through public spending. In addition, it might be noted that on the old definition of healthcare spending up to 2013, the UK ranked 23rd.³

Changes over time in UK health spending

Focusing on the path of UK healthcare expenditure this decade presents equal cause for concern. Spending on the NHS has been ‘protected’ compared to other departments. But, on several fundamental measures, the UK’s public funding of healthcare is receding. Between 2009/10 and 2015/16, funding for the English NHS rose by 1.1% per year in real terms.⁴ While such constraint was not unusual across advanced countries following the financial crash,⁵ the three-year period after 2010 represented the tightest three-year period of real UK healthcare spending since the early 1950s.⁶

As can be seen in Figure 2, during this parliament, healthcare spending in England is due to rise by around 1% per annum in real terms. This is very low in historical terms. Since 1950, UK spending on healthcare has risen by an average of 3.8% per annum.⁷ This funding constraint is being accompanied by financial strains on the frontline. In 2015/16, the provider sector was in deficit to the tune of £2.45bn.⁸ While there has been significant pay restraint in the NHS this decade, this cannot be relied on as a mechanism to reduce costs in the long-term.

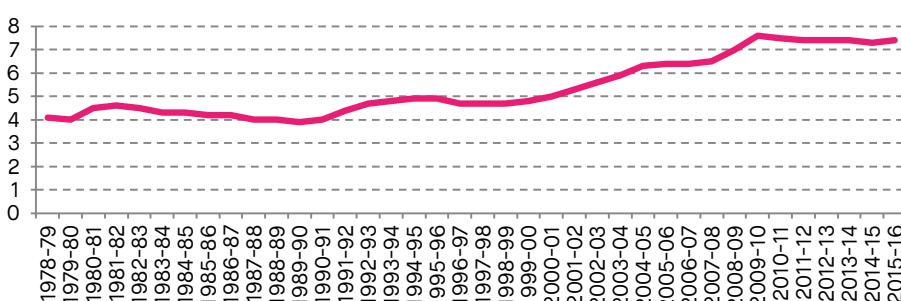
Figure 2: Current and projected spending on the Department of Health in England (£ billions, real terms in 2015/16 prices)⁹



Source: Data taken from Health Select Committee, *Impact of the Spending Review on health and social care* (2016)

On a second frequently-used measure, namely the proportion of GDP dedicated to healthcare, the UK is witnessing a near unprecedented fall. Figure 3 shows that on this measure spending peaked in 2010 and subsequently fell. It is set to fall below 7% of GDP during the second half of this decade.¹⁰

Figure 3: Public spending on UK healthcare as proportion of GDP over time (%)



Source: Data taken from OBR, *Fiscal sustainability and public spending on health: Charts & Tables* (September 2016)

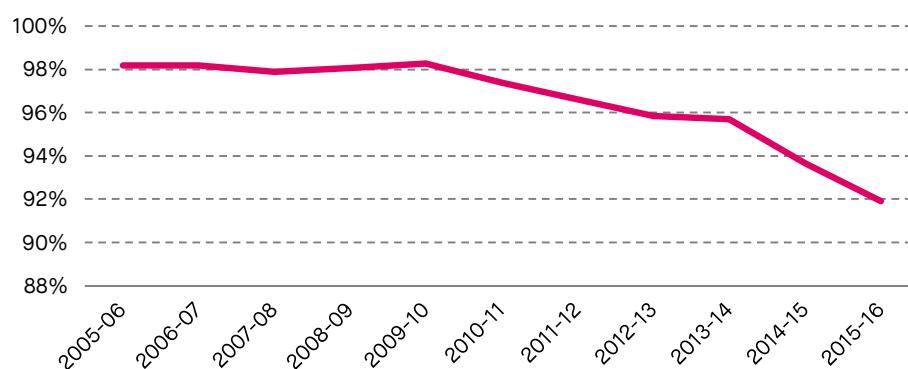
The situation in social care is, if anything, more acute. Funding for publicly-provided social care fell in real terms by an average of 2.2% per annum between 2009/10 and 2014/15.¹¹ Subsequently, public funding for social care has increased with the introduction of the Social Care precept and the expansion of the Better Care Fund.¹² However, the most recent report on social care funding by the Association of Directors of Adult Social Services (ADASS) found that, although there has been a small increase in funding for social care in the last year, it is insufficient to match cost increases driven by the National Living Wage and growing demand.¹³ A joint report by the Health Foundation, King's Fund and Nuffield Trust revealed that the number of people aged over 65 accessing publicly-funded social care has fallen by a quarter since 2010; and the report called for an additional £1.9 billion per year for social care.¹⁴ Meanwhile, the recent State of Care report by the Care Quality Commission argued that social care is reaching a 'tipping point' due to a combination of under-funding, rising demand and staffing shortages.¹⁵

Concerns about the quality and accessibility of care

In a publicly-provided care system, calls of imminent collapse are hyperbole. An under-resourced NHS will continue to treat patients in their millions – though it can be expected to do so less well, less promptly and in a narrower range of ways.

On a number of core measures the NHS is displaying signs of lower performance. Data on the proportion of patients for emergency admissions that were seen within four hours have fallen progressively during the first half of this decade and markedly so in the last two years (see Figure 4). NHS Providers has reported that the 18-week referral to treatment target for elective operations is now being missed routinely.¹⁶

Figure 4: Percentage of A&E patients seen within four hours or less (%)



Source: Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England. NHS England data.¹⁷

In terms of care outcomes, the UK performs well in many areas.¹⁸ These include suicide rates, diabetes hospital admissions and influenza vaccination. However, the UK performs comparatively poorly in a number of important areas of care:

- The UK is the fifth from bottom of OECD countries for five-year relative survival for cervical cancer and fourth from bottom for colorectal cancer on the same measure.¹⁹
- Survival rates for breast cancer are also below the OECD average (although improvement in the past decade has been faster than the OECD average).²⁰

- Survival rates after hospital admission for a heart attack or stroke are worse than in many OECD countries – although it should be noted that these are improving rapidly.²¹
- The interface between health and social care is poor – for instance the rates of delayed transfers of care from hospital have risen successively since 2013-14.²² A significant proportion of hospital admissions are avoidable.

At a headline level, research has calculated that 46,413 people die each year in the UK because they were treated on the NHS rather than by a healthcare system with the best outcomes in the world.²³ It does not appear that UK performance is determined primarily by higher levels of inefficiency. While it is hard to compare efficiency levels across countries, past research that has looked at average length of stay in hospital as a proxy measure of efficiency in hospital suggests that the UK performs better than the OECD average.²⁴

Focus of this report

It is in this context that additional funding for the NHS became one of the central debating points in the referendum on the European Union. Subsequently, there have been calls from some quarters for a ‘Brexit bonus’ – notwithstanding the pressures on the public finances.²⁵ Recent years have also seen calls for a new long-term funding settlement for health and social care from across the political divide.²⁶ In early 2016, Stephen Dorrell, Norman Lamb MP and Alan Milburn called for a cross-party review of the future funding of health and social care. In September 2016, Norman Lamb MP, Liz Kendall MP and Dr Dan Poulter MP issued a joint statement warning of ‘existential challenges’ to the NHS due to funding shortages and challenges in social care, and called for a cross-party commission to initiate a conversation with the public on what steps to take.²⁷ The influential Health Committee recently described the funding challenge as ‘colossal’.²⁸

A large number of think tank reports have considered the funding gap and presented arguments for closing the budget shortfall by a specific year. Here, we ask whether the UK should establish an on-going long-term target or commitment for healthcare funding with the purpose of setting it on a sustainable trajectory in the medium to long-term future. In particular, we consider how such a long-term funding target could be designed.

The rest of this research assesses the following questions:

- What benefits could the UK potentially achieve from having a formal target for healthcare expenditure?
- What are the potential limitations of a target? And could these be overcome? And, if so, in what ways?
- What should any funding target look like? And, what should it seek to track or target?

2. WHY CONSIDER A HEALTHCARE FUNDING TARGET?

This section discusses why a healthcare funding target should be considered and why the UK could potentially benefit from introducing a funding target for public spending on healthcare in the UK.

Why healthcare is a special case

How spending decisions on healthcare are made currently

Healthcare spending is decided by the Westminster parliament for England and by the devolved assemblies in Northern Ireland, Scotland and Wales. The funding for the Department for Health in England is set through a periodic spending review. As with other departments such as education and justice, spending reviews typically occur every three years. Local authorities have statutory responsibility for public health and for social care services. The main source of council revenues is from taxes imposed on their local household and business populations, although they also get specific public health grants from central government. Councils set annual budgets.

Ahead of the last general election, Simon Stevens, the Chief Executive of NHS England, published the Five Year Forward View which articulated a vision for how services should be reformed and improved over the course of the new parliament, estimated a short-term funding gap of £30bn by the end of the parliament and requested the Government to set aside £8bn of additional spending. This £8bn was intended to be accompanied by £22bn of efficiency savings.

The exceptionalism of healthcare funding and spending

Given its peculiar features, a strong argument can be made to consider healthcare funding a special case as distinct from, say, education. First, long-termism is exceptionally important across the wider health economy because the life sciences sector is unusually capital intensive and has a large level of R&D spending. Certainty over future resources affects the decision-making environment for commissioners and the investment case for pharmaceutical firms.

