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The bottom line

Understanding the NHS deficit and why it won't go away

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The Department of Health accounts, published in July, showed a nominal improvement in the NHS's reported financial wellbeing in 2016/17, with a modest underspend of £560 million on its £118 billion budget for current expenditure in England – compared to an effective £200 million overspend in 2015/16.

But there is little doubt those headline figures mask continued serious difficulties, particularly for the 238 separate NHS hospitals and other NHS provider trusts in England that provide the vast bulk of NHS-funded 'secondary care', comprising acute hospital, specialist, community and mental health care. Together those organisations consume well over two-thirds of the DH's total spending. So when they catch cold, the rest of the NHS does too.

This briefing assesses the financial health of those providers by unpicking the headline figures presented in the official accounts to reveal the true underlying state of the NHS's finances today, and to outline prospects for the next three to four years.

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Key points

- NHS trusts have begun the current financial year, 2017/18, on course for an underlying overspend or deficit of £5.9 billion. To meet their reported deficit target of £500 million, they will need to cut their operating costs by £3.6 billion and receive temporary extra funds of £1.8 billion.

- This would require trusts to make savings in one year equivalent to 4.3 per cent of their operating costs – far in excess of any level achieved over recent years and likely to be almost impossible to deliver.

- A more likely scenario is that they will make cost savings similar to the level made last year. That would collectively leave the trusts with an underlying deficit of around £3.5 billion.

- The headline deficit for 2016/17 (which ended in March 2017) was £791 million. However, that figure was flattered by billions of pounds' worth of one-off savings, temporary extra funding and accountancy changes that did nothing to improve the underlying state of provider finances. Once they are removed, the underlying deficit for 2016/17 is £3.7 billion.

- This is compared to an underlying deficit the year before, 2015/16, of £4.3 billion. As trusts also had to soak up additional inflation costs in 2016/17, the reduction in the underlying deficit between 2015/16 and 2016/17 actually represents providers making £2.3 billion in permanent savings.

- Projections of future years suggest that, even under optimistic assumptions for inflation and continued high levels of savings, NHS providers will continue to run a large collective underlying deficit until at least 2020/21.

Hospital deficits stabilised?

The financial performance of NHS providers is managed by the regulator NHS Improvement and detailed in its quarterly reports, as well as in its annual accounts. These reports showed that for the year ended in March 2017, the headline NHS provider deficit reduced from a reported £2.5 billion in 2015/16 to £791 million in 2016/17.[1]

NHS Improvement heralded that movement as "an improvement of £1.7 billion" in the financial health of NHS hospitals and other services.[2]

But is that improvement real and, perhaps more importantly, is it sustainable?

The NHS provider deficit is, at bottom, simply the amount hospitals and other services spend in excess of the income or funding they have coming in over a year.

The widespread nature of these deficits in 2015/16 led to the creation of an emergency sustainability fund, which injected £1.8 billion extra funding into the provider sector in 2016/17. So on the face of it, providers should have overspent by less in 2016/17 because they received £1.8 billion more in funds.

That would not matter too much if the extra £1.8 billion was available to providers on a recurrent, ongoing basis. After all, if organisations are routinely spending more than they have coming in, one way to address the problem would be to increase their routine income.

However, the £1.8 billion is only available on a temporary basis, and its distribution between hospitals is uncertain and unreliable (see Box 1 on page 4). One way therefore to assess the real underlying health of the NHS's service providers is to look at what the 2016/17 deficit would be without that temporary boost in income.

Subtracting the £1.8 billion from the reported £791 million deficit to reach a £2.6 billion deficit for 2016/17 might lead a cynic to believe the financial position of NHS providers had, if anything, got even worse compared to be year before, or at best stood still. However, NHS finances – and particularly accountancy practices – are more complicated than that.

Box 1: When £1.8 billion isn't £1.8 billion

Launched at the 2015 Spending Review and allocated in 2016/17, the £1.8 billion 'sustainability fund' was created from an annual £2.1 billion to £3.4 billion of NHS England's budget earmarked as the sustainability and transformation fund (STF). The original intention was that only in 2016/17 would £1.8 billion of the STF be used to fund provider overspending. Then, from 2017/18 onwards, a progressively increasing share of the total fund would be shifted away from 'sustainability' and towards 'transformation' as investment in new NHS services and system redesign.

In practice, however, NHS England has had to concede that £1.8 billion *will* continue to be needed to fund provider overspending until at least 2018/19.[3]

But that still does not mean the £1.8 billion is recurrent for providers.

If the £1.8 billion was recurrent, it could have been used to address provider deficits by permanently increasing the amount paid to them for the patients they treat by an overall £1.8 billion from 2016/17 onwards. But that would imply that payments to hospitals and other providers would be £1.8 billion higher than they would otherwise be in every year that followed, meaning the £1.8 billion could never be shifted towards transformation spending.

Instead of using the £1.8 billion to increase recurrent provider income, the 'extra' cash is being used – perhaps counter-intuitively – as an incentive to cajole providers into further cutting their expenditure.

That is being done by giving each provider a financial target each quarter to reduce their expenditure, so that they report a progressively improving financial position – either as a decreasing deficit, or as an increasing surplus.

Around 57 organisations missed these quarterly targets in 2016/17, meaning they will find it nigh on impossible to catch up and reach the further stretched targets for 2017/18.

But even for the providers who did manage to meet their targets and win a share of the £1.8 billion in 2016/17, there was a major catch: every penny of the extra cash had to be used to improve their 'bottom line'.

That meant that even providers who ended 2016/17 in surplus were not allowed to spend any of their share of the £1.8 billion. Instead it had to be used to create a gross surplus to offset the even bigger gross deficit ran up by other providers.

