Spending Review 2013

Overview

On 26 June George Osborne will deliver his second Spending Review as Chancellor, outlining departmental spending allocations for 2015-16. Unlike in 2010, when it was anticipated that the four year settlement would distribute all the cuts needed to balance the public books, behind this one-year Spending Review loom two further years of deep cuts, to be announced by the next government.

The Chancellor has ruled out further cuts to the welfare budget at this Spending Review, so savings will come entirely from departmental spending (DEL). Preserving the ringfences on the health, schools and international development budgets will mean deeper cuts for non-protected departments, leading many to argue that it is time to abandon these ringfences. The health ringfence has recently come under particular scrutiny.

This briefing looks at the scale of cuts being made to current spending at this Spending Review in the context of the entire fiscal consolidation, and shows that despite the difficulties of making the £11.5bn of cuts required, this Spending Review represents only a fraction of the remaining £33bn consolidation needed to get the public finances back on track by 2018.[1]

The briefing also considers the implications of maintaining the ringfence on health spending in both the short-term and longer-term. We show that, while protecting NHS spending inevitably means a tighter settlement for other departments, abandoning it is unrealistic.

Indeed, a further three years without a real-terms increase in health spending is likely to put unsustainable pressure on the NHS, requiring it to meet what we call the 'Post-Nicholson Challenge' of finding £34bn of efficiency savings over seven years. This is internationally and historically unprecedented. Under these conditions, a universal health service free at the point of use will struggle to meet the ever-rising expectations of patients. Policymakers are therefore coming to a fork in the road: the NHS will have to change fundamentally and in ways that will threaten its universality, or much higher taxes will be needed to pay for the services voters expect.

[1] In 2015-16 prices

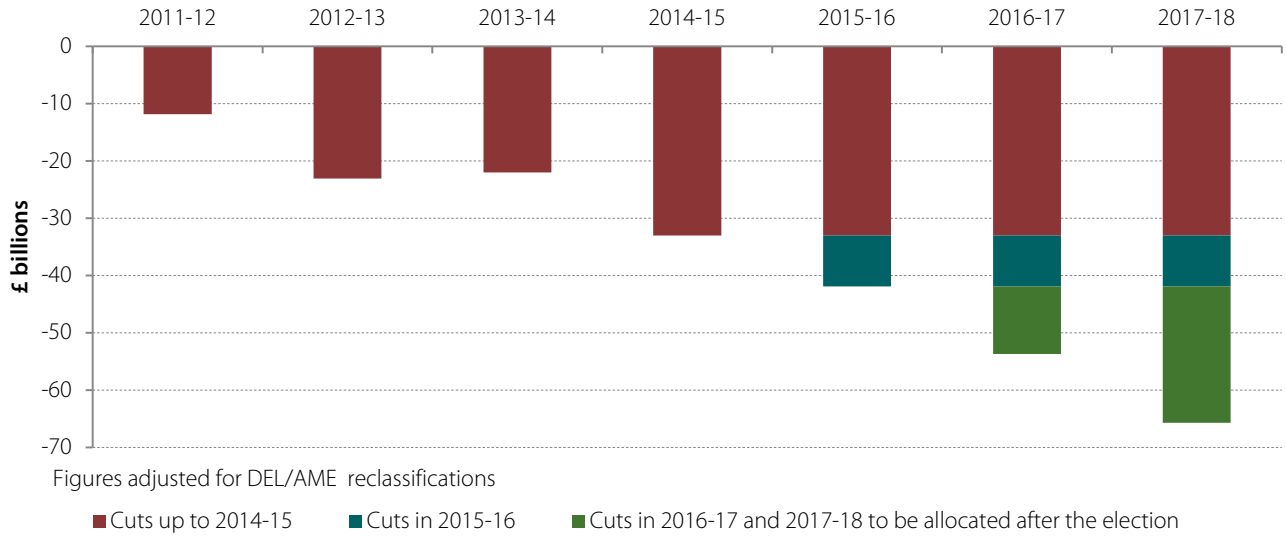
The scope of the 2013 Spending Review[2]

At the 2010 Spending Review the Chancellor announced departmental spending reductions of 8.3% as part of his overall plan to eliminate the cyclically adjusted current budget deficit within four years. Cuts varied significantly across departments. Health, schools and international development were ringfenced, leaving other departments to take substantial cuts: the Department for Business, Innovation and Skills saw its budget cut by 25%, the Home Office by 23% and the Ministry of Justice by 23%.

