Blair's billions: where will he find the money for the NHS?

John Appleby, Sean Boyle

Government ministers have often committed to increased levels of NHS expenditure—but conditional on real growth in the economy as a whole. The prime minister's new spending pledge—to raise total (public and private) healthcare spending to match the European Union (EU) average as a proportion of gross domestic product by 2006—is largely independent of the performance of the economy.[1] No matter how well the economy does, health spending must grow much faster to meet the pledged target.

Since this pledge, many have queried the arithmetic rigour of Tony Blair's calculations and the financial feasibility of hitting the target he has set,[2–4] It now seems that the government's interpretation of the EU average (8.0%) is wrong and that a more accurate figure is 9.0%. If this new figure is accepted, what are the options open to the government in order to fulfil Blair's pledge?

Summary points

The prime minister has pledged to raise total UK healthcare spending by 2006 to match the European Union (EU) average as a proportion of gross domestic product (9.0% in 1997, not 8% as indicated by the prime minister)

All other things being equal, NHS spending would need to increase in real terms by 9.7% a year over five years (by £29.2bn in total) to reach the 9% target

There are three ways to increase healthcare expenditure: increased government spending, shifts in public spending towards the NHS, and increased private healthcare spending

Increasing taxes (such as 10p on the basic income tax rate or increasing VAT to 27%) or borrowing could fund the necessary increased spend but would be politically and economically unacceptable and could substantially increase government spending as a proportion of gross domestic product (from 39.7% to over 56%)

At one extreme, money could be shifted from defence and the Home Office, reducing spending in these areas to zero after five years; more realistically, increased tax revenues arising from a growing economy could fund increased NHS spending but would leave very little real growth (on average 0.7%) for other departments

Depending on private healthcare spending alone would require an economically unrealistic threefold increase in private spending, and, even if it could be done, would raise questions of equity of access to health care

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How can the pledge be funded?

The Treasury estimates that UK gross domestic product will be £870.2bn for 1999-2000 (at 1998-9 prices). The Treasury's prebudget report of November 1999[5] suggests that gross domestic product will grow in real terms by 2.25% up to and including 2004-5, to reach £972.5bn. If the share of gross domestic product devoted to health care is to reach the EU average of 9% by this date, total healthcare spending must reach £87.6bn (9% of £972.5bn).

We estimate that total healthcare spending in Britain is currently £57.5bn (6.6% of gross domestic product). The funding "gap" is therefore £30.1bn in real terms—requiring a real growth in NHS spending of about 9.7% a year from 2000-1 to 2004-5. The enormous increases in public (or private) spending needed to reach the EU target have far reaching implications for government spending as a whole and raise questions about the feasibility of meeting the target.

Increasing healthcare spending faster than the growth rate of the economy means that there are limited options for funding this expenditure. The choices for the government are to

- Increase total government expenditure by increased taxation or borrowing
- Shift public spending to the NHS
- Expand the private sector.

Increased total government expenditure

Assuming healthcare spending in the private sector increases at the same real rate as the economy (2.25% a year), NHS spending will have to increase by 9.7% in real terms over the next five years if the EU target is to be met by 2004-5. This implies a real increase of just over £29bn (in 1998-9 prices) in NHS funding—nearly 60% more than is currently spent.

If other government spending is not to be affected by extra spending on the NHS, then the latter must remain a constant proportion of all government spending—that is, 14.4%. This means that total government spending (total managed expenditure) must also grow at 9.7%, increasing from an estimated £343.1bn this year[5] to over £545.1bn by 2004-5. Box 1 illustrates some of the taxation implications of this increase. But increasing total managed expenditure at this rate means that its share of gross domestic product would also increase—from about 39.7% this year to over 56% by 2004-5 (fig 1). Such a share is unprecedented in the postwar UK economy and, as the sole solution to increasing spending, is likely to be politically and economically unacceptable.

Moreover, the government has already indicated a "growth envelope" for total managed expenditure of 2.25%—in line with predicted growth in gross domestic product.[7] If this proves to be the case and total government spending (excluding health) were to grow at this rate, while health increased at 9.7% a year, then total managed expenditure as a proportion of gross domes-

Box 1: What would increased total government expenditure mean in tax terms?

To raise another £29.2bn over five years is equivalent to increasing the basic rate of income tax each year by over 2p in the £1 (assuming 1p gives £2.65bn in tax revenue[6]). Alternatively, an immediate increase in VAT from 17.5% to nearly 27% would have a similar effect. And an increase in tobacco duty of about £2 a packet each year would raise around £29.2bn by 2004-5.