In total, £715 million of the £1.8 billion allocated in 2016/17 now sits as unspent surplus in provider bank accounts. Furthermore, these providers will struggle to spend that cash in 2017/18 too. As the income was earned in 2016/17, spending it in 2017/18 would result in them breaching their target income and expenditure surplus for 2017/18 –

because it would imply spending more in 2017/18 than income earned. Breach that target, and they will miss out on any additional tranches of the £1.8 billion, plus risk regulatory intervention.

So although the £1.8 billion 'extra' cash received by providers in 2016/17 boosted their income for the year by around 2.3 per cent, it did nothing to increase their spending, which at most increased only in line with the volume of extra work they undertook.*

This was not a mistake, or quirk of the system, it was the deliberate intention of the way the cash was allocated: as an incentive to reduce costs further down towards the level of recurrent income available to providers, rather than to increase that income closer towards actual costs. For this reason, it is necessary to subtract the temporary £1.8 billion sustainability income when assessing the underlying health of provider finances.

Underlying deficits: the 2015/16 expenditure-over-income gap

If we want to assess how NHS providers **really** did in 2016/17 compared to 2015/16, we first need to know how they **really** did in 2015/16. That means stripping out the one-off accountancy adjustments and non-recurrent savings that flattered (i.e. reduced) the reported £2.5 billion deficit (or annual overspend) figure for 2015/16.

This is important because the root cause of the NHS provider deficit is that provider costs now systematically outstrip their income. It costs more to treat each patient, on average, than the income hospitals and other providers receive to carry out those treatments.

* The raw, unadjusted figures for total expenditure in 2016/17 show a cash increase of 4 per cent. This is consistent with 1 per cent net inflation (after efficiencies) and a 3 per cent increase in activity. The multiple changes in sector reporting over the last two years – with the merger of the Trust Development Authority and Monitor – together with the large value of accountancy changes, make it difficult to assess a like-for-like adjusted figure (controlled for the number of organisations), but figures set out in NHS Improvement's consolidated foundation trust accounts[4] suggest any adjustment would result in an even lower increase in operational expenditure in 2016/17.

We can view that mismatch between expenditure and income as a trading gap, which has emerged as a direct consequence of deliberate NHS policy over the last decade (see Box 2).

Box 2: The trouble with tariff

Since the mid-2000s, the predominant method for funding NHS providers in England has been through the national NHS tariff. This is essentially a price list for thousands of treatments and packages of care, which determines how much NHS commissioners pay providers for each patient they treat.

But the tariff is not just a system for funding hospitals – it is also a mechanism for extracting efficiency savings. In the early years of the tariff, that was done by increasing tariff prices each year by slightly less than inflation – meaning NHS providers had to absorb some of the cost of inflation themselves, by improving efficiency.

However, from 2011/12 onwards tariff prices were cut in cash terms, year after year, meaning providers not only had to absorb all of the cost of inflation each year, but also reduce the cash amount they effectively spent on treating each patient as well.

That meant that by 2015, hospitals and other providers were paid £92.50 in cash to care for a patient they would have received £100 to care for in 2010 – the equivalent of a real-terms cut to just £80, and annual year-on-year cuts of 4 per cent.

For the first few years of the policy, providers kept up with those year-on-year reductions in their income by cutting their operating costs at a similar rate. But by 2013/14, the pace of provider cost-cutting started to fall behind the pace of the yearly cuts to the tariff. That was the first year an underlying deficit of around £600 million emerged in provider finances – representing the gap that year between the income providers earned under the tariff and their actual expenditure.

But cash cuts to the tariff continued unabated every year up until 2015/16, with providers' own cuts to their operating costs falling systematically short. That meant that by 2015/16, provider expenditure was running at around 5.5 per cent higher than their recurrent income as determined by the tariff.

In recognition of this structural driver behind the annual provider overspend or deficit, tariff prices were increased in cash terms for the first time this decade in 2016/17. However, this increase was still significantly below the level of inflation. As such, the increase in tariff prices merely stopped the size of the deficit growing larger still. It did nothing to actually close the expenditure-over-income gap behind it.

(For a more detailed account of how this income-and-expenditure gap developed, see our *Feeling the crunch* briefing from August 2016.[5])

As with any business with expenditure routinely in excess of its income, the gap does not get reset at the start of each new financial year. The gap remains, from the first patient treated on the first day of the new year when, in the absence of a sudden, radical reduction in cost or increase in funding, the provider sector will again spend more caring for each patient than the income it receives for doing so.

The real deficit at the end of 2015/16 doesn't therefore just tell us about the state of NHS finances that year, it also tells us a lot about the starting point for the year that followed – the expenditure-over-income gap hospitals faced on day one of the new year.

Accountancy wheezes

One-off savings and accountancy adjustments can obscure the true size of that gap in the reported accounts. And while such changes happen all the time, there is significant evidence[6] that the last few months of the financial year 2015/16 saw an unprecedented flurry of big ticket accountancy 'wheezes', as the Department of Health scrambled (unsuccessfully in the end) to stay within its budgetary spending limits.*

Indeed, NHS Improvement have disclosed that the reported £2.5 billion deficit for 2015/16 was flattered by the inclusion of £1.2 billion of what it called "non-operational improvement" measures – largely paper-based accountancy changes that minimised the expenditure-over-income gap by either reducing reported spending for the year or increasing reported income.[7] These were changes to the **reported** figures in the accounts, rather than reflecting actual cash transactions in real life. The changes reduced the 'bottom line' deficit figure on paper, but did very little to close the expenditure-over-income gap for providers as they did nothing to reduce their day-to-day operational costs, or to increase their actual income.

* In 2015/16, the Department of Health avoided breaching its main spending limit by omitting to inform Parliament and the Treasury that it received £400 million more in national insurance contributions than the budget originally forecast. Without that 'oversight', the Department would have overspent its revenue budget by £200 million. For further information, see the Auditor and Comptroller General's note in the DH accounts for 2015/16.[8]

Non-recurrent savings

In addition to these paper gains from accountancy changes, the 2015/16 deficit figure included the impact of around £640 million non-recurrent cost savings. These were genuine savings to operating costs, or increases in income, but ones that could apply for one year only – such as a one-year rebate on hospital catering services, or the profit from selling part of a hospital's estate.