Second, a number of factors serve to push up healthcare spending in advanced countries. These are discussed in greater detail in Section 3, but they comprise:

- Population growth – as with education and other services, more people cost more money.
- Changing composition of the population – older people consume more healthcare than young people and a population with a larger cohort of individuals in older age will therefore be more expensive to serve.
- Longer lives – longer lives may lengthen periods of morbidity (although this is disputed).
- Income effects –people spend more on healthcare treatments as their incomes rise.
- Productivity improvements in healthcare often run at approximately 1% per year rather than 2% in the wider economy.²⁹ Wage inflation in healthcare is, therefore, typically

greater. ‘Protecting’ the health budget by increasing it by the general inflation rate does not, therefore, necessarily fully shield the health service from increased costs.

- Technological developments in healthcare provide huge opportunities to improve patient care, access and life expectancy. By promoting longer healthy lives, such advances in turn can boost labour market participation, economic growth, productivity improvement and higher tax revenues. Alongside these gains – in contrast to most other sectors of the economy – technology often pushes up costs because the productivity enhancing-improvements that they trigger in healthcare delivery are less significant than the opportunities they create for additional spending (through new treatments, heightened expectations among consumers and expansion of treatments).
- The evolution of diseases (including the growth in co-morbidities) may lead to higher costs.

Potential benefits of applying a healthcare funding target

Below we consider some of the potential benefits to introducing a funding target for healthcare.

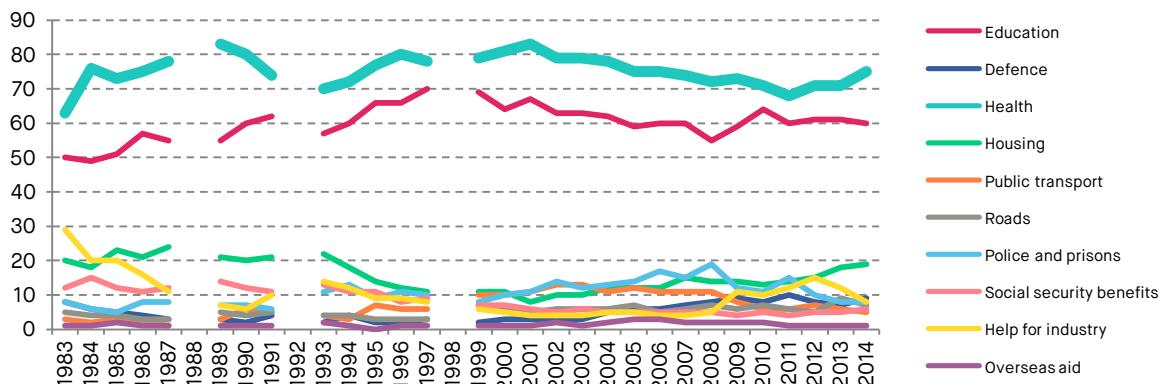
1. Ensuring that the future healthcare spending profile better reflects changes in the underlying costs that can't be controlled

As indicated above, healthcare funding needs to be set on a more stable and sustainable trajectory for the long-term so that it better reflects underlying cost changes. There is a consensus among health economists that funding for healthcare will have to increase in the future, although the level of increase is contested. A target could re-adjust horizons so that over a given period funding for healthcare would reflect factors such as a growing population, the costs of treatment and growing expectations.

It is equally important here that any target does not unnecessarily inflate healthcare funding at the expense of other spending priorities and individual consumption. The lesson of the Triple Lock in pensions is salutary, as it is widely considered to be unsustainable in the long-term.

2. Instilling public confidence by demonstrating that future healthcare spending will adapt to meet changing public expectations whilst remaining affordable

The EU referendum campaigns demonstrated the popular salience of funding for the NHS, with prominent Leave campaigners pledging variously an additional £100m and £350m a week for the NHS.³⁰ Polling reinforces the fact that the public looks positively on higher levels of health spending. In 2015, nine in ten UK adults supported the view that the NHS faced a funding problem, with three in ten reporting it to be ‘severe’.³¹ Those who reported there being a funding problem were also much more likely to be dissatisfied with the NHS. A target could help instil confidence among the population that governments are taking the necessary steps to provide good quality care and meet growing expectations. The NHS has also consistently been rated the highest priority by the public for additional government expenditure over the last three decades.

Figure 5: What should be the priority for extra government spending? (%)

Source: British Social Attitudes survey³²

Public confidence may also be considered a good in itself because healthcare provision is a fundamental security for the population. By enhancing public confidence, a funding target may also make the task of raising sufficient revenue for healthcare less politically tortuous. To achieve benefits in these areas, a funding target would have to be simple, easily comprehensible and tangible. This may mean that public confidence may best be achieved through a focus on the outcomes which the public ultimately care about as well as funding levels (which are a means to that end).

3. Providing greater certainty to investors in the health economy

The wider health economy is a crucial sector in the UK, driving productivity, exports and high-value growth as well as improvements in healthcare that benefit UK patients. The latest ONS data shows that ‘medicinal and pharmaceutical products’ are the third largest category of UK exports, constituting 8.5% of the value of all UK exports.³³ More broadly, the UK Life Sciences sector has a turnover of more than £60bn a year, generating exports of £30bn a year and a trade surplus of £3bn.³⁴ Many of its 220,000 jobs are high-value, with pharmaceutical manufacturing employees having the highest gross value added (GVA) of any high-technology sector.³⁵ More broadly, the health economy is a capital intensive sector in which there is significant R&D investment. As Figure 6 shows, the pharmaceutical industry accounted for around a fifth of R&D spending in the UK in 2014 (data for 2015 will be published in November 2016).

Figure 6: Expenditure by UK businesses on performing R&D, by largest product groups in 2015 (2015 prices)



Source: ONS, *Business enterprise research and development, UK: 2015 (2016)*

The UK's combination of a national health system alongside a leading pharmaceutical and biotech sector offers huge economic opportunities, not least in the context of genomics and personalised medicine. The Government can seek to encourage investment and growth in this sector via measures such as industrial policy and tax measures. But, the Government's role as procurer is also hugely significant. It is well-placed to provide private investors with the long-term certainty to encourage them to invest in new drugs and innovative treatment methods. Uncertainty about the timing and level of reimbursement can lead to lower levels of investment and innovation.³⁶ Currently, despite having a well-established regulator, decisions are prone to revision. For example, the Pharmaceutical Price Regulation Scheme (PPRS) claws back a proportion of the costs of drugs from pharmaceutical firms (£1.4 billion since 2014),³⁷ and this principle is set to be extended through the Health Service Medical Supplies (Costs) Bill.³⁸ Greater funding certainty could provide a more conducive environment for long-term decisions on investment.

4. Providing greater certainty to commissioners to enable good strategy making

Funding certainty over the medium to long-term could help commissioners make better judgements on de-commissioning programmes, commissioning the best value treatments and re-designing services. This could enable productivity-enhancing investments in the health service via new technologies and better treatments for patients. The Government has acknowledged the potential importance of greater certainty for commissioners by introducing multi-year funding allocations for Clinical Commissioning Groups. For instance, in relation to the Five Year Forward View, the Government is providing a three-year binding allocation and a two-year indicative allocation.³⁹ As the King's Fund has noted, this additional flexibility should aid strategic planning.⁴⁰ More generally, NHS England is requiring local areas to develop Sustainability and Transformation Plans to assess how services should be delivered up to 2021.

A funding target that provides more predictable and steady increases in funding may enable the healthcare system to make best use of any funding growth it receives. A glance at history suggests that our current healthcare funding system is prone to feast and famine. During famines, it is difficult to find the cash to take investment opportunities or to re-design services to improve care and drive efficiencies. This principle has been accepted in the front-loading of the additional spending during this parliament. Conversely, there have been concerns that the NHS has not coped efficiently with past spending surges (e.g. in the 2000s).⁴¹

Analysing potential objections and downsides associated with a target

Alongside the potential benefits described in Section 2, there are also a number of potential downsides to be considered. Any target must be designed to overcome them as far as possible. Before we discuss these in detail we look at what lessons can be learned from current and past spending targets.

Case studies of lessons from other funding targets

The UK has already experimented with funding targets in a number of areas. Below we observe some of the associated benefits and potential challenges. Two important areas of government activity are currently subject to a target – or to be more exact a regulated or legal spending floor. The Department for International Development has an overseas aid budget equivalent to a minimum of 0.7% of the UK's GDP. This minimum is enshrined in UK law via the International Development (Official Development Assistance Target) Act 2015. The target stems from a United

Nations resolution of 1970 and relates to the amount spent on overseas development assistance. As of 2015, only six countries (including the UK) spend more than 0.7% of GDP on overseas aid.⁴²

The Ministry of Defence has an expenditure floor of 2% of GDP, which relates to a 2006 NATO target for affiliated countries.⁴³ It is interesting to note that the target in defence is propping up a spending level that has fallen dramatically; whilst the target in international development is raising expenditure far above its historical level. In the case of defence spending, the rationale for the spending target is a collective action problem – in other words in the absence of the measure, countries could free-ride on the efforts made by other countries (most especially in this instance the USA). The international development target is structured more as a moral commitment device.

