



NHS funding and expenditure

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Author: Rachael Harker, Social and General Statistics

Expenditure on the NHS has risen rapidly and consistently since it was established on 5th July 1948. In the first full year of its operation, the Government spent £11.4bn on health in the UK. In 2008/09, the figure was nearly ten times that amount: £110bn. Growth in health expenditure has far outpaced the rise in both GDP and total public expenditure: each increased by a factor of around 4.8 over this period.

Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations. Per head, Northern Ireland spends the most on health services (£2,213 per head in 2009/10) and England spends the least (£1,875 per head).

The focus of this note is on the structure, funding process and expenditure of the NHS in England. The structure and expenditure of the UK NHS is described briefly in Section 1. Expenditure in England is dealt with in Section 2.

Currently, around 80% of NHS funding in England is allocated to 152 Primary Care Trusts, according to a population and needs-based formula. From this money, PCTs are free to commission health services to meet local needs. Though most commissioning still takes place within the NHS, PCTs are increasingly purchasing services from the independent and voluntary sectors, and from local authorities. Information about the determination of PCTs' allocations and local variation in funding levels can be found in the Library Standard Note [Primary Care Trusts: funding and expenditure](#).

The structural reorganisation proposed in the Department of Health White Paper [Equity and Excellence](#) means that the funding system looks set to change. PCTs are to be abolished, with responsibility for local commissioning, and hence the bulk of the NHS budget, passed to groups of GPs. Section 3 gives more detail about the *current* structure of the NHS in England and the relationship between the different organisations within it.

The largest categories of NHS expenditure are mental health services, circulation problems and cancer treatment, which together account for almost a third total expenditure. Section 2.2 gives a detailed breakdown of expenditure by category.

For detailed figures showing health expenditure year-by-year in the UK and England, refer to the tables at the end of this note. Headline expenditure figures are updated on a quarterly basis in the Social Indicators page [Health expenditure](#). Some details of expenditure in each of the devolved assemblies can be found in Table 3 at the end of this note.;

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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.

Each country has chosen to structure its National Health Service differently. The structure of the NHS in England is described in detail in Section 3. A common theme of NHS funding across the countries is the allocation of a significant proportion of the NHS budget to local organisations (Primary Care Trusts or Health Boards), which are responsible for meeting local need. Another common strand is for allocations to these organisations to be informed (but not entirely determined) by a needs-based funding formula, on the principle that it is desirable to achieve equal access to healthcare for people at equal risk across the country

The key difference between the countries lies in the role of the internal market. England and Northern Ireland have a 'purchaser/provider split', whereby one part of the health service (the purchaser) is responsible for contracting with the NHS and independent-sector organisations (the providers) to supply services for patients. Scotland and Wales have moved away from these market-orientated models since devolution: they dismantled the purchaser-provider split in 2004 and 2009 respectively. Local health boards in these countries are now responsible for both funding *and* provision of NHS services.

1.2 Sources of funding

The vast majority of NHS funding ultimately derives from central (UK) taxation. Within the block grant allocated to each devolved administration (via the Barnett formula), each country is free to decide how much to spend on the NHS.

The NHS can also raise income from patient charges, sometimes known as 'co-payments'. Devolved administrations have control over the level at which these are set.

Prescription charging

In England, eligible patients pay a prescription charge of £7.20 per item (or alternatively 'subscription'-type charges). Wales, Scotland and Northern Ireland have abolished prescription charging. In 2009/10, England raised £470m through the prescription charge (0.5% of the NHS resource budget)¹

¹ NHS Business Services Authority

Dental Charging

All the devolved administrations charge for NHS dental treatment (although exemptions differ). In England, patients pay between £16.50 and £198 depending on the complexity of work performed.² In Wales, the range is £12 to £177.³ In Northern Ireland, patients pay 80% of the cost of treatment, up to £384; Scotland operates a similar system.⁴ Income raised through dental charges amounted to £597.6m in England in 2009/10⁵; in Wales, the figure was £26.9m⁶.

Other sources of income

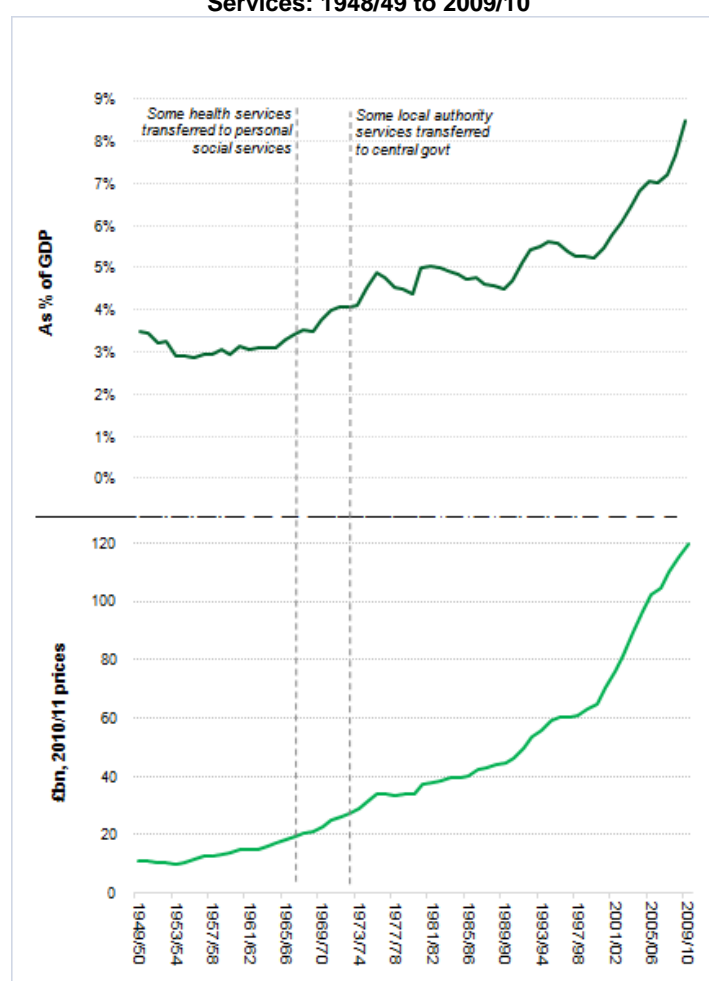
Other, less significant sources of income are earned, for example, through charging overseas visitors and their insurers for the cost of NHS treatment. Hospitals can also raise revenue through car parking charges, patient telephone services etc. In addition, NHS Trusts can earn income through treating patients privately: in England, NHS Trusts generate 0.8%