Such savings (or extra income) provided a sticking plaster to help reduce the expenditure-over-income gap for 2015/16, but as they were one off only, they did nothing to reduce the cost base that rolled forward into the following year. They were the organisational equivalent of a student who runs out of cash at the end of term, and spends the last month sleeping on friends' sofas to save on rent. Their bank balance might suggest they are not past their overdraft limit, but in practice they can only survive through emergency measures and drawing on one-off favours. In underlying terms, they are bust.

Adding both those sums – the paper gains and the non-recurrent savings – back onto the reported deficit for 2015/16 increases the figure from the £2.5 billion shown in the accounts to reveal an underlying deficit nearer £4.3 billion.

That £4.3 billion is the true size of the expenditure-over-income gap NHS hospitals and other services faced by the end of 2015/16: the equivalent to having to run the health service on empty for the last three weeks of the year.*

* An illustration of how this gap was the starting point for the new financial year in 2016/17 is available by turning to NHS Improvement's financial report for the first three months of 2016/17.[9] That shows an underlying deficit (after excluding non-recurrent savings in the period and 'extra' payments from the sustainability fund) of £1.04 billion. Extrapolating from that to a full-year forecast reveals that hospitals and other services started 2016/17 on track for an underlying deficit of around £4.3 billion – just what we would expect if that was the gap between income and expenditure at the end of the previous year.

Finding the underlying deficit for 2016/17

Just as the headline deficit for NHS providers in 2015/16 understated the true underlying position, so too does the reported deficit for 2016/17. In addition to the £1.8 billion in temporary extra funding, 2016/17 saw its own set of opaque paper gains and one-off savings, which again flattered the bottom line but did little or nothing to reduce the sector's cost base or increase its recurrent income.

NHS Improvement's report on the 2016/17 financial year shows that providers made £790 million non-recurrent savings during the year – savings that will need to be found elsewhere in 2017/18 as the eliminated cost was on a one-off basis only.[10] Movement in the financial position in the last few months of the year also suggest accountancy changes flattered the accounts with paper gains in the region of £300 million.

Comparing like for like

Taking account of all these factors makes it possible to see and compare the underlying health of NHS providers in 2015/16 and 2016/17. As Figure 1 and the table on page 10 show, adding the £1.8 billion in temporary funding, the paper gains and one-off savings back onto the figure for the end of 2016/17 reveals an underlying NHS provider deficit of £3.7 billion. This is an improvement on the previous year's deficit, but at around £600 million, it is somewhat less than the reported improvement of £1.7 billion.

Figure 1: Underlying NHS provider deficits

Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17

£m, cash	2015/16 (£m)	2016/17 (£m)
Reported deficit in accounts	**-2,450**	**-791**
Extra sustainability income 2016/17		1,800
Paper gains from accountancy changes	1,200	300
Non-recurrent savings made in year	640	790
Underlying deficit for year	**-4,290**	**-3,680**
Improvement in underlying deficit		**600**

Figures have been rounded.
Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17

Swimming against the tide: the impact of inflation

However, it would be doing the NHS provider sector a disservice to suggest hospitals and other health services 'only' saved in the region of £600 million in 2016/17.

In practice, NHS providers saved far more than just the £600 million improvement in their underlying deficits in 2016/17. In addition to inheriting a £4.3 billion gap between their annual income and costs at the start of the year, providers' problems were further exacerbated by the impact of inflation that widened that gap further still.

The rate of inflation experienced by NHS providers is influenced by the specific bundle of goods and services the sector needs to pay for – particularly clinical staff and medicines. NHS Improvement, together with the Department of Health and Treasury, periodically publish a set of "economic assumptions" detailing the expected rate of inflation in NHS costs, with the current set (published in March 2016) covering the financial years 2016/17 to 2020/21.[11]

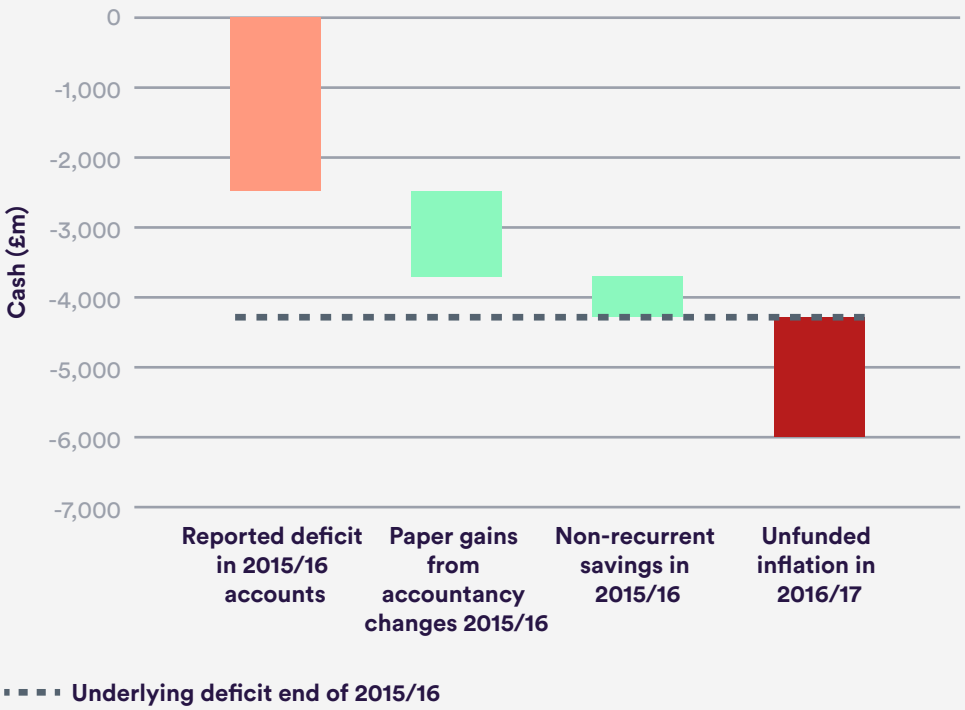
These official assumptions are keenly watched by NHS organisations, not least because the NHS tariff that sets the prices paid to providers to care for each patient they treat assumes that a sizeable proportion of inflation each year will be absorbed by providers themselves – through cost efficiencies, rather than increases in payment. In 2016/17 (and again 2017/18 and 2018/19)[12] that proportion was set at 2 per cent – the so-called "efficiency factor".