But the Chancellor's deficit reduction policy has not gone according to plan, as the size of the structural deficit has been revised up since 2010. The lack of growth in the economy means that £33bn in further cuts to current spending has had to be pencilled in for the years 2015-16 to 2017-18 in order to meet the Government's rolling five-year target to eliminate the cyclically adjusted current deficit. Existing plans show this £33bn coming entirely from DEL, though this may change after the election as the Chancellor seeks to spread the pain through further cuts to welfare and/or tax rises.

However, the Chancellor has ruled out further cuts to welfare at this Spending Review, making clear that it will both focus exclusively on DEL and will only cover the fiscal year 2015-16. This means that the Treasury is looking to Government departments to achieve £11.5bn of savings for 2015-16, leaving the bulk of further cuts (or tax rises), in 2016-17 and 2017-18, to be identified after the election, as the graph below demonstrates.

Chart 1.1: Cumulative cuts in Resource DEL since 2010-11 - current plans (today's prices)



[2] In this briefing, we focus on the planned cuts to current spending – in this case resource DEL. Capital DEL is also being cut by over 3%.

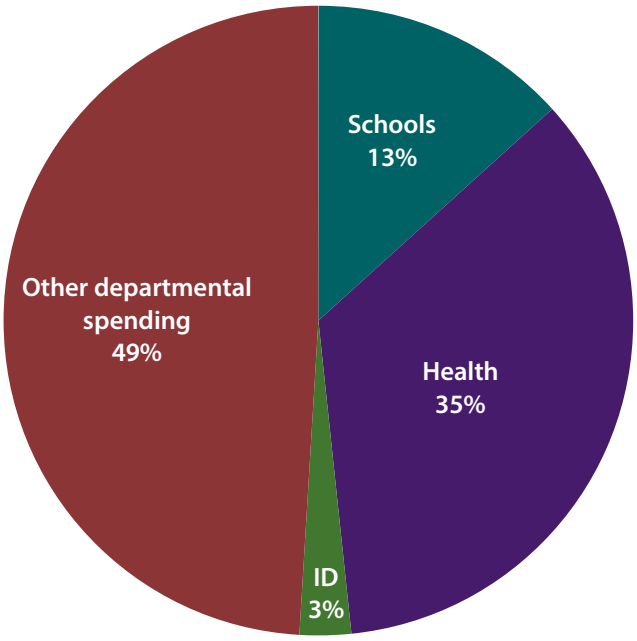
The £11.5bn to be found at this Spending Review includes around £1.5bn of cuts that were announced at the last Budget and have already been allocated.[3] Overall, we are expecting to see a 3.4% fall in departmental budgets in 2015-16, compared to previously planned spending in 2014-15, which needs to be allocated across the departments.

The impact of ringfencing on other departments

The NHS ringfence set out at the last Spending Review in fact gave health a 2% real terms increase over the period from 2011-12 to 2014-15.[4] Assuming that health is given a 'flat real' settlement in this spending round, the health budget will account for over a third of all departmental current spending in 2015-16. With the addition of schools and international development, ringfenced spending is set to make up around half of departmental current spending for that year.

The chart below shows how 2015-16 resource DEL spending is split between protected and non-protected spending.

Chart 1.2: Departmental current spending in 2015-16



[3] This £1.5bn has in fact been brought forward to 2014-15, hence the £11.5bn figure represents the cut to spending against previously planned spending in 2014-15.

[4] This figure differs from that in the 2010 Spending Review due to updated inflation figures for the years 2010-11 to 2014-15

All of this means that the £11.5bn in cuts to be announced on 26 June must be found from a much smaller part of the budget. Non-protected departments comprise around a quarter of total current spending and around half of departmental spending. The ringfences therefore bring the percentage cut required from non-protected departments to around 8% in 2015-16.[5] On the back of four years' deep cuts, this is set to put some departments under huge strain.

For this reason pressure to lift the ringfence is growing. Numerous commentators and think tanks have suggested that the health ringfence in particular is unjustifiable in this context. But would removing the health ringfence be a good idea? A closer look at the drivers of departmental spending reveals that, despite the implications for other departments, attempting to do so is entirely unrealistic.

Health: is 'flat real' really flat?

What does it mean for health spending to be 'flat in real terms'? The Government forecasts a general price index - known as the 'GDP deflator' – which acts as a benchmark. Implicitly, spending settlements that keep pace with this inflation measure supposedly allow the public service in question to be maintained. But this makes two assumptions. First, that the prices of things that a department spends its money on only rise at the same rate as general prices. Second that unchanged spending power will allow the department to provide services that continue to meet user expectations over time.