of core revenues from private patients, whereas the proportion remains much lower in the rest of the UK (0.2% in Wales, and 0.1% in Scotland and Northern Ireland).

1.1 Total expenditure

Chart 1 (also see Table 1) shows expenditure by central government on health⁸ in the UK, net of receipts from patients, as a percentage of GDP (top line) and in 2008/09 prices (bottom line). Figures are presented from 1949 onwards, although some changes in the responsibilities of the NHS mean that the series is not fully consistent over the period. In 1949/50 – the first full year of the NHS – spending amounted to £10.7 billion in 2010/11 prices, or 3.5% of GDP. By 2009/10, spending had increased more than tenfold in real terms to reach £122bn, or 8.5% of GDP. Although it has risen consistently over the period, spending has accelerated in recent years. Between 1999/00 and 2009/10, real-terms expenditure rose by 88%.

Chart 1 General government expenditure on UK Health Services: 1948/49 to 2009/10



² UK Statutory Instrument 2009/407 *The National Health Service (Dental Charges) Amendment Regulations 2009*

³ Wales Statutory Instrument 2006/491 *The National Health Service (Dental Charges) (Wales) Amendment Regulations 2006*

⁴ Northern Ireland Statutory Rule 2005/72 and Scotland Statutory Instrument 2005/121/

⁵ NHS Information Centre *NHS Dental Services for England 2009/10*

⁶ Welsh Assembly Government *NHS Dental Services 2009/10*

⁷ The vast majority of government health expenditure goes toward the NHS (around 97% in England); also included are local authority spending on health, Department for Business Innovation and Skills grants to the Medical Research Council and National Lottery Spending on Health. This definition allows aggregate spending figures for the UK to be presented.

Chart 2 shows the annual percentage changes in real terms central government expenditure on the UK NHS from 1950/51 onwards. The data is also shown in Table 1 at the end of this note.

A negative change has occurred on just six 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 annual expenditure increase since 1950/51 is 4.9%. However, between 2000/01 and 2009/10 average annual spending growth has been 6.5% which is higher than at any other time in the history of the NHS.

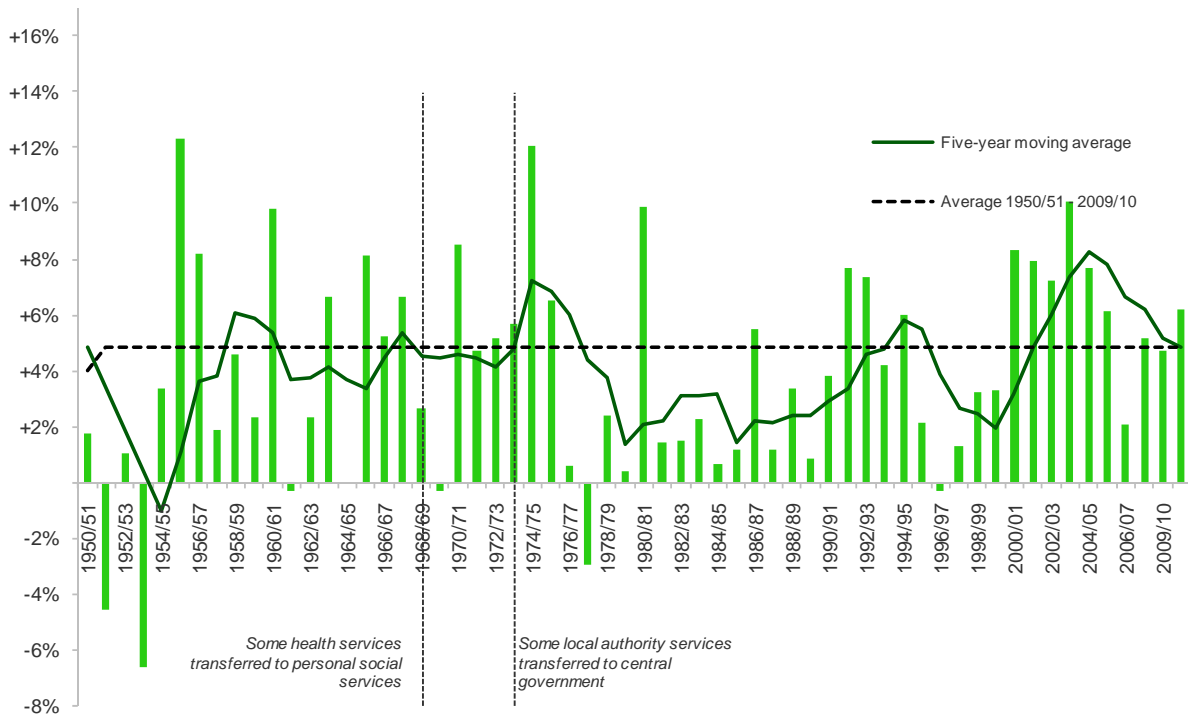


Chart 2: Annual change in real terms general government expenditure on the UK NHS: 1950/51 to 2009/10

