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Feeling the crunch: NHS finances to 2020

Summary

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About this report

As recognised by the NHS's Five Year Forward View, by 2020 the NHS will need to find savings of around £22 billion in order to balance its books. But there has been no clear articulation of how that gap is expected to be closed. The options for doing so include NHS providers becoming more efficient; NHS commissioners reducing the pace at which NHS activity is increasing each year, either through reducing demand or limiting access to care; more funding for the NHS; or some combination of these. This is a summary of a longer analysis examining different scenarios to determine exactly what it would take to close the gap.

Read the full-length analysis at www.nuffieldtrust.org.uk/feeling-the-crunch

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About the author

Sally Gainsbury joined the Nuffield Trust in October 2015 as Senior Policy Analyst. Her focus is on health and social care funding and the NHS financing system. She also contributes to the Trust's rapid response and analysis of emerging policy issues.

Prior to joining the Trust Sally was an investigative journalist at the *Financial Times*, working on UK and international investigations spanning public spending, tax avoidance and money laundering. Before joining the *FT* Sally was chief reporter and news editor at *Health Service Journal*.

Sally has a PhD in history and a Master's degree in politics.

The NHS faces a £22 billion funding shortfall four-and-a-half years from now. That is no longer an abstract number designed to scare the NHS into action. Its reality is hitting home already: a £3.7 billion underlying provider deficit in 2015–16, commissioners only balancing their books through one-off, non-recurrent funds, and finally the Department of Health busting its budget by £200 million despite having made over £1 billion worth of technical adjustments and switches.

Yet we still know little about how the £22 billion gap will be closed. This analysis is an attempt to set out how the gap might be closed in theory, if things – many things – go well, and to raise some alarms about what might happen in practice if they don't.

In order to do this, our research models how much care the NHS can afford to provide over the next four-and-a-half years, given the budget set in the 2015 Spending Review.

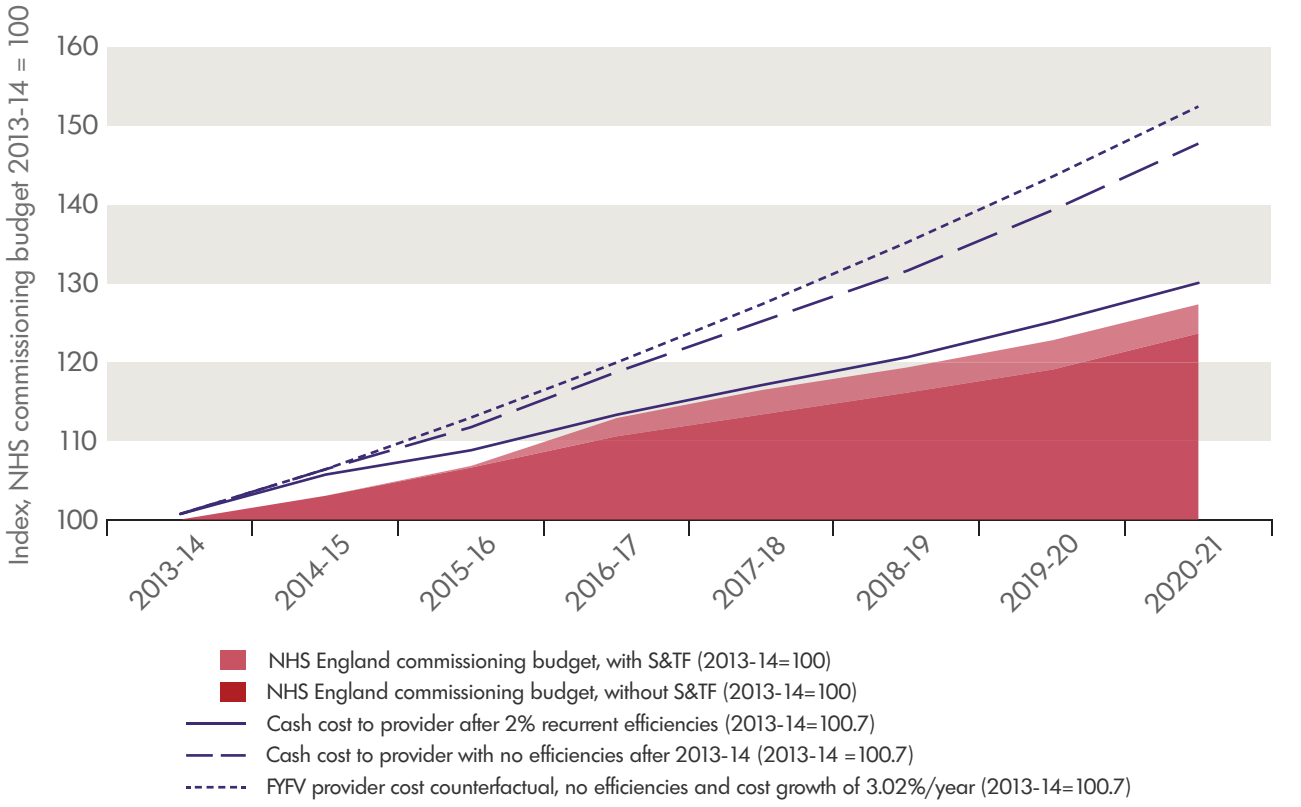
At present, the NHS is providing around 3.1% more services a year, by treating more patients, with more complications, through higher-quality and faster health care.