Increasing taxation is a particularly sensitive political issue. The apparently paradoxical views of the public—willing to be taxed more to increase NHS spending, but traditionally unwilling to vote for parties with such a manifesto commitment—may arise from the public's scepticism that, when in office, politicians may tax but not spend (on health care).

A more radical tax solution—which could go some way to connecting taxpayers with NHS spending—could be a form of hypothecated tax. However, it is difficult to see how this would bypass political and Treasury influence without incurring problems such as variations in revenue linked not to the need for health care but to broader macroeconomic changes in the economy. Someone has to set the rate for the tax, and if this is not done through an accountable political process then how is it to be done?

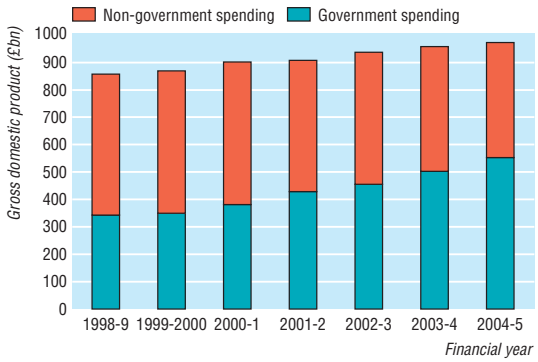

Fig 1 How government spending would have to increase if NHS spending were to remain a constant proportion of government spending yet increase in real terms by 9.7% a year for the next five years

tic product need increase only from 39.7% to 41%. But the result would be a shift in the profile of government spending towards health similar to that described in the next section.

Similar problems arise if the government were to increase its borrowing rather than increase taxation. Moreover, this would, at best, only ever be a short term solution.

Shifting government expenditure

A second option is to shift public expenditure to health care from some current use. If the overall level of total managed expenditure as a proportion of gross domestic product is to stay constant at the current level of just below 40%, the proportion of this spent on health care would have to increase from the current 14.4% to over 20%.

This could be done, but it would probably require a combination of real reductions and no (or minimal) real increases in other areas of spending. If total managed expenditure is to remain at a constant proportion of a gross domestic product that is growing in real terms, then it will also grow in real terms—by around £41bn between now and 2004-5. The extra spending needed for the NHS, £29.2bn, could be funded from this growth in total managed expenditure, but this will leave little or no growth for other departments (see box 2). NHS spending apart, it would leave total government spending growing at just under 0.7% in real terms for the next five years. Apart from a period in the late 1980s, at no time in the past 35 years has government spending (minus health spending) grown so slowly for such an extended time.

Increased private healthcare expenditure

A third way of increasing overall spend on health would be to encourage increased spending within the private sector, essentially through more out-of-pocket payments or by increased private insurance—as argued by, for example, the Centre for Policy Studies[8]. Currently, the proportion of total spend that is private is low by EU standards—15% compared with an average across the European Union of around 24% (figures for 1997[9]).

However, to match overall EU levels purely by increased private expenditure would require an immense increase in this part of the total over the next five years. Even assuming that NHS funding increased at a real rate of 5% a year, private spending would need to increase from current levels of around £8bn to over £24bn (fig 2). This would imply an unprecedented rate of real growth of over 25% a year and would bring the proportion of total health expenditure funded privately up to nearly 28%, a level currently matched by Germany, Italy, the Netherlands, and Portugal.

Conclusions

The government could use a combination of the options presented above—raising taxes and shifting public spending, for example. However, we have illustrated the extent of the government's pledge to the NHS over the next five years. It means greater public spending, a shift away from other traditional areas of public spending, or a massive increase in private expenditure on health care. This will be true even if the

Box 2: Implications of shifting government expenditure to health care

For 2000-1, total managed expenditure is set to consist of departmental expenditure limits—education, health, defence, etc—of £189.7bn and annually managed expenditure—social security, payment of government debt interest, etc—of £179.1bn, a total of £368.8bn. The seven top spending departments account for 82% of departmental expenditure limits.[5]

At one extreme, the £5.83bn annual real increase in NHS spending needed over five years to bring total healthcare spending up to 9% of gross domestic product could be found by reducing, say, the budgets for defence, the Home Office, and culture, media, and sport to zero by 2004-5.

A less painful solution would be to fund NHS expansion out of the £41bn real increase in total managed expenditure, leaving other departmental budgets to grow at around 0.7% a year in real terms. To this extent, achieving the health spending target would be made more difficult if the economy did not grow as fast as expected.

