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Health spending in the *Fiscal sustainability report*

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Outline

- **OBR's approach** to modelling public finances in the medium term and long term;
- The role of the **demography** in the *Fiscal sustainability report*;
- **Non-demographic** drivers of health spending;
- Changes to modelling **public health spending** in the *2017 Fiscal sustainability report*;
- Implications for the path of **public debt**;

From the medium term forecast...

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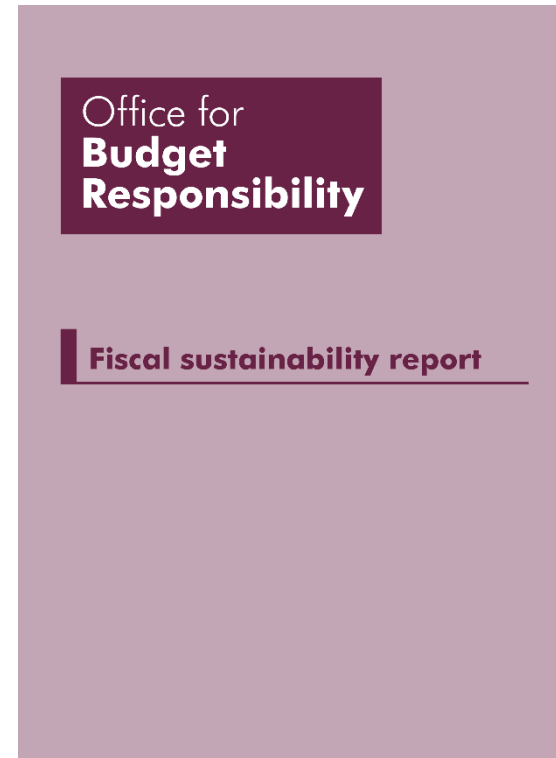
Economic and fiscal outlook

- Next five years;
- Defined Government policy;
- Health set as Departmental expenditure limit in Spending Review (to 2019-20) and latest top-down policy decisions beyond.

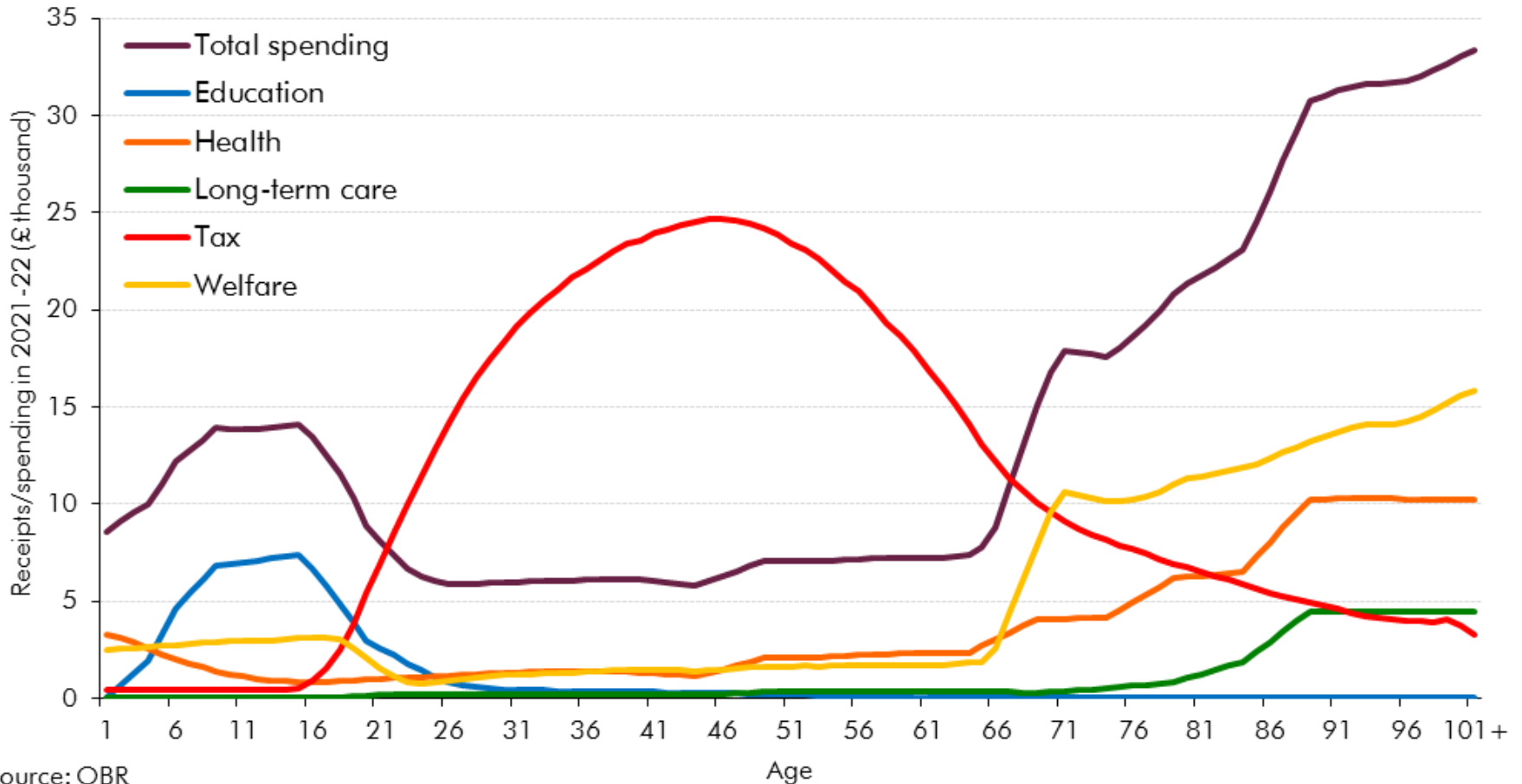
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... to the long term projection

- Next 50 years (to 2066-67);
- Projections, not forecasts;
- Unchanged Government policy beyond the jump-off point in 2021-22;
- Functional definitions of public spending on health, education, etc.