In the case of health, neither of these two assumptions holds. NHS costs rise much faster than general prices, being subject to unique pressures. What users perceive as providing the 'same level of service' involves ever larger costs: as new technologies emerge, people expect them to be available; meanwhile an ageing population inevitably means that the same amount of money won't go as far in the years ahead.

A 'flat real' settlement for the NHS is therefore not what it sounds like since it is defined with reference to an irrelevant price index. To keep up with rising input costs, growing demand, and the public's expectations for an adequate healthcare system, growth in spending on health has historically outstripped GDP growth. Spending rose from 3.4% to 8.2% of GDP over the last fifty years.[6]

The public's expectations around new technologies are particularly powerful drivers of NHS spending. As technology has brought better treatments, new drugs, developments in equipment and surgical procedures, the public has expected the NHS to keep pace and deliver the best service available. A 2010 RSA/ Ipsos MORI study found that 72 % of

[5] This is estimated on the basis that protecting health and education spending will effectively also result in some protection of the block grant going to Scotland, Wales and Northern Ireland. Previous estimates suggest that health and education account for over half of devolved spending. See, for example, David Bell, *Devolution in a Downturn*, (IPPR, 2010) and King and Eiser, "Reform of the Barnett Formula with needs assessment; can the challenges be overcome?", 2013

[6] John Appleby: *Spending on health and social care over the next 50 years: Why think long term?* (The Kings Fund, 2013)

the public felt the NHS "should provide all drugs and treatments, no matter what they cost".[7] Similarly the King's Fund has shown that as incomes have grown throughout history, citizens have wanted to spend disproportionately greater amounts on healthcare.

According to the 2002 Wanless Review, which looked at future trends in healthcare spending, around 60% of the total increase in spending over 20 years would be driven by improvements in quality and the adoption of new medical technology. This was in the scenario where health spending rises by the least of Wanless's three scenarios on health spending.[8] Although innovation can lead to savings in some areas, the dominant effect of new technology in health is to drive costs up as the latest advances are adopted.

Keeping up with the frontier of medical treatments is not just a 'nice to have'. MRI scanners and keyhole surgery – standard interventions in healthcare today – were only invented a generation ago. At the time they may have seemed like the stuff of science fiction. To do with out them today would seem primitive. With the relentless advance of technology our perception of what constitutes adequate care evolves.

For all these reasons, health spending has grown at an average annual rate of 4% above the growth in general prices represented by the GDP Deflator since 1950.[9] Past efforts to restrict spending growth below this level have tended to come unstuck. The 1990s provides the best comparative example of what happens when we seek something close to a flat real settlement on the NHS. Spending on the NHS increased by 3.2% a year in real terms between 1979 and 1997, by which time it was widely acknowledged that the NHS was not meeting patients' needs and health had become a mainstream electoral issue.[10] The subsequent surge in spending on the NHS after 2002 was largely a response to the effects of the earlier squeeze.

The Post-Nicholson Challenge

So what would be the real impact of a further three years of 'flat real' budgets for the health service? As we have seen, the 2010 Spending Review gave the NHS a close to flat real terms settlement, with a small rise in spending of 2% over four years. But, had healthcare spending been allowed to grow in line with the long-term trend of 4% real terms growth per year - the rate needed to provide a service that meets the public's expectations - it would have been £126bn by 2014-15. This would have been £16bn higher than the actual settlement in cash terms. The 2% settlement can therefore be seen not as a ringfence or indeed slight rise in spending, but an effective cut of £16bn from the health budget in terms of what patients expect the NHS to deliver. Given the size of the deficit, this may have been unavoidable, but it should not be confused with having been a particularly good settlement for health.

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[7] RSA 2020 Public Services Trust and Ipsos MORI: *What do people want, need and expect from public services?*, 2010