We can calculate how much that extra 3.1% will cost NHS hospitals and other services to provide by looking at how much inflation the NHS is expected to face over the next four-and-a-half years.

In Figure 1 we set these rising costs for the whole of the NHS out first as an index, where the NHS budget in 2013–14 is set at 100, and a 10% increase in cost is shown as 110.

The shape of the graph is familiar: the purple dotted line at the top represents NHS England's 'do nothing' scenario, where unit costs simply rise in line with inflation because providers do not make efficiency savings to offset it. The red shaded area shows the NHS's total available resources – made up of its core budget, with the light red area representing the £2 billion to £3.4 billion a year top-up to this from the Sustainability

Figure 1: Index of 3.1% annual activity growth applied to NHS-wide costs

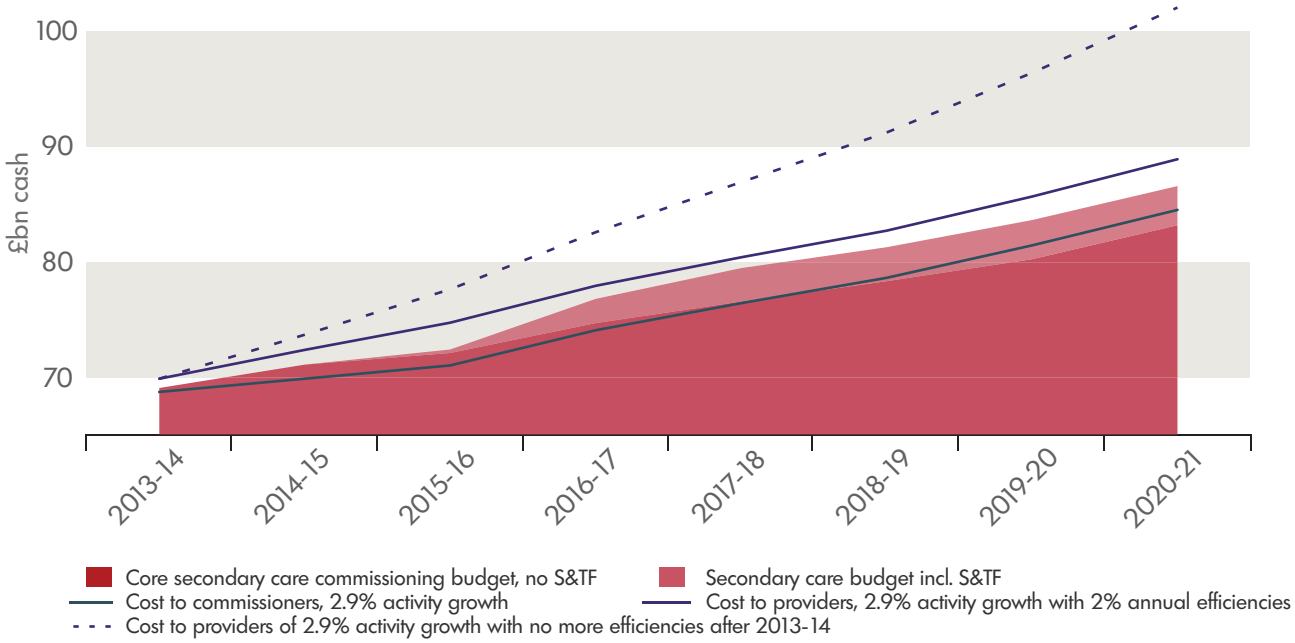


and Transformation Fund (S&TF), which we will discuss later. The gap of almost a fifth between the two by 2020–21 is close to £22 billion – the original 'NHS funding gap' highlighted in NHS England's Five Year Forward View (FYFV).

The full analysis discusses the situation across the whole of the NHS in detail. However, in this summary we look at what the funding shortfall means for NHS trusts providing secondary care across England, and the commissioners who pay for and plan that care on behalf of patients. Collectively, these services cover care in acute and specialist hospitals, mental health and community services and make up almost three quarters of all NHS revenue spending. They are also where the bulk of NHS England's estimated £15 billion of 'locally delivered' savings will need to come from.

Figure 2 presents the secondary care-only version of the £22 billion funding gap. The core secondary care budget is shown by the red area in the chart, while the light red line supplements that by adding the entire Sustainability and Transformation Fund. That £2 billion to £3.4 billion a year fund was announced as part of the 2015 Spending Review and has two purposes: first, to bail out provider deficits in the short term, and second, to fund investment in the service transformation set out in the Five Year Forward View in order to secure the long-term sustainability of NHS services and modernise models of care.