How we model tax and spending

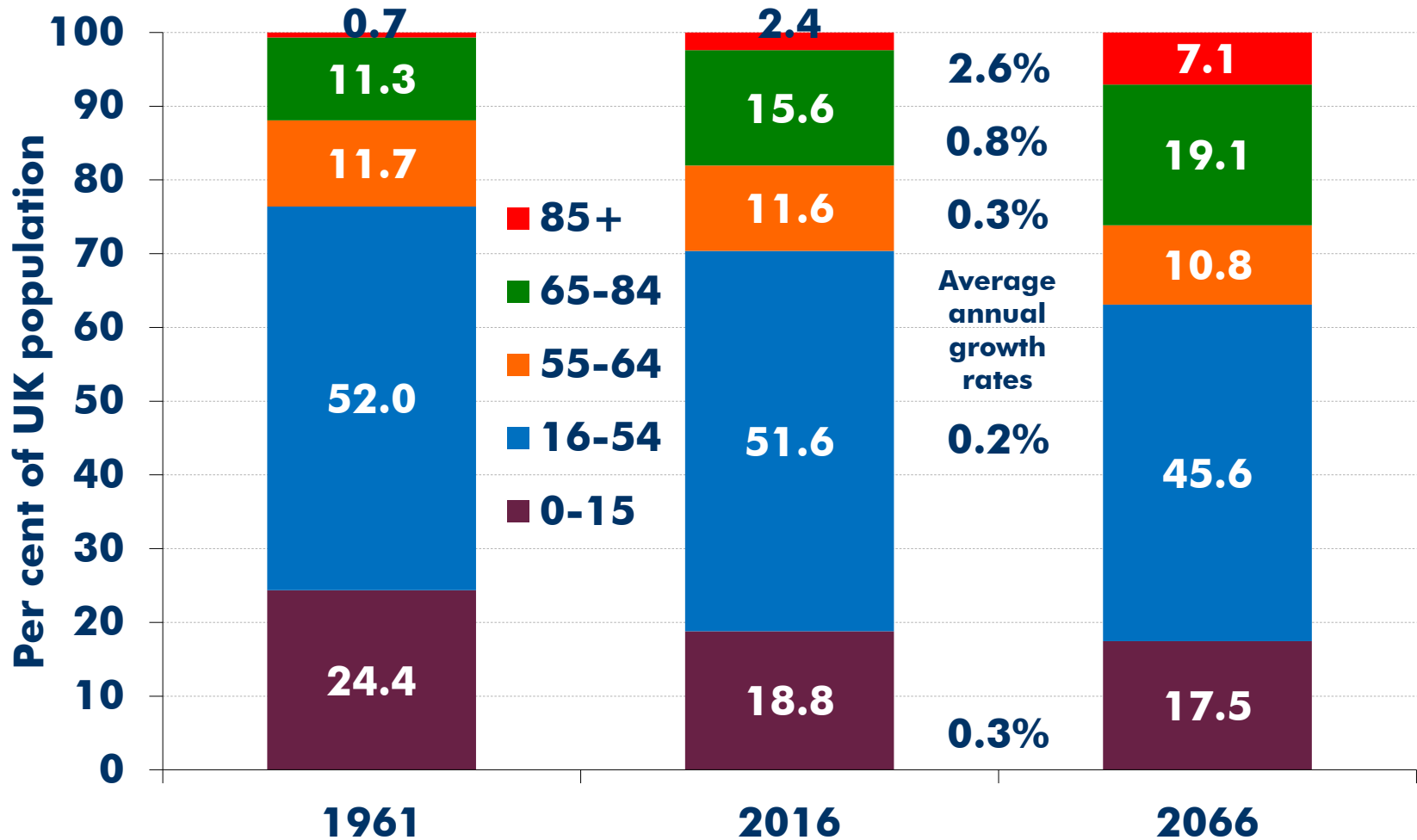


Source: OBR

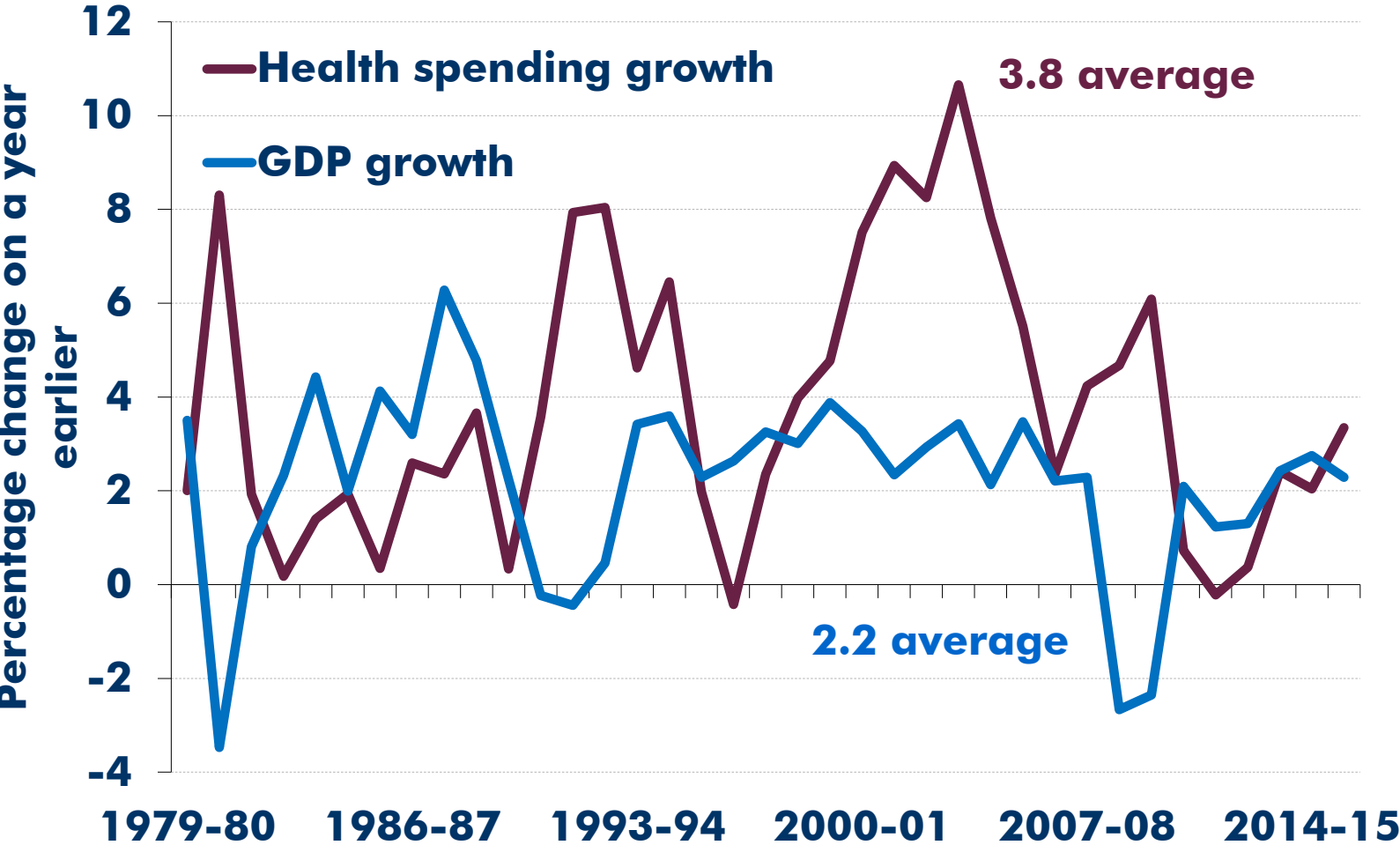
Receipts/spending per capita in 2021-22

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Role of demography



Real health spending in the UK



Drivers of long-term health spending projections

- Demographics
- Income effects
- Other cost pressures

Demographics

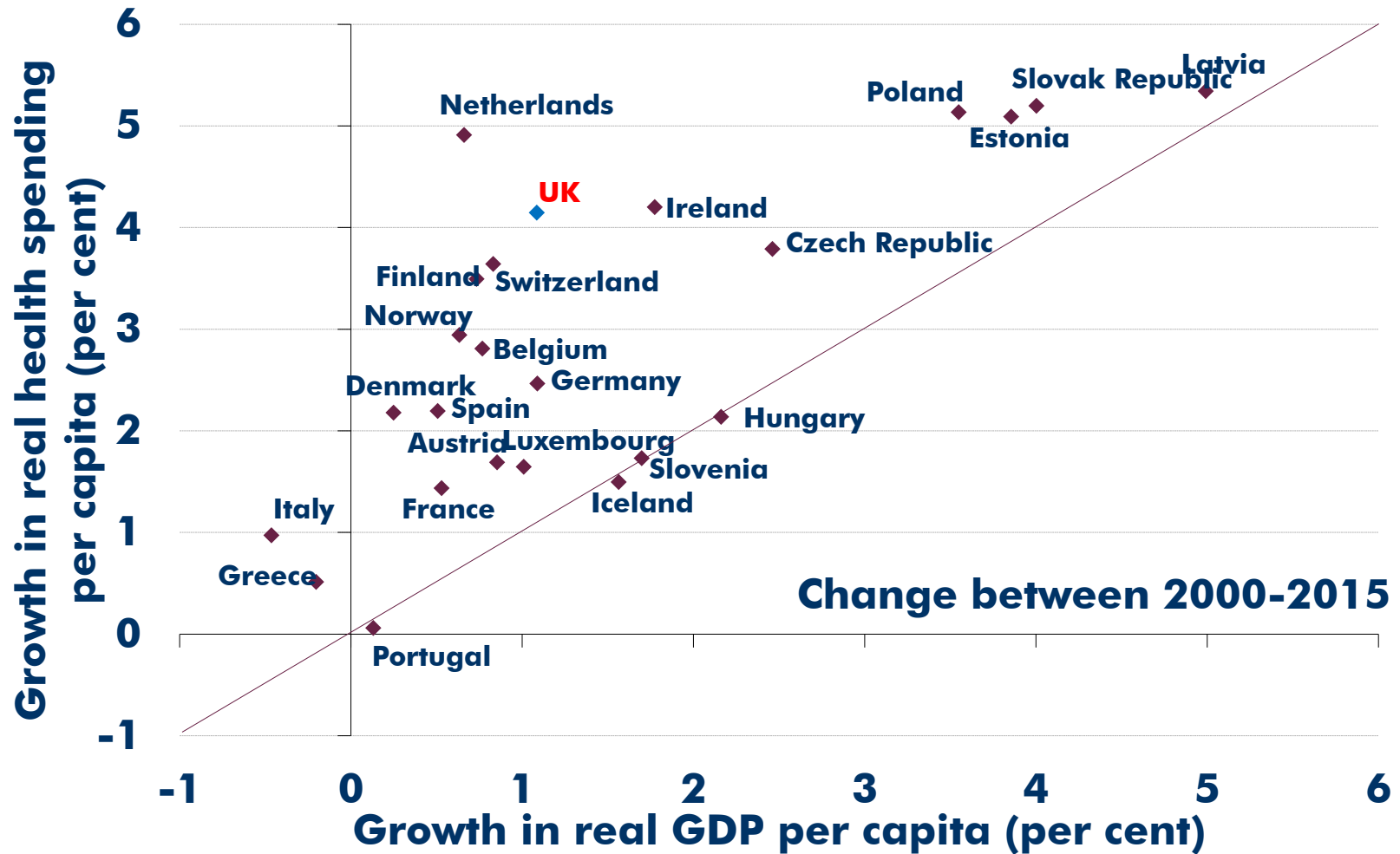
Age specific effects

- Population size and ageing (as per capita costs are higher for older people) increase total spending but little evidence to suggest these pure demographic effects are necessarily the main driver
- Proximity to death is the key driver within age-related spending as costs associated with the final months of life are much higher.

Morbidity

- Do gains in life expectancy change the amount of time in ill health
 - Expansion of morbidity – technology prevents fatal outcomes but time spent in ill-health increases (negative for public finances)
 - Compression of morbidity – technology prevents the onset of chronic illnesses and associated conditions (positive for public finances)
 - Dynamic equilibrium – ill health increases but severity of morbidity falls. Interventions delay the end of life and improve quality of life, more ill health but less intensive treatment (+/- for public finances)
- For our projections we assume that increases in life expectancy are split between extra time spent in good and ill health (reduced health spending by 0.7 per cent of GDP in 2066-67)

