Is the NHS UNDERFUNDED?

Many argue that the NHS is "structurally sound… just underfunded". But is that really the case? KRISTIAN NIEMIETZ investigates

The NHS is 'at breaking point', 'starved of resources', 'on the verge of collapse', overstretched, underfunded, and everybody knows it.

According to *The Telegraph*, "[The] NHS faces biggest financial crisis 'in a generation'"[1]. "Yet as the NHS deals with the worst "cash crisis in a generation" we can disclose things are only going to get worse", adds *The Mirror*[2].

Such articles often imply that there is nothing structurally wrong with the NHS – all it lacks is money. It is widely believed that, if the NHS were 'properly funded', it would be second to none.

Proponents of this line of argument have a point. Funding constraints are real. The NHS has been protected from budget cuts, and there have even been modest real-term increases in spending (by 3.2 per cent between 2009/10 and 2014/15, Appleby et al 2015).

But the increase in demand has been even greater. It is therefore likely that the more recent problems experienced by the health service – such as deficits and missed targets – are to a large extent a financial matter.

But there are a number of problems with the tendency to ascribe every problem to 'underfunding', and with the

[1] "NHS faces biggest financial crisis 'in a generation' ', *Telegraph*, 09 October 2015.
[2] NHS facing worst ever winter as Tory hospital cuts could see 35,000 doctors and nurses lose their jobs', *The Mirror*, 10 October 2015.

eagerness to hold the NHS blameless.

Lack of revenue-raising powers

Firstly, we cannot treat funding levels as an external constraint which has nothing to do with the health system as such. In a fully tax-funded system, healthcare spending decisions will always be political decisions.

The NHS's budget will always be whatever the government of the day decides it should be. Sometimes we will agree with that government's spending priorities, and sometimes we will not. This is a feature, not a bug.

You cannot sensibly advocate a system which vests politicians with so much power, and then be constantly outraged when those politicians do not use that power in the way you want them to use it. Yet that is precisely what many of the most ardent supporters of the NHS do.

In insurance-based systems, such as the social health insurance (SHI) systems of Switzerland and the Netherlands, politicians cannot directly control the level of healthcare spending. Insurers are free to set their own premium rates, and if those rates are insufficient to cover their expenses, they can raise them. They do not have to ask politicians for permission first, or wait until a government sympathetic to their position is voted in.

In theory, one could imagine the NHS operating in a similar way: It could be given its own revenue-raising powers, e.g. an 'NHS contribution', comparable with National Insurance contributions, accruing directly to the NHS.

- The NHS budget crisis has been all over the news, and for good reason: financial pressures on the service are real.
- But there is a problem with the frequent implication that the health system bears no blame for its financial woes, and that all would be well if only politicians showered it with money.
- In a single-payer system, healthcare spending levels will always be politicised decisions, which can lead to overfunding as well as underfunding. Ironically, those who defend that decision-making mechanism most vigorously are also the ones who are least happy with the outcomes it produces.
- In insurance-based systems, politicians cannot directly control healthcare spending. If there is a demand for additional spending, providers and insurers will oblige.
- Insurance-based systems can also afford higher spending levels, because insurance premiums are an economically less damaging way of raising revenue.
- There is, however, no reason to assume that an increase in spending would solve the health service's woes. The NHS also performs poorly in efficiency rankings, suggesting that it has greater untapped efficiency reserves than most comparable systems.
- The implication is that even if UK health spending rose to, for example, Swiss levels, we would still not achieve Swiss health outcomes, because we do not achieve anything like Swiss efficiency in the UK health system.

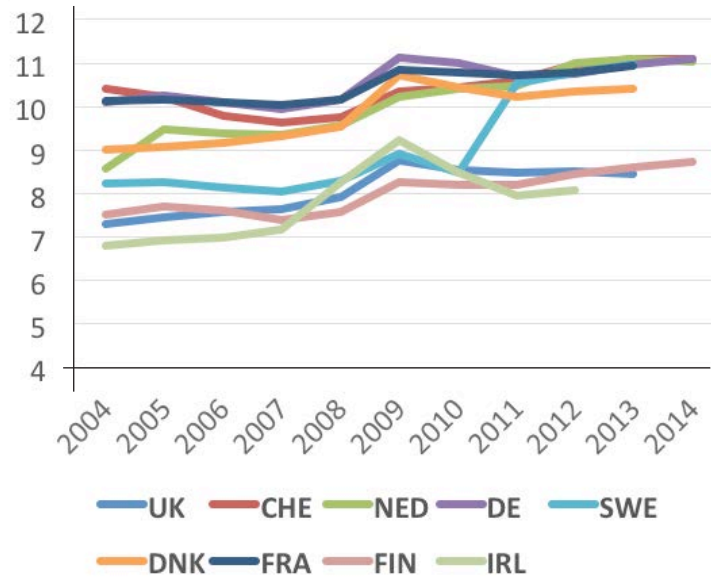
But the monopoly status of the NHS makes this unfeasible in practice. Insurers in SHI systems can be given the autonomy to set their own premiums, because competition with other insurers prevents them from abusing it. If an insurer charges unreasonably high premiums, they will lose customers.

The NHS, as a single-payer system, would face no such constraints, which is why it cannot be given quasi-tax-raising powers. It is therefore reliant on the government of the day for its funding.