That meant that while the official forecast showed that NHS providers would experience cost inflation averaging around 3.1 per cent in 2016/17 (the equivalent to around £2.5 billion in extra costs), payments to providers through the national tariff were only increased by 1 per cent, leaving providers to absorb the remaining £1.7 billion (or 2 per cent) in cost inflation through their own efficiencies.

Figure 2 below appends this unfunded cost of inflation to the underlying deficit to show the full scale of the financial gap NHS providers faced for the financial year 2016/17. This gap was made up of the £4.3 billion underlying deficit (or expenditure-over-income gap) inherited from the previous year, plus £1.7 billion of unfunded inflation, bringing the total gap to £6 billion.

This £6 billion cost pressure is the real context against which the £3.7 billion underlying deficit providers ended 2016/17 with should be measured.

Figure 2: Measuring the scale of the financial challenge in 2016/17

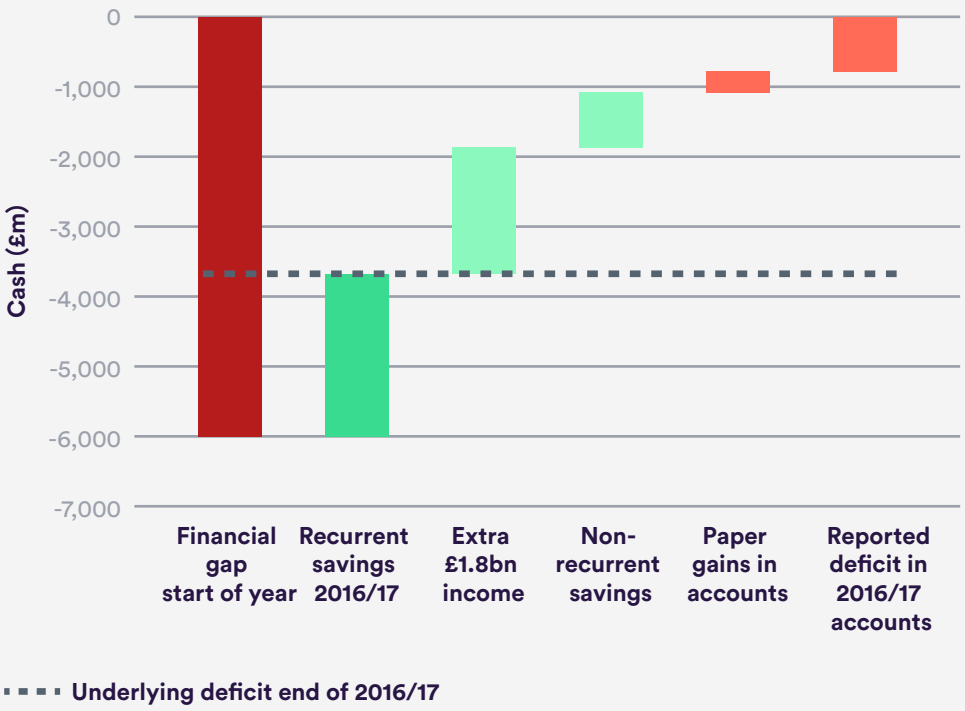


Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17

Tackling the £6 billion problem in 2016/17

The £3.7 billion underlying deficit for 2016/17 was achieved by providers finding £2.3 billion worth of recurrent cost savings. Without those savings, the sector would have ended the year with an eye-watering £6 billion deficit. The savings were the equivalent to a recurrent – or permanent – saving in provider operating costs of around 2.7 per cent. But as we have described, the first two percentage points of that saving were needed simply to offset inflation. That left just 0.7 per cent – or £600 million – to marginally reduce the underlying year-end deficit from £4.3 billion in 2015/16 to £3.7 billion in 2016/17.

Figure 3: Addressing the £6 billion challenge in 2016/17



Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17

£m, cash	2016/17 actual (£m)
Underlying cost pressures for year:	
Underlying deficit inherited from previous year	-4,290
Unfunded inflation for year	-1,700
Total challenge for year	**-5,990**
addressed by:	
recurrent cost savings in year	2,310
non-recurrent cost savings in year (a)	790
extra sustainability funding (b)	1,800
paper gains from accountancy changes (c)	300
Reported position in end-of-year accounts (d)	**-791**
Underlying position at the end of the year (d minus a, b & c)	**-3,680**

Figures have been rounded.
Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17

Increased cost pressures in 2017/18

Looking forward to the rest of this financial year, the official NHS inflation forecast would imply that providers will again experience a further £1.7 billion of unfunded inflationary pressures, as their costs are projected to rise by 2.3 per cent while the national tariff, which determines how much NHS commissioners pay providers, has only increased by 0.3 per cent.

However, NHS Improvement analysis of provider spending plans for 2017/18 suggests the official set of economic assumptions are now substantially out of date: providers are this year forecasting cost inflation around £500 million (or 0.6 percentage points) higher than the official forecast, leaving them facing cost increases of around 2.9 per cent.[13] Yet still the tariff prices determining how much providers will be paid will only increase by 0.3 per cent.

