NHS expenditure in England

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Social and General Statistics

This note looks at aggregate NHS expenditure figures in England and the UK. Section 1 details government spending on the NHS in the UK since its inception in 1948. Section 2 analyses the financing structure of the English NHS, including details of allocations received by primary care trusts since 2002/03. Headline expenditure figures are updated on a quarterly basis in the Social Indicators page *Health expenditure*.[1]

Contents

[1] SN/SG/2640

1 The UK NHS

1.1 Structure

The NHS was established on 5 July 1948, with the aim of providing a comprehensive range of health services to all UK citizens, financed by general taxation and free at the point of use.

The responsibility for the provision and development of health services lies ultimately with the Secretary of State for Health in England, the Minister for Health and Community Care for Scotland, the Minister for Health and Social Services for Wales and the Minister for Health, Social Services and Public Safety for Northern Ireland. They are supported by the Department of Health in England, the Scottish Executive Department of Health in Scotland, the NHS Directorate in Wales and the Department of Health, Social Services and Public Safety in Northern Ireland. The Scottish Parliament has competence over health and the National Assembly for Wales (NAW) has powers to shape the delivery of health services. However, unlike the Scottish Parliament, the NAW does not have law-making power over the running of the NHS. The Northern Ireland Assembly is intended to take an active role in shaping health services in the Province.

1.2 Total expenditure

Table 1 and Chart 1 detail expenditure by central government on the NHS in the UK, net of receipts from patients. Figures are presented from 1949 onwards, although some changes in the responsibilities of the NHS mean that the series is not consistent over the period. In 1949/50 – the first full year of the NHS – spending amounted to £11 billion in 2007/08 prices, or 3.5% of GDP. By 2006/07, spending had increased more than nine-fold in real terms, to £102 billion (at 2007/08 prices), or 7.3% of GDP. Although it has risen consistently over the period, spending has accelerated in recent years. Between 1997/98 and 2007/08, real-terms expenditure rose by 82%.

Chart 2 details the annual percentage changes in real terms central government expenditure on the NHS from 1950/51 onwards. The largest single increase occurred in 1974/75, with spending increasing by 16.7%. However, this followed the transfer to the government of expenditure by local authorities on provision of health centres, health visiting, home nursing, ambulance services, vaccination and immunisation. Other than the period including 1974/75, the largest five-year moving average increase occurred in 2002/03 (+7.2%).

A negative change has occurred on just eight occasions. The largest of these decreases (-6.3%) occurred in 1953/54. Since 1956/57, the five-year moving average has always been positive. The average change over the period is +3.8%.

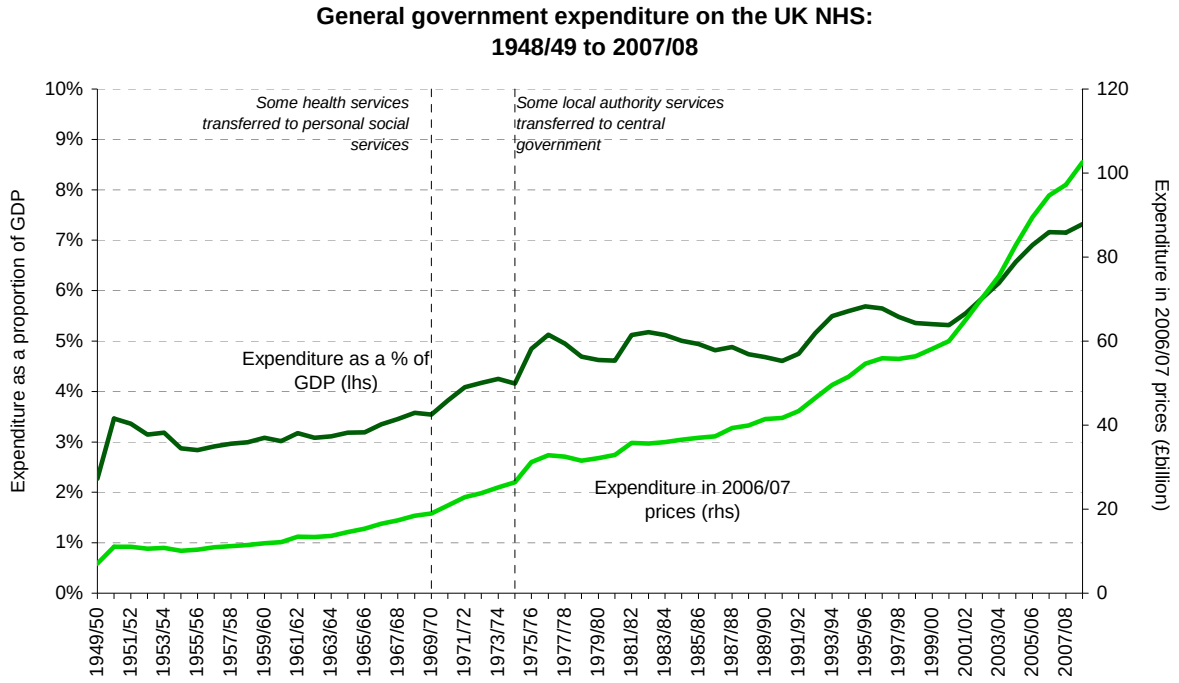

Chart 1: General government expenditure on the UK NHS: 1948/49 to 2005/06
Sources: ONS, *Annual Abstract of Statistics: 2008*, Table 10.22, and earlier editions;
ONS database, *series YBHA*, *ABMI* and *YBGB*;
Health Committee, *Public Expenditure on Health and Personal Social Services 2007: Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Committee*, HC 26-i, 8 November 2007, Table 2