Efficiency reserves

But whatever the funding mechanism, there is also good evidence that the NHS has more ability than other systems to benefit from greater efficiency. It has greater 'efficiency reserves' than most comparable systems. Healthcare spending in the UK is lower than in most neighbouring countries (see figure), and NHS supporters often jump from this observation to the conclusion that the NHS must be more efficient than other systems. This is, to say the least, a bit of a stretch.

Figure1. Total healthcare spending (public + private) as a % of GDP, 2004-2014



Source: -OECD (2015)

The OECD has compiled an holistic estimate of health system efficiency (Joumard et al, 2010). It models health systems as 'production functions' which transform inputs into outputs, subject to external constraints such as lifestyle factors (consumption of tobacco and alcohol, fruit and vegetables etc.).

They find that, given each country's health spending and lifestyle factors, the UK has greater potential to improve outcomes than most other Western European countries.

It is worth noting in passing that some of the countries which receive similarly poor efficiency scores also have structurally similar health systems.

So, even though some European countries spend more on healthcare than the UK, it is nevertheless the UK which has greater efficiency reserves in the system. Others spend more, but they also appear to spend it better.

GIVEN EACH COUNTRY'S HEALTH SPENDING AND LIFESTYLE FACTORS, THE UK HAS GREATER POTENTIAL TO IMPROVE OUTCOMES THAN MOST OTHER WESTERN EUROPEAN COUNTRIES

The deadweight loss of tax funding

A simple cross-country comparison of health spending misses the fact that different funding methods differ in the costs they impose on the wider economy. In terms of its economic impact, a pound of healthcare spending is not always equal to a pound of healthcare spending: it does matter how that pound is raised.

Suppose one country financed its health system through a beer tax, and another, otherwise identical country, financed it through a wine tax. Other things equal, you would expect lower levels of beer consumption in the first country, and lower levels of wine consumption in the second country.

Now suppose, instead, that one country financed its healthcare system through a tax on labour, while another country financed it through a lump-sum tax not connected to any particular activity. Other things equal, you would expect lower levels of labour supply in the first country.

The comparison between a tax-funded and a premium-funded system is not that far away from this hypothetical example. Imagine that both in the UK and in Switzerland, health expenditure rises by one percentage point of GDP, leading to a tax increase in the UK, and an equivalent premium increase in Switzerland.

In Switzerland, health insurance premiums are flat fees. From the perspective of a Swiss family, they are a fixed cost which they cannot avoid or significantly alter, much like the cost of staple food or heating fuel. So the family

would just have to accept the increase, and find savings elsewhere. But there would be no further economic cost, because there would be no change in people's behaviour.

In the UK, the increase in healthcare costs would most likely lead to an increase in income tax, since this is the most important source of revenue at the national level.

But this not the whole story. The tax increase would make working, saving and investing less lucrative, which means that, at the margin, people would reduce their engagement in these activities.

Tax funding comes at a greater economic 'deadweight loss' than premium funding, because it changes people's behaviour to a greater extent. Other systems can afford higher spending levels, because they are funded in economically less damaging ways .

OTHER SYSTEMS CAN AFFORD HIGHER SPENDING LEVELS BECAUSE THEY ARE FUNDED IN ECONOMICALLY LESS DAMAGING WAYS

Conclusion

There can be no doubt that the NHS is feeling the pinch. And yet the generally accepted view that the NHS would be a world-class system if only politicians increased funding should be called into question.

Firstly, even if it were true that the service's woes are entirely due to financial constraints, it would still be wrong to treat these as an exogenous constraint that is imposed upon the system by an outside force.

Rather, it is part and parcel of a single-payer system that budgets are set by politicians, and as with any political decision, some of us will agree with it and some of us will not.

In insurance-based systems, spending levels result from the interaction of demand and supply, not unlike in a 'normal' market. That level of spending may well be higher than the level politicians would have chosen. Insurance-based systems can also afford higher spending levels, because premiums come at a lower economic cost than taxes.

Having said that, even though healthcare spending in the UK is lower than in most neighbouring countries, OECD estimates suggest that the NHS has greater untapped efficiency reserves than most other systems. There is no discernible connection between spending levels and efficiency.

The UK, Ireland and Finland are among the lower spenders, but they also receive some of the worst efficiency scores. Switzerland and Japan are among the highest spenders, but they also receive some of the highest efficiency scores.

It is possible to spend large sums of money well, and it is possible to spend lower sums wastefully.

But, whatever the current spending level, it seems a sensible rule of thumb that the countries which are furthest away from the efficiency frontier should seek to move closer to that frontier first before considering further increases in spending•

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References

Appleby, J.; B. Baird, J. Thompson, J. Jabbal (2015) The NHS under the coalition government. Part two: NHS performance, London: The King's Fund.

Joumard, I., André, C. and Nicq, C. (2010) Health care systems: Efficiency and institutions. OECD Economics Department Working Papers, No. 769. Paris: OECD.

OECD (2015) OECD Health Statistics 2015, available at http://www.oecd.org/health/health-data.htm

[3] This is a simplification. The Swiss system is financed through flat-rate premiums, but not all SHI systems are: The German system is financed through income-related contributions, and the Dutch system is financed through a combination of both. Income-related contributions act like a flat tax: the deadweight loss is lower than under a progressive tax, but higher than under a poll tax.