At an international level there has also been significant interest in developing baseline health funding targets for developing countries. For instance, as part of the Abuja Declaration in 2001, African countries committed to increasing the proportion of government spending dedicated to healthcare to 15%. A World Health Organisation analysis ten years on found that 27 countries increased the proportion of total government expenditure allocated to health, seven countries reduced the proportion and 12 countries exhibited no discernible reduction or uplift. Only two countries achieved the goal.⁴⁴ More recent discussion has focused on increasing the proportion of GDP in these countries that is spent on healthcare, with a benchmark of 5% of GDP identified as a potential baseline to aim for in developing countries.⁴⁵

Table 1: Lessons from similar funding targets in the UK

Target area	Purpose	Effects and summary lessons
International development spending – 0.7% of GDP from 2015	<i>Moral/soft power</i>	<p>Thus far effective as commitment device.</p> <p>Provided headroom to help tackle the Ebola epidemic, including a £427 million package of support to help ‘contain, control, treat and ultimately defeat’ Ebola.⁴⁶</p> <p>Attacked for inefficiency on grounds of the department having insufficient mechanisms for distributing grants. Also criticised for allocating funding to corrupt governments. A petition calling for ‘[providing] money only for truly deserving causes, on a case-by-case basis.’ received 236,000 responses.⁴⁷</p> <p>Criticised for re-classifying other spending to help meet target.</p> <p>Overseen by rules decided by OECD and by external monitoring.</p> <p>Attempts to establish external scrutiny through the Independent Commission for Aid Impact.</p>
Defence spending – 2% of GDP from 2015	<i>Collective action problem</i>	<p>Thus far effective as commitment device.</p> <p>Criticised for the re-classification of spending that made it easier to hit the target. The Defence Select Committee claimed that the goalposts had been ‘shifted’ making it easier for the government to meet its 2% target (to the extent at least that spending was re-categorised to meet a new definition).</p> <p>Concern that target may lead to complacency.⁴⁸</p> <p>Overseen by rules decided by NATO and by external monitoring.</p>
State pension – ‘Triple Lock’ which ensures that the pension is increased by CPI inflation,	<i>Raise the state pension level and reduce pensioner</i>	<p>Has had a significant effect on reducing pensioner poverty and allowed the state pension to catch up ground lost in relation to earnings during the 1980s and 1990s.</p> <p>Criticised for having a ratchet effect and increasing benefits for older people</p>

earnings inflation or 2.5%, whichever is the highest (from 2010)	poverty	inexorably and contributing to intergenerational injustice. ⁴⁹ Criticised for being unaffordable in the long-term.
--	---------	--

1. A funding target could tie the hands of government unhelpfully unless there is some short-term flexibility

An important consideration is whether a funding target may tie the hands of government excessively. For instance, in a severe economic downturn or fiscal crisis, the Treasury may want the flexibility to be able to adapt the short-term level of spending. This is likely to become an increasingly important consideration because NHS spending rose from around 10% of total public spending in the mid-1980s to 18% in 2013-14.⁵⁰

An inflexible target may also potentially raise concerns about overspending and prioritisation relative to other services or commitments. For instance, as noted in Table 1, the international development target has attracted criticism from certain parts of the media for spending money unjustifiably. The wider context of multiple spending commitments is also important given the Government is already obliged to spend 2% of GDP on defence and 0.7% of GDP on international development, as well as a long-term commitment to raise the state pension (via the ‘Triple Lock’).

It may be advisable for any target to provide an element of flexibility.

2. A funding target is vulnerable to being gamed unless the rules are clear and there is robust independent oversight

As with service delivery targets, a funding target may be open to gaming – in this instance by political masters themselves rather than providers. As noted above, in the realms of both defence and international development, critics have noted that the Government has been helped by reclassification of spending to help meet the target.

In the case of a healthcare funding target, external oversight would be needed to guard against double-counting, over-counting and deliberate changes to the rules. For instance, accusations previously surfaced that the Better Care Fund was double-counted in both the social care and NHS budget.⁵¹ More recently, the Health Select Committee has disputed the Government’s claim that the NHS will receive an additional £10bn over the parliament.⁵²

International targets have the benefit of supra-national governance, rules and monitoring (see case studies above). However, it might be noted that the Government also set up the Independent Commission for Aid Impact to scrutinise government spending on aid associated outcomes, and this could be replicated in healthcare. The SMF has previously argued that an Office for Patient Outcomes (2016) should provide an independent view on care outcomes and the UK already has a highly-respected monitor in the Office for Budget Responsibility.

3. A funding target risks distorting priorities unless social care outcomes are considered

There is a risk that a funding target could establish a false and counterproductive fault-line between healthcare and social care. Successive governments have embarked on a quest to integrate health and social care. Inadequate social care provision can create additional inefficiencies in care treatment if, for instance, patients end up needing expensive care in the NHS because they have been ineffectually looked after in the community, or staying in hospital for unnecessarily long periods for the same reason.⁵³ Integrated care is the route more generally to personalised care. Stephen Dorrell – until 2014 the Chair of the Health Select Committee –

recently labelled the ‘fetishising’ of the NHS budget unhelpful given that it was often accompanied by starving social care of adequate resources.⁵⁴ This suggests that the scope of any target will need to be broad enough to capture all health spending (including preventative spending such as through public health) and facilitate cross-working with social care.

A target for public sector funding may also pre-determine the share of contributions to health spending from public rather than private sources. Given the lack of political appetite for shifting to more out-of-pocket payments from individuals this appears to be a manageable restriction. It might also be noted that the proportion of public contributions to total healthcare expenditure has remained comparatively constant: since 2000, they have varied between a low of 79% (for instance in 2000 and 2015) and a height of 83% (in 2009).⁵⁵ If political appetite changed in the future and there was a desire to alter the balance of funding then the Government could potentially consider a total funding target (including public and private resources).

It will be important that the funding target is designed so as to interact effectively with spending areas outside of the NHS, especially social care.

4. A funding target cannot deal with operational incentives and would have to be accompanied by a rigorous focus on operational efficiencies

Arguably, total flexibility over funding gives Ministers more bargaining power in negotiations with health agencies. For instance, the nature of the deal agreed between the Government and NHS England was that NHSE will deliver £22bn of efficiencies during the parliament (or equivalent to productivity gains of around 2.4% each year), whilst receiving £8bn of additional funding. By committing to a longer-term target in advance, the government may feel that it is sacrificing its bargaining power within Whitehall. However, such bargaining is ultimately of secondary importance compared to the structure of the incentives within the healthcare system – for instance the incentives on NHS Trusts and Foundations to deliver the best outcomes and to budget.

In practice, government will have to continue to prioritise operational efficiencies with or without a target.

3. WHAT A FUNDING TARGET SHOULD LOOK LIKE

Desirable features of a funding target

The last section showed that there could be significant potential benefits from introducing a long-term healthcare funding target, based on:

- Setting a future spending trajectory that better reflects changes in the underlying costs that the government cannot control.
- Instilling public confidence including by demonstrating that future healthcare spending will adapt to meet changing expectations whilst being affordable.
- Providing greater certainty to commissioners and potential investors in the health economy.

At the same time, the target needs to be designed to ensure that the following potential downsides are overcome:

- A funding target would tie the hands of government unhelpfully unless there is some flexibility.
- A target risks distorting priorities unless social care outcomes are factored in
- A funding target is vulnerable to being gamed unless the rules are clear and there is robust independent oversight.
- A funding target does not affect the importance of getting the incentives in the healthcare system right.

Understanding the cost pressures

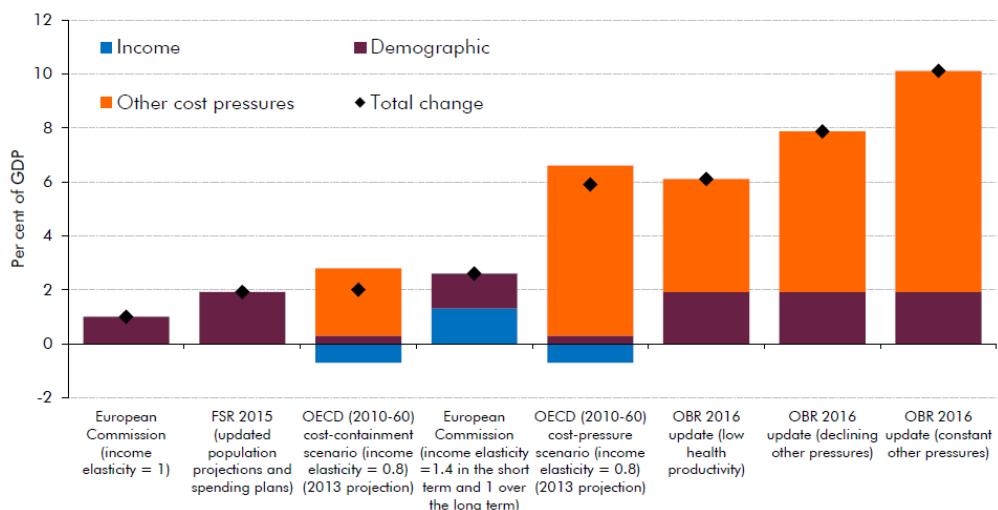
Although studies have disagreed as to their relative importance, there is consensus that a number of factors drive higher healthcare spending in advanced countries. These are described below.