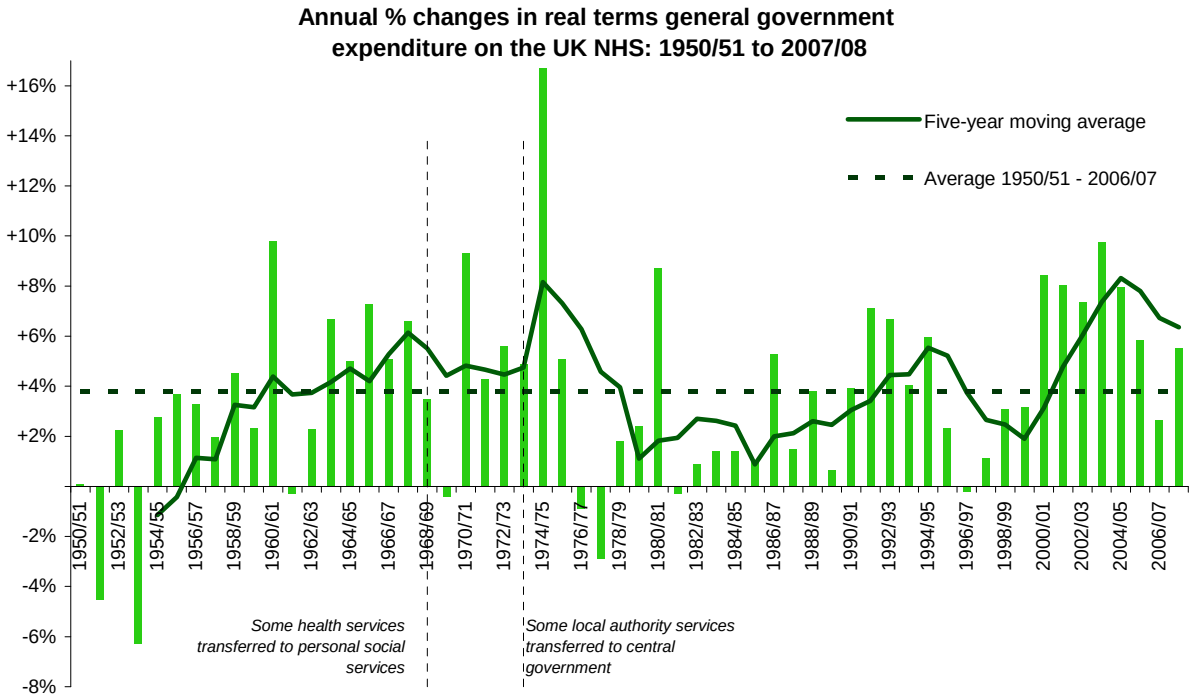

Chart 2: Annual change in real terms general government expenditure on the UK NHS: 1950/51 to 2006/07
Sources: ONS, *Annual Abstract of Statistics: 2008*, Table 10.22, and earlier editions;
ONS database, *series YBHA*, *ABMI* and *YBGB*

2 NHS England

2.1 Structure

As discussed in Section 1.1, each of the home countries has responsibility for its own NHS. The various authorities and trusts charged with managing health care in England are described on the NHS website.[2]

2.2 NHS authorities and trusts

Authorities and trusts are the different types of organisations that run the NHS at a local level. England is split into ten strategic health authorities (SHAs), set up in 2002 to develop plans for improving health services in their local area and to make sure their local NHS organisations were performing well.[3] Within each SHA, the NHS is split into various types of trusts that take responsibility for running the different NHS services in their local area. The different trust types are:

Acute trusts

Hospitals are managed by acute trusts, which aim to ensure that hospitals provide high-quality healthcare, and that they spend their money efficiently. They also decide on a strategy for how the hospital will develop.

Acute trusts employ a large part of the NHS workforce, including nurses, doctors, pharmacists, midwives and health visitors, as well as people doing jobs related to medicine – physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists and psychologists. There are many other non-medical staff employed by acute trusts, including receptionists, porters, cleaners, specialists in information technology, managers, engineers, caterers and domestic and security staff.

Some acute trusts are regional or national centres for more specialised care. Others are attached to universities and help to train health professionals. Acute trusts can also provide services in the community, for example through health centres, clinics or in people's homes.

Foundation trusts

Foundation trusts are a new type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population. Foundation trusts have been given much more financial and operational freedom than other NHS trusts and have come to represent the government's commitment to de-centralising the control of public services. These trusts remain within the NHS and its performance inspection system. They were first introduced in April 2004, and at the time of the last update to this note, there were 109 foundation trusts in England.

Ambulance trusts

There are currently 12 ambulance services covering England, which provide emergency access to healthcare. The NHS is also responsible for providing transport to get patients to hospital for treatment. In many areas it is the ambulance trust that provides this service.

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[2] http://www.nhs.uk/aboutnhs/howtheNHSworks/authoritiesandtrusts/Pages/Authoritiesandtrusts.aspx

[3] 28 SHAs were established in 2002: the number was reduced to ten on 1st July 2006.

Care trusts

Care trusts are organisations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services. Care trusts are set up when the NHS and local authorities agree to work together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services. At the moment there are only a small number of care trusts, though more are expected in the future.

Mental health trusts

Mental health trusts provide health and social care services for people with mental health problems. Mental health services can be provided through GPs, other primary care services or through more specialist care. This might include counselling and other psychological therapies, community and family support or general health screening. For example, people suffering bereavement, depression, stress or anxiety can get help from primary care or informal community support. If they need more involved support they can be referred for specialist care.

Primary care trusts

Primary care is the first point of contact most people have with the NHS. It includes services provided by GPs, opticians, dentists, pharmacists, health workers and other community-based practitioners. NHS walk-in centres and the NHS Direct phone line service are also part of primary care. All of these services are managed by local primary care trusts (PCTs). PCTs work with local authorities and other agencies that provide health and social care to make sure that a local community's needs are being met.

PCTs are now at the centre of the NHS and control 80% of the NHS budget. As they are local organisations, they are best positioned to understand the needs of their community, so they can make sure that the organisations providing health and social care services are working effectively.

For example, PCTs must make sure there are enough services for people within their area and that these services are accessible. It must also make sure that all other health services are provided, including hospitals, dentists, opticians, mental health services, NHS walk-in centres, NHS Direct, patient transport (including accident and emergency), population screening, and pharmacies. They are also responsible for getting health and social care systems working together for the benefit of patients.

Special health authorities

Special health authorities are health authorities that provide a health service to the whole of England, not just to a local community – for example, the National Blood Authority. They have been set up to provide a national service to the NHS or the public, under section 11 of the NHS Act 1977. They are independent, but can be subject to ministerial direction like other NHS bodies.

Figure 1 describes the interaction of some of these authorities and details the changes in structures between 2004/05 and 2006/07. Overall, the number of organisations within the NHS reduced from 590 in 2004/05 to 372 in 2006/07.