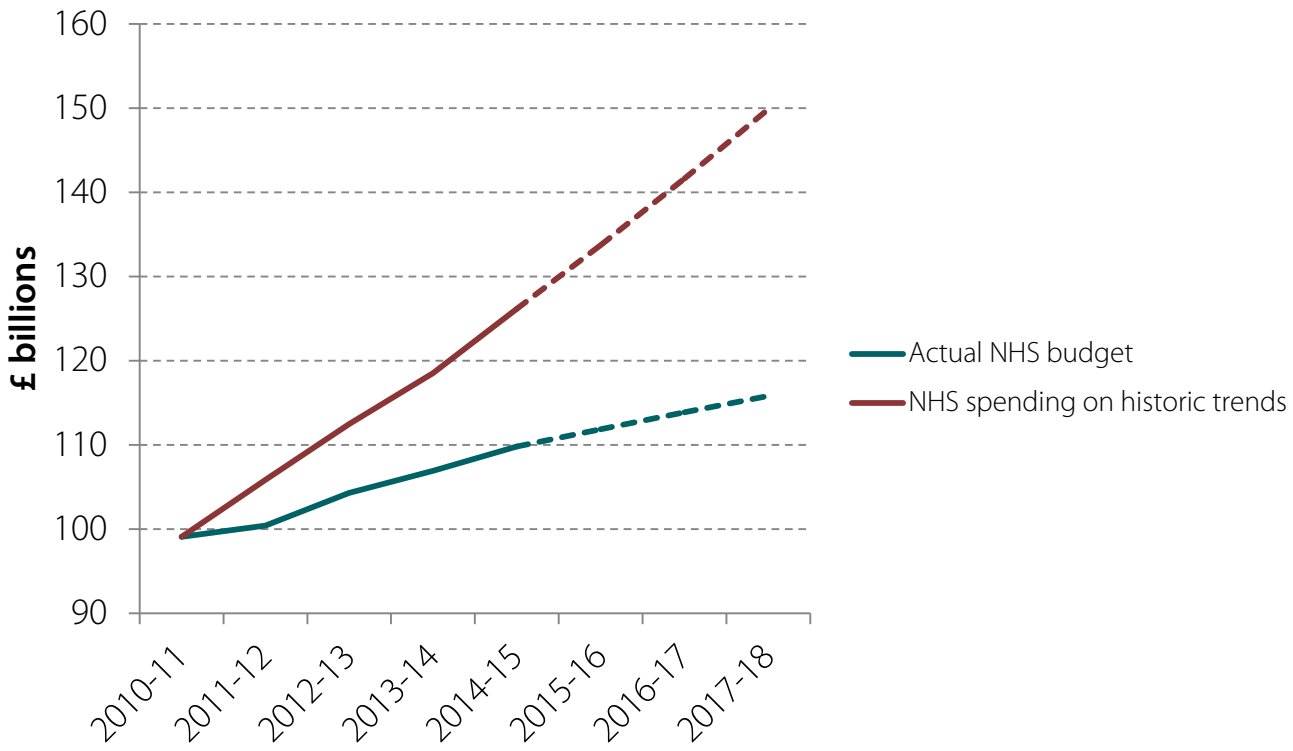
[8] The King's Fund (2013), Spending on health and social care over the next 50 years; Wanless (2002), Securing our future health

[9] Ibid

[10] The Institute for Fiscal Studies, *Public Spending under Labour* (London: 2010)

The budget squeeze on the NHS up to 2014-15, set out in the so-called "Nicholson Challenge", is therefore more significant than the concept of ringfenced spending suggests. But, as the graph below shows, continuing it for three further years, to 2017-18 will result in health spending slipping yet further behind the level that history suggests is required to meet patients' expectations.

Chart 1.3: NHS Spending 2010-11 to 2017-18: the growing gap (cash terms)



The chart shows that If the NHS is to receive only flat real settlements for the three years from 2015-16, health spending will be £34 billion lower in 2017-18 prices than if it had been allowed to increase at 4% per year real terms. This means that by 2017-18 a flat real settlement will have imposed an effective cut on the NHS of around a quarter (23%). In other words, the NHS now faces a much bigger "Post Nicholson Challenge" of finding efficiency savings of £34bn. To say that this is historically unprecedented is to understate the challenge.

Achieving these levels of savings is inconceivable without the result being substantially poorer health services by the end of the decade. Policymakers are therefore at a fork in the road: either publicly funded healthcare will become more heavily rationed or user charging introduced, with consequences for the universality of the NHS; or substantial tax rises will be needed to maintain an adequate service.

Conclusion: the end of the NHS as we know it?

The June 2013 Spending Review raises tough questions about the viability of the continued ringfence on NHS spending. When combined with the protection that exist on the schools and international development budget, ringfenced spending accounts for over half of all departmental spending – and therefore pushes deep cuts on other departments. How feasible these are remains to be seen.

But the health service has to run to stand still. The unique nature of health means that, the ringfence is an effective cut, hampering the NHS's ability to keep up with technology and patient expectations. Politicians therefore have a stark choice to make after the next election: unless they are prepared to impose significant tax rises to fund healthcare, we will see the end of an NHS free at the point of use that adequately meets the needs and expectations of the population.