Box 3: How could private healthcare spending be increased?

The first problem with funding increased healthcare spending through the private sector is how this can come about. Currently, UK citizens are free to buy many forms of private medical insurance and to pay directly for health care from private providers. How is the public to be persuaded to spend over three times more on private health care than it does at present?

Subsidies from government that effectively lower the price of, say, private medical insurance are a rather roundabout way of doing this. It makes more sense for the government to spend taxpayers' money directly on health care through the NHS, rather than risk wholly or partly subsidising the earnings of private healthcare providers (through increased prices) without much impact on the volume of care provided.

Providing an "opt out" scheme from the NHS by reducing income tax payments for those who go private merely increases private spending at the cost of reduced NHS spending, at one extreme leaving total healthcare spending neutral.

If these problems were not enough, there is also an issue of distribution or equity that needs to be addressed. Over 75% of current public expenditure is for people aged over 65 years and for children. In other words, just £12bn of the current NHS budget is spent on adults of working age. If this is where most of the growth in private spend can feasibly occur, then this could mean an end to a universal healthcare service and a very overt split between those who contribute to NHS funding (but use the private sector) and those who use the NHS.

government were to stick to its misleading interpretation of the EU average spend on health care of 8% of gross domestic product. All options have attendant problems and knock on effects. Although there seems no question that there is a popular desire to spend more on health care—and primarily through the NHS (preserving a commitment to inequality in funding that favours the poor)—the scale of spending increases raises difficult choices.

More radical solutions for bridging the funding gap, such as a form of hypothecated tax, may well bring benefits (not least additional money for the NHS) but also raise several questions. Who sets the tax rate? How are fluctuations in the tax yield dealt with so as not to create uncertainty for NHS planning? Will identifying each taxpaying individual's NHS contribution undermine the universal (and essentially altruistic) nature of NHS funding and provision? To what extent will taxpayers' expectations and use of the NHS be raised as they begin to make connections between their personal contribution and their own use of the NHS?

Although there may be uncertainty as to where Britain is starting from and where it has to go in terms of healthcare spending, it is certain that the NHS will receive substantial real increases in funding over the next few years. A question for the service is how it should spend this money to bring about real improvements in health and in patients' experience of the NHS.

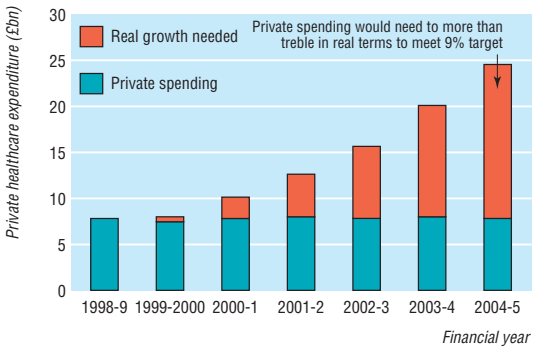

Fig 2 How private healthcare expenditure would have to increase to close the "funding gap" if NHS expenditure increased in real terms by 5% a year yet total healthcare spending increased in real terms by 9.7% a year for the next five years

Competing interests: None declared.

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Corrections and clarifications

Leg length and risk of cancer in the Boyd Orr cohort
An error in this paper by D J Gunnell and colleagues from more than a year ago (1998;317:1350-1) has only just come to light. In the final sentence of the first paragraph of the subjects, methods, and results section, the z score for each unit of leg length is 3-4 cm (not 3-4 mm).

Tumour markers in malignancies
An author's error in citing a type of leukaemia also slipped past our editorial team in this Regular Review by Annika Lindblom and Annelie Liljegren (12 February, pp 424-7). The second sentence of the last paragraph before the conclusion (p 426) should have read: "The Philadelphia chromosome in chronic myeloid leukaemia [not chronic lymphocytic leukaemia] is the best known example [of translocations creating fusion proteins in haematological diseases]."

How we improved our treatment of hypertension
A misunderstanding over initials caused an error to creep into this filler by Alexander Williams (29 January, p 309). In the penultimate paragraph it is not the Prescription Pricing Authority that scrutinises the practice but the local patient practitioner services authority.

Internal and external morality of medicine: lessons from New Zealand
A reader alerted us to a misspelling of his name in a reference cited in this paper by Charlotte Paul (19 February, pp 499-503). The name of the fourth author in reference 8 (p 503) should be Mullins, not Mullen.