HFMA introductory guide to NHS finance

Chapter 12: How the NHS is financed

Chapter 12. How the NHS is financed

Overview

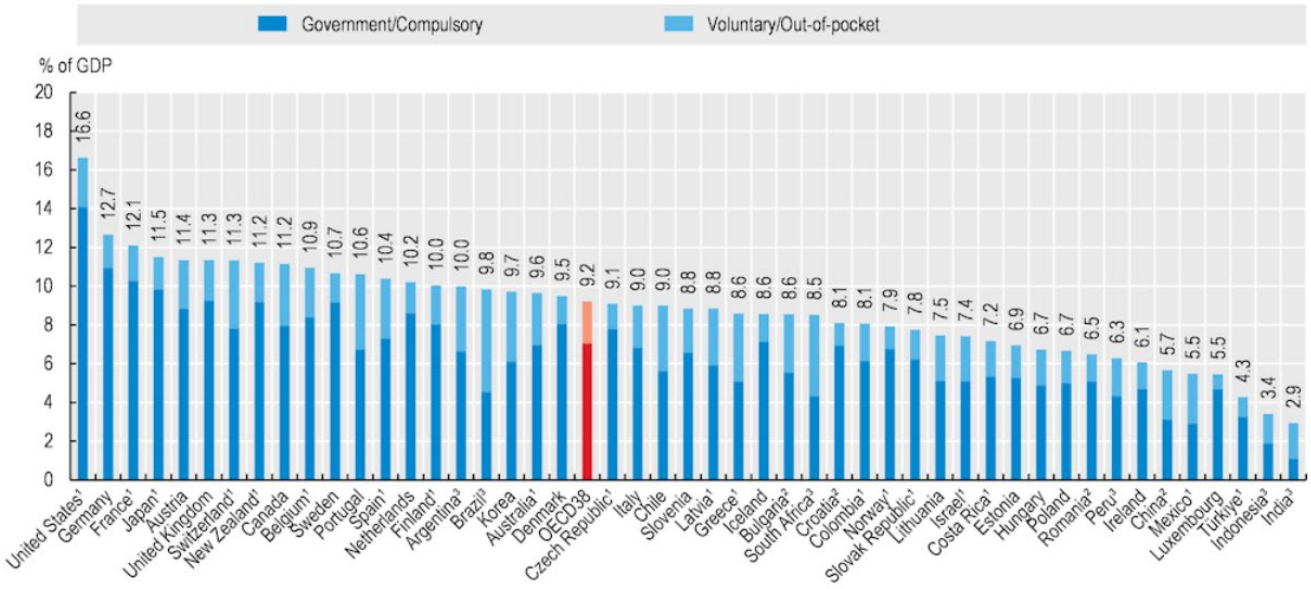
Health spending has always been a topic of political and public interest.

This chapter focuses on how resources are allocated nationally for the NHS and how they are divided amongst the different areas of health spending. It also gives an idea of the scale of UK spending on health compared with other countries.

12.1 UK spending levels

The Organisation for Economic Cooperation and Development (OECD) has published *Health at a Glance 2023*[220], providing a comprehensive group of indicators that looks at population health across OECD members. The report identifies that during 2022, the United Kingdom spent 11.3% of gross domestic product (GDP or national wealth) on health compared with an average across the 30 OECD countries of 9.2%. Although some countries spend more, 12.70% in Germany and 16.6% in the USA, UK expenditure on healthcare is broadly in line with other countries and the OECD average.

Health expenditure as a share of GDP, 2022 (or nearest year)



Source: OECD, Health at a glance 2023: 7. Health expenditure, figure 7.1

The levels of spending described above are funded differently depending on the health system in place. Private health insurance is a significant feature of some OECD countries[221]. In the United States, around one third of all spending is via private health insurance. In Switzerland, it is around half, and in the Netherlands, private health insurance accounts for roughly 60% of spend. In around half of the remaining OECD countries, spend through private insurance is approximately 5% or less.