Income effect

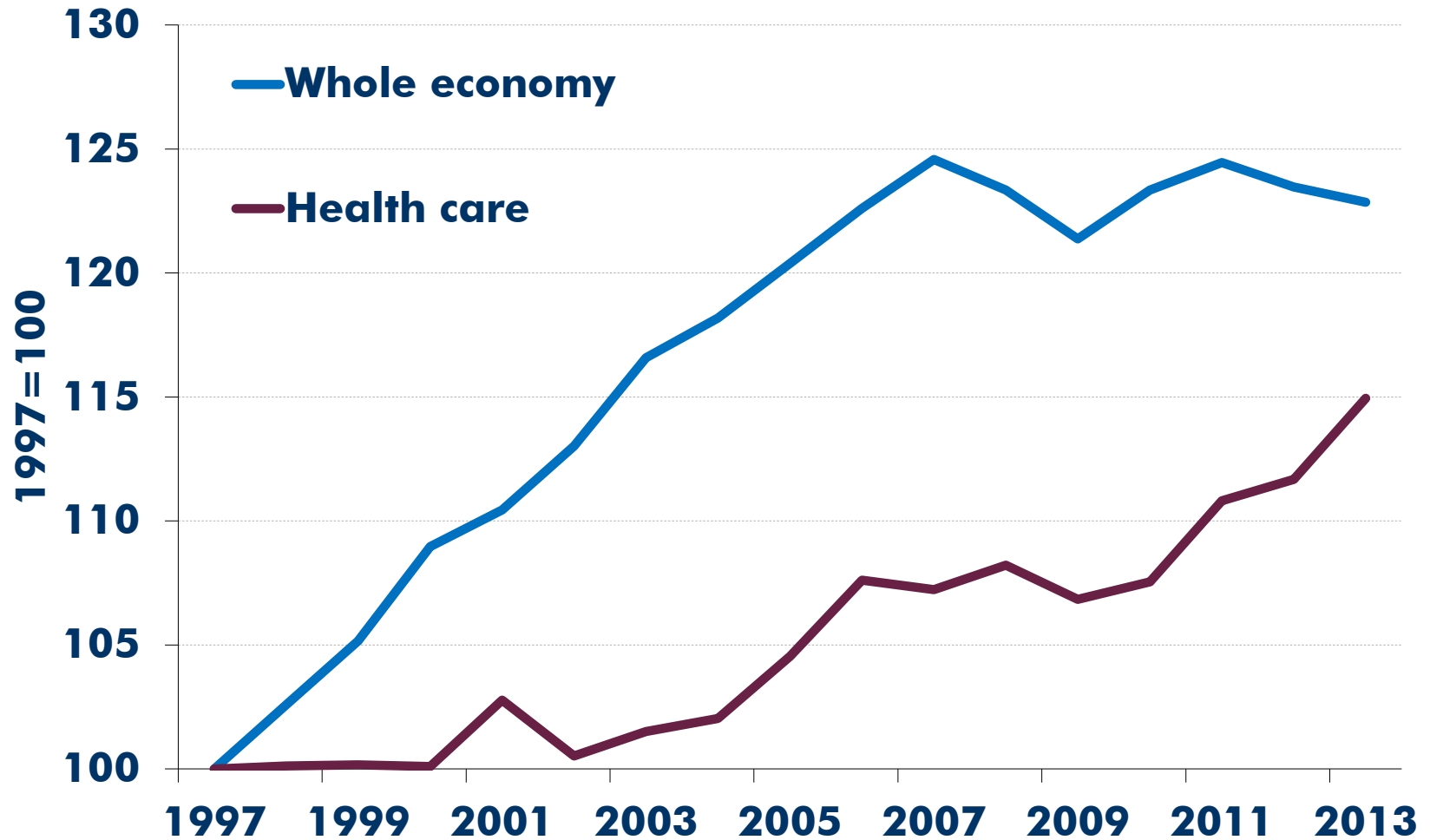


We assume that health spending rises with national income (elasticity = 1) – over 50 years an alternative assumption would see spending trending up or down

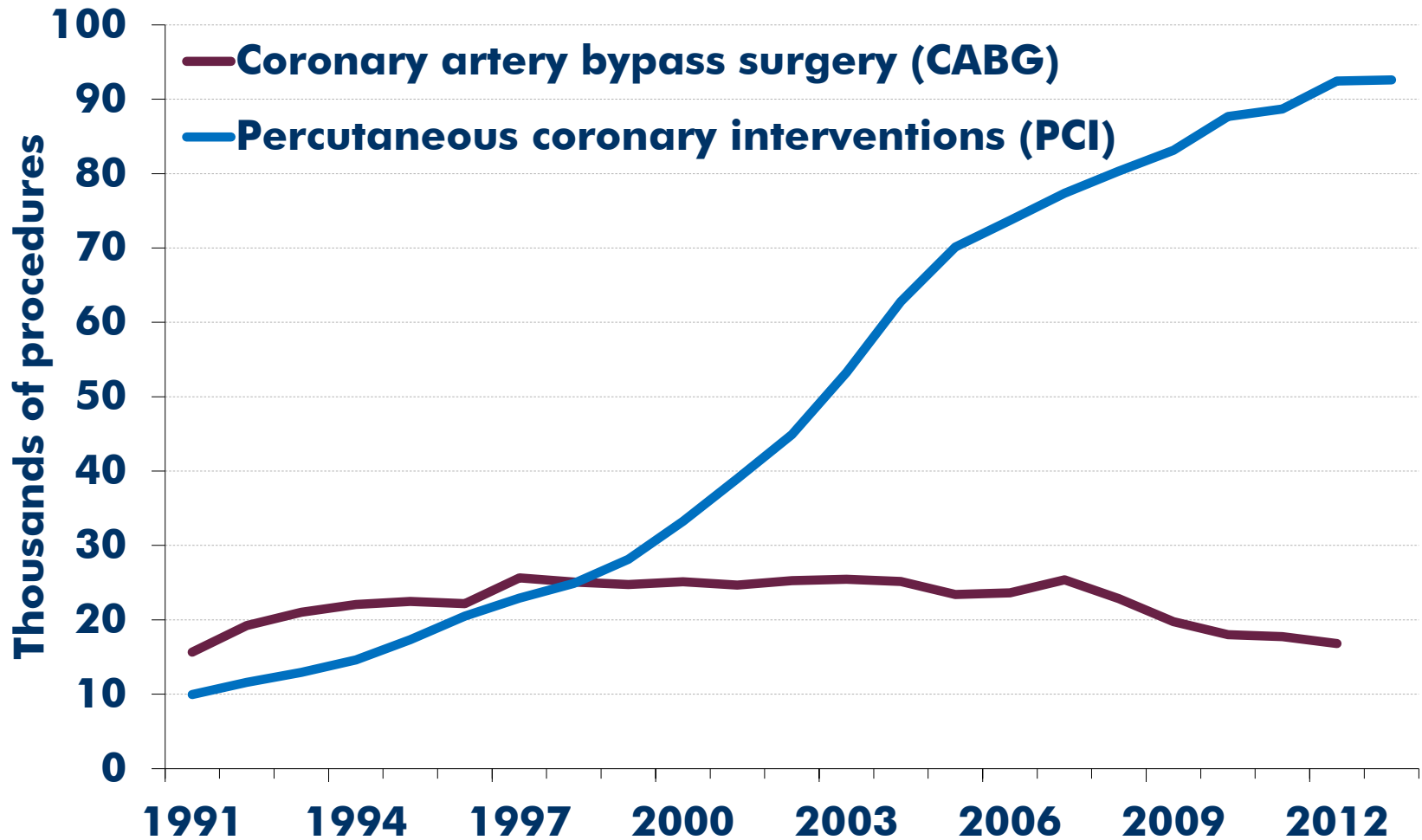
Other cost pressures

- Increasing relative health care costs (inc. productivity)
- Technological advances
- Rise of chronic conditions