Figure 2: Funding gap in secondary care: 'base reform' scenario



We use a slightly lower rate of activity increase here (2.9%), which reflects NHS England's assumption for activity growth in secondary care (the overall NHS average is pushed up by higher growth in the prescribing budget).

The purple dashed line shows how much secondary care activity will cost providers without any efficiencies from 2013–14 onwards. By 2020–21 the gap between those costs and the total budget is £16 billion.

The solid purple line shows what provider costs would be after efficiencies (of 2% a year from 2015–16 onwards). Those efficiencies close the gap between costs and the total budget to £2.3 billion in 2020–21. But that is only after the entire S&TF has been used on funding activity increases – which would mean it could not be used to invest in new services and NHS transformation.

If we exclude the S&TF, the secondary care deficit after 7 years of recurrent provider efficiencies of 2% a year would be £5.7 billion by 2020–21.

Sharing the £5.7 billion pain: commissioners hit bust by 2018–19

Looking at where that £5.7 billion would sit gives us an idea of what the incentives might be to address it. The solid teal line on Figure 2 shows how much that secondary care would cost commissioners – these are the organisations who purchase and plan care on behalf of patients. The price paid by commissioners is determined by the NHS tariff. Prices in the tariff are deliberately held low each year, in order to try and incentivise providers to cut their costs (see the full analysis for more detail).

The graph shows that there is no point at which commissioner payments would meet the actual cost of providing care. That is because even if providers make 2% cost savings a year, tariff prices will be cut by an equal proportion, and so the level of their deficit will remain similar in proportion to what it is today – reaching around £4.4 billion in cash terms by 2020–21.

But there is bad news for commissioners too: from 2018–19 onwards, the core secondary care budget will be insufficient to cover the tariff rate for the quantity of care provided. By 2020–21, commissioners would be overspending their core budget by £1.3 billion a year.