[220] OECD, *Health at a glance 2023*, November 2023
[221] OECD, *Private Health Insurance Spending - Brief*, March 2022

UK levels of funding

In terms of overall funding levels, the Labour Government made a commitment in 1997 to increase NHS funding to a level that would bring the UK's health spending in line with the average for the rest of Europe. The first step toward this target was taken in the 2000 budget, with a further significant increase in 2001. However, it was the 2002 budget that gave the first indication of the substantial and long-term increases required if that promise was to be delivered. Funding for these increases was achieved by the introduction of employer and employee national insurance surcharges at a rate of 1%, and from the release of funds from other sources, enabled by the government's comprehensive spending review (CSR). The CSR process is designed to assess critically the spending of government departments in the light of changing priorities.

Successive budgets maintained the commitment to longer-term funding increases. However, the 2007 CSR process led to more modest increases for the three-year period from 2008/09 compared with the preceding period, averaging 3.9% growth in real terms, compared with 7.5% for the previous CSR period.

The impact of the economic downturn following the banking crisis in 2008 led to warnings about the future funding of the NHS.

In preparation for tighter times ahead, efficiency savings targets steadily moved upwards. To help achieve these targets and in line with a renewed emphasis on quality, the Department of Health expected NHS organisations to meet the 'quality, innovation, productivity and prevention (QIPP) challenge'. In practice, this meant organisations had to follow 'lean management principles' of avoiding duplication, preventing errors that then need to be corrected, and stopping ineffective practices. Inevitably this involved a focus on reducing back-office functions and (from a finance perspective) re-ignited the debate about the relative advantages and disadvantages of shared services.

The spending review in November 2015 focused on the need to reduce the public sector borrowing requirement while investing in key services notably the NHS in order to support the delivery of the Five Year Forward View. The health budget was increased by a further £10bn, taking the projected NHS spending in England from £101bn in 2015/16 to an estimate £120bn in 2020/21[222].

In 2018, the then prime minister announced a long-term funding settlement for the NHS, outside of the normal spending review cycle. An additional £20.5bn[223] was committed by 2023.

The 2020 spending review[224] only set out plans for the 12 months from April 2021, due to the disruption caused by Covid-19 to public spending and the uncertainty in long term planning. However, the review set out that the NHS in England would get an extra £6.3bn to help meet the government's commitment to get the NHS budget to £148.5bn by 2023-24. The devolved nations received a corresponding uplift to funding based upon the Barnett formula which determines how money is allocated across the United Kingdom. Discussions continue regarding the appropriateness of the formula with arguments that a more needs-based formula should be applied. Details of the formula, and discussions concerning its application, were outlined in a 2022 House of Commons briefing paper *The Barnett formula*[225] .

The autumn budget and spending review in 2021[226] established a three-year budget for the Department of Health and Social Care, representing a 4.1% increase over the 2022 – 2025 period for the department. The spending review also set out capital funding for the next three years.

---

[222] HM Treasury, *Spending review and autumn statement 2015*, updated November 2015
[223] Department of Health and Social Care, *Prime Minister sets out 5-year NHS funding plan*, June 2018
[224] HM Treasury, *Spending Review 2020*, updated December 2020
[225] House of Commons Library, *The Barnett formula and fiscal devolution*, September 2023
[226] HM Treasury, *Autumn budget and spending review 2021,* October 2021

Subsequent budgets and government statements have provided further funding across the spending review period. The Department of Health and Social Care's 2022/23 planned revenue spend of £173.9bn[227] is expected to increase to £180.5bn in 2024/25.

12.2 The role of HM Treasury

The responsibility for allocating and managing the finances of national government lies with the Chancellor of the Exchequer, who leads HM Treasury (the Treasury). To promote better planning of public spending the Treasury undertakes periodic spending reviews to set departmental expenditure limits (DELs) for each government department. DELs usually cover a period of three years.

The DELs announced in the spending reviews are confirmed twice a year – through the main and supplementary estimates[228], where the government sets out how it will finance its spending commitments and makes any necessary or technical adjustments to its spending plans.