Productivity growth in health care



Role of technology

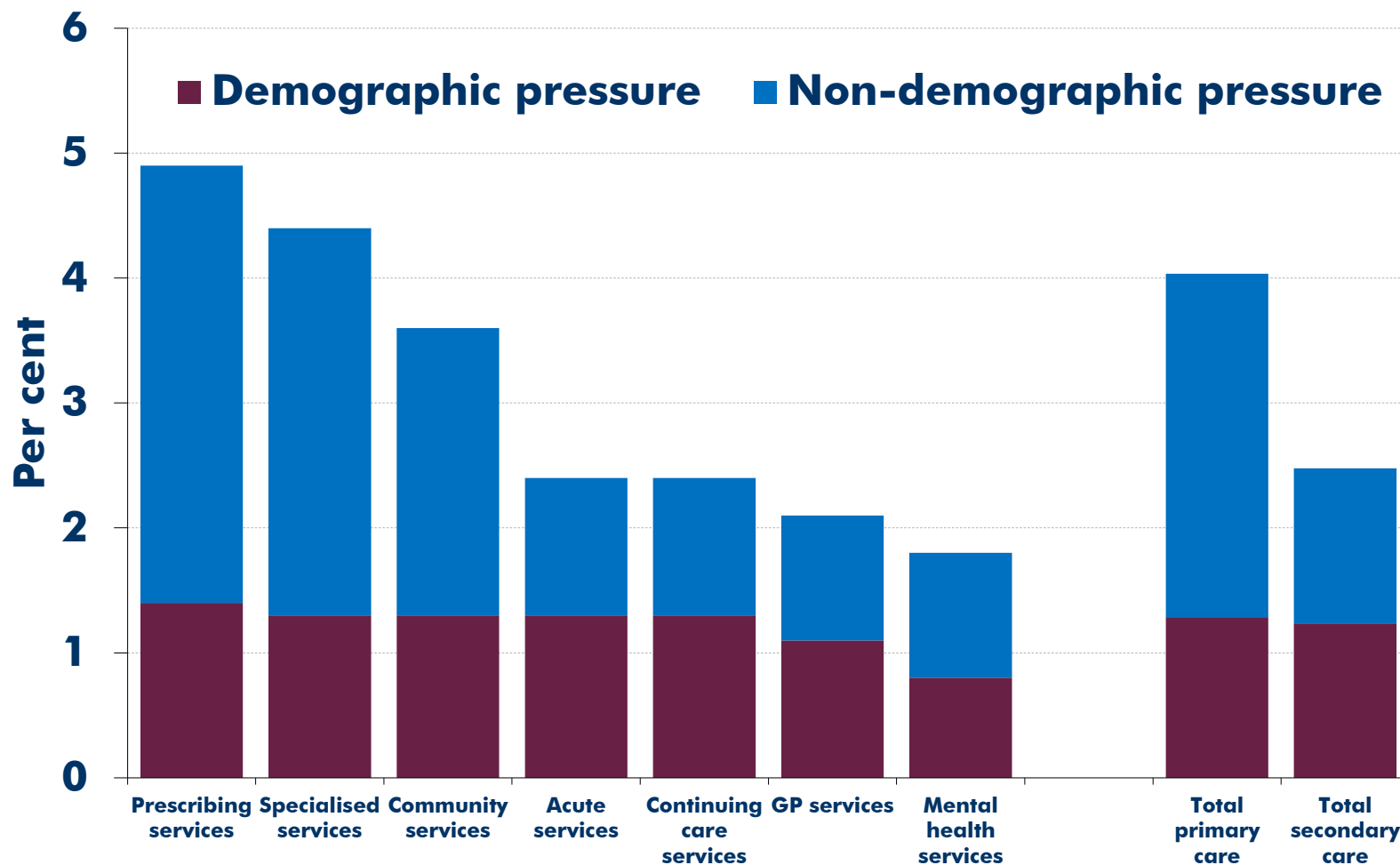


New tech opens new treatment opportunities where they didn't exist or expands treatment to more patients (treatment expansion)

