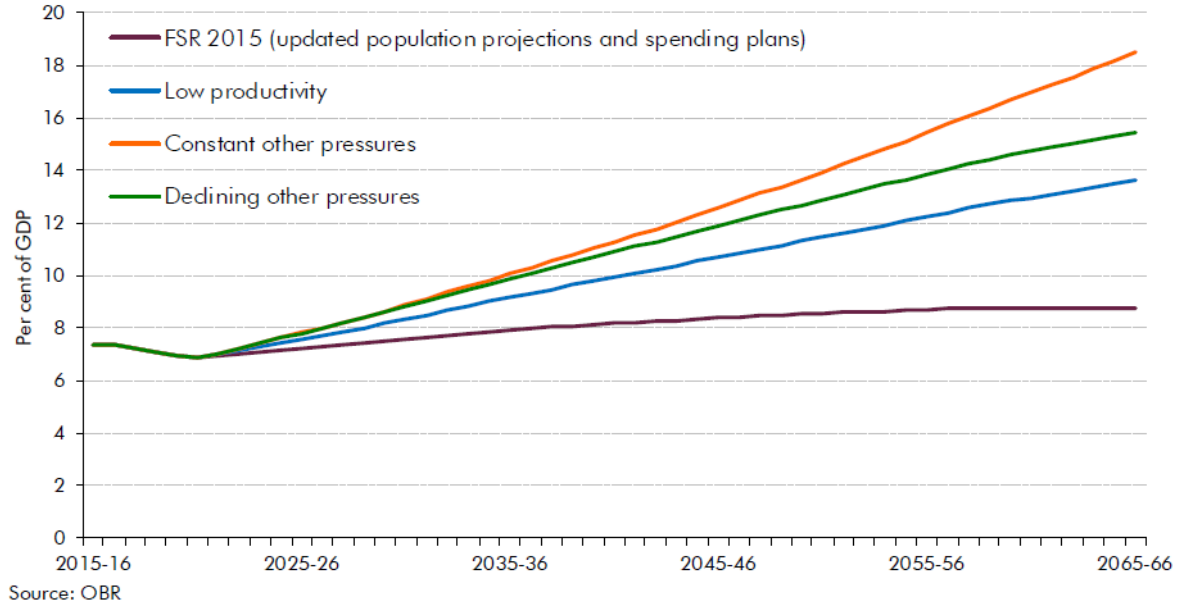
Paul Johnson – Written evidence (NHS0195)

1. To what extent do you agree with the OBR's latest analysis of long term projections on health spending?

The main point is that long term projections are extremely sensitive to assumptions. The main projections from previous years suggest only relatively modest increases in health spending over the medium to longer term because they only factor in the impact of an ageing population. They assume that productivity in healthcare grows along with that in the rest of the economy, and don't account for increases in other cost pressures. So at best one can think of these projections as lower bound, but probably they are below a reasonable lower bound.

You will be familiar with chart 3.7 from the OBR's latest working paper on the topic, reproduced below which shows just how sensitive the future projections are to different assumptions. The line tracing out a lower productivity scenario, based on historic experience of productivity in health, is certainly in my view a more realistic scenario than the main FSR 2015 scenario. Additional cost pressures could make a big additional impact.

Chart 3.7: Long-term projections and other cost pressures



Source: OBR

The differences between these scenarios have a very big impact on long term fiscal sustainability. Just the difference between the FSR 2015 scenario and the low productivity scenario comes to 2% of GDP within two decades. (For comparison the triple lock adds no more than 1% of GDP to pension costs by the same date). Given these projections and historical and international experience it would surprise me if we could contain health spending growth to much less than 3% of GDP over the next 20-25 years. That inevitably implies more spending cuts elsewhere, or tax rises.

2. How can the Government accommodate a growth in health spending?

As a nation we could decide to increase taxes by 2 or 3% of GDP over the next couple of decades. That would not be easy but it would not take tax to unusually high levels by UK historic or European standards. Further cuts of that magnitude to other areas of public spending, on top of those implemented or planned over this decade, would likely be really quite difficult. That said big changes in the shape of the state have happened before. We have dramatically reduced our spending on defence, housing and industrial support over recent decades, by more than enough effectively to fund increased spending on health and welfare. Which areas of current activity could be cut in the same way going forward it is hard to see from our current vantage point.

It has been suggested that funding would be made easier by hypothecating some source of tax revenue to the NHS. That could mean simply saying that a tax rise is being used to provide extra money, as happened with the increase in NICs introduced in 2001, explicitly for that purpose. That is an option, essentially a way of selling a tax rise to make it politically more palatable. A more serious kind of hypothecation would tie NHS funding to revenues from a particular source. For it to be real hypothecation that would require funding to rise and fall with the revenues, which would be patently absurd. That leaves two alternatives. One is just to pretend that revenues are hypothecated, and not cut services when revenues fall. I am deeply uncomfortable with that since it seems to be designed deliberately to fool people. An alternative would be to set up a fund into which extra revenues from the tax are placed during good times and from which the NHS could borrow during bad times, with the rate of the tax varying to ensure balance over time. The Treasury would, rightly, want to count any borrowing in the fund against public borrowing. The temptation to spend additional revenues when they are buoyant would seem just as big as at present. Politics apart it is hard to see any argument for such a convoluted arrangement. But politics matter and it may be that there is a case for some such arrangement if taxes cannot otherwise be increased to pay for a service people want. But it should be clear the case only exists as a second best option in face of political failure.

3. It has been suggested that the cycle of ‘boom and bust’ in funding for the NHS is one of the weaknesses of the system. Do you think it is possible to deliver more sustainable levels of funding?

The pattern of spending on health over the last 25 years – famine, feast, famine – is clearly sub-optimal. It is almost certain that had we started with spending where it was in 1992 and increased on a smooth and planned path to its current level, the money could have been used more efficiently, possibly significantly so. There is an inherent set of challenges here. The changes are in large part related to overall fiscal and economic conditions. The swift increases in the 2000s were in part predicated on a presumption that the economy would continue to grow. It is hard to think of a set of public institutions which would have slowed growth in spending in the 2000s and then kept spending rising after 2010 given other economic and fiscal knowledge and policy at the time.

4. The OBR's expert independent analysis of spending in health spending clearly provides a vital insight into the sustainability of the health system. Given the extent of the pressures on both the health and social care systems, do you think further independent analysis of the funding and workforce needs for the health and care system based on a rounded assessment of medical advance, demography and productivity would be beneficial?

I am not an expert on what does exist, but my sense is this does not exist at present in an independent, usable and fully credible form. If it does not the case for doing it strikes me as being very strong.

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