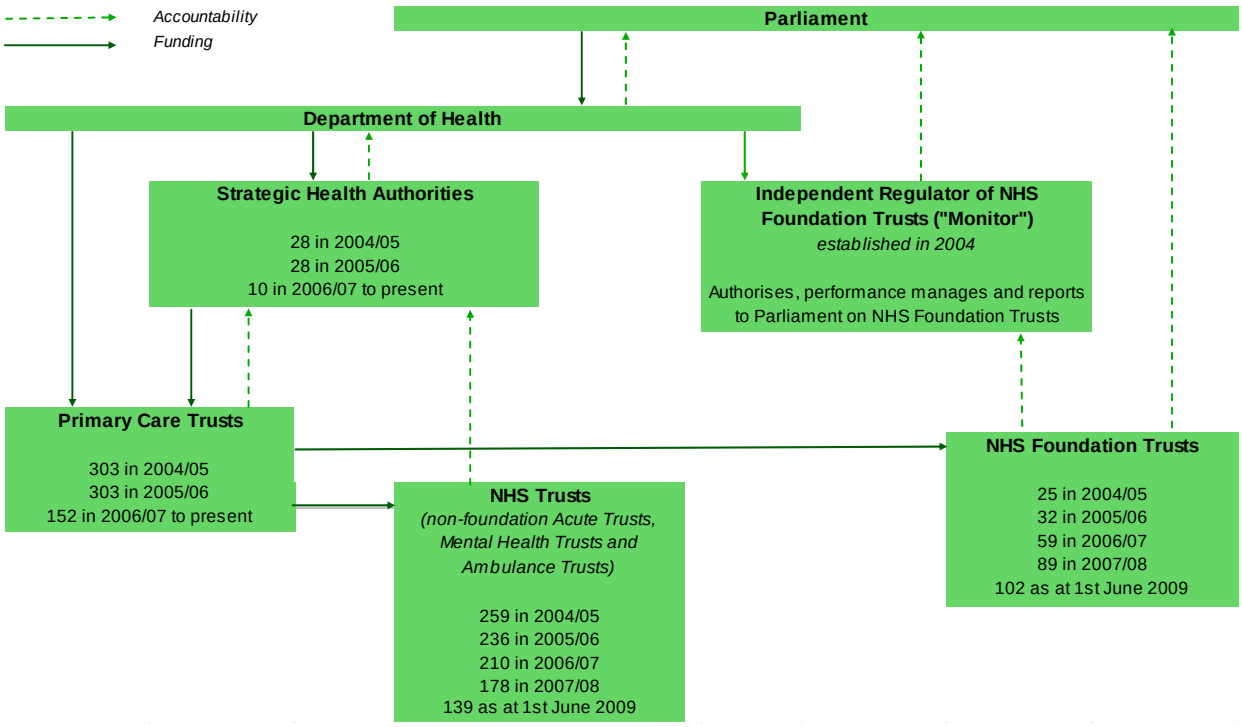

Figure 1: Structure of the NHS in England: 2004/05 to 2006/07
Source: Adapted from Audit Commission & NAO, *Report on the NHS Summarised Accounts 2006-07: Achieving Financial Balance*, 11 December 2007, Figure 1: http://www.nao.org.uk/publications/nao_reports/07-08/0708129_I.pdf

2.3 Total expenditure

Table 2 details NHS public spending in England in each year since 1974/75, net of patient charges and receipts. Earlier data is not available on a consistent basis. Although real-term expenditure appears to have risen from £23.7 billion in 1974/75 to a planned £102.3 billion in 2008/09, changes in accounting procedures mean that no meaningful comparison of spending over the period can be made. However, year-on-year real-term increases can be quoted on a consistent basis: in this context, annual changes have been predominantly positive, with just two real-term decreases: in 1977/78 and 1996/97. Chart 3 shows the annual real-term increases along with a moving five-year average. The largest five-year moving average (+7.5%) occurred in 2003/04.

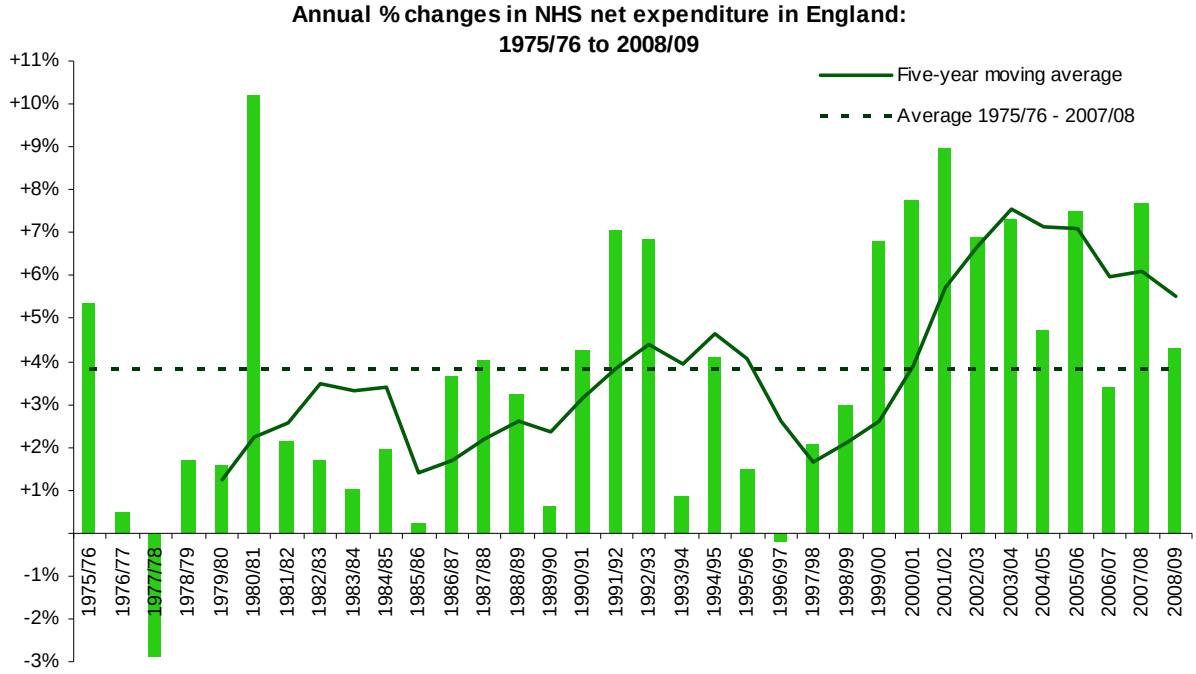

Chart 3: Annual change in real terms NHS net expenditure in England: 1974/75 to 2008/09

Sources: HMT, The Government's Expenditure Plans, various years;
Department of Health, Departmental Reports, various years;
Health Committee, *Public Expenditure on Health and Personal Social Services 2008: Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Committee*, HC 1190, 13 November 2008, Table 1a;
Department of Health, Departmental Report 2007, Table 9.1;
HMT, GDP deflator, at 23 December 2008

2.4 Funding process

Figure 1 describes the NHS funding process. The Department of Health provides funds directly to SHAs and PCTs, which they are then responsible for spending. The funding process is described in more detail in the joint National Audit Office/Audit Commission publication, *Financial Management in the NHS*:

> The majority of funding for the NHS is provided by the Department of Health (the Department). The Department provides resources directly to Strategic Health Authorities and Primary Care Trusts. Primary Care Trusts pay NHS Trusts, NHS Foundation Trusts, primary healthcare providers, and private-sector healthcare providers for the healthcare that they commission from them. NHS Trusts and Foundation Trusts also receive a small amount of funding from the Department or other sources, such as local authorities and charitable donations (…)
>
> The funding provided to the NHS is reported in the Department's consolidated resource account, which is audited by the Comptroller and Auditor General… The individual accounts of Strategic Health Authorities, Primary Care Trusts, and NHS Trusts are audited by auditors appointed by the Audit Commission under the Audit Commission Act 1998. These appointed auditors provide an audit opinion on the annual accounts of each organisation.
>
> The Department produces accounts summarising the financial statements of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. The Comptroller and Auditor General is required under the National Health Service Act 1977 to certify each of the summarised accounts and to lay copies of them, together with his report on them, before both Houses of Parliament…

The individual accounts of each NHS Foundation Trust are audited by auditors appointed by the Foundation Trust's Board of Governors. These individual accounts are consolidated by the Independent Regulator of NHS Foundation Trusts ('Monitor'), into a single account, which is audited by the Comptroller and Auditor General under an agreement with Monitor. This consolidated account is laid before both Houses of Parliament as part of Monitor's statutory reporting duty under the Health and Social Care (Community Health and Standards) Act 2003.[4]

Figure 2 details disposition of NHS resources in 2008-09. It shows that PCTs control around 80% of the NHS budget.

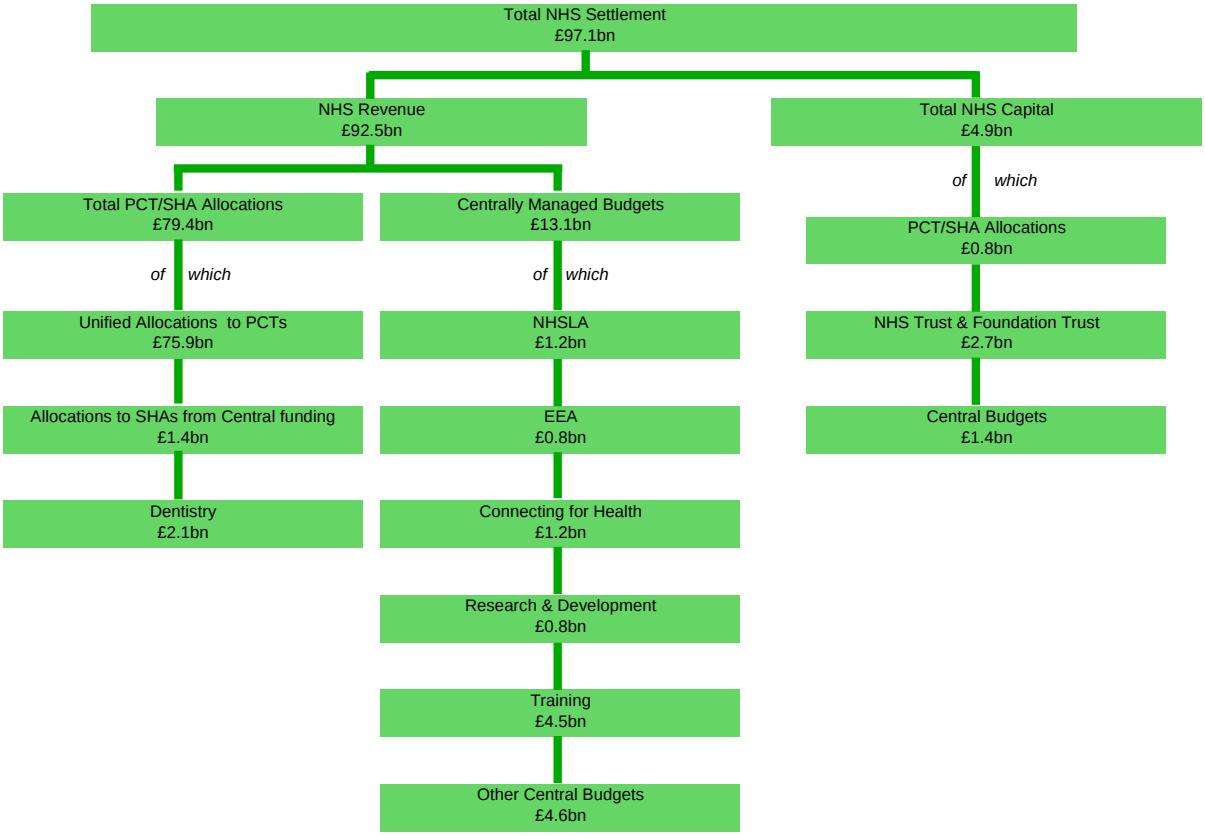

Figure 2: Disposition of NHS resources 2008-09
Source: Department of Health, *Departmental Report 2008*, Figure 9.5
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908

[4] NAO & Audit Commission, *Financial Management in the NHS: NHS (England) Summarised Accounts 2004-05*, June 2006, paras 1.3-1.8: http://www.nao.org.uk/publications/nao_reports/05-06/05061092_I.pdf

2.5 Primary Care Trust allocations

Allocations process

The four-stage process used to determine the allocations received by each PCT is explained in the Department of Health's latest *Departmental Report*:

> Four elements are used to set PCTs' actual allocations:
>
> - weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs' target shares of available resources based on the age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services;
>
> - recurrent baselines – represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year;
>
> - distance from target (DFT) – this is the difference between weighted capitation targets and recurrent baselines. If a weighted capitation target is greater than a recurrent baseline, a PCT is said to be under target. If a weighted capitation target is smaller than a recurrent baseline, a PCT is said to be over target; and
>
> - pace of change policy – this determines the level of increase which all PCTs get to deliver on national and local priorities and the level of extra resources to under-target PCTs to move them closer to their weighted capitation targets. *[i.e. PCTs do not receive their target allocation immediately but are moved to it over a number of years].* The pace of change policy is decided by Ministers for each allocations round.

Weighted capitation targets

The first stage of this process requires crude PCT population estimates, based on 2006 population projections, to be weighted. A number of different weights are applied, and the process is fairly complex: Figure 3 describes the method. Each PCT's final "unified weighted population" is based on a combination of the three components of recurrent revenue allocations: Hospital and Community Health Services (HCHS), prescribing, and primary medical services. Each of these three components is itself first weighted, however, according to the age, additional need and unavoidable cost differences for the PCT in question. In addition, the figures for Prescribing and Primary Medical Services are further adjusted or "normalised" to account for discrepancies in national totals.