Table 2: Summary of factors contributing to cost pressures in healthcare

Population growth	At a crude level, more people cost the health service more money to look after, notwithstanding the fact that a larger population may also drive higher growth and tax revenues. This is true especially for ‘people services’ such as health and education. In the decade from 2014, the population was set to grow by about 7% although doubts over future immigration policy mean that the future level of population growth is arguably less certain than historically. ⁵⁶
Composition of the population	The demographic characteristics of the population may alter the level of funding needed for healthcare. Longer lives do not necessarily mean higher healthcare costs if longevity simply delays the onset of ill health to later in life rather than triggering longer periods of ill health. ⁵⁷ The OBR’s modelling showed that varying the assumptions on morbidity has a comparatively limited effect on the percentage of GDP spent on healthcare. ⁵⁸ However, as Appleby notes, the demographic shape of the population may still be important in determining the future shape of healthcare costs. ⁵⁹
Income effects	As incomes rise, people often spend more on healthcare treatments, including potentially a higher proportion of their higher income. This is because people put a high value on remaining well. In a rationed system like the UK this is exhibited by the government making more advanced and expensive treatments available and improving access.
Costs inflation in healthcare	History suggests we may expect productivity improvements in healthcare to be more limited than in the wider economy. Since the late 1970s, productivity has run at approximately 1% per year compared to around 2% in the wider economy. Healthcare is a comparatively labour-intensive service and thus the impact of inflationary pressures on wages is more material. This is known as Baumol’s ‘cost disease’. ⁶⁰ It is too early to conclude, but post-crisis productivity in the UK economy has been much lower than anticipated and much lower than the historic average. ⁶¹ To this extent, Baumol’s disease is on the mend. However, future productivity remains uncertain – see for instance the significant year-on-year variation in calculations of NHS productivity over the last five years by the Centre for Health Economics at the University of York. ⁶² Many reports have emphasised how sensitive future healthcare spending projections are to productivity rates. ⁶³
Technological developments	Technological advances in healthcare increase the range and costs of potential treatments over time. New medicines and techniques mean that diseases that were previously untreated now are treated, whilst access is widened to treatments over time. At the same time, technological developments contribute to health gains and to economic growth as people can stay in work for longer and work more productively. With advances in genetics, genomic sequencing and personalised medicine, potential developments are huge over the next few decades, but the nature of the gains is unpredictable.
Evolution of diseases	The evolution and prevalence of diseases (including the growth in co-morbidities) may lead to higher costs. For instance, the Nuffield Trust found that the likelihood of being treated in hospital for a chronic condition appears to have increased over time even for people in the same age bands. ⁶⁴ For instance, lifestyle factors will affect healthcare costs, whether this is lower levels of smoking over time (although the UK still has a significant population of smokers) and a growing proportion of the population who are obese. ⁶⁵

A number of studies have sought to assess the relative importance of these different factors. The OBR's recent report on fiscal sustainability of health spending provides a useful meta-analysis of how different studies have assessed them.

Figure 7: OBR analysis of long-term projections of changes in health spending (2020-2060 unless otherwise stated)



The demographic components in the European Commission and OECD projections include an assumption of compression of morbidity and are therefore not entirely comparable with OBR scenarios that are purely demographically driven.

Source: European Commission, OECD, OBR

Source: OBR, *Fiscal sustainability and public spending on health* (September 2016)

A number of features are striking. First, the huge range in predictions over this long-run period. Part of this stems from different decisions on which variables to include. A number of studies, such as that of the European Commission decide to exclude other cost pressures, or to focus on demographic factors (such as the OBR's annual Fiscal sustainability report). In contrast, other studies have included a wider range of factors. Second, there is reasonable similarity in many cases about the effects of demographic factors,⁶⁶ but there is huge variation in interpretation of the effect of other cost pressures (including healthcare productivity, technological developments and disease evolution). In many respects this is simply because estimating these costs is an extremely difficult exercise and usually relies on extrapolating historical experiences; factors such as technology are often the residuals leftover once other factors have been accounted for; and many of the empirical analyses have been carried out in the USA which is an outlier in terms of healthcare funding and in its level of private financing.⁶⁷ As an example of the variation, studies have attributed between a quarter and three quarters of the growth in spending in advanced economies to technological change.⁶⁸ NHS England estimated the non-demographic cost pressures in health spending across different parts of the NHS. These ranged from 1% increases per year (for acute services and GP services) to 3.4% increase per year for (prescribing services).⁶⁹

It might be noted therefore that some of the potentially important factors determining future healthcare costs are also very uncertain. For instance, the OBR shows that there is very significant divergence on the contribution of technological developments and other costs pressures to future health spending levels.

A further consideration in terms of a funding target is that, in a rationed system, governments may wish to contain some of these future costs as far as possible and prefer to address them as and when they arise rather than factoring them into a funding target. While we can be relatively

confident that structural demographic factors will have a predicted effect, it is less clear that future technological advances will have the same impact as in the past.⁷⁰

Options appraisal

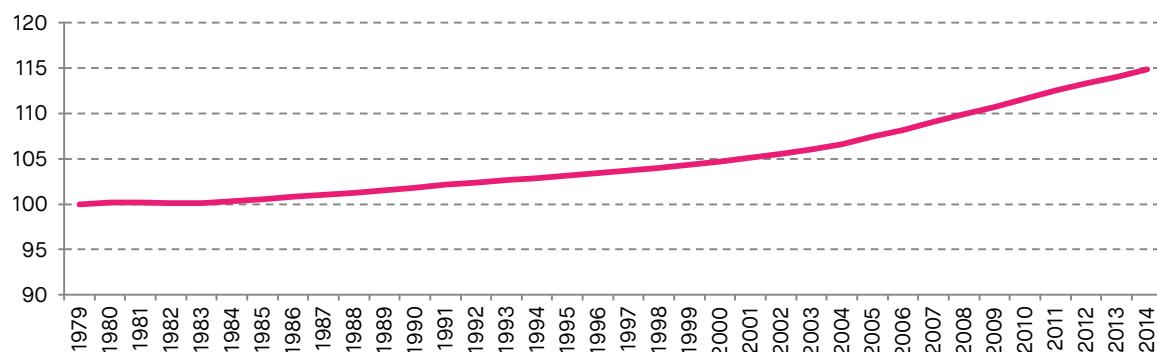
Below we consider four principal policy options that could achieve some of the benefits described above. These have been chosen as realistic and practicable options – though of course the long-list for potential targets is lengthy. Annex 1 provides a more detailed assessment of the different options against the objectives set out earlier.

Option 1. Population tracker – a target that tracks changes in the size and composition of the population.

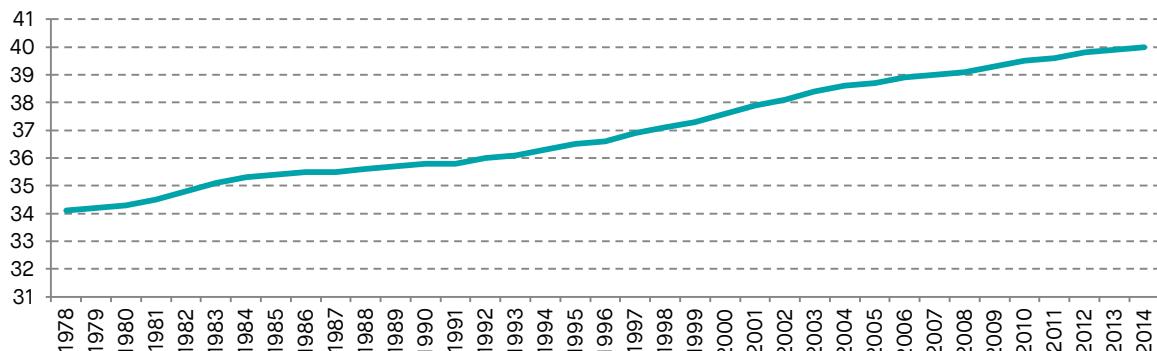
This is a policy neutral or ‘policy-off’ target as it makes no adjustments for future rationing decisions and assumes that care is static. At its simplest level, a larger population requires more resources. The UK’s population is set to expand further in the decades ahead, although the scale of future growth is uncertain particularly as a consequence of the UK voting to leave the EU.⁷¹ The composition of the population matters because the size of different age cohorts in the population will affect the costs. For instance, the bulge among the ‘Babyboomers’ is likely to mean higher costs as this group near the age at which health costs are more intense.⁷² This is likely to increase the demand for healthcare costs.