Other cost pressures

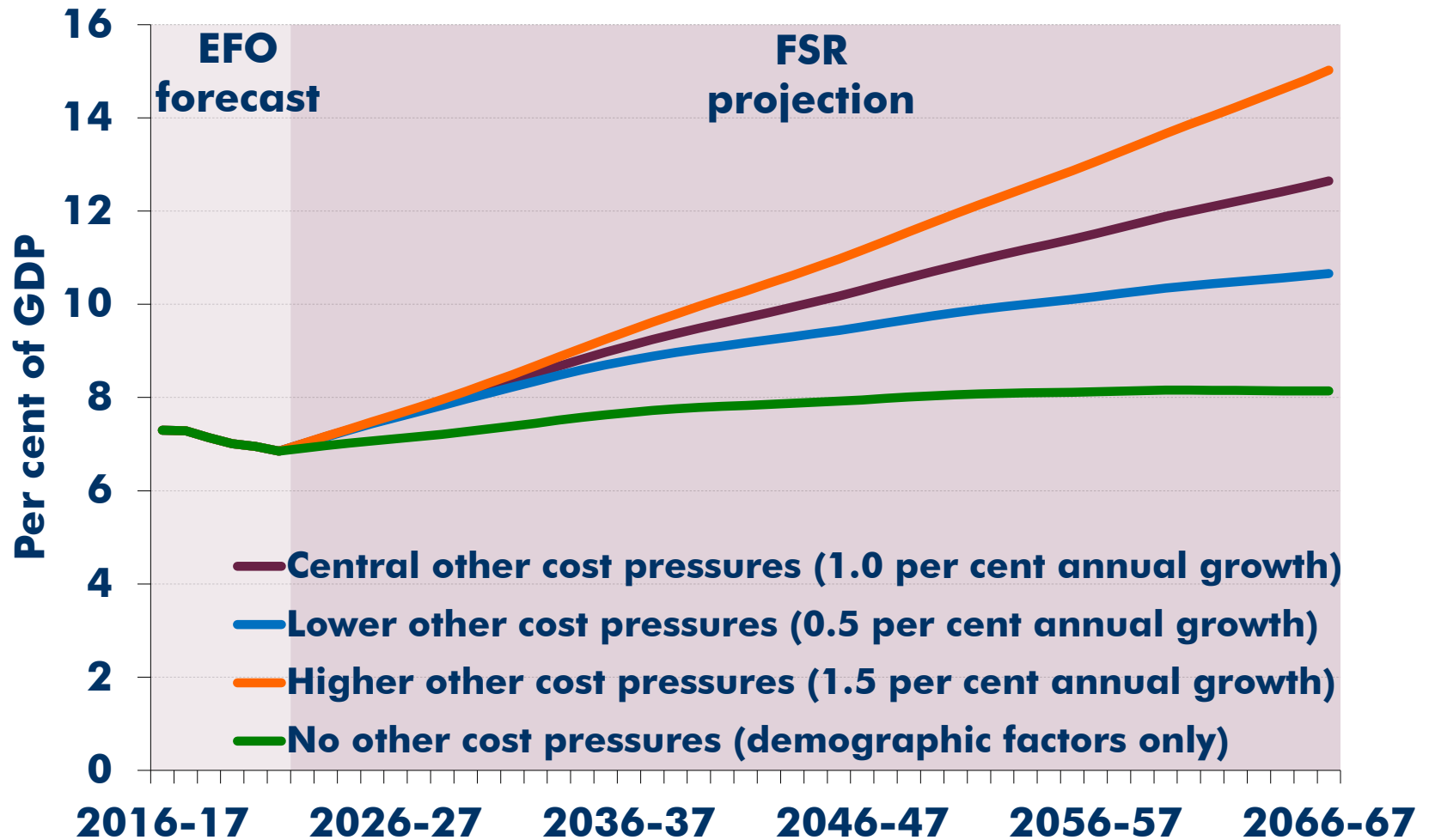
- Increasing relative health care costs (inc. productivity)
- Technological advances
- **Rise of chronic conditions**
 - Dementia
 - Lifestyle changes, increasing rates of obesity increase heart diseases and diabetes...
 - ...which can be co-morbid – poor physical health can increase poor mental health, complicates treatment further