2 NHS England - expenditure

2.1 Total expenditure

Table 2 at the end of this note shows NHS public spending and planned expenditure in England from 1974/75 to 2014/15, net of patient charges and receipts. Earlier data is not available on a consistent basis.

Although real-terms expenditure has risen from £23.7 billion in 1974/75 to £102.0 billion in 2010/11, changes in accounting procedures preclude consistent comparisons of spending over long periods. However, year-on-year real-term increases can be quoted on a consistent basis:

Chart 3 shows the annual real-term increases along with a moving five-year average. The largest five-year moving average (+7.6%) occurred over the period 1999/2000 to 2003/04. Based on inflation figures published in the March 2011 Budget, the lowest five-year moving average is set to occur over the 2010/11 to 2014/15 period, as the effects of the expenditure limits announced in the 2010 Spending Review set in.

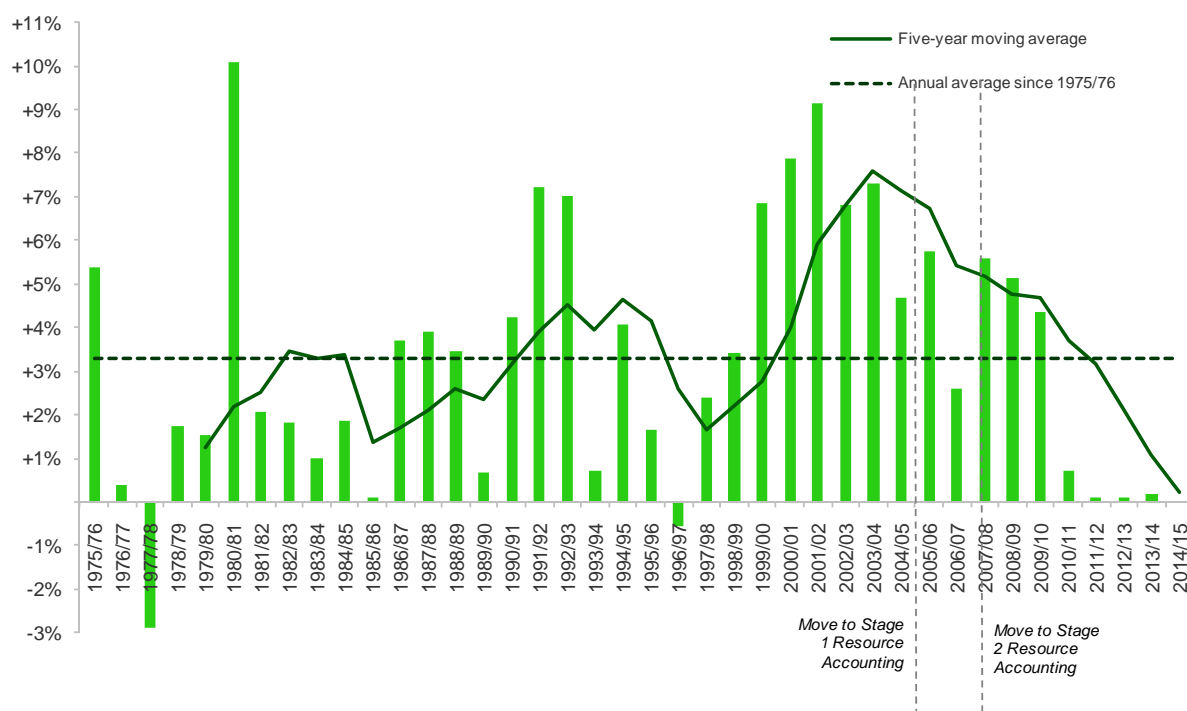


Chart 3: Annual percentage change in real terms NHS expenditure and planned expenditure in England:

1974/75 to 2014/15

2.2 Expenditure by category

Since 2003/04, the Department of Health has collected expenditure data categorised by the medical condition or area of health to which it is directed. This allows spending on e.g. cancer, circulatory problems etc. to be identified. Chart 4, below, shows spending per head across England in 2003/04, 2006/07 and 2008/09 broken down by programme budget categories.

The largest spending category across this period has been mental health problems. In 2008/09, NHS expenditure on mental health was £200 per head, up from £148 in 2003/04. Circulatory problems are another major spending category, though the increase in spending has been less dramatic; £144 per head in 2008/09 as compared with £114 2003/04.