This broad weighting process has been in place since 1976. The Resource Allocation Working Party (RAWP) was set up in 1974 "with a view to establishing a pattern of distribution responsive objectively, equitably and efficiently to relative need and to make recommendations". The RAWP formula was introduced in 1976, replacing the Crossman Formula which had been in place between 1971 and 1975, and remained in use until 1988. Reviews of the formula were carried out throughout the 1980s and 1990s, resulting in a number of modifications.[5]

Since 1997, there has been an increasing emphasis on the additional need element. Following the Acheson Report into Inequalities in Health in 1998,[6] ministers announced

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[5] Department of Health RAWP4, *A brief history of resource allocation in the NHS: 1948-98*: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515

[6] Sir Donald Acheson, *Independent Inquiry into Inequalities in Health*, September 1998:

another review of the formula, emphasising its active role in reducing 'avoidable health inequalities'. An interim health inequalities adjustment was introduced in 2001/02 and a primary care additional need adjustment was introduced in 2002/03. Additional need adjustments, incorporating data such as the 2000 Indices of Deprivation, were included in the 2003/06 allocations round. In the 2006/08 round, several more changes were made; most notably, these included a new primary medical services component to replace the General Medical Services Cash and Non-Cash Limited (GMSCL and GMSNCL) components, and the use of ONS population projections (rather than estimates), in informing PCT's unified weighted populations.

The 2009/10 and 2010/11 allocations were informed by a comprehensive review undertaken by the Advisory Committee on Resource Allocation (ACRA), an independent committee comprising NHS management, GPs and academics. The review started in 2005 and was completed in December 2008, with the allocations being announced that same month. The review and resulting allocations were guided by broadly similar principles to those set out in the Acheson report; namely 'to provide equal access to healthcare for people at equal risk and to contribute to the reduction in avoidable health inequalities'[7]. A summary of the adopted recommendations is given on pages 7-12 of the Department of Health's *Resource Allocation: Weighted Capitation Formula – sixth edition*.

One of the more notable changes is the adoption of a separate formula for health inequalities. ACRA determined that it was not technically possible to fully achieve both objectives of equal access for equal need and a reduction in health inequalities within a single formula. Therefore, it recommended a separate formula be specifically designed to address the objective of reducing avoidable health inequalities, and that this formula be applied to all three components of recurrent revenue allocations (HCHS, prescribing and primary medical services). The measure of health inequality they selected as most objective and robust was Disability Free Life Expectancy (DFLE). However, the weighting of this formula (i.e. its relative importance) within the overall additional need adjustment was left for Ministers to decide: this weight has duly been set at 15 per cent.

Another significant but more technical change involved the way in which acute and maternity needs were modelled within the HCHS component of the formula. Specifically, maternity need is now calculated separately from acute need. Meanwhile, acute need, which had previously been measured using indices of age-related need and additional need[8] has been replaced by a one-stage approach that allows for the relationship between age-related need and additional need to vary between age bands.

The latest *Exposition Book* details the 2009/11 weighted and normalised populations for each of the three components and shows the associated unified weighted population for each PCT. The spreadsheet details the sources of the weighted data and shows how the final unified weighted figure is reached. A full technical explanation of the weighted capitation formula used for the 2009/11 allocations round is provided in the Department of Health's *Resource Allocation: Weighted Capitation Formula* booklet.[9]

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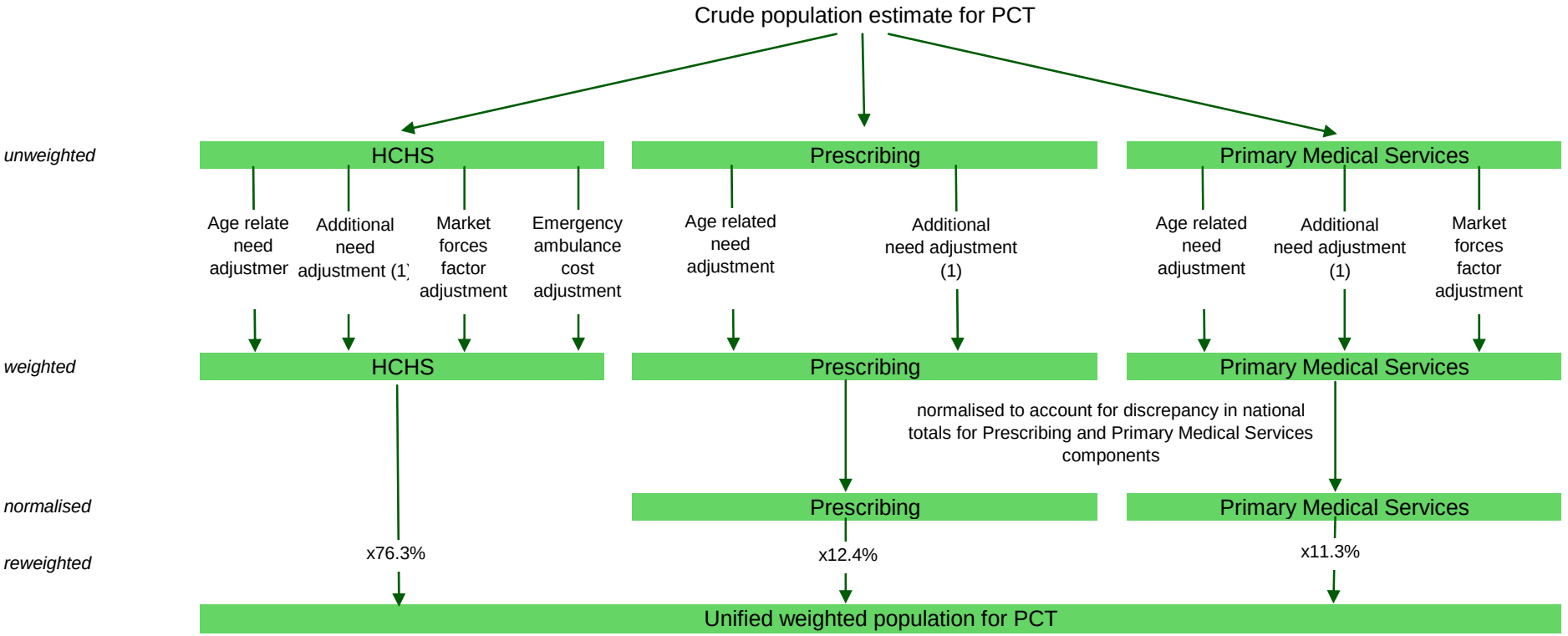
[7] Report of the Advisory Committee on Resource Allocation (December 2008). The terminology appears to have strengthened slightly since the 2006/08 round, the stated objective of which was to achieve 'similar levels of healthcare for populations with similar healthcare need'.

[8] I.e. need over and above that accounted for by age.