Public expenditure falls into one of two categories:

- DEL spending is expenditure on the running costs of each government department. For the DHSC this includes the costs of running hospitals, including staff costs, as well as the provision of other healthcare services. Departments are not allowed to overspend the annual DEL
- annually managed expenditure (AME), is expenditure that cannot reasonably be subject to firm, multi-year limits in the same way as DEL. Examples of such spending are social security benefits that fluctuate depending on the level of unemployment.

Together, DEL plus AME equal total managed expenditure (TME).

A key issue for any government is the relative level of public spending compared to national wealth (GDP). Relative to GDP (which itself fluctuates from year to year), UK public spending has varied from 35.1% in 1998/99 to a high of 52.0% in 2020/21. This high was due to increased government expenditure due to the Covid-19 pandemic combined with the reduced GDP due to the pandemic. Public spending statistics are released on a regular basis by HM treasury to provide detailed information on public spending[229].

HM Treasury allocates DELs between revenue and capital spending. Revenue spending is for day-to-day items such as salaries and running costs; capital spending is for buying larger items such as buildings and equipment, that have a usable life of over one year.

The *Autumn budget and spending review*[230] set out the resource limits for the DHSC to 2024/25. These were updated in the November 2023 *Autumn statement*[231] which resulted in the following pattern of allocations of revenue and capital DELs to government departments:

Resource DEL (RDEL) excluding depreciation

	Outturn 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Health and Social Care	171.8	174.6	177.2

[227] HM Treasury, *Spring budget 2023*, March 2023
[228] HM Treasury, *Main estimates*, updated May 2023
[229] HM Treasury, *Public Spending Statistics,* updated February 2023
[230] HM Treasury, *Autumn budget and spending review 2021*, updated February 2023
[231] HM Treasury, *Autumn statement 2023*, November 2023

	Outturn 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Of which: NHS England	*155.1*	*161.1*	*162.5*
Education	76.4	81.7	84.9
Defence	32.5	32.2	32.8
Devolved nations	64.9	66.8	67.1
All other departments	99.9	101.4	105.2
TOTAL RDEL	**445.5**	**456.7**	**467.2**

Source: Table 2.1, Autumn statement 2023, HM Treasury

Departmental Capital Budgets - Capital DEL (CDEL)

	Outturn 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Health and Social Care	9.9	12.1	12.6
Defence	20.3	18.3	18.9
Science, Innovation and Technology	10.5	13.1	13.8
Transport	20.5	20.7	20.5
Devolved nations	10.9	11.2	10.3
All other departments	28.2	40.2	42.1
Total capital DEL	**100.3**	**115.6**	**118.2**

Source: Table 2.2, Autumn statement 2023, HM Treasury

Funding for health services in other UK nations is included in the separate Northern Ireland, Scottish and Welsh block grants. Any changes in planned spending in the NHS in England are matched by relative increases within these block grants through an allocation process called the Barnett formula[232]. However, the individual administrations may spend less or more than these amounts on health services depending on their own priorities.

[232] House of Commons library, *The Barnett formula and fiscal devolution*, September 2023

12.3 The role of the Department of Health and Social Care

The Department of Health and Social Care (DHSC) decides how the funding it receives from HM Treasury is allocated in England. Health and social services in Northern Ireland, Scotland and Wales are the responsibility of the devolved administrations (see chapters 20 to 22).

Most of the total NHS settlement (see table above) is allocated to NHS England. A percentage of this allocation is set aside for its own commissioning responsibilities and running costs, with the balance allocated to integrated care boards (ICBs).

The DHSC retains part of the allocation to meet:

- its own running costs
- the costs of various central health and miscellaneous services - for example, some centrally administered services and centrally managed projects for the benefit of the NHS (such as clinical negligence); a range of statutory and other arm's length bodies funded centrally - for example, the NHS Business Services Authority and Health Education England (see chapter 3 for details)
- the costs of local authority public health spending – this is covered by a separate ring-fenced budget (from the DHSC's allocation) that is passed to and managed by local authorities[233].