Research by the IFS has estimated that population growth and the changing age structure of the population may necessitate real increases in health spending of 1.2% per year – in order to maintain current average levels of real spending per person at each age.⁷³ It is noticeable that this growth rate alone is greater than the increases allocated during the current decade. As Figure 8 illustrates, the cumulative changes to the UK’s population since 1979 are important though far from overwhelming. The population has grown by around 15% in the past three and half decades. The growth in the future could, however, be somewhat steeper. Compared to a population of 64.6 million in 2014, the ONS projects a population of 70 million by 2027.⁷⁴ The increase in the median age – as a rough proxy for the composition of the population – has increased by 18% over a similar period (see Figure 9). The median age is set to rise further to 40.9 in 2024 and 42.9 in 2039.⁷⁵ Meanwhile, the proportion of the population aged over 65 will grow from 13.8% in 1974 to 17.7% in 2014 and is forecast to grow to 19.9% in 2024.⁷⁶

Figure 8: Cumulative changes in UK population from 1979 (1979=100)



Source: ONS, *Overview of the UK population: February 2016*

Figure 9: Changes to the median age of the UK population

Source: ONS, *Overview of the UK population: February 2016*

Advantages:

- The target would be relatively simple.
- The target would also instil confidence in terms of affordability as any increases would relate to the age-adjusted size of the population.
- Compared to some other future potential drivers of costs (for instance technological developments) demographic factors are more predictable.
- Provides a high level of certainty about future funding levels.

Shortfalls and challenges:

- This target makes no account of the increases associated with rising expectations that come with increases in income or technological developments. It therefore does not properly reflect many of the accepted cost drivers.

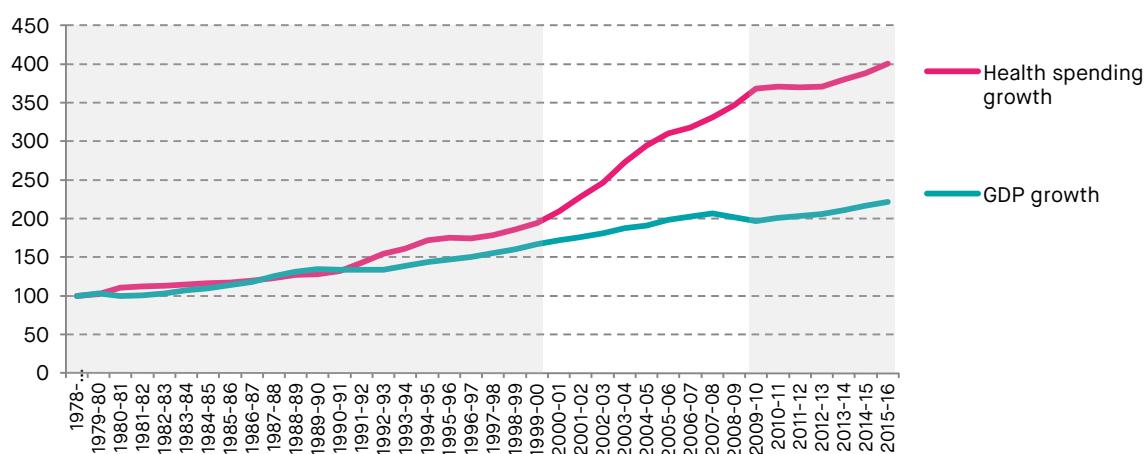
Conclusion:

- Although simple to sell to the public, a population tracker provides an insufficient account of future spending pressures.
- Assuming it required an increase of 1.2% in real terms per annum to keep up with the demographic changes and that the increases applied through this parliament, healthcare spending would be £3bn per year higher by 2020/21 than the projected spending allocation in that year (in 2015/16 prices).

Option 2. GDP tracker – this would track future changes in GDP

This measure would incorporate an adjustment for the size of the population and for increases in income in one measure. Studies have found that at a cross-country level, the strongest predictor of healthcare spending is national income. Countries with higher per capita income spend a bigger amount on healthcare – although it should be noted that this is income per person rather than per country.⁷⁷ Over some periods of history, real-terms increases in UK healthcare spending have borne some similarity to GDP growth: see the periods 1978 to 2000 and 2010 to 2015 shaded in grey in Figure 10 below. In the last decade, healthcare spending rose at a much more rapid pace. There would be a question as to whether this should be established as an on-going tracker that changes in line with recent or forecast GDP or set as a proportion of GDP. In devising specific funding goals for a specific date, a number of think tanks have chosen a proportion of GDP. For instance, the Barker Commission argued that health and social care expenditure should reach 11% to 12% by 2025.⁷⁸

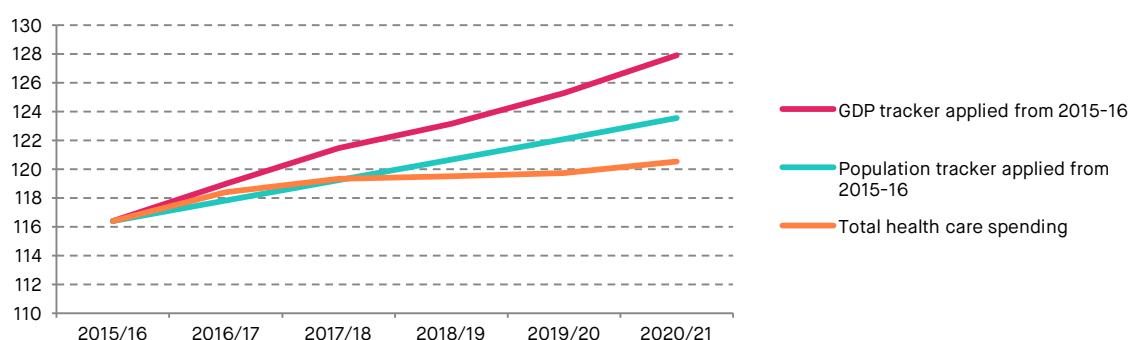
Figure 10: Growth in real-terms healthcare spending and GDP over time in the UK (1978-79=100)



Source: Data developed from OBR, *Fiscal sustainability and public spending on health: Charts & Tables* (September 2016)

A GDP tracker would result in higher levels of healthcare spending compared to current allocations. Figure 11 below illustrates the projections based on current policy compared with the rate of increase under a GDP tracker and a population tracker.

Figure 11: Illustration of different spending outcomes – Total healthcare spending in England (£ billions, 2015/16 prices)



Source: Health Select Committee data; GDP Growth forecasts taken from OBR, November 2016 Economic and fiscal outlook

Advantages:

- A GDP tracker would have the benefit of having similar characteristics to the funding targets for defence and international development. This may make it comprehensible to the public as well as easy to measure given it is already used as a metric in other departments.
- Because it would increase spending on health services as economic growth rises, this measure would express affordability in so far as tax revenues should also increase.
- It would provide a reasonable level of certainty to investors by removing policy uncertainty.

Shortfalls and challenges:

- Short-term cyclical fluctuations in the economy may make tracking GDP year-on-year a bumpy ride. For instance, in-year analysis shows that health spending has grown markedly at times where GDP has fallen. In fact, health spending has often been counter-cyclical, for instance in the early 1980s, the early 1990s and indeed in the most recent economic downturn.⁷⁹ This may be the consequence of policy decisions. Or it may be because health conditions deteriorate during economic downturns (less likely in short-run scenarios) or because demand switches from private providers to public providers.⁸⁰ It may also be a consequence of the inability of governments to quickly adjust their spending on health. For this reason, it may be advisable to adjust funding levels in line with average GDP growth over a 3-year period.
- A GDP tracker may alter spending in the wrong direction to population composition – for instance a bulge of retirees may limit the scope for GDP growth due to lower workforce participation whilst at the same driving higher demand for healthcare.
- To the extent that GDP and earnings tend to go up at the same time, this device would track changes in labour costs. However, it would not capture other potential cost pressures that may stem from technology or the evolution of diseases.

Conclusion:

- A GDP tracker would be a feasible measure that captures some of the core future cost pressures. It may need to be accompanied by additional target measures to ensure that the public is assured that the government is making new treatments available and improvements in care quality. Issues it would have to confront include fluctuations in GDP, how to additionally account for other costs, and whether GDP growth should be established as a minimum increase or a pure tracker.

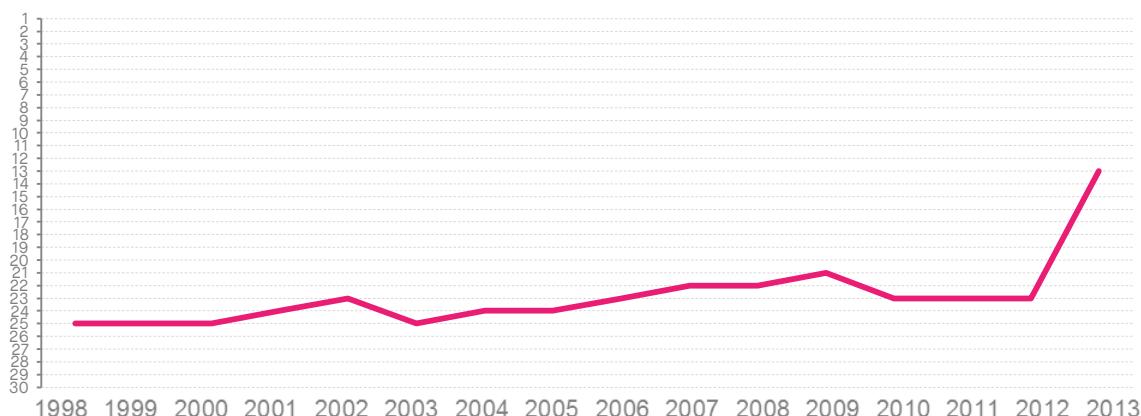
Option 3. Relative international target – this would aim to hit a certain target relative to other similar countries

This approach would replicate that adopted by the Labour Government in the 2000s – although the comparator countries could be different as could the specific metric chosen. In 2000, Tony Blair committed to increasing the proportion of GDP spent on healthcare to match the average of the 14 other countries of the European Union. In 2000, the UK spent 6.3% of GDP in healthcare compared to an average of 8.5%.