This means that although providers reduced their underlying deficit to £3.7 billion by the end of 2016/17, on day one of the new financial year they faced an expenditure-over-income gap widened by even more unfunded inflation than the official forecast anticipated – around £2.2 billion in total. This expanded the overall gap for 2017/18 to £5.9 billion – almost back to where it was at the start of the previous year.

Mission impossible? Plans for 2017/18

For the current financial year, providers have been given a target to collectively end the year with a reported deficit of just under £500 million, after receipt of a further £1.8 billion in 'extra' sustainability funding. To achieve that, from their starting position of a £5.9 billion gap for the year, they will need to make cost savings of £3.6 billion. That is equivalent to a 4.3 per cent cut to their operating costs, and half a billion more than their total (recurrent and non-recurrent) savings in 2016/17.

Annual financial reports by NHS Improvement and its predecessor regulator Monitor show that the highest level of cost efficiencies that NHS foundation trusts have managed in the past decade was 3.9 per cent – for one year only – back in 2011.[14]

In the years since then, Monitor and NHS Improvement have assessed provider cost savings to be in the region of 2.7 per cent to 3.7 per cent a year.[15] On average, until last year, around a fifth of those annual savings were non-recurrent, meaning they did nothing to reduce the underlying gap between provider income and expenditure. In a further indication of the troubles experienced by the sector, that proportion increased to a quarter in 2016/17 – suggesting providers are running out of places to find permanent savings to their cost bases.

This track record suggests that savings of 4.3 per cent in 2017/18 will be next to impossible, even if a fifth to a quarter of the savings were made non-recurrently.

A more plausible scenario for 2017/18

A more plausible, if still stretching, savings expectation for this financial year might be to repeat the 3.7 per cent total cost reduction made in 2016/17, while reducing the proportion of those savings made non-recurrently back to a fifth – and so the equivalent to increasing the rate of recurrent cost savings from 2.7 per cent last year to 3 per cent.

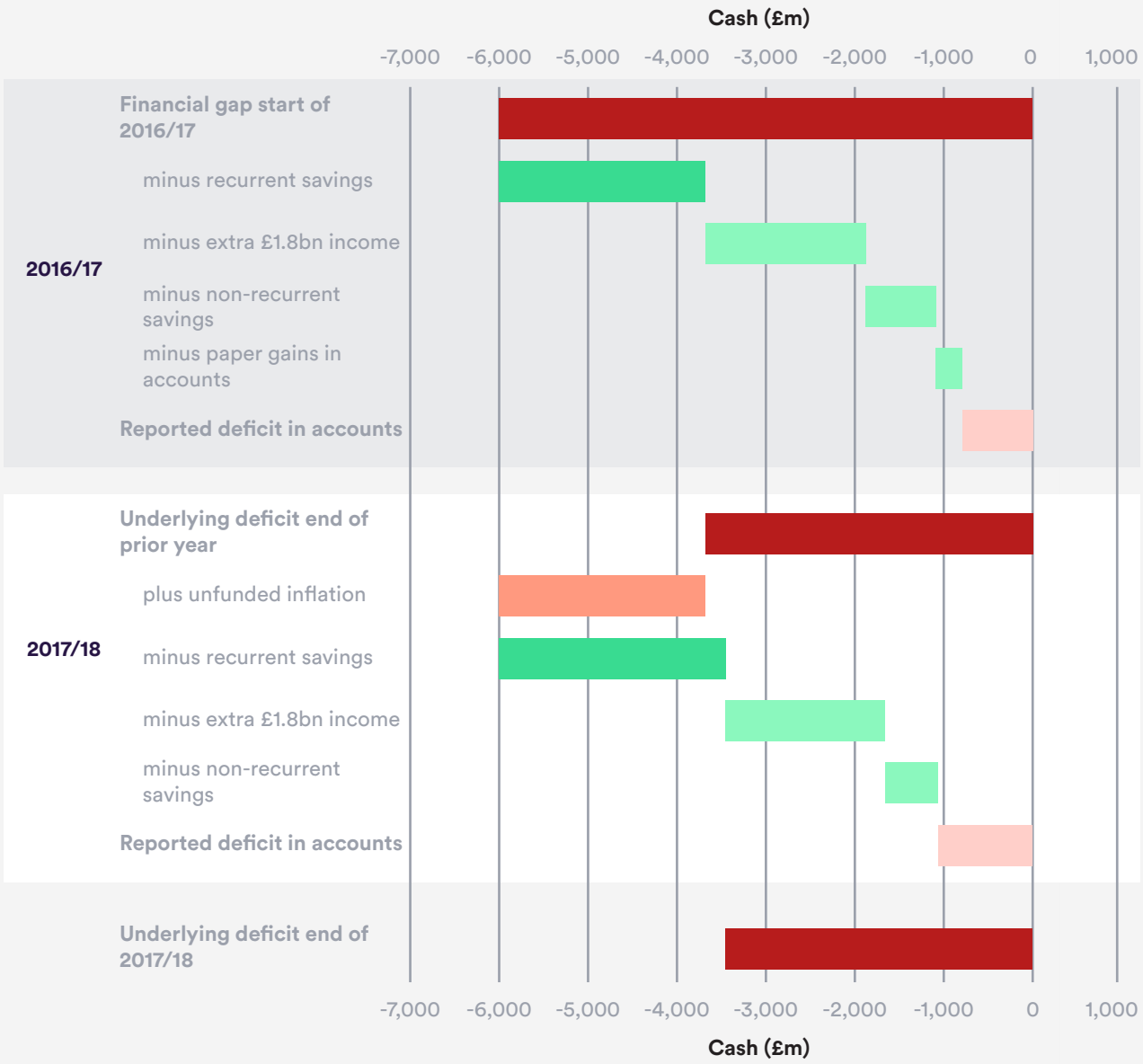
If providers managed that, they would marginally reduce the underlying deficit from £3.7 billion at the end of 2016/17 to £3.5 billion for 2017/18. That reduction would be significantly smaller than the reduction between 2015/16 and 2016/17, as the bulk of the recurrent savings made this year would be needed to offset around £2.2 billion of unfunded inflation (see Figure 4). Under this scenario, unless providers were able to find yet more paper gains from accountancy changes, the reported deficit in the sector-wide accounts would be bigger than the £791 million reported in 2016/17.