[9] Department of Health, *Resource Allocation: Weighted Capitation Formula*, Fifth Edition, 27 May 2005: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4112065

Recurrent revenue allocations process: PCT population weighting



(1) As per ACRAs recommendation, the additional need adjustment now incorporates a separate health inequalities formula applied to all elements of the weighted capitation formula (HCHS, Prescribing and Primary Medical Services). The measure of health inequality is based on Disability Free Life Expectancy (DFLE) data for each PCT

Source: Derived from DH *Exposition Book*

Figure 3: Recurrent revenue allocations process: PCT population weighting

To exemplify how populations are weighted according to their healthcare needs, chart 4 plots the 2009/10 age and additional need indices for the prescribing component of PCT allocations in England[10]. The indices are normalised to reflect age/deprivation relative to the national average; as such, the age and additional need indices for England as a whole are both equal to 1. Relative to this, the upper left quadrant includes those PCTs serving younger populations with higher perceived needs, while the lower right quadrant covers those PCTs serving older PCTs with lower perceived needs. In both these quadrants, the weightings work in opposite directions, meaning that the final allocations provided to these PCTs depends on the magnitude of these opposing indices. In the remaining two quadrants the age and additional need indices reinforce each other. As such, PCTs in the upper right quadrant (older, more deprived) always received higher than average allocations while PCTs in the lower left quadrant (younger, less deprived) always received lower than average allocations.

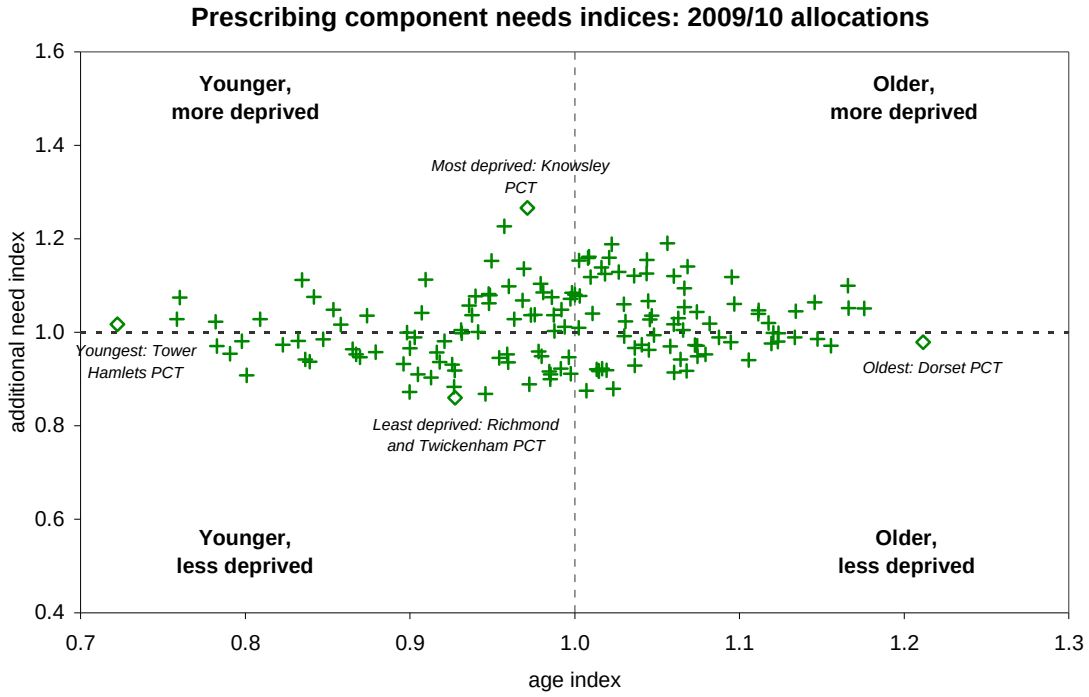


Chart 4: Prescribing component age-related versus additional needs indices: 2009/10 allocations
Source: DH, *Exposition Book*

PCT allocations and distances from target 2003/04 to 2010/11

Allocations

A total of £164 billion has been allocated to PCTs for the 2009/11 round. As detailed above, around 80% of total NHS spending is made directly available to PCTs via such allocations. However, changes in geographies and methodologies, and the expansion of PCTs' responsibilities in recent years, make it difficult to present a consistent time series for any particular area. For example, in 1999/2000 unified allocations replaced revenue cash limits. This bringing together of funding for all hospital and community services, prescribing and general practice infrastructure into a single stream at health authority and primary care group level had the effect of increasing recorded per capita allocations. More recently, the responsibilities of PCTs were increased as part of the 2006/08 resource allocation process, with allocations increasing accordingly; for instance, PCTs assumed responsibility for commissioning all elements of primary dental care services from 1 April 2006.

[10] As described above, the most significant component of PCT allocations (the HCHS component) now uses a one stage process to measure age-related and additional need; the prescribing component, however, has retained the two-stage framework.

Figures for total allocations, allocations per capita and distances from target for each PCT in the years 2003/04 to 2008/09 are provided in Table 28b of the Health Select Committee's Public Expenditure on Health and Personal Social Services 2008 report[11].

Distances from target

The outputs of the weighted capitation formula are not sums of money but shares of overall resources[12] to which PCTs are deemed to be entitled, given the size and healthcare needs of their populations. To the extent that these differ from the existing resource shares, achieving the target requires redistribution of funding from PCTs that are over target (i.e. receiving more than a fair share as deemed by the formula) to PCTs that are under target (i.e. receiving less than a fair share).

This redistribution does not occur immediately, and generally PCTs never receive an allocation equal to their target share; rather, they are moved gradually towards their target over the course of an allocations round. The difference between a PCT's actual allocation and its target for a given year is known as the 'closing distance from target'[13], and the rate at which PCTs are moved towards their target is known as the 'pace of change'. Whilst the allocations formula is devised by an independent committee, the pace of change remains a ministerial decision. For the current (2009/11) allocations round, the pace of change has been set at 5.5%, implying that £8.6bn (5.5% of the 2009/10 and 2010/11 baselines) is available for redistribution between PCTs. This is insufficient to ensure full redistribution in line with the weighted capitation formula recommendations, meaning PCTs' allocations will be on average 4.3% away from target in 2009/10 and 4.1% away in 2010/11.

Chart 5 shows how distances from targets flattened between 2003/04 and 2007/08 as PCTs moved toward their target allocations, but have opened out again at the start of the new round (2009/10) as a result of changes to the formula redefining target resource shares. Whilst in 2003/04, two PCTs were receiving allocations 15% below target and one was receiving allocations 31% above target, by 2007/08 the extremes had reduced to -4% and 13%; meanwhile, for 2009/10, the range has expanded again (-8.6% to 23.5%). Note that because no baseline or formula changes were made for the 2008/09 allocations[14], the distances from target for this period are identical to those from 2007/08.