Commentators at the time criticised the target on a number of grounds. In particular they argued that the mechanism for calculating the average was wrong, that comparing healthcare spending across countries was difficult due to inconsistencies, and that the actual target took little account of spending power per capita.⁸¹

As an illustration of some of the potential vagaries of international comparison, Figure 12 shows the UK's ranking in the last decade within the OECD (note, not the EU benchmark). Three things are noticeable – first the UK made only marginal progress against this set of countries despite hugely increasing spending in the 2000s. Second, the jump up the rankings in 2013 was when the UK's healthcare spending was reclassified and different countries were reclassified as different times. Third, the UK's position generally bobs around – as a consequence of the actions of other countries as well as its own.

Figure 12: The UK's ranking among OECD countries as measured by proportion of GDP spent on healthcare



Source: OECD data

Advantages:

- If designed well, it could be an aspirational target that could win public support to facilitate the necessary funding for the NHS.
- It would be a holistic target – in other words it could potentially capture all factors affecting healthcare spending (assuming, that is, that the comparator countries were doing so).
- In the 2000s, it coincided with significant increase in funding, potentially acting as an anchor.

Shortfalls and challenges:

- Tracking the healthcare spending of other countries would leave the UK vulnerable to changing economic and political conditions in these countries which may have no bearing on UK healthcare costs or affordability.
- It is unclear which countries should be selected as comparator and why they would be chosen given the different conditions across different economies, healthcare systems and populations. For instance, would the USA be used as a benchmark? If not, why not?
- Other countries may have less cost efficient systems rather than being objectively better.
- A comparative target will always be moving itself and therefore difficult to strike. This will also limit the certainty it can provide about future funding levels.
- Classifications of health spending change over time

Conclusion:

- Despite providing a holistic view of health spending, there would be significant flaws with a comparative target.

Option 4. A 'Dual target' - a commitment to increase public spending on healthcare each year (in line with GDP or population) combined with a commitment to achieve specified health outcome improvements.

A funding target with a dual commitment may be a route to achieving a balance between reflecting underlying predictable cost increases, assuring the public that important care quality objectives will be achieved, whilst adapting to emerging and less predictable cost pressures over time.

A care commitment could function in a number of ways including triggering additional funding for the health service in the event that certain health outcomes are not achieved. This would have the benefit of allowing healthcare spending to adapt to conditions over time. It may be useful for the Government in advance to at least identify potential costs associated with achieving certain care outcomes (where possible).

Alternatively, it could be structured along the lines of the Cancer Drugs Fund (CDF). The CDF was set up in 2011 and made additional money available so that some drugs rejected or not appraised by the National Institute of Health and Care Excellence (NICE) could be approved for use through the NHS. The CDF has helped treat 95,000 patients in England. However, there has been an un-readiness to commit the necessary funding.⁸² A new CDF is replacing the old scheme with a different mechanism for approval. In either instance, it will be very important that patient outcomes are properly measured and captured – for instance, the National Audit Office concluded that there was insufficient data collected by hospital trusts to enable a judgement on the effectiveness of the CDF.⁸³

In such a scheme, the care commitment would run in parallel with a formula to increase spending each year (such as described in Option 1 or 2).

Advantages

- Having a care outcome commitment may offer further reassurance to the public that care quality is being pursued.
- It may be a reasonable mechanism to ensure that costs associated with new treatments – for instance newly available drugs – are built into the system. Although this would only apply to areas of care specified in the targets.
- A dual target could provide a steady base of certainty around funding although the investor community would not have complete confidence about medium term spending due to uncertainty as to whether care outcomes are met.

Shortfalls and challenges

- More complex than a unitary target.
- May be difficult to specify a small number of care targets.

Conclusion

- The 'Double target' may offer a route to achieving a balance between reflecting underlying cost increases, assuring the public that important care quality objectives will be achieved, whilst guarding against unnecessary cost inflation. While less simple than option 1 or 2, it may provide additional public confidence that healthcare priorities will be resourced effectively.

Conclusions

In designing a target, it is clear that there are a number of trade-offs, including the extent to which a target covers structural factors which we may be more confident in predicting or all potential cost drivers, some of which we are much less confident about.

- The ‘Population Tracker’ would be a simple target. It would be a fiscally conservative option which would provide stability and certainty by reflecting population change though at the expense of an inability to reflect many of the other important cost pressures.
- The ‘GDP tracker’ would have the benefit of replicating the device used in international development and defence. As an instrument it would capture changes in the size of the population and recognise that wealthier societies typically wish to spend more on healthcare. However, on its own, it would fail to incorporate future changes in healthcare spending driven by factors such as technological developments, inflationary costs pressures in healthcare delivery and disease evolution.
- The ‘Relative Measure’ would repeat a device used by Tony Blair in the 2000s, when the purpose was to motivate and justify higher public spending on healthcare. This measure could potentially capture a wide sweep of underlying cost pressures but only if the benchmark countries were doing so and if their healthcare financing and delivery structures were sufficiently similar to the UK’s to draw comparisons of any value. Under this target, NHS funding would be vulnerable to changing economic and political conditions in comparator countries which may have no bearing on UK healthcare costs or affordability.
- The ‘Double target’ may offer a route to achieving a balance between reflecting underlying cost increases, assuring the public that important care quality objectives will be achieved, whilst guarding against unnecessary cost inflation. While less simple than option 1 or 2, it may provide additional public confidence that healthcare priorities will be resourced effectively.

4. DESIGNING THE TARGET

This section sets out a proposed healthcare funding target and how it could work.

How a dual target would work

Our proposed healthcare funding target would comprise two elements:

- **'NHS Funding Rule'**

This would set a funding floor which would ensure that healthcare funding would, at a minimum, rise at the rate of GDP growth.

- **'Priority Care Commitments'**

Each five years, the Government would establish a small number of priority care outcomes to target. We envisage that some of the 'Priority Care Commitments' would be benchmarked against international performance. Outcomes in these areas should be reviewed regularly and if requisite levels of improvement were not observable after three years, the Government would commit to investing additional funding to pursue these objectives more aggressively.

For the purposes of transparency, the Government should at the outset estimate the costs of achieving the target outcomes (where possible). As an example, the Independent Cancer Taskforce set out six strategic priorities by 2020, including targets for prompter diagnosis, for patient access to information and reducing smoking prevalence. The Taskforce costed these interventions at around £400m per year.⁸⁴

This device would commit the Government to make additional spending increases if care outcomes were not on course to achieve the specified improvements set out. (These funding increases would be in addition to the annual increases tracking GDP under the 'NHS Funding Rule').

Scope of target

There are compelling arguments for the target to cover both health and social care. There is natural leakage between the two sectors (for instance institutionally through the Better Care Fund but also informally at a local level through joint commissioning and integrated delivery). Joint planning, funding and commissioning is a prerequisite to effective integrated care. This could be achieved by two routes – first, applying the funding rule (as a minimum annual increase) to social care as well as health; and second, targeting a social care outcome. It should be noted that wider reforms of the funding of social care are also needed (and promised in the Conservative Party manifesto).⁸⁵

More broadly, the target should be applied to healthcare spending generally rather than funding for NHS England. There has recently been much commentary about the funding commitments made by the current Government, their value in real terms and the extent to which they reflect increases to the total budget of the Department of Health or only to the budget of NHS England (a sub-set of the Department) and a reduction in other areas of healthcare spending.⁸⁶ Under a target focused on health spending generally, spending on preventative care (which may be less

visible to the public but no less important than traditional spending) will be less vulnerable to cuts.

Tracking GDP growth as a minimum

As noted earlier, it would be undesirable for healthcare funding to fluctuate in tandem with GDP year-on-year. Because the rule applies a minimum increase, it would not mean that funding would automatically fall in a recession. In calculating the minimum increase, this could be calculated as an average of GDP growth across a number of years.

Responding to other cost pressures

Part of the rationale of a dual target is that where treatment costs increase (for instance due to technological advances and better, more expensive, treatments becoming available) or where healthcare productivity lags behind general economy productivity thus inflating the costs of care, the Government will have to respond by committing additional spending as and when specific care objectives are not met.

Deciding on the ‘Priority Care Commitments’

Part of the purpose of the Care Commitments is to help adjust future spending in line with costs that may not be reflected fully in GDP movements, such as the availability of new technology and the age profile of the population. Therefore, it would be advisable for at least some of the targets to capture potential changes in these areas.