That would mean commissioners would need to spend part of the S&TF on bailing out deficit-ridden providers, and the other part on subsidising their own bills to providers. And even after that, the secondary care sector would still be in deficit.

The fact that the deficit would now be shared between commissioners and providers means that both types of organisation would have to work hard to reduce it. This will be the focus of local Sustainability and Transformation Plans, which are due to be finalised by October 2016.

Increase provider efficiency to free up investment for transformation?

For their part, hospitals and other NHS services are now being asked to make 4% cost savings this financial year – double the rate they have managed to make over recent years. That would involve cutting around £3 billion in costs this year.

Figure 3 on the next page shows how much provider costs will reduce if they manage to make 4% cost saving for the next two years and then follow it in 2018–19 with a slightly reduced cost saving of 3%.

Making those cost cuts would bring provider costs down into line with the payments they receive from commissioners by 2018–19. But doing so would involve providers cutting £10 billion out of their cost base permanently, in just three years.

If providers managed that, then large chunks of the S&TF would no longer be needed to bail out provider deficits and could instead by used to invest in service transformation (see Figure 4 on the next page).

Figure 3: Funding gap in secondary care: 'extra provider efficiency for 3 years' scenario

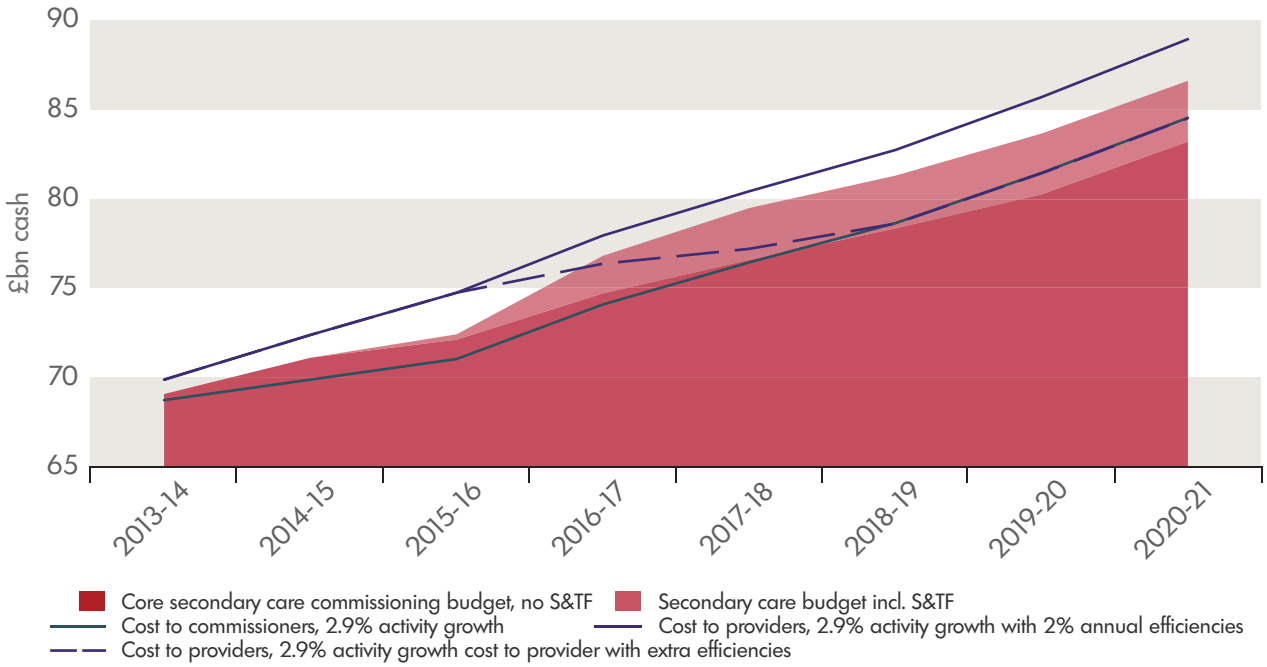
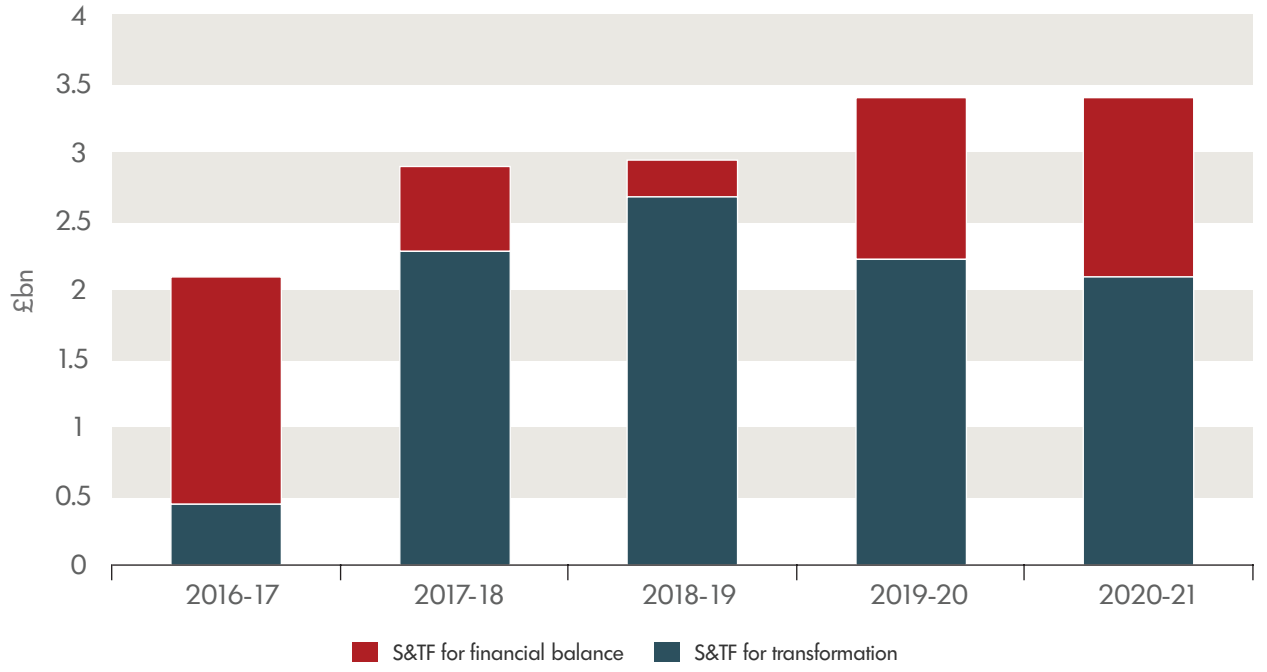


Figure 4: S&TF available for transformation: 'extra provider efficiency for 3 years' scenario