Prospects for 2018/19 and beyond

Uncertainties around the level of inflation the NHS provider sector (as with the UK economy as a whole) will experience after 2017/18 make forecasting even short-term financial positions difficult.

It is also unlikely that providers could continue to make year-on-year cuts to their operating costs as high as the overall 3.7 per cent achieved in 2016/17, and modelled in our scenario for 2017/18. It might be more realistic to instead anticipate a slight slowdown in the rate of annual cost cutting, to the average rate achieved by the foundation trust sector since 2010 of around 3.3 per cent overall a year – with around 2.4 per cent of that made recurrently. Such an overall rate, however, would still be significantly in excess of the 1.5 to 2.5 per cent range that a recent review by NHS Improvement's predecessor found was sustainable.[16]

Figure 4: The never-ending challenge of financial recovery – a scenario for 2017/18



Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17 (analysis includes Nuffield Trust modelling of income and expenditure for years after 2017/18)

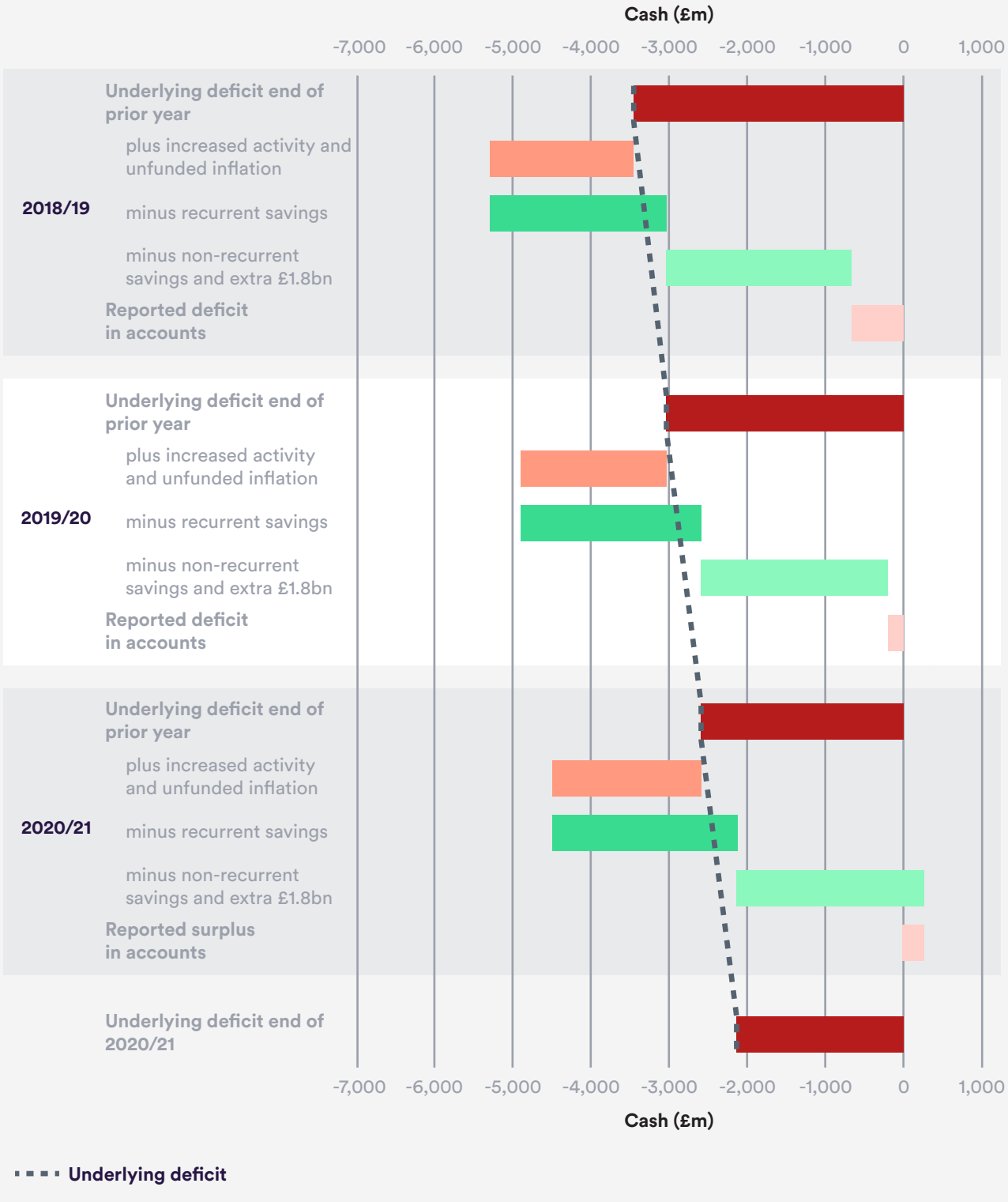
If we assume the annual rate of provider cost savings were to return to the 3.3 per cent mark from 2018/19 onwards, then we can model two potential scenarios.

Under the first, we might optimistically assume that the rate of cost inflation in the provider sector would return to the levels set out in the official forecast – so around 2 per cent in 2018/19. However, even under that scenario, annual cost cuts of 3.7 per cent in 2017/18 followed by three years at 3.3 per cent would still not close the expenditure-over-income gap. Instead it would reduce from around 5.5 per cent in 2015/16 to around 2.5 per cent in 2020/21. This means that although non-recurrent savings and continued sustainability fund payments of £1.8 billion may enable providers to finally report a very small surplus in 2020/21, the underlying gap between their recurrent income and expenditure would still be a very significant £2 billion or more (see Figure 5).