At the same time, despite performing very well in many aspects of healthcare, there are areas where the UK performs comparatively poorly and where improvements should be prioritised and resourced. Drawing on OECD data, insights from the QualityWatch initiative and other sources, some areas that could be focused on in the ‘Priority Care Commitments’ include:

- Cancer survival rates: Outcomes for cancer in the UK show a very mixed picture. The UK is the fifth from bottom of OECD countries for five-year relative survival for cervical cancer and fourth from bottom for colorectal cancer on the same measure.⁸⁷ Survival rates for breast cancer are also below the OECD average (although improvement in the past decade has been faster than the OECD average).⁸⁸ This target may work particularly well as it is the health issue that the largest proportion of public are concerned about.⁸⁹
- Thirty-day mortality after admission to hospital for acute myocardial infarction (AMI) is poor compared to many OCED comparators.
- Rates of delayed transfers of care from hospital have risen successively since 2013-14.⁹⁰ Including this as a target may help promote the adequate resourcing of social care and usefully target the interface between health and social care. Along with other measures around access to publicly-funded adult social care, this commitment could also help ensure the appropriate resourcing of social care.
- Lowering the prevalence of smoking. The UK has made significant advances in reducing the adult smoking rate. However, the UK’s adult daily smoking rate is around average for OECD countries,⁹¹ and there would be significant health gains from reducing rates.

Introducing the reform

The overall purpose of this policy reform would be to introduce greater certainty into healthcare funding, to instil public confidence and, as far as possible, to establish a longer-term, more sustainable approach to healthcare funding that is determined more by the underlying costs than shorter-term political considerations.

To achieve these aims it would be beneficial to legislate for the principles of the funding target, although future governments would be free to commit additional funding to healthcare and to select the care outcomes that they are targeting.

The target should seek to be on-going for the purposes of sustainability and certainty but in its initial period we would envisage it being established for 10 years. Given uncertainties in some of the underlying cost pressures in the longer-term (such as technology), the target should be reviewed at regular intervals (as with the State Pension Age).

Oversight, accountability and data

Under the funding target described here, an independent body would be needed to provide external scrutiny of care outcomes and thus hold Ministers to account. The OBR already executes an important role as monitor of the public finances, and would play a complementary role determining the annual update in health spending. The SMF recently published a report advocating an independent Office for Patient Outcomes to monitor health outcomes.⁹² The health sector is fortunate to have a number of expert think tanks, such the King's Fund, the Nuffield Trust and the Health Foundation that also provide independent external scrutiny and specific initiatives such as QualityWatch. As noted earlier, the Government will also have to ensure that the requisite data is collected so that outcomes can be monitored.

Potential future funding levels and costs of the target

Had healthcare spending increased in line with GDP growth (as per this 'NHS Funding Rule') throughout this parliament, it would mean healthcare spending would be around £7.4 billion higher in real terms in 2020-21 than it is currently forecast to be (2015-16 prices).⁹³

If the 'NHS Funding Rule' were to be introduced from the beginning of 2017-18 – in other words, if the budget for 2016-17 is taken as the baseline – it would mean an additional £6.8bn in 2020-21 compared to current spending forecasts.⁹⁴ In the context of the Chancellor's current fiscal commitments, additional revenue would be needed to the order of around 1.5p on the Basic Rate of Income Tax or 2p on the main employee rate of National Insurance Contributions.⁹⁵ Having a target itself may help to make the case with the public for additional resources for the NHS.

However, in the medium- to long-term, one of the benefits of linking spending in broad terms to GDP is that economic growth should also boost revenues for the Exchequer and therefore promote affordability.

ANNEX

Table 1: Summary of how different types of target perform against principal objectives

	Population tracker	GDP tracker	Relative measure	Double target	Historic increase
Provide public confidence	Transparent and simple.	Similar to other measures for defence and international development that have already been implemented. Simple	Used previously. Aspirational Unclear that the public would appreciate a stated aim to climb to the top on expenditure.	While a dual target would introduce an element of complexity, the rhetorical effect of other such devices has been notable. For instance, the 'Triple Lock' on pensions has been a very successful rhetorical (if not policy) device. By targeting both a funding floor and a care quality benchmark it would express affordability as well as ambition on quality.	Arbitrary – not clear that the public would accept the premise.
Providing certainty to commissioners and investors	Yes – demographic factors are comparatively predictable, notwithstanding uncertainties over future life expectancy and immigration. Changing morbidity assumptions has only modest effect on health spending levels. ⁹⁶	Reasonable – more effective in the long-term given forecast growth projects than for year-on-year fluctuations in GDP. For instance, this approach would have meant a real-terms reduction in healthcare funding in the early part of this decade. This could be overcome by structure of the target. Some evidence that health spending functions counter-cyclically.	Vulnerable to changing economic conditions in the comparator countries that do not affect the UK Vulnerable to policy decisions in comparator countries.	Would provide certainty on a minimum level of funding increase and would allow investors to invest in treatments in specific areas of healthcare where there are commitments. Indeed, the Government may partially determine areas based on where it believes investment is most needed.	Yes. Provides a rigid increase that provides certainty to commissioners and investors.
Reflects underlying cost changes?					
Population size	Yes	Yes	Only to the extent that the experience of comparator countries is the same	Yes	Only to the extent that the experience of the past is a guide to future pressures.
Population composition	Yes	No	Only to the extent that the experience of comparator countries is the same	Only via commitments to increase funding if specific care outcomes are not met.	Only to the extent that the experience of the past is a guide to future pressures.
Income effects	No	Yes	Only to the extent that the experience of comparator countries is the same	Yes	Only to the extent that the experience of the past is a guide to future pressures.
Technological advances	No	Only in so far as they are an expression of higher incomes affording more expensive treatments	Only to the extent that the experience of comparator countries is the same	Only via commitments to increase funding if specific care outcomes are not met.	Only to the extent that the experience of the past is a guide to future pressures.
Healthcare costs inflation	No	Would track general inflation and wage growth in the wider economy.	Only to the extent that comparator countries adjust for this.	Only via commitments to increase funding if specific care outcomes are not met.	Only to the extent that the experience of the past is a guide to future pressures.
Affordability and cost control	High	Medium – would express affordability because tax revenues would expect to increase as GDP rises.	Low	Medium - would express affordability because tax revenues would expect to increase as GDP rises.	Low – assumes that future costs pressures mimic past pressures.

ENDNOTES

- ¹ <https://www.theguardian.com/politics/2016/oct/14/no-extra-money-for-nhs-theresa-may-tells-health-chief>
- ² For a discussion of the OECD's new accounting method see John Appleby 'How does NHS spending compare with health spending internationally?', King's Fund blog, 20 January 2016; ONS, Methodology: Introduction to health accounts (2016)
- ³ OECD, Focus on health spending, 2015
- ⁴ Health Foundation, Representation to the 2015 Comprehensive Spending Review (September 2015)
- ⁵ OECD, Focus on health spending, 2015
- ⁶ Rowena Crawford and George Stoye, 'Challenges for health spending', Green Budget 2015 (IFS, 2015)
- ⁷ Rowena Crawford and George Stoye, 'Challenges for health spending', Green Budget 2015 (IFS, 2015)
- ⁸ Phoebe Dunn, Helen McKenna and Richard Murray, Deficits in the NHS 2016 (King's Fund, 2016)
- ⁹ Note, the figures for each year published by the Health Select Committee are slightly lower than the figures published by the Nuffield Trust, the Health Foundation and the King's Fund, in their report, The Autumn Statement. This is partly explained by the fact that the latter used 2016-17 prices rather than 2015-16 prices. Notwithstanding this, the growth between 2015/16 and 2020/21 is very similar: £4.1bn (Health Select Committee, 2015-16 prices) and £4.2bn (think tanks, 2016-17 prices).
- ¹⁰ Note, the different figures here compared to the OECD classification derive from different classifications of healthcare spending.
- ¹¹ Sarah Lafond, Anita Charlesworth and Adam Roberts, A perfect storm: an impossible climate for NHS providers' finances? An analysis of NHS finances and factors associated with financial performance (Health Foundation, 2016)
- ¹² Health Select Committee, Impact of the Spending Review on health and social care (2016)
- ¹³ <https://www.adass.org.uk/media/5379/adass-budget-survey-report-2016.pdf>
- ¹⁴ Health Foundation, King's Fund and Nuffield Trust, The Autumn Statement: joint statement on health and social care (November 2016)
- ¹⁵ http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf
- ¹⁶ NHS Providers letter to Dr Sarah Wollaston, 5 September 2016
- ¹⁷ Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England. NHS England data.
- ¹⁸ For a good overview of where the UK performs well, average and poorly, see Health Foundation report. See also OECD, Health at a Glance 2015: How does the United Kingdom compare? (2015), OECD, Reviews of Health Care Quality: United Kingdom 2016 (2016) accompanying detailed tables in OECD, data / tables and detailed 2016 publication.
- ¹⁹ OECD, Health Statistics 2015
- ²⁰ OECD, Reviews of Health Care Quality: United Kingdom 2016 (2016)
- ²¹ OECD, Health at a Glance 2015: How does the United Kingdom compare? (2015)
- ²² Measures from the Adult Social Care Outcomes Framework England 2015-16, Final release Published 05 October 2016; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557886/meas-from-asc-of-eng-1516-Report.pdf
- ²³ Kristian Niemietz, The UK Health System: an international comparison of health outcomes (IEA, 2016)
- ²⁴ Natalie Berry, How does the NHS compare with health systems in other countries? (Health Foundation, 2015)
- ²⁵ <http://www.bbc.co.uk/news/uk-politics-37435648>. For instance, Lord Lansley recently called for £5bn to be allocated to the NHS from net savings from the UK's contribution to the EU budget
- ²⁶ http://www.normanlamb.org.uk/cross_party_commission_nhs_and_social_care
- ²⁷ <https://www.nursingtimes.net/news/politics/call-for-cross-party-commission-into-health-service-crisis/7010691.article>
- ²⁸ Health Select Committee, Impact of the Spending Review on health and social care (2016)
- ²⁹ For UK general economy productivity, see Daniel Harari, Productivity in the UK (House of Commons, 2016). For productivity in UK healthcare, see OBR, Fiscal sustainability and public spending on health (September 2016)
- ³⁰ <http://www.bbc.co.uk/news/uk-politics-eu-referendum-36450749>
- ³¹ John Appleby, Ruth Robertson and Eleanor Taylor, 'NHS Trends in dissatisfaction and attitudes to funding', British Social Attitudes Survey 33 (2015). http://www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf
- ³² <http://www.bsa-data.natcen.ac.uk/>
- ³³ ONS, UK trade: Aug 2016: Total value of UK imports and exports of goods together with indices of volume and price, including an early monthly estimate of the value of trade in services (2016)
- ³⁴ Maintaining and growing the UK's world leading Life Sciences sector in the context of leaving the EU (2016)
- ³⁵ Maintaining and growing the UK's world leading Life Sciences sector in the context of leaving the EU (2016)
- ³⁶ Kaplan Warren, 'Benefit, Risk and Innovation in Pharmaceutical Research and Development: opportunities and issues', 2004.
- ³⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/553432/2016_Q2_acc.pdf
- ³⁸ Department of Health, Health Service Medical Supplies (Costs) Bill factsheet. <https://www.gov.uk/government/publications/health-service-medical-supplies-costs/health-service-medical-supplies-costs-bill-factsheet>
- ³⁹ https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_.17.12.15-Allocations.pdf
- ⁴⁰ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Planning-guidance-briefing-Kings-Fund-February-2016.pdf
- ⁴¹ See for instance the comments of Lord Warner (previously a Health Minister in the Labour Government) during evidence session for House of Lords Health Sustainability Committee.
- ⁴² House of Commons Briefing paper, The 0.7% aid target: June 2016 update (2016)
- ⁴³ House of Commons Defence Committee, Shifting the goalposts? Defence expenditure and the 2% pledge (April 2016)
- ⁴⁴ World Health Organisation, The Abuja Declaration: Ten Years On (2011)