[11] This table is not currently online. A table from the 2007 report is available from http://pubs1.tso.parliament.uk/pa/cm200708/cmselect/cmhealth/excel2/excel.htm

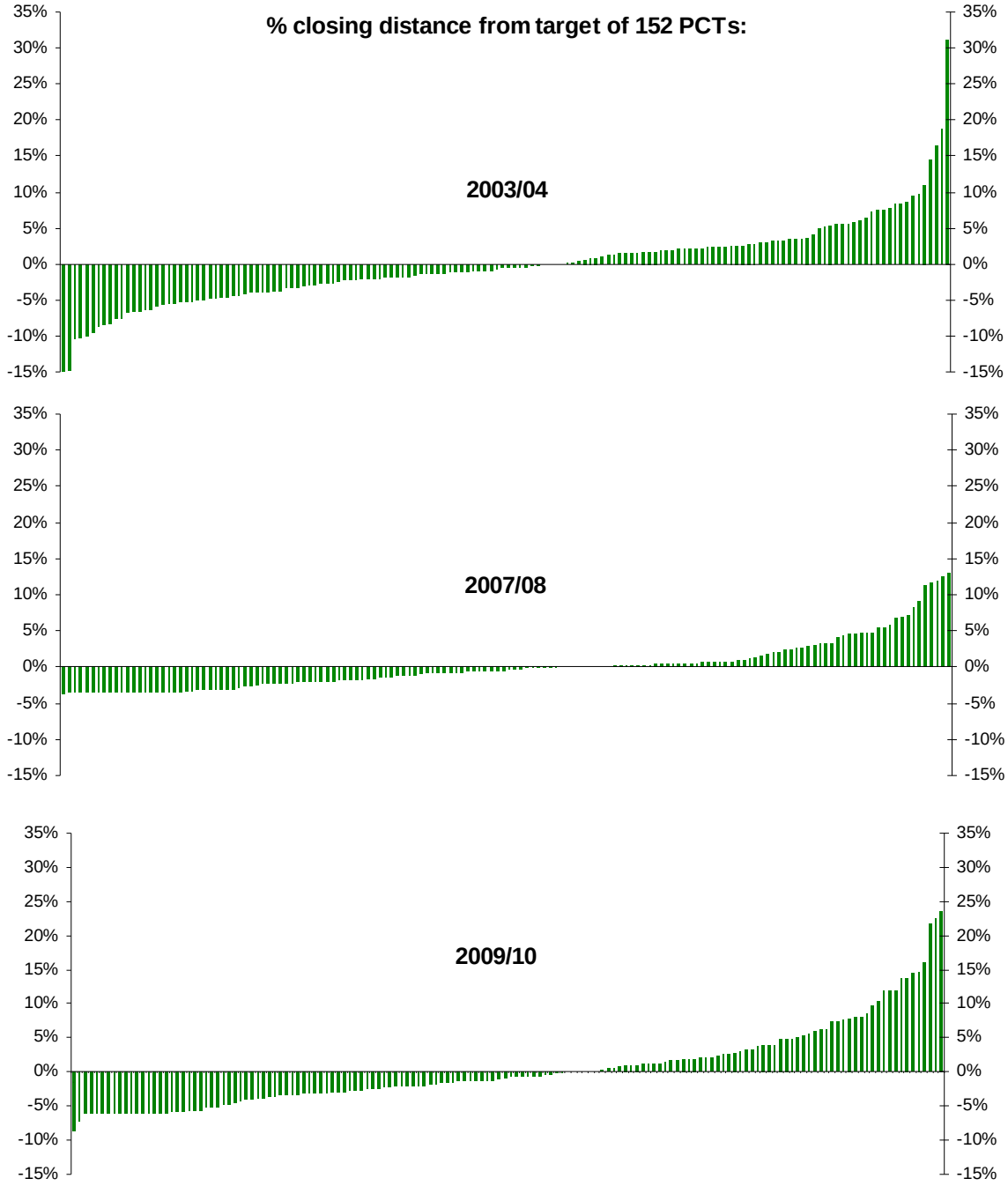
[12] The overall (national) funding allocated to PCTs is announced after each comprehensive spending review

[13] The 'opening distance from target' is the difference between target allocation for the current year (e.g. 2009/10) and actual allocation from the previous year (e.g. 2008/09).

[14] The ACRA review of the weighted capitation formula was not completed in time to inform the 2008/09 allocation, and as such the allocation for that year equated to a flat 5.5% rise for all PCTs.

Chart 5: Proportional distances from targets of PCT allocations in England: 2003/04 to 2009/10

Sources: Health Committee, *Public Expenditure on Health and Personal Social Services 2007: Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Committee*, HC 26-I, 8 November 2008, Table 28 and 2007 Table 58; DH *Exposition Book*



