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Addressing the fiscal and sustainability challenges for the NHS

Despite increased spending, the service and workforce challenges faced by the NHS still demand urgent reforms.

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The NHS is a social insurance system funded predominantly through general and broad-based taxation, which continues to offer protection from the financial consequences of ill health.[1] Provision of NHS services is based on clinical need rather than the ability to pay and is generally progressive, therefore facilitating redistribution of resources from the rich to the poor.[2] That said, there are both funding and delivery issues with the NHS that are currently undermining the efficient delivery and access to healthcare.

The UK spent £292 billion, or 10.9% of its national income (gross domestic product [GDP]), on healthcare in 2023.[3] In 2022, nine of the EU14 countries (the 14 countries who were members of the EU prior to 2004) spent more on healthcare per head (in terms of US dollar purchasing power parity) than the UK and six invested over 20% more (Germany, Netherlands, Austria, France, Luxembourg, Sweden).[4] The UK spend per head prior to the COVID-19 pandemic was the second lowest of the G7 wealthy nations.[5]

Looking at the percentage spent on healthcare across the austerity years (2010–2019), this barely changed from 9.8% of GDP in 2010 to 10% in 2019.[3] Indeed, for the period from the last year of the Brown government (2009–2010) to the year 2018–2019 (prior to the pandemic), the average annual rate of growth in UK healthcare expenditure in real terms was 2.1% compared with 3.3% under the Thatcher and Major Conservative governments, and 6% under the Blair and Brown governments. Although private spending on healthcare as a proportion of total healthcare spending has been rising in the UK (from 16.9% in 2009 to 20.7% in 2019), most of our healthcare expenditure (just over 80%) continues to be financed by the government.[6] The level of healthcare expenditure to be attained in the UK is, in other words, a political choice.

Most objective economic commentators, including the London School of Economics and Political Science–*Lancet* Commission,[7] believe that healthcare expenditure should rise by a minimum of 4% per annum over a ten-year period to improve the quality of care given the various growing pressures on the NHS. The independent Office for Budget Responsibility (OBR) forecasts that, on average, actual total healthcare expenditure will be 3.3% per annum in real terms over the medium term.[8] In fact, in Labour's October 2024 Budget, the NHS was a clear winner with expenditure growth although lower than desired by many economic commentators.

The NHS will receive annual increases of 3.4% in real terms during this government's expenditure period (until 2028–2029). While other government departments will experience annual growth in real terms of 3.4% until 2025–2026, expected growth will then flatline (falling to -0.1% annual growth in real terms between 2026–2027 and 2028–2029).

Will this expenditure growth be enough to meet the pressures on the NHS? How does the forthcoming NHS ten-year plan tally with these expenditure levels? What is required to improve the NHS? Some possible answers are given below.

Healthcare expenditure growth must cover the supply responses to the demands placed on the NHS. A major driver of demand, population health, is unfortunately worsening.[9] Although individuals are living longer now than two decades ago, growth in life expectancy stalled before the COVID-19 pandemic and has reduced in the years since the pandemic.[10] Indeed, healthy life expectancy has been falling since 2010. These trends in life expectancy growth reflect not only benefits from health technology leading to the increased life expectancy (particularly in some disease areas, such as cardiovascular disease) but also individuals living longer with more comorbidities; the extra life years lived are with increased ill health for many. Self-reported disability-associated health had risen from a prevalence of 19% at the turn of the century to 24% by 2022–2023.

Moreover, the NHS does poorly compared with other high-income countries in relation to important health outcomes, including survival rates from common cancers and infant mortality.[7] In delivering care to meet growing demographic demands, the NHS has fewer nurses and clinicians than comparable high-income countries, and until recently, there was no viable workforce plan.[11] The OBR states that in order to deliver the last government's workforce plan, health expenditure would have to grow by 3.6% per annum in real terms, which is slightly more than the expenditure growth commitment in the October 2024 Budget.[8] This means that even before taking account of demographic pressures, and the adoption and diffusion of new technology to improve the quality of delivery, the NHS will be on the back foot going forwards to 2028–2029.

Part of the solution to the matching of NHS supply to demand pressures lies in improving service delivery. However, the

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NHS faces challenges in this area as it employs approximately 1.5 million staff, with around 60% of provider spending allocated to the workforce.[11] Furthermore, there is a misalignment between the 5-year fiscal cycle (which allocates resources to the NHS from tax income) and the 8–10-year cycle that is associated with the training of new clinicians. This could be aligned more effectively by removing politics from the NHS and establishing a fully independent institution (like the OBR) to provide oversight and reporting on NHS funding needs, workforce planning, service delivery and outcomes, ensuring a more strategic and long-term approach to meeting healthcare demands. It could also provide information on the consistency of a patient's journey.