- ⁴⁵ Di McIntyre and Filip Meheus, *Fiscal Space for Domestic Funding of Health and Other Social Services* (Chatham House, 2014)
- ⁴⁶ <https://www.gov.uk/government/topical-events/ebola-virus-government-response/about>
- ⁴⁷ <https://petition.parliament.uk/petitions/125692>
- ⁴⁸ House of Commons Defence Committee, *Shifting the goalposts? Defence expenditure and the 2% pledge* (April 2016)
- ⁴⁹ Work and Pensions Select Committee, *Intergenerational fairness* (2016)
- ⁵⁰ Rowena Crawford and George Stoye, 'Challenges for health spending', *Green Budget 2015* (IFS, 2015).
- ⁵¹ <http://www.parliament.uk/business/committees/committees-a-z/commons-select/communities-and-local-government-committee/news/better-care-fund-report/>
- ⁵² See article in *The Times*, 31.10.2016 and Health Select Committee report.
- ⁵³ SMF, *Putting Patients in Charge* (2015)
- ⁵⁴ Give cash to social services and not the NHS, says health chief, 11 October 2016, *The Times*
- ⁵⁵ Data taken from OECD Data on Health expenditure and financing.
- ⁵⁶ ONS, *National Population Projections: 2014-based Statistical Bulletin* (2015)
- ⁵⁷ John Appleby, *Spending on health and social care over the next 50 years – why think long term?* (King's Fund, 2013).
- ⁵⁸ OBR, *Fiscal sustainability and public spending on health* (September 2016)
- ⁵⁹ John Appleby, *Spending on health and social care over the next 50 years – why think long term?* (King's Fund, 2013).
- ⁶⁰ <http://www.economist.com/node/21563714>
- ⁶¹ Daniel Harari, *Productivity in the UK* (House of Commons Library Note, 2016)
- ⁶² Chris Bojke, Adriana Castelli, Katja Grašič, Daniel Howdon, Andrew Street, *Productivity of the English NHS: 2013/14 Update* (University of York, 2016)
- ⁶³ See for instance, Derek Wanless, *Securing our Future Health: Taking a Long-Term View – Final report* (2002). See also the appraisal of NHS funding following the review which found that productivity gains (in unit costs) had been significantly below what had been expected. Derek Wanless, John Appleby, Anthony Harrison and Darshan Patel, *Our Future Health Secured? A review of NHS funding and performance* (King's Fund, 2007).
- ⁶⁴ Adam Roberts, Louise Marshall and Anita Charlesworth, *The funding pressures facing the NHS from 2010/11 to 2021/22: A decade of austerity?* (Nuffield Trust, 2012)
- ⁶⁵ House of Commons Library note, *Obesity Statistics* (2016)
- ⁶⁶ See also the NHS England calculation of demographic cost pressures per year.
- ⁶⁷ Rowena Crawford and George Stoye, 'Challenges for health spending', *Green Budget 2015* (IFS, 2015)
- ⁶⁸ OBR, *Fiscal sustainability and public spending on health* (September 2016)
- ⁶⁹ [https://www.parliament.uk/documents/commons-committees/Health/CSR0107-NHS-England-TT\(CSR0107\).pdf](https://www.parliament.uk/documents/commons-committees/Health/CSR0107-NHS-England-TT(CSR0107).pdf)
- ⁷⁰ This is acknowledged for instance in OBR, *Fiscal sustainability and public spending on health* (September 2016)
- ⁷¹ See for instance the speech of the Home Secretary Amber Rudd at the Conservative Party Conference 2016.
- ⁷² John Appleby, *Spending on health and social care over the next 50 years – why think long term?* (King's Fund, 2013).
- ⁷³ Rowena Crawford and George Stoye, 'Challenges for health spending', *Green Budget 2015* (IFS, 2015)
- ⁷⁴ ONS, *National Population Projections: 2014-based Statistical Bulletin* (2015)
- ⁷⁵ <http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalphopulationprojections/2015-10-29>
- ⁷⁶ ONS, *Overview of the UK population: February 2016* (2016)
- ⁷⁷ <https://ourworldindata.org/financing-healthcare/>
- ⁷⁸ Independent Commission on the Future of Health and Social Care in England, *A new settlement for health and social care: Final report* (King's Fund, 2014)
- ⁷⁹ OBR, *Fiscal sustainability and public spending on health* (September 2016)
- ⁸⁰ <https://www.imf.org/external/pubs/ft/spn/2009/spn0923.pdf>
- ⁸¹ John Appleby and Sean Boyle, *NHS spending: the wrong target (again)?* (2001)
- ⁸² <http://www.bbc.co.uk/news/health-35650170>; <https://www.england.nhs.uk/cancer/cdf/>;
<http://breastcancernow.org/news-and-blogs/blogs/the-new-cancer-drugs-fund-what-are-the-changes-and-how-might-they-affect-you>
- ⁸³ National Audit Office, *Investigation into the Cancer Drugs Fund* (2015)
- ⁸⁴ Independent Cancer Taskforce, *Achieving World-class cancer outcomes – a strategy for England, 2015-20* (2015)
- ⁸⁵ SMF, *Putting Patients in Charge* (2015)
- ⁸⁶ See for instance, House of Commons debate; Health Select Committee, *Impact of the Spending Review on health and social care* (2016)
- ⁸⁷ OECD, *Health Statistics 2015*
- ⁸⁸ OECD, *Reviews of Health Care Quality: United Kingdom 2016* (2016)
- ⁸⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/342029/PHE_public_opinion_slide_set.pdf
- ⁹⁰ Measures from the Adult Social Care Outcomes Framework England 2015-16, Final release Published 05 October 2016; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557886/meas-from-asc-of-eng-1516-Report.pdf
- ⁹¹ Health and Social Care Information Centre, *Statistics on Smoking England, 2016* (2016)
- ⁹² Emran Mian, *Office for Patient Outcomes (SMF, 2016)*
- ⁹³ Based on forecasts in the OBR March 2016 report. <http://cdn.budgetresponsibility.org.uk/March2016EFO.pdf>. The 2015 GDP growth figure of 2.2% taken from ONS, *Gross Domestic Product: Preliminary Estimate, Quarter 4 (Oct to Dec 2015)* (2016)
- ⁹⁴ Introducing the first 'GDP growth' increase to healthcare funding in 2016 rather than 2017 makes little difference because the Government frontloaded some of its spending increases for NHS England.

⁹⁵ See p18 onwards in Adam Roberts, Spencer Thompson, Anita Charlesworth, Ben Gershlick and Alfie Stirling, Filling the Gap: tax and fiscal options for a sustainable UK health and social care system (Health Foundation and IPPR, 2015).

⁹⁶ OBR, Fiscal sustainability and public spending on health (September 2016)

