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Commentary

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Is the NHS underfunded? Three approaches to answering the question

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The adequacy of funding for the National Health Service (NHS) is a perennial issue[1,2] and one that has become particularly prominent in recent years.[3] The way 'underfunding' is understood influences perceptions about how much resource is needed and where it ought to be channelled. This in turn has profound implications for patients, citizens and staff. In this article, we examine what it means to claim that health systems are underfunded and whether this applies to the contemporary NHS. We identify three main approaches to studying the issue and uncover the value judgements inherent in each approach. We argue that there is evidence to support the current claim of underfunding and conclude by suggesting future avenues for addressing this critical issue, both in the UK and elsewhere.

The underfunding debate

Underfunding implies that there is insufficient resource to deliver a service, given the demands placed on it. Current demand pressures in the UK, and other high-income countries, include population ageing and technological advances. These combine to increase the prevalence of chronic disease and the treatment options for those people.[4] On the resource side, the UK and many other countries experienced an extended period of public sector austerity after the 2008 financial crisis. Imbalances between supply and demand are likely to lead to underfunding, characterised by staff shortages, treatment delays, dated infrastructure and low investment.[5]

Achieving the 'right' level of funding has been at the centre of political debate for most of the 75 years of the NHS. Indeed, in 1948, at the founding of the NHS, Nye Bevan said: 'We shall never have all we need. Expectations will always exceed capacity. The service must always be changing, growing and improving – it must always be inadequate.'[6] One of the early independent verdicts on NHS funding was delivered by a committee set up by the Conservative government, chaired by economist Claude Guillebaud in 1956, which concluded that it was probably underfunded. Different approaches have been used at different times to study how much funding is needed for the NHS,[2] and subsequent history suggests that funding levels are rarely considered to be adequate. A previous article illustrated seven approaches to thinking about underfunding.[1] We argue that these broadly fall into three categories (Table 1).

An economics approach

In economic terms, healthcare is underfunded if investment is too low to achieve allocative efficiency. This means that the marginal benefit of spending exceeds the marginal cost, considering costs and benefits to patients, the healthcare system and wider society and, as a result, further investment ought to improve social welfare. Many countries evaluate costs and benefits in this way for specific clinical interventions to judge whether they are cost-effective and *ought* to be funded on value-for-money grounds. An economics approach offers a clear analytical approach to sifting different claims on resource and considering patient need in the sense that it prioritises claims where patients have greatest capacity to benefit.

Applying an economic approach to judge whether there is underfunding *overall* in the NHS is challenging because of the informational requirements.[7] However, research has shown that in England the health benefits of public health spending (per £) are around four times greater than secondary care spending.[8] This suggests that public health is underfunded relative to secondary care. Furthermore, the presence of access problems and waiting times for cost-effective services, such as bariatric surgery or psychological interventions for children, acts as another indication of underfunding when judged through an economics perspective.

Table 1. Approaches to studying health service underfunding.

Three approaches	Dixon et al. (1997) approaches
Economics approach: the use of *economic* (cost and benefit) data to work out which spending claims ought to be funded.	Economics approach Needs approach Rationing approach
Benchmarking approach: the use of *rules of thumb and external comparisons* to establish whether spending is too low or high.	International approach Affordability approach Incremental approach
Political approach: the use of the *political process* to uncover, sift and address claims.	Public opinion approach

There are, nevertheless, challenges with relying solely on an economics approach. Economic evidence is less readily available for real-world infrastructure decisions, such as a new hospital or expansion in workforce, compared to clinical interventions. Furthermore, while cost effectiveness ratios help us to prioritise resources *within* a budget, they are not terribly helpful for judging how big the budget should be in total or how this should change over time in response to demand pressures. And, as with all approaches, there are value judgements, with an economics approach prioritising 'the greatest good for the greatest number', which may conflict with other distributive or clinical judgements.

A benchmarking approach

Benchmarks allow us to examine healthcare funding in relation to a norm, often generated from external comparisons. These include comparisons of spend with other countries, with other areas of the public sector, within a country over time, and in relation to disease burden. Such methods offer a relatively simple way of seeing whether healthcare spending may be lower than expected.

Comparison with other high-income economies[9] and the EU-15 countries[5] shows that the UK is slightly below average in terms of spend per person on health. The UK has fewer hospital beds, key clinical staff and less equipment per capita.[9] Historically, healthcare spend in the UK has grown at >3.5% per year, but between 2010 and 2019, it grew at a markedly slower rate of <2%.[5]

Benchmarks provide a pragmatic way of highlighting underfunding concerns, but they can be arbitrary. Comparing spend with other countries does not provide an indication of why a certain level would be seen as appropriate, or how that ought to change. Different countries may differ in their healthcare needs, and growth rates in spending may need to reflect changes in epidemiology, service availability, efficiency and public values.[5]

A political approach

A third approach for analysing underfunding claims is politics. Discussions about healthcare funding are played out through debate, media, pledges and elections. This suggests that the correct level of funding results from the political system, with parties promising that they will provide more (or less) funding to the NHS or to certain services, in response to public opinion.