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At present, access to care is often uncoordinated and inadequate at critical stages of the patient pathway. Patients face challenges such as difficulties in accessing general practitioner (GP) services, long waiting times for hospital referrals, limited capacity during the transition from diagnostics to treatment, and poor arrangements for transitional care during ward transfers, discharge and follow-ups.[7] While some of these issues reflect resource constraints, others are due to a lack of oversight. Full auditing of patient journeys by an independent institution could help highlight and address problematic issues at both the local and national level, ensuring a more streamlined and effective healthcare system.

An independent institute could also improve the collation of resource information, identify areas for improvement and where the NHS should disinvest from low-value healthcare, defined as interventions where evidence suggests it confers no or very little proven patient benefit, or a higher risk of harm.[12] In addition, it could help in workforce planning.[13] Currently, although the NHS tracks full-time equivalent employees, it lacks comprehensive data on the actual hours worked, staff turnover, and movement in and out of the NHS. Such information is better recorded in the hospital sector but remains inadequate in primary, community and mental health sectors. Furthermore, the institute could aid the publication of more comprehensive information on GP practice delivery, complementing existing data on hospital trusts. A ten-year planning period would also aid capital investment and infrastructure development, ensuring that the NHS is equipped to meet future healthcare demands effectively.

An organisation as large and complex as the NHS, along with its individual components, requires much more accurate information relating to workforce planning, provision and changing demand patterns. It has been said that the NHS is undermanaged but overadministered.[14] Administration is important for data collection, collation and reporting. These data need to be retained, and feedback needs to be provided to patients on their various diagnostic and treatment journeys. Nevertheless, the NHS also requires better management.

The NHS operates as a social insurance system, with healthcare delivery serving as the benefits gained from that system. In any insurance system, comprehensive and accurate data are fundamental, not only on the supply (resource) side but also to provide better feedback to patients. Management of the system requires data administrators to relate information to managers, who can then make strategic decisions to deliver the healthcare benefits more effectively and efficiently. Financial incentives, such as GP and hospital reimbursement, can help as they should form part of this strategic management and be tied more closely to individual and population health outcomes.

As an insurance system, one policy option could be the implementation of a 'contract' between patients and providers, specifying what diagnostic and treatment care they should expect for certain episodes of planned care and chronic disease management. This contract could be based on suitably amended treatment guidelines, such as those based on local or National Institute for Health and Care Excellence guidelines. As primary initiators of episodes of care, GPs could take responsibility for overseeing the delivery of these contracts. This would help align patient expectations with the consistent delivery of care across the NHS. However, implementing such a policy would require a revised budget for primary care to ensure sufficient capacity for managing and monitoring these contracts. In 2022–2023, NHS England spent 9.5% of the Department of Health and Social Care budget on primary

care services – a decline of more than two percentage points since 2015–2016.[15]

Some gaping holes exist in delivery, with mental health being one of the most under-resourced areas given the growing demands. Here, patient-led care could be more prominently focused on day centres. If individuals received disability benefits, these could be (suitably) linked to compulsory attendance, with outreach workers aiding attendance where necessary. And, of course, the large elephant in the room is social care. Spending by English local authorities on adult social care services, net of income from fees (e.g. fees from those who are only eligible for partial support and therefore pay 'tariff income'), was cut by around 10% between 2009–2010 and 2014–2015 before recovering steadily, and by 2022–2023, spending was around 10% above its 2009–2010 level in real terms, but this is not enough to meet growing demands.[16]

Social care should be part of a national coordinated service with the NHS. Currently, there is often poor coordination during transfer from the NHS to social care providers. This is partly exacerbated by lack of shared information systems, and no national compulsory or comprehensive surveys that describe transitional care arrangements between NHS and social care providers. NHS England also halted publication of delayed transfers of care from the NHS from 2019–2020.[17] Without better funding and workforce management in the social care sector, the NHS will continue to face significant capacity constraints. With hospital bed levels among the lowest in Europe,[7] these constraints will hinder any efforts to improve service delivery and manage patient flow effectively.

We await the NHS ten-year plan, which is meant to build on the triumvirate of moving care from hospitals to the community, better use of health information technology (HIT) and prevention. Clearly, expenditure constraints are going to persist in making it difficult to deliver large benefits under increased demand pressures with efficiency gains alone. Investment in GP and social care is essential if capacity for community care is to be increased. HIT provision of information to the patient (through expanding the NHS app) is only part of the picture; the supply side data and equipment has to be heavily invested in.

Relying on prevention for an ageing population that is deteriorating in health is a big ask, even if the level of resources required for meaningful prevention strategies can be found and ringfenced for protection. More importantly, future planning requires alignment of fiscal and workforce planning cycles but there is little sign that this is occurring. The planning process itself is on the back foot given that the NHS fiscal environment has already been set by the October 2024 Budget, with the resources for this parliamentary cycle allocated before a comprehensive assessment of the demand that needs to be satisfied has been fully articulated. This misalignment between planning and resource allocation leaves the NHS playing catch-up as it attempts to address its long-term challenges.

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