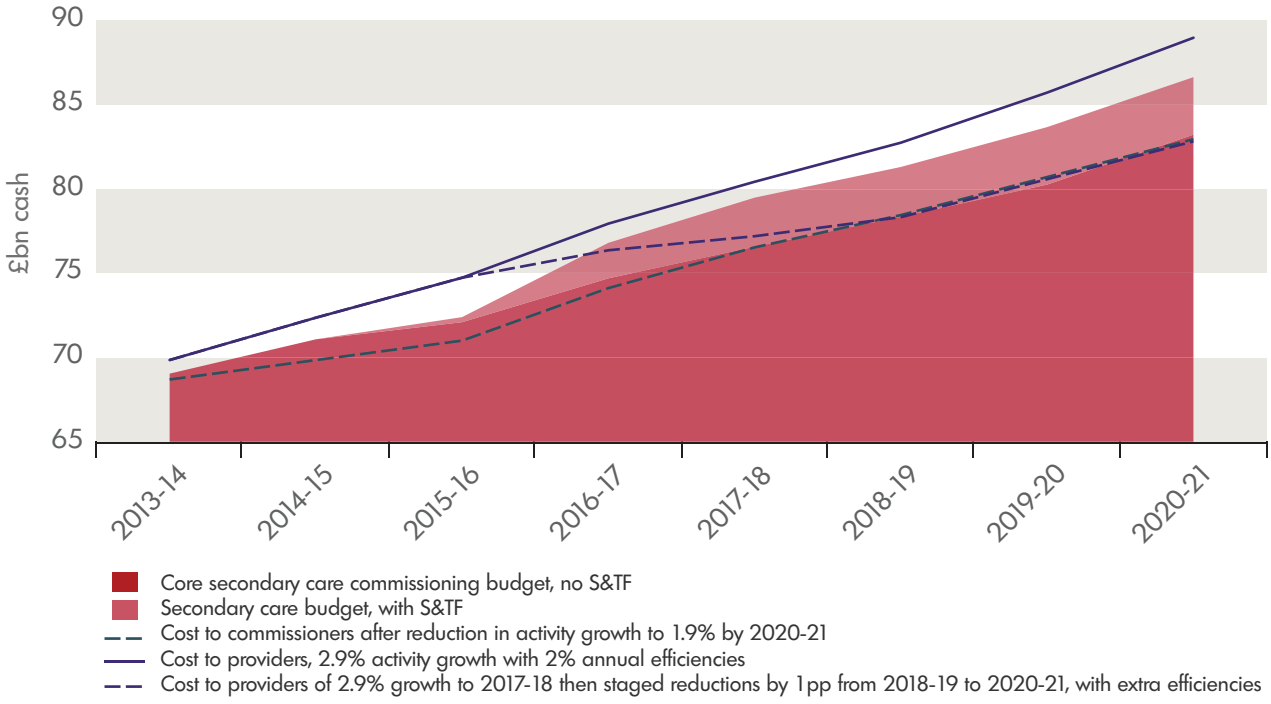
That investment would still be necessary, because even if providers made £10 billion of cumulative cost savings, commissioners would still be buying more care than they could afford from their core budgets.

To bring themselves back into balance, commissioners would then need to reduce the rate at which activity levels were growing in order to bring their purchasing into line with their care budgets.

NHS England hopes that by investing the S&TF in service transformation and new models of care that improve population health, commissioners will be able to reduce the rate at which demand for NHS care is growing in the secondary care sector from 2.9% a year to 1.9%.

Figure 5 shows the impact such a slowdown in the rate at which NHS activity was increasing would have if it was phased in from 2018–19 (reducing the growth rate to 1.9% by 2020–21). It would mean that, by 2020–21, the secondary care sector would finally live within its core budget. But these are big requirements: first providers have to make huge cost savings at twice the rate they have managed in recent years, and then commissioners have to invest the freed-up funds in schemes that succeed in reducing demand for care, rather than simply adding to the overall growth rate even further.

Figure 5: Funding gap in secondary care: 'one percentage point reduction' scenario