3 Tables

Table 1: Net government expenditure on the UK NHS: 1948/49 to 2007/08

Government expenditure on the NHS: 1948/49-2006/07: UK

	Net expenditure (£million)[1]			Net expenditure (£ million at 07/08 prices)[2]			Annual % increase in real terms			Net expenditure as a proportion of GDP[2]		
	A	B	C	A	B	C	A	B	C	A	B	C
1948/49[3]	276			7,005						2.3%		
1949/50	446			11,058			+57.9%			3.5%		
1950/51	460			11,066			+0.1%			3.4%		
1951/52	475			10,565			-4.5%			3.1%		
1952/53	518			10,803			+2.3%			3.2%		
1953/54	499			10,123			-6.3%			2.9%		
1954/55	525			10,404			+2.8%			2.8%		
1955/56	568			10,907			+4.8%			2.9%		
1956/57	621			11,194			+2.6%			3.0%		
1957/58	661			11,496			+2.7%			3.0%		
1958/59	711			11,886			+3.4%			3.1%		
1959/60	735			12,127			+2.0%			3.0%		
1960/61	824			13,429			+10.7%			3.2%		
1961/62	846			13,369			-0.4%			3.1%		
1962/63	894			13,635			+2.0%			3.1%		
1963/64	969	1,069		14,552	16,057		+6.7%			3.2%	3.5%	
1964/65	1,061	1,163		15,381	16,863		+5.7%	+5.0%		3.2%	3.5%	
1965/66	1,201	1,319		16,488	18,101		+7.2%	+7.3%		3.3%	3.7%	
1966/67	1,318	1,447	1,420	17,324	19,021	19,203	+5.1%	+5.1%		3.5%	3.8%	3.7%
1967/68	1,442	1,588	1,558	18,412	20,278	20,467	+6.3%	+6.6%	+6.6%	3.6%	3.9%	3.9%
1968/69[4]	1,546	1,709	1,676	18,982	20,981	21,168	+3.1%	+3.5%	+3.4%	3.5%	3.9%	3.8%
1969/70		1,797	1,762		20,907	21,089		-0.4%	-0.4%		3.8%	3.7%
1970/71		2,111	2,071		22,841	23,053		+9.3%	+9.3%		4.1%	4.0%
1971/72		2,405	2,362		23,815	24,062		+4.3%	+4.4%		4.2%	4.1%
1972/73		2,746	2,696		25,154	25,406		+5.6%	+5.6%		4.2%	4.2%
1973/74[5]		3,101	3,055		26,396	26,752		+4.9%	+5.3%		4.2%	4.1%
1974/75			4,095			31,215			+16.7%			4.8%
1975/76			5,470			32,815			+5.1%			5.1%
1976/77			6,249			32,517			-0.9%			4.9%
1977/78			6,896			31,562			-2.9%			4.7%
1978/79			7,835			32,128			+1.8%			4.6%
1979/80			9,195			32,909			+2.4%			4.6%
1980/81			11,944			35,761			+8.7%			5.1%
1981/82			13,267			35,664			-0.3%			5.2%
1982/83			14,385			36,003			+0.9%			5.1%
1983/84			15,383			36,496			+1.4%			5.0%
1984/85			16,312			36,999			+1.4%			4.9%
1985/86			17,434			37,361			+1.0%			4.8%
1986/87			18,982			39,332			+5.3%			4.9%
1987/88			20,300			39,928			+1.5%			4.7%
1988/89			22,400			41,455			+3.8%			4.7%
1989/90			24,200			41,730			+0.7%			4.6%
1990/91			27,100			43,378			+3.9%			4.8%
1991/92			30,900			46,459			+7.1%			5.2%
1992/93			34,200			49,558			+6.7%			5.5%
1993/94			36,600			51,553			+4.0%			5.6%
1994/95			39,400			54,633			+6.0%			5.7%
1995/96			41,400			55,903			+2.3%			5.6%
1996/97			42,800			55,772			-0.2%			5.5%
1997/98			44,500			56,414			+1.2%			5.4%
1998/99			46,900			58,167			+3.1%			5.3%
1999/00			49,400			60,008			+3.2%			5.3%
2000/01			54,200			65,067			+8.4%			5.6%
2001/02			59,800			70,296			+8.0%			5.9%
2002/03			66,200			75,482			+7.4%			6.2%
2003/04			74,900			82,863			+9.8%			6.6%
2004/05			82,900			89,467			+8.0%			6.9%
2005/06			89,700			94,703			+5.9%			7.2%
2006/07			94,500			97,218			+2.7%			7.1%
2007/08			102,000			102,000			+4.9%			7.3%

Notes:
[1] Minor inconsistencies in the figures presented in the Annual Abstract mean that figures must be presented as three overlapping series.
[2] GDP and GDP deflator figures before 1955/56 estimated from calendar year figures.
[3] Period 5 July 1948 to 31 March 1949.
[4] From April 1969 some services transferred to personal social services.
[5] Expenditure by local authorities on provision of health centres, health visiting, home nursing, ambulance services, vaccination and immunisation etc. was transferred to central government on 1 April 1974.

Sources:
ONS, *Annual Abstract of Statistics: 2007* , Table 10.22, and earlier editions
ONS database, *series YBHA* , *ABMI* and *YBGB*
HM Treasury *Public Expenditure Statistical Analyses 2009*

Table 2: NHS net expenditure in England: 1974/75 to 2008/09

NHS net expenditure: 1974/75 - 2007/08: England

	Net NHS expenditure			Net NHS expenditure per household	
	Cash prices (£billions)	Current (07/08) prices (£billions)	Real terms change (%)	Cash prices (£)	2007/08 prices (£)
Cash					
1974/75	3.3	25.0	17.3%	204	1,527
1975/76	4.4	26.3	5.4%	268	1,599
1976/77	5.0	26.4	0.4%	304	1,595
1977/78	5.6	25.6	-2.9%	333	1,537
1978/79	6.3	26.1	1.7%	373	1,553
1979/80	7.4	26.5	1.6%	440	1,565
1980/81	9.7	29.2	10.1%	568	1,709
1981/82	10.9	29.8	2.1%	625	1,715
1982/83	11.8	30.3	1.8%	677	1,737
1983/84	12.5	30.6	1.0%	710	1,741
1984/85	13.4	31.2	1.9%	755	1,757
1985/86	14.2	31.2	0.1%	790	1,740
1986/87	15.2	32.4	3.7%	837	1,786
1987/88	16.7	33.6	3.9%	909	1,835
1988/89	18.4	34.8	3.4%	993	1,876
1989/90	19.9	35.0	0.7%	1,058	1,866
1990/91	22.3	36.5	4.2%	1,177	1,925
1991/92	25.4	39.1	7.2%	1,323	2,043
1992/93	28.0	41.9	7.0%	1,450	2,173
1993/94	28.9	42.2	0.7%	1,492	2,176
1994/95	30.6	43.9	4.1%	1,568	2,251
1995/96	32.0	44.6	1.6%	1,630	2,275
1996-97	33.0	44.4	-0.5%	1,673	2,250
1997/98	34.7	45.4	2.4%	1,749	2,293
1998/99	36.6	47.0	3.4%	1,837	2,359
1999/00	39.9	50.2	6.8%	1,989	2,504
Stage 1 Resource Basis					
1999/00	40.2	50.6	-	2,005	2,524
2000/01	43.9	54.6	7.9%	2,172	2,700
2001/02	49.0	59.6	9.2%	2,389	2,904
2002/03	54.0	63.6	6.8%	2,608	3,071
Stage 2 Resource Basis					
2002/03	57.0	65.3	-	2,753	3,152
2003/04[1]	64.2	71.5	7.3%	3,070	3,422
2004/05	69.1	75.4	5.4%	3,278	3,581
2005/06	75.8	80.6	6.9%	3,561	3,787
2006/07	80.6	83.2	3.2%	3,744	3,865
2007/08[2]	88.7	88.7	6.7%	4,079	4,079
2008/09[3]	96.2	93.4	5.3%	4,383	4,255

Notes:
[1] The difference between 2002-03 and 2003-04 is artificially high owing to HMT classification changes. However, the real terms increase is adjusted for this.
[2] Estimated outturn.
[3] Plan.

Sources:
1974/75 - 1984/85: HMT, *The Government's Expenditure Plans*, various years
1985/86 - 1992/93: Department of Health, *Departmental Reports*, various years
1993/94 - 2003/04: Health Committee, *Public Expenditure on Health and Personal Social Services 2006: Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Committee*, HC 1692-I, 26 October 2006,
2004/05 - 2008/09: Department of Health, *Departmental Report 2008*, Table 9.2
GDP deflator: HMT, *GDP deflator*, at 23 December 2008