12.4 The role of NHS England

NHS England is responsible for using the funding it receives from the DHSC to deliver the *NHS Mandate*[234] (the mandate). In practice this means that NHS England's allocation must fund the costs of:

- directly commissioning activities – including the primary medical services provided by dentists, community pharmacists and opticians; specialised services; offender and military healthcare
- ICB allocations that fund the services they commission including elective and emergency hospital care, community care and mental health services (see chapter 5 for more information on the role of ICBs)
- the running costs for NHS England itself, its regional teams, local professional networks, clinical senates, and networks
- running ICBs (known as the running cost allowance)
- some services that are commissioned by local authorities.

For 2022/23 the total revenue budget allocated to NHS England to deliver the mandate was £152.6bn. Performance against that mandate will be published in the 2022/23 annual report and accounts. For 2023/24 the revenue allocation totals £171.3bn[235].

The 2021/22 NHS England annual report and accounts[236] sets out the performance against the mandate for that year.

---

[233] Department of Health and Social Care, *Public health ringfenced grant 2023 to 2024: local authority circular, March 2023*
[234] Department of Health and Social Care, *NHS mandate 2023*, June 2023
[235] Department of health and Social Care, *2023 to 2024 financial directions to NHS England*, March 2023
[236] NHS England, *Our 2021/22 annual report,* January 2023

	Plan £bn	Actual £bn	Underspend against plan £bn
Direct commissioning	29.1	28.8	0.3
NHS England administration, central programmes and other	6.5	6.3	0.2
CCGs	115.0	114.8	0.2
Total	**150.6**	**149.9**	**0.7**

Source: Our 2021/22 Annual Report, England

12.5 ICB allocations

NHS England publishes detailed allocations to Integrated Care Boards as part of the annual planning process. In January 2023, allocations and supporting guidance, were issued for 2023/24 and 2024/25[237].

Once an ICB has been notified of its allocation for the forthcoming period, it plans how to use the funding across the full range of services that it commissions with the overall aim of improving the health and wellbeing of its population. An ICB commissions services from a range of providers including NHS trusts and foundation trusts, the private and voluntary sectors (see chapter 15 for more on commissioning).

12.6 NHS trusts and NHS foundation trusts

Funding secondary care

Most of the community, acute, specialist and mental healthcare in England is provided by NHS trusts or NHS foundation trusts. These trusts meet the costs of providing healthcare services (staff salaries are normally the largest element) and receive income from ICBs (and for some services, from NHS England) via contracts that specify the quantity, quality, and price of services to be provided. Each ICB (or NHS England) is responsible for meeting the cost of services provided to its population in line with the contract's terms. ICBs, NHS England, and providers are responsible for ensuring that patient treatments are clinically appropriate and provided in a cost-effective way.

Trusts also receive some income from other sources such as private patient income, hosting services, car park receipts, leasing of buildings and research and development. For teaching hospitals, the latter can be significant (see chapter 7 for details).

Many trusts also have access to funds donated by members of the public on a charitable basis. However, these can be used only for the purpose for which they were given – for more about charitable funds see chapter 19.

Funding research and development

NHS funded research is overseen by the National Institute for Health Research (NIHR). The NIHR is funded by the DHSC to improve the health and wealth of the nation through research and is headed by the chief scientific adviser and director of science, research, and evidence. The NIHR is a virtual organisation hosted by NHS providers, universities, and life science organisations. Its day-to-day

[237] NHS England, *Allocation of resources 2023/24 to 2024/25*, updated June 2023

operations are run through six coordinating centres that allow the NIRH to commission and fund research, provide facilities and people within the clinical research network and support those who are carrying out, training, and participating in research.

Funding for NHS bodies can come through the NIHR Central Commissioning Facility that supports various research programmes, as well as a service to support those applying for the research programmes. The following schemes are also managed by this facility:

- applied research collaborations (ARCs) that support applied health and care research that meets the needs of local populations and increases the rate at which research is implemented into day-to-day practice. There are 15 ARCs in England that share a £135m five-year funding investment, announced in July 2019[238].
- clinical research facilities (CRFs) for experimental medicine. CRFs are purpose-built, cutting-edge facilities with specialist clinical, research and support staff. They are found in 28 NHS hospitals where universities and NHS organisations work together on dedicated programmes of patient-orientated experimental medicine research. In February 2022, CRFs were awarded £161m to be shared by the 28 organisations over five years[239].
- biomedical research centres (BRCs) – that are collaborations between universities and NHS organisations to translate lab-based breakthroughs into potential new treatments, diagnostics, and medical technologies. The 20 BRCs received £816m from 1 April 2017 to be spent over 5 years[240].