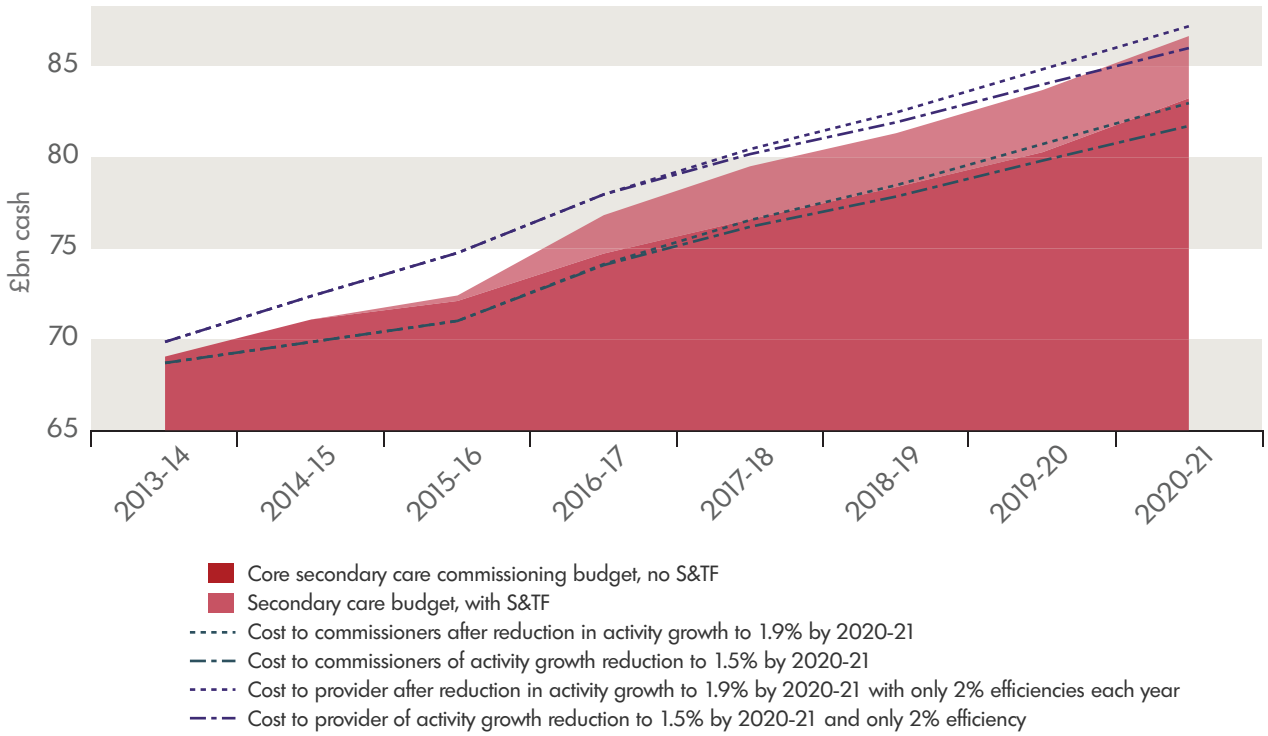


Rationing without investment

If either of those two big asks fail, the NHS may need to look to a more unpalatable alternative to cutting its costs. This could involve crude service rationing: not genuinely reducing the need and demand for growth in health services through improving population health, but restricting access to services, either by cutting them altogether or raising the thresholds for treatment.

Figure 6 on the next page shows the impact of the same staged reduction in the activity growth rate to 1.9% explored above, but with provider efficiencies at 'just' 2% a year. But as the figure shows, that won't work. Attempting to balance the NHS budget through a one percentage point reduction in activity alone is not a viable option: provider costs by 2020–21 would still be £4 billion above the core secondary care commissioning budget. Even after spending all of the S&TF on plugging provider deficits, the system as a whole would be spending £0.5 billion a year more than its total available resource.

Figure 6: Funding gap in secondary care: 'demographic growth-only' scenario



To bring the NHS into financial balance without provider efficiencies above 2% a year would require crude rationing to go even further and to reduce the rate of growth right down to 1.5% a year. That is the level of growth NHS England estimates is needed every year just to keep up with population growth and ageing. It implies, then, that the quality and standards of NHS services would need to be frozen at today's levels, as the growth associated with bringing in new treatments and rising public expectation would need to be removed.

Even after cutting that, the NHS would still need to spend the entire S&TF on plugging provider deficits. However, in this scenario, the NHS will have given up on the ambition to invest in genuinely reducing the growth in demand through improved services and population health, and so a transformation fund may no longer be necessary.

But that precarious balance would be achieved at the cost of preserving the NHS in aspic: standing still and deliberately halting any further advancement in health care quality, such as the adoption of new treatments available elsewhere in the developed world.

The political acceptability of that – following a Brexit campaign which highlighted a potential £350 million extra for the NHS a week – is highly questionable.

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