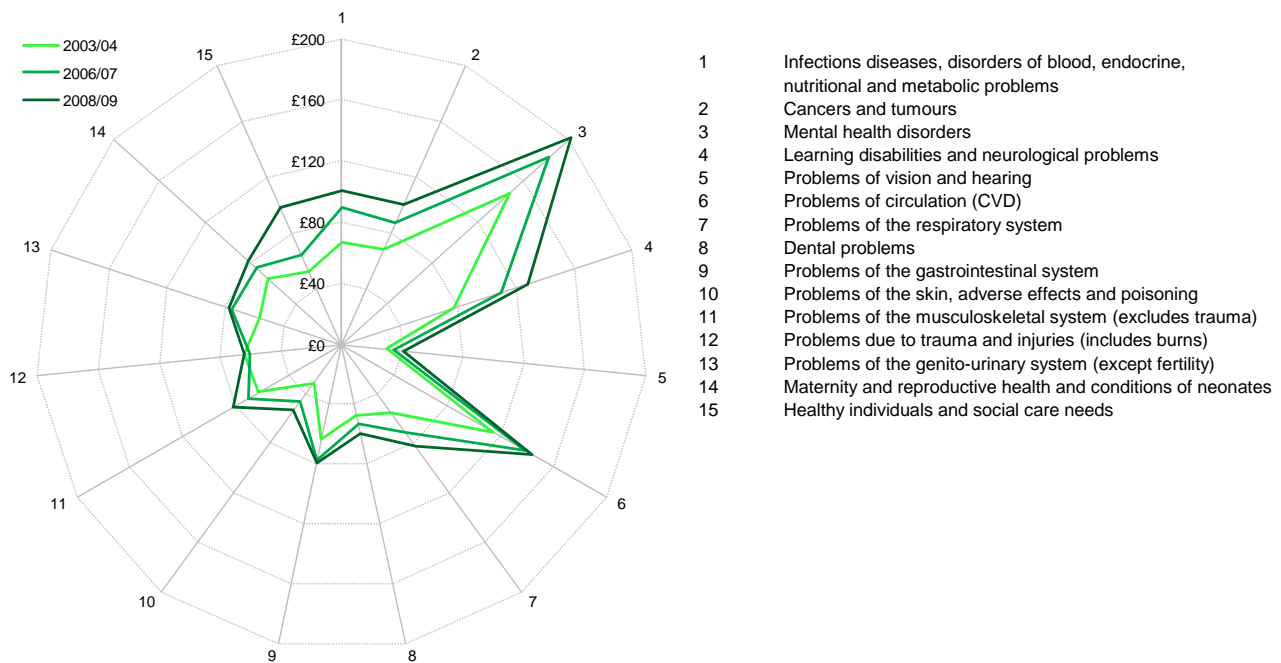


Chart 4: Expenditure by programme budget category, selected groupings, £s per head, 2003/04 to 2008/09

Source: HC Health Committee *Public Expenditure on Health and Personal Social Services 2009*; DH Programme Budgeting Data

Notes: *i) Expenditure classified to the category 'other' is not included in the chart. This category comprises around 20% of total programme budget expenditure*

ii) Growth in social care expenditure is partly affected by a change in calculation methodology, which arose following the move to Area Based Grant funding to Local Authorities in 2008/09.

2.3 Capital spending

Public capital spending

Changes to Government accounting procedures preclude comparison of NHS capital spending over long periods. The table on the right shows NHS public capital funding since 1997/98, in cash terms and 2008/09 prices.

NHS - public capital funding 1997/98 to 2008/09, £m

| | cash | 2008/09 prices |
|-----------|-------|----------------|
| 1997/98 | 1,560 | 2,030 |
| 1998/99 | 1,308 | 1,667 |
| 1999/2000 | 1,515 | 1,894 |
| 2000/01 | 1,870 | 2,307 |
| 2001/02 | 2,106 | 2,541 |
| 2002/03 | 2,411 | 2,818 |
| 2003/04 | 1,891 | 2,150 |
| 2004/05 | 3,206 | 3,546 |
| 2005/06 | 3,102 | 3,369 |
| 2006/07 | 4,236 | 4,468 |
| 2007/08 | 4,104 | 4,207 |
| 2008/09 | 4,585 | 4,585 |

Source: HC Health Committee *Public Expenditure on Health and Personal Social Services 2009*

Private Finance Initiative (PFI)

Since 1997, much capital spending has taken place 'off balance sheet' through the Private Finance Initiative (PFI)⁸. The NHS has been the single largest user of PFI, in terms of repayment commitments undertaken. Under PFI, private sector consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by the NHS Trust. Payments are made by Trusts over the lifetime of the scheme, rather like a mortgage.

There are currently 103 signed NHS PFI schemes in England (see Chart 5), with a projected total cost over their lifetimes of £65.1bn. Annual payments in 2009/10 were £1.1bn.

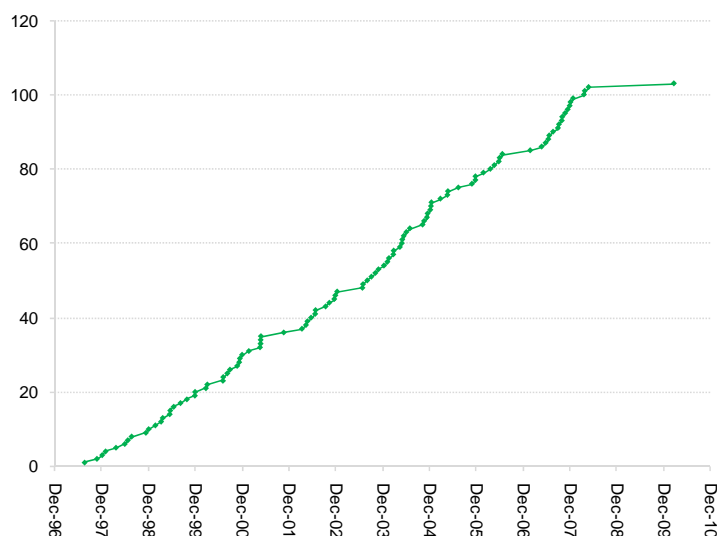


Chart 5: Number of signed NHS PFI schemes

Source: Deposited Paper DEP2010-1307

⁸ In devising PFI schemes, the requirement to achieve off-balance sheet treatment was specifically asserted by DH guidance produced in 1999 (see, for instance, [here](#)). Reference to this requirement has been removed from 2005.