Pressures in the NHS

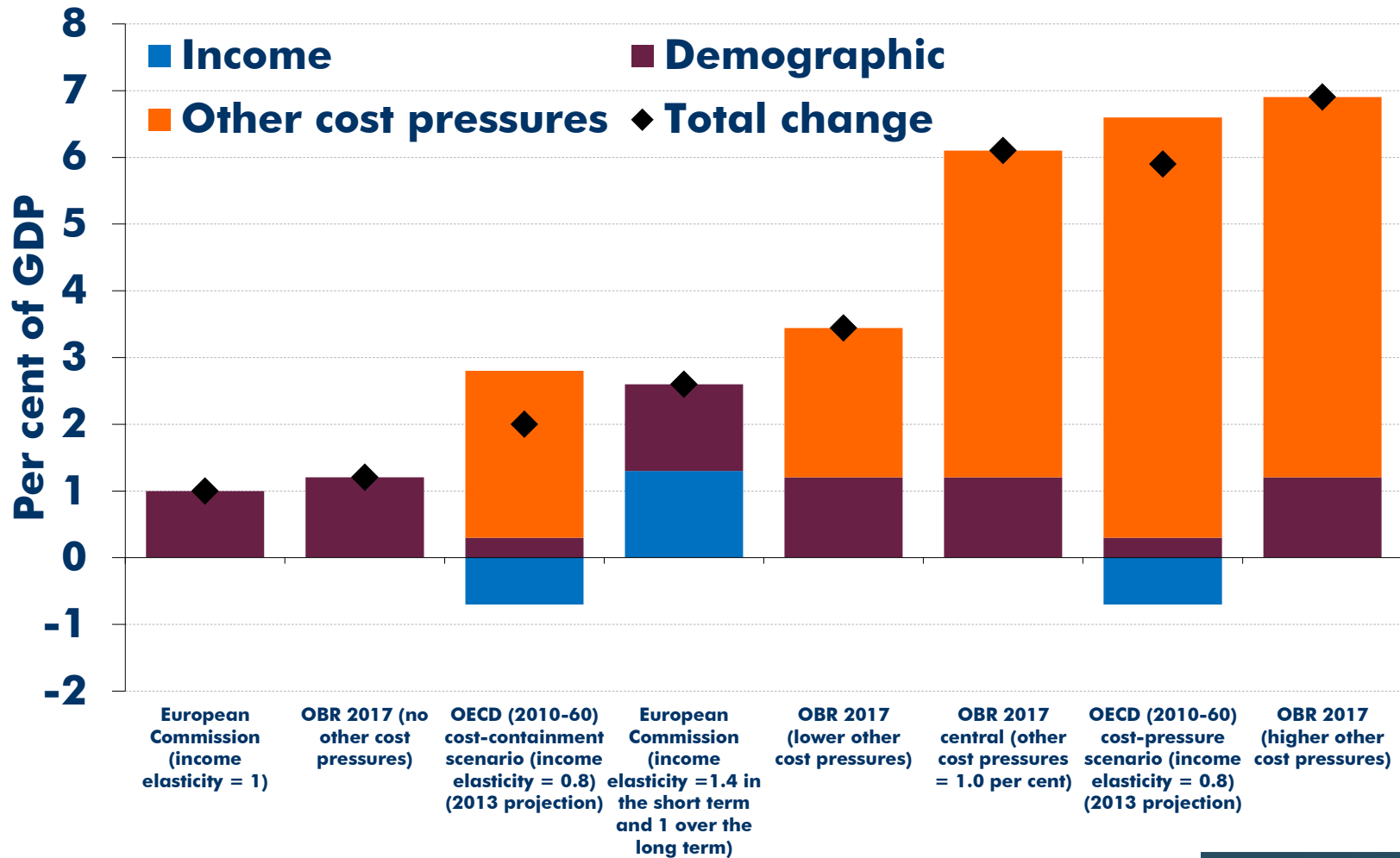


Change in 2015-16

Health spending sensitivities

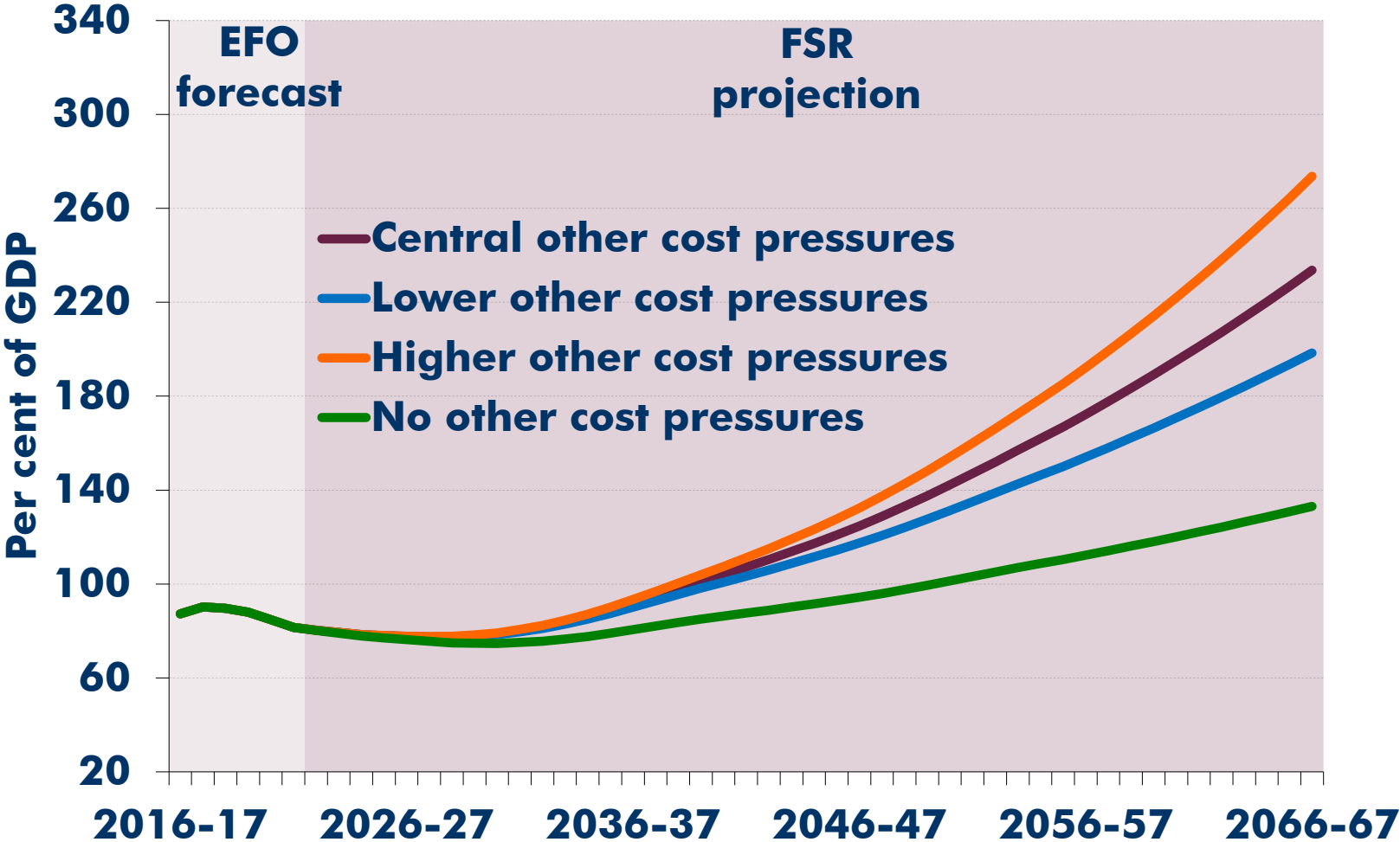


Comparison with other projections



Change between 2020-2060 unless otherwise stated

Public debt sensitivities



Conclusions

- **Substantial fiscal challenge** from rising health care costs over the longer term;
- **Demography** to be a growing driver of spending as the population ages;
- **Non-demographic pressures** likely to continue raising health spending;
- **Sensitivity analysis vital** given the scale of uncertainty.