Recent opinion polls in the UK show that a large majority think that the NHS needs increased funding, with a key priority being investment in the health and social care workforce.[10] In 2023, we have seen the main political parties support an ambitious and expensive workforce strategy,[11] which may be viewed as a political response to this public perception of underfunding. 'Political underfunding' can also be seen to occur when a political or legal commitment has been made to provide a service, but delivery is inadequate due to limits on funding. For example, in the NHS in England there is a constitutional commitment to ensuring patients wait less than 18 weeks between referral and treatment, but as of August 2023, more than 40% of patients (>3 million) waited longer than this.[12]

The problems with relying on politics alone to address underfunding include the shortcomings of the 'manifesto model', which lacks mechanisms to keep governments to its manifesto promises, and that voters are presented with packaged 'set menus' rather than necessarily endorsing every single *a la carte* item. Furthermore, those with the loudest

Table 2. Is the NHS underfunded?

Three approaches	Underfunding in the NHS
Economics approach	Public health underfunded relative to acute care. Underfunding where there are cost-effective services that cannot be accessed or have a long waiting list. Information constraints make it difficult to judge whether NHS overall is underfunded.
Benchmarking approach	UK spends less per capita than comparator countries and invests less in workforce and capital. Health spending is growing at a historically low rate.
Political approach	Public perception of underfunding with some public commitments to waiting times and services not being met.

NHS: National Health Service.

voices ('squeaky wheels') may secure resources even though needs might be greater elsewhere.[13] The latter may explain, in part, the underfunding of public health where those lobbying against, rather than for, public health measures tend to hold greater power.[14]

Conclusion

The perception of underfunding, both overall in the NHS and in specific sectors, will differ depending on which approach is taken to its measurement. However, all three approaches we have summarised point towards some element of current underfunding in the NHS (Table 2).

There is no easy fix to underfunding through changing the way healthcare is financed and so additional and sustained financing is important at the macro level.[3,5] Furthermore, underfunding is a nuanced issue – not just about the sum total of money going into the health system, but also about the adequacy of resourcing within individual health and care services and sectors. As all health systems have elements of wasteful spending[15] – or overfunding – an element of addressing underfunding ought to aim to reallocate this to underfunded activities.

Dixon et al. state 'No single approach can determine the right level of funding uncontroversially because the decision requires value judgments as well as empirical evidence'.[1] This is certainly true but a blended understanding of underfunding using economics, benchmarks and politics may help us understand why some areas of apparent underfunding get more attention than others. Tackling such challenges requires research into the causes and (potential) solutions to cases of underfunding. This involves understanding how economic factors (such as the supply and demand) interact with the political institutions of resource allocation.

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References

1. Dixon J, Harrison A and New B. Funding the NHS. Is the NHS underfunded? *BMJ* 1997; 314: 58.
2. Smee C. *Speaking Truth to Power: Two Decades of Analysis in the Department of Health*. London: Radcliffe, 2005.
3. House of Lords Select Committee on the Long-term Sustainability of the NHS. *The long-term sustainability of the NHS and adult social care*, 2017. https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf
4. Robinson M. *Bigger Government: The Future Government Expenditure in Advanced Economies*. House of Lords: Arolla Press, 2020.
5. Charlesworth A, Anderson M, Donaldson C, Johnson P, Knapp M, McGuire A, et al. What is the right level of spending needed for health and care in the UK? *The Lancet* 2021; 397: 2012–2022.
6. Toynbee P. For all the hyperbole, Bevan would have approved of this. *The Guardian*, July 1, 2008.
7. Appleby J and Harrison A. *Spending on Health Care: How Much is Enough*? London: The King's Fund, 2006.
8. Martin S, Lomas J and Claxton K. Is an ounce of prevention worth a pound of cure? A cross-sectional

study of the impact of English public health grant on mortality and morbidity. *BMJ Open* 2020; 10: e036411.
9. Anandaciva S. *How does the NHS compare to the health care systems of other countries?* London: The King's Fund, 2023.
10. Health Foundation. *Public Perceptions of Health and Social Care: What are the Priorities Ahead of a General Election*? London: The Health Foundation, 2023.
11. Warner M and Zaranko B. *Implications of the NHS Workforce Plan*. London: Institute for Fiscal Studies, 2023. https://ifs.org.uk/publications/implications-nhs-workforce-plan#:~:text=The%20plan%20suggests%20the%20number,%25%20and%203.4%25%20per%20year.
12. NHS England. *NHS Referral to Treatment (RTT) Waiting Times Data*. London: Author, 2023. https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
13. Maynard A. Ethics and health care 'underfunding'. *J Med Ethics* 2001; 27: 223–227.
14. Hemenway D. Why we don't spend enough on public health. *N Engl J Med* 2010; 362: 1657.
15. Gautam A. *Tackling Wasteful Spending on Health*. Paris: OECD, 2017.