The NHIR clinical research network coordinating centre manages the clinical research network that comprises

- 15 local clinical research networks (LCRN) covering all of England
- 30 clinical research specialties
- national specialty leads.

NHS bodies and individuals can access funding from the various work streams depending on whether they are one of the lead organisations or undertake work in a particular area of research.

Funding clinicians' training

In addition, some trusts receive substantial sums through placement fees for undergraduate healthcare professionals as well as salary and training costs for post graduate healthcare professionals. These funding flows are managed by NHS England via a system of education tariffs[241].

12.7 Primary care services

Most primary care services are provided by independent contractors such as general medical practitioners (GPs), general dental practitioners (GDPs), pharmacists and ophthalmic practitioners. While they are an integral part of the NHS, these contractors operate as small businesses that contract with the NHS to provide primary care services. Contracts are designed to reward the quality of treatment.

NHS England, and ICBs under delegated commissioning arrangements, pay primary care service providers according to nationally negotiated contracts. Local enhanced services cover specific needs

---

[238] National institute of health and care research, *Collaborating in applied health research*, 2023
[239] National institute for health and care research, *New funding boost for delivery of early stage clinical research across England*, February 2022
[240] Department of health and Social Care, *New £816 million investment in health research*, September 2016
[241] Department of Health and Social Care, *Healthcare education and training tariff: 2023 to 2024*, March 2023

of patients in the area are negotiated locally - for example, GP practices receive a global sum to cover the provision of core services to their registered patient list and additional 'quality' payments for achieving goals set out in the quality and outcomes framework (QOF).

The interface between primary and secondary care is not always clear and is becoming more blurred as services become more integrated. GPs with specialist interests are increasingly playing a significant part in delivering patient care outside of the traditional hospital routes. On the other hand, some NHS providers are now employing GPs and are providing primary care services in the community to the local population.

See chapter 6 for more on primary care services.

12.8 What is the money spent on?

The DHSC publishes consolidated accounts for the whole of the NHS in England each year.

Analysis of the expenditure from the 2021/22 group accounts[242], identifies total expenditure across the DHSC group of £244.2bn, of which £112.8bn (46%) was spent by NHS providers. Staff costs account for 31% (£76.7bn) of operating expenditure for the DHSC as a group, but at NHS provider level, they account for 63.3% (£71.5bn) of NHS provider expenditure.

Analysis of NHS England's annual report and accounts 2021/22[243] reveals that NHS operating expenditure (excluding funding of group bodies) totalled £149.3bn. Of this, approximately 69% (£102.9bn) of commissioner's expenditure is on secondary care, while 18% (£26.5bn) is spent on primary care.

Key learning points

- The UK spends just over 10% of GDP on health – around the OECD average.
- The government and HM Treasury determine how much money each government department receives based on spending reviews.
- Money is allocated for both day-to-day (revenue) and capital spending.
- The Department of Health and Social Care (DHSC) decides how the budget is used with over 91% of the revenue budget going to NHS England.
- The DHSC keeps some money for central services and arms' length bodies such as Office for Health Improvement and Disparities and Health Education England.
- NHS England allocates the bulk of the money it receives to ICBs but keeps some to fund its own direct commissioning functions and running costs.
- NHS trusts and foundation trusts receive the bulk of their income via contracts with ICBs and NHS England; other sources include income from research and development.
- Primary care services are provided predominantly by independent contractors who receive income via contracts agreed with ICBs or NHS England.

[242] Department of Health Social Care, *DHSC annual report and accounts: 2021 to 2022,* February 2023
[243] NHS England, *Our 2021/22 annual report,* January 2023

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects. It also highlights online learning courses that are available. The directory of resources can be found here.