A second scenario might see inflation continue to rise at 0.6 per cent above the current official forecast – due to continued increases in the cost of drugs and clinical supplies or perhaps an unfunded lifting of the current cap on staff pay. If that were the case then our modelled savings would result in the underlying deficit growing to over £3.7 billion by 2020/21 (see Figure 6 on page 20), leaving the expenditure-over-income gap at around 4 per cent.*

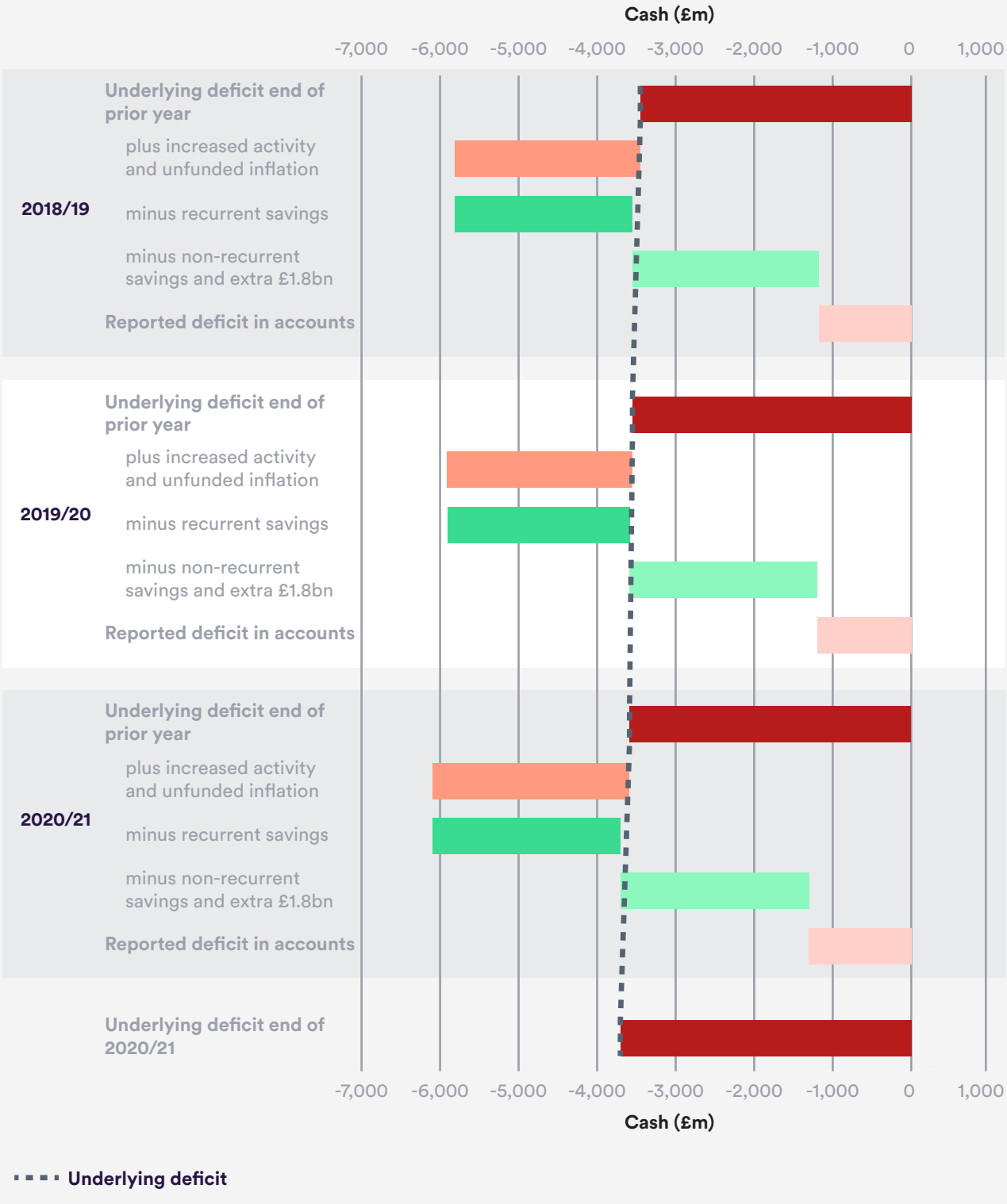
* Note that our models for forecasting the years from 2017/18 do not assume any further benefits to the reported position from accountancy changes. Were they to occur, they could reduce the reported deficit shown in the accounts beyond the figures suggested in our model, but would not affect the underlying position.

Figure 5: Prospects for 2018/19 to 2020/21 Scenario A: Inflation returns to NHS Improvement forecast from 2018/19



Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17 (analysis includes Nuffield Trust modelling of income and expenditure for years after 2017/18)

Figure 6: Prospects for 2018/19 to 2020/21 Scenario B: Inflation continues to rise at 0.6 per cent above forecast



Source: Nuffield Trust analysis of NHS Improvement quarterly reports, 2015/16 and 2016/17 (analysis includes Nuffield Trust modelling of income and expenditure for years after 2017/18)

While these scenarios would see the provider sector continue to have significant overspends, it is important to put these in the context of a decade of funding restraint that will see the amount providers are paid per patient frozen in cash terms in both 2018/19 and 2019/20. As explained in Box 2 on page 6, that planned cash freeze follows five years of cash reductions from 2011/12 to 2015/16, and will mean that by 2020/21 providers will be paid £95 in cash to treat the same patient they would have been paid £100 to treat in 2010 – the equivalent of a real-terms reduction in their income per patient of around 25 per cent.