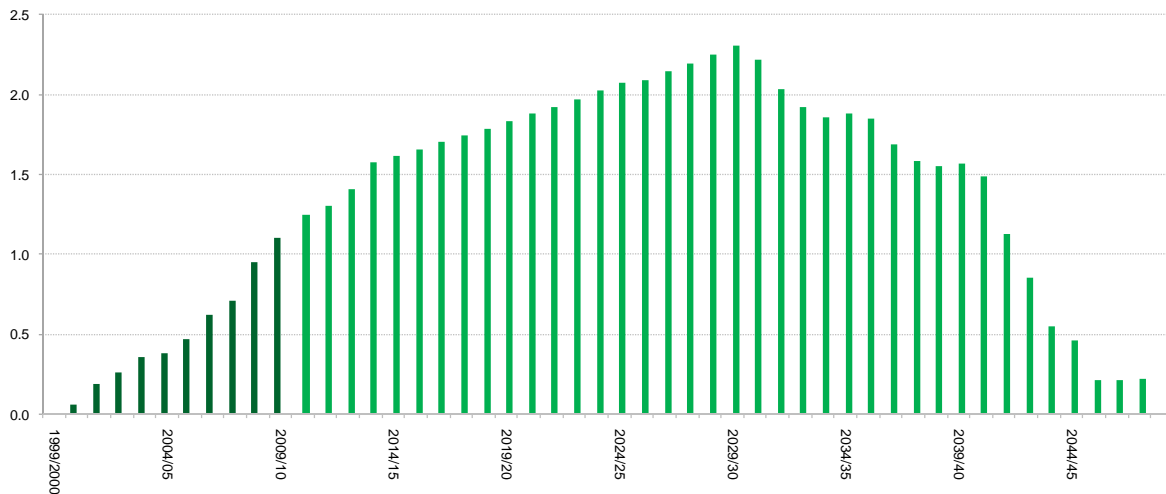


Chart 6: Annual payment schedule for all NHS PFI schemes signed before 15th June 2010 over contracts' lifetimes

Source: Deposited Paper DEP2010-1307

3 NHS England – funding process and structure

3.1 Funding process

The NHS England revenue and capital budgets are announced in the Department of Health's expenditure plans, published as part of each Spending Review.

Around 80% of NHS funding (£84bn in 2010/11) is allocated to the 152 Primary Care Trusts (PCTs), which are responsible for commissioning (i.e. purchasing) health services to meet local need. The money PCTs receive is non-ringfenced, though some constraints exist, such as the requirement to fund drugs that the National Institute for Health and Clinical Excellence (NICE) has endorsed, and the achievement of centrally determined policy objectives such as the reduction of health inequalities. Allocations to PCTs are usually announced in the NHS Operating Framework to cover the Spending Review period. They are informed, but not entirely determined by, a needs-based formula which aims to provide equal levels of access to health services for people at equal risk, and reduce avoidable health inequalities. The determination PCT allocations is described in more detail in the Library Standard Note <<>>.

Funds flow from PCTs to NHS hospitals and other providers either via contracts, or through a system known as Payment by Results, which uses a "tariff" based on national average costs for each type of treatment. More details on the commissioning role of PCTs can be found in the Library Standard Note [NHS Commissioning](#).

The remaining 20% of the NHS budget comprises capital spending, and funds distributed to deliver regional and national programmes and services. For instance, Strategic Health Authorities receive around £6bn for local management of national programmes (e.g. the

National Screening Programme) and for delivery of education and training for the NHS workforce. Separately, funding is also provided to some Special Health Authorities providing national-level services (e.g. the NHS Blood and Transplant authority; the NHS Litigation Authority).

Capital resources are allocated to PCTs and directly to NHS Trusts each year based on financial plan returns. Other budgets, such as those for Strategic Health Authorities, Arm's Length Bodies etc. are centrally determined each year by the Department of Health.

Figure 2 shows the disposition of NHS resources in 2008/09.