The cash reduction in the amount providers are paid for each patient they treat means that, although the numbers of patients and treatments grow by around 3 per cent a year, overall provider spending is set to grow by less than half a percentage point in real terms each year until 2020/21. That is because even the very high levels of deficit forecast above will only be achieved if the provider sector continues to make annually recurrent cost savings of more than £2.3 billion a year – significantly higher than the level implied by Lord Carter's 2015 review of hospital efficiency for the Government.[17]

Catching cold: the impact on commissioners

If the majority of organisations that provide the vast bulk of NHS services are systematically finding themselves in an underlying income-and-expenditure deficit, one solution might be to increase their recurrent funding.

One mechanism for doing that might be to increase the tariff prices (or any other form of payment) paid to providers for treating each patient – perhaps by at least sticking to the principle that 'only' the first 2 per cent of inflation should be absorbed by the sector itself. That would see the extra £500 million of inflation hitting providers this year being funded by commissioners – NHS England and clinical commissioning groups.

The problem with that solution, however, is that it has already been done once – in 2016/17 – and commissioners can ill afford to do it again. The 1 per cent increase in tariff prices paid to providers last year was made after five successive years of cash cuts, which the widespread nature of hospital deficits finally showed to be unsustainable.

But increasing tariff prices, without increasing overall NHS funding, simply shifts part of the provider deficit problem to secondary care commissioners, who are already feeling the strain of the 2016/17 tariff price increase.

The average cash growth in commissioner budgets between 2016/17 and 2020/21 is less than 2.7 per cent a year, leaving them unable to fund the current 3 per cent rate of activity growth, let alone pay a marginally higher price for that activity – particularly between 2017/18 and 2019/20 when the average cash increase to their budgets will be down to 2.3 per cent a year.

Bursting point

NHS England's accounts for 2015/16 showed that just under 63 per cent of the total commissioning budget was spent on buying secondary care from NHS acute, specialist, community and mental health providers that year. The rest of its budget is spent predominantly on primary care, pharmacy, dentistry and buying health care from non-NHS bodies, including charities and local authorities.[18]

But in 2016/17 alone – the year of the meagre 1 per cent increase in tariff cash prices – the share of the commissioning budget spent on secondary care increased by around half a percentage point.* Two more, very modest, cash increases to tariff prices are planned for the period 2017/18 to 2020/21 – neither of them more than 0.8 per cent a year. But if the volume of secondary care activity continues to grow at its current rate of around 3 per cent a year, even those very modest rises in tariff prices will see the share of the commissioning budget spent on such activity increase to just under 65 per cent by 2020/21.

That two-percentage-point increase may sound small, but it is equivalent to an annual overspend by NHS commissioners of over £2 billion by 2020/21, compared to a scenario where their spending on secondary care rises sustainably, in line with growth in their overall budget. Put another way: the effective secondary care

* The raw expenditure figures presented in NHS England's accounts suggest an even larger increase in the share of its budget (net of sustainability funding) spent on secondary care between 2015/16 and 2016/17. However, that is in part due to a reclassification of some dental care as "secondary care". After adjusting the figures to reflect this, the increase is nearer half a percentage point.[19]

commissioning budget is already at bursting point; it can barely contain the current level of growth in secondary care activity, let alone find room to fund a cash increase in what providers are paid to carry out that activity.

Raiding the sustainability and transformation fund

We have already seen that even after substantial recurrent annual savings, the provider sector is likely to continue to overspend in the region of £2 billion to £3.7 billion a year up to 2020/21 – depending on the actual rate of cost inflation experienced over the next four years. That is because without a further increase in the amount commissioners pay providers for the patients they treat, providers will still need to spend between 2.5 per cent and 4 per cent more on treating patients than the income they receive for doing so (down from 5.5 per cent more in 2015/16).

The good news is that the Department of Health will just about have sufficient budget headroom to more or less cover that gap in provider finances – in the form of the sustainability and transformation fund (STF) that will reach £3.4 billion in 2020/21.

The bad news is that not only is that fund supposed to be used for investment in new services and system transformation, but more pressingly commissioners will increasingly need to use the fund to bail out their own overspending. Commissioner payments to providers may still be in the region of 2.5 to 4 per cent less than actual provider costs by 2020/21, but without a significant slowdown in activity growth, commissioners will not be able to meet those payments from their core budget that year and will be around £2 billion short.

Put another way: while the invoices providers send to commissioners – priced up under the national tariff – will not be sufficient to cover provider costs, budget constraints on commissioners mean they won't even be able to afford to pay those insubstantial invoices in full.

As the STF can only be spent once, the prospect of a dual provider and commissioner overspend on secondary care points to an overall deficit in the

whole system of between £1 billion and £2.5 billion a year by 2020/21, even after raiding that year's £3.4 billion STF in full.

Transformation, in that scenario, would need to be quietly forgotten amid the more pressing need to ensure staff wages and invoices for clinical supplies were paid.

The option remains, of course, to cut the NHS's coat to suit its relatively shrinking cloth, but measures to more tightly ration access to NHS care, or even to rationalise provision on a reduced number of sites (let alone reduce or slow improvements in quality) prove unpopular, and in some cases risk increasing costs either elsewhere or at a later date.

It is therefore worth putting the undoubtedly large secondary care deficit we project here for 2020/21 into context: increasing NHS funding in 2020/21 by £2.5 billion above current plans to absorb our forecast dual commissioner and provider deficit that year would still see NHS funding as a percentage of projected Gross Domestic Product (GDP) in England fall from around 7.3 per cent in 2017/18 to 7.2 per cent in 2020/21.

Increasing funding by a further £3 billion – in effect establishing a new transformation fund, as our projections envisage the existing one being fully consumed by provider and commissioner deficits – would merely halt that fall. NHS funding in 2020/21 would be left at 7.3 per cent of GDP – exactly where it is now.*

This suggests that while the NHS secondary care system may be in financial crisis, the solution to that crisis is not beyond the reach of the public purse.

* For a more detailed analysis of health spending plans set against GDP, see Gainsbury and Appleby (2017).[20]

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