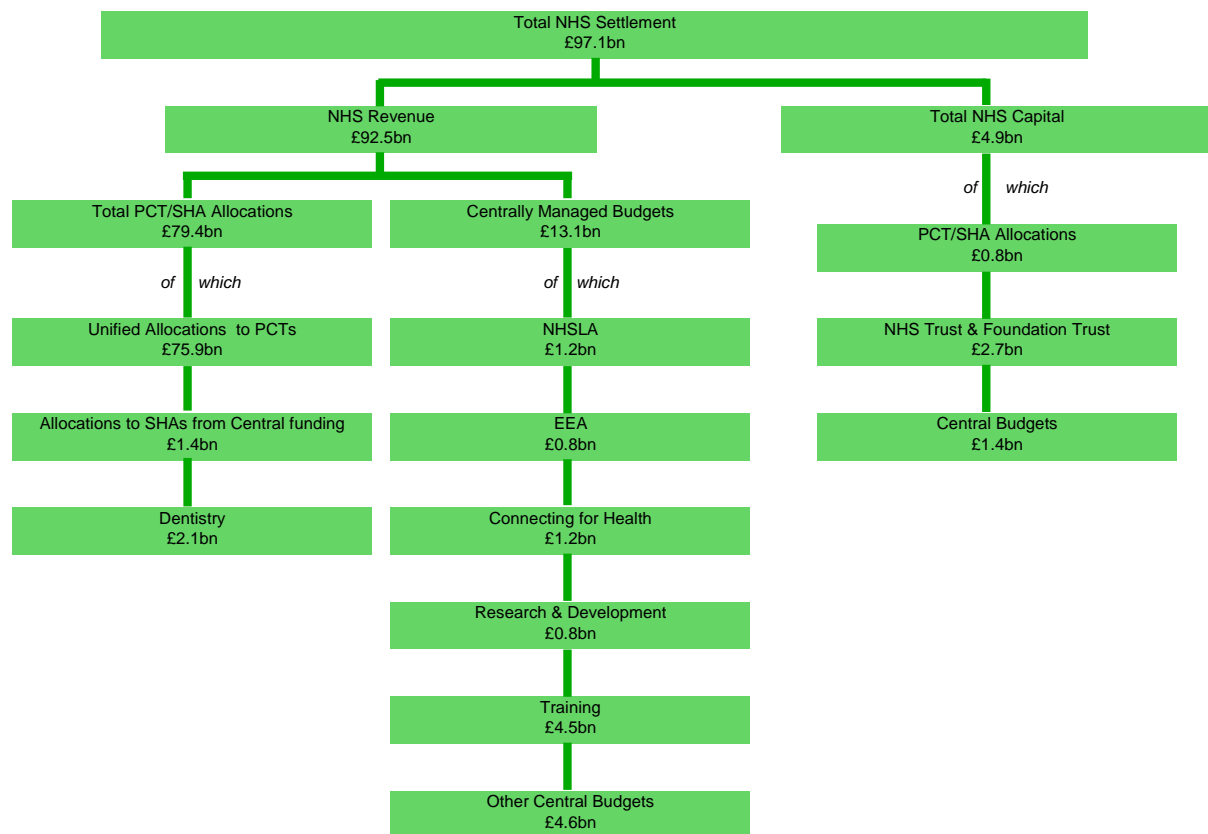


Figure 2: Disposition of NHS resources 2008-09

Source: Department of Health, *Departmental Report 2009*, Figure 9.5

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908

3.2 Structure

The current structure of the NHS in England is illustrated in the diagram below.

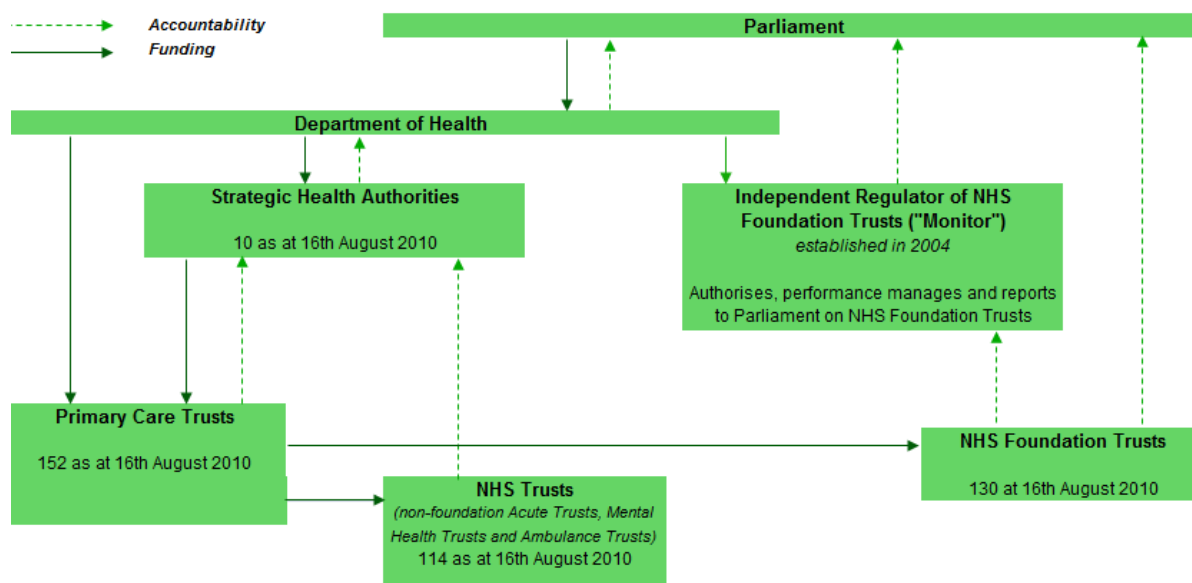


Figure 1: Structure of the NHS in England

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_1.pdf

3.3 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 health services in their area and to make sure local NHS organisations were performing well.⁹ 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 numbers of different trust types are shown in Chart 5. Their roles are described below¹⁰:

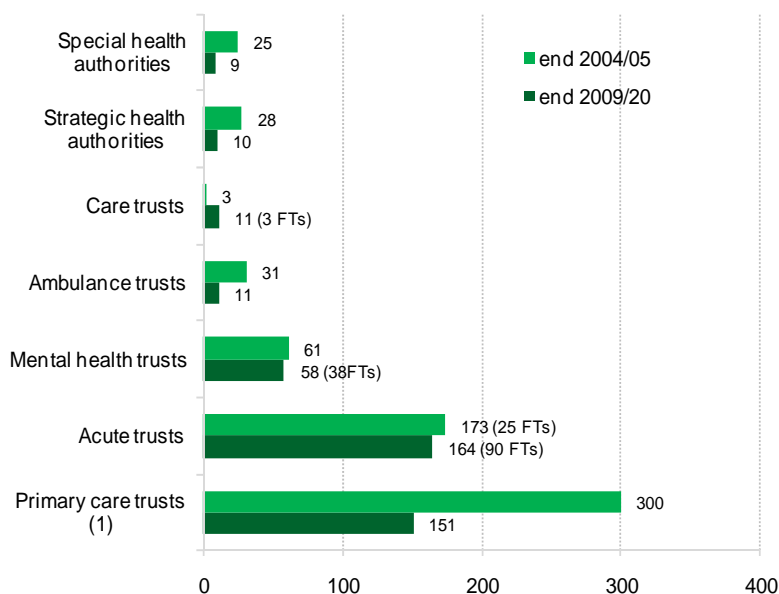


Chart 5: number of NHS organisations in 2004-5 and 2009/10 (figures in brackets show number of trusts with Foundation status)
Note (1): figures exclude care trusts with commissioning responsibility (3 in 2004/05 and 1 in 2009/10)

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

¹⁰ A complete and up-to-date list of NHS Trusts and authorities can be found on the NHS website [\[http://www.nhs.uk/ServiceDirectories/Pages/AcuteTrustListing.aspx\]](http://www.nhs.uk/ServiceDirectories/Pages/AcuteTrustListing.aspx)

Primary care trusts

PCTs are responsible for commissioning (i.e. purchasing) health services from NHS providers and other organisations in order to meet local health need. This includes primary care services provided by GPs, opticians, dentists, pharmacists, health workers etc. It also includes secondary care services such as hospital and mental health services. The system used to pay for much hospital care is called Payment by Results (PbR), which uses a “tariff” based on national average costs for each type of treatment. A full description of the commissioning role of PCTs can be found in the Library standard note [NHS Commissioning](#).

Foundation trusts

Foundation trusts are a type of NHS trust run by local managers, staff and members of the public. They are not a separate type of trust; Foundation ‘status’ is simply something that certain types of NHS trust can acquire¹¹. Foundation Trusts are given much more financial and operational freedom than other NHS trusts. They remain within the NHS: their clinical performance is assessed by the Care Quality Commission and their financial affairs are regulated by Monitor. They were first introduced in April 2004 and initially comprised only acute (hospital) trusts. Starting in 2006 a number of mental health trusts and care trusts have been granted Foundation status, and some ambulance trusts are also expected to become Foundation trusts before the end of 2010. At the time of the last update to this note, there were 130 foundation trusts in England. The number of each type of Foundation Trust is shown in Chart 5, above. The Department of Health White Paper *Equity and Excellence* set out the coalition Government’s plans for all NHS Trusts to have Foundation status by 2013/14.

Acute trusts

Hospitals are managed by acute trusts. They are responsible for the quality of care and the efficient use of resources within hospitals, and also for controlling their strategic direction.

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. Other non-medical staff are employed by acute trusts, including receptionists, porters, cleaners, IT specialists, 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.

Ambulance trusts

There are currently 11 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.

¹¹ Acute trusts, Care Trusts, Mental Health Trusts and Ambulance Trusts can acquire Foundation status.

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. There are currently 11 care trusts in England.

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.

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. There are currently 9 special health authorities.

4 Tables

Table 1: Net government expenditure on the UK NHS: 1948/49 to 2009/10

| | Net expenditure (£million) ¹ | | | Net expenditure (£ million at 2010/11 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 | | | 6,843 | | | | | | 2.3% | | |
| 1949/50 | 446 | | | 10,761 | | | +57.3% | | | 3.5% | | |
| 1950/51 | 460 | | | 10,952 | | | +1.8% | | | 3.5% | | |
| 1951/52 | 475 | | | 10,453 | | | -4.6% | | | 3.2% | | |
| 1952/53 | 518 | | | 10,560 | | | +1.0% | | | 3.2% | | |
| 1953/54 | 499 | | | 9,859 | | | -6.6% | | | 2.9% | | |
| 1954/55 | 525 | | | 10,189 | | | +3.3% | | | 2.9% | | |
| 1955/56 | 568 | | | 11,441 | | | +12.3% | | | 2.9% | | |
| 1956/57 | 621 | | | 12,377 | | | +8.2% | | | 2.9% | | |
| 1957/58 | 661 | | | 12,613 | | | +1.9% | | | 2.9% | | |
| 1958/59 | 711 | | | 13,187 | | | +4.6% | | | 3.1% | | |
| 1959/60 | 735 | | | 13,494 | | | +2.3% | | | 3.0% | | |
| 1960/61 | 824 | | | 14,820 | | | +9.8% | | | 3.1% | | |
| 1961/62 | 846 | | | 14,776 | | | -0.3% | | | 3.1% | | |
| 1962/63 | 894 | | | 15,115 | | | +2.3% | | | 3.1% | | |
| 1963/64 | 969 | 1,069 | | 16,120 | | | +6.6% | | | 3.1% | 3.4% | |
| 1964/65 | 1,061 | 1,163 | | 16,843 | 18,466 | | +4.5% | | | 3.1% | 3.4% | |
| 1965/66 | 1,201 | 1,319 | | 18,184 | 19,964 | | +8.0% | +8.1% | | 3.3% | 3.6% | |
| 1966/67 | 1,318 | 1,447 | 1,420 | 19,133 | 21,008 | 20,616 | +5.2% | +5.2% | | 3.4% | 3.7% | 3.7% |
| 1967/68 | 1,442 | 1,588 | 1,558 | 20,349 | 22,410 | 21,987 | +6.4% | +6.7% | +6.7% | 3.5% | 3.9% | 3.8% |
| 1968/69 ⁴ | 1,546 | 1,709 | 1,676 | 20,821 | 23,014 | 22,569 | +2.3% | +2.7% | +2.6% | 3.5% | 3.8% | 3.8% |
| 1969/70 | | 1,797 | 1,762 | | 22,950 | 22,503 | | -0.3% | -0.3% | | 3.8% | 3.7% |
| 1970/71 | | 2,111 | 2,071 | | 24,894 | 24,422 | | +8.5% | +8.5% | | 4.0% | 3.9% |
| 1971/72 | | 2,405 | 2,362 | | 26,039 | 25,574 | | +4.6% | +4.7% | | 4.1% | 4.0% |
| 1972/73 | | 2,746 | 2,696 | | 27,397 | 26,898 | | +5.2% | +5.2% | | 4.1% | 4.0% |
| 1973/74 ⁵ | | 3,101 | 3,055 | | 28,855 | 28,427 | | +5.3% | +5.7% | | 4.1% | 4.1% |
| 1974/75 | | | 4,095 | | | 31,853 | | | +12.1% | | | 4.5% |
| 1975/76 | | | 5,470 | | | 33,927 | | | +6.5% | | | 4.9% |
| 1976/77 | | | 6,249 | | | 34,125 | | | +0.6% | | | 4.8% |
| 1977/78 | | | 6,896 | | | 33,124 | | | -2.9% | | | 4.5% |
| 1978/79 | | | 7,835 | | | 33,907 | | | +2.4% | | | 4.5% |
| 1979/80 | | | 9,195 | | | 34,039 | | | +0.4% | | | 4.4% |
| 1980/81 | | | 11,944 | | | 37,395 | | | +9.9% | | | 5.0% |
| 1981/82 | | | 13,267 | | | 37,938 | | | +1.5% | | | 5.1% |
| 1982/83 | | | 14,385 | | | 38,502 | | | +1.5% | | | 5.0% |
| 1983/84 | | | 15,383 | | | 39,364 | | | +2.2% | | | 4.9% |
| 1984/85 | | | 16,312 | | | 39,632 | | | +0.7% | | | 4.8% |
| 1985/86 | | | 17,434 | | | 40,106 | | | +1.2% | | | 4.7% |
| 1986/87 | | | 18,982 | | | 42,310 | | | +5.5% | | | 4.8% |
| 1987/88 | | | 20,300 | | | 42,797 | | | +1.2% | | | 4.6% |
| 1988/89 | | | 22,400 | | | 44,223 | | | +3.3% | | | 4.6% |
| 1989/90 | | | 24,200 | | | 44,600 | | | +0.9% | | | 4.5% |
| 1990/91 | | | 27,100 | | | 46,296 | | | +3.8% | | | 4.7% |
| 1991/92 | | | 30,900 | | | 49,836 | | | +7.6% | | | 5.1% |
| 1992/93 | | | 34,200 | | | 53,508 | | | +7.4% | | | 5.4% |
| 1993/94 | | | 36,600 | | | 55,737 | | | +4.2% | | | 5.5% |
| 1994/95 | | | 39,400 | | | 59,078 | | | +6.0% | | | 5.6% |
| 1995/96 | | | 41,400 | | | 60,346 | | | +2.1% | | | 5.6% |
| 1996/97 | | | 42,800 | | | 60,143 | | | -0.3% | | | 5.4% |
| 1997/98 | | | 44,500 | | | 60,939 | | | +1.3% | | | 5.3% |
| 1998/99 | | | 46,900 | | | 62,898 | | | +3.2% | | | 5.3% |
| 1999/00 | | | 49,400 | | | 64,973 | | | +3.3% | | | 5.2% |
| 2000/01 | | | 54,200 | | | 70,362 | | | +8.3% | | | 5.5% |
| 2001/02 | | | 59,800 | | | 75,934 | | | +7.9% | | | 5.8% |
| 2002/03 | | | 66,200 | | | 81,438 | | | +7.2% | | | 6.1% |
| 2003/04 | | | 74,900 | | | 89,612 | | | +10.0% | | | 6.5% |
| 2004/05 | | | 82,900 | | | 96,500 | | | +7.7% | | | 6.8% |
| 2005/06 | | | 89,600 | | | 102,441 | | | +6.2% | | | 7.0% |
| 2006/07 | | | 94,500 | | | 104,534 | | | +2.0% | | | 7.0% |
| 2007/08 | | | 102,200 | | | 109,903 | | | +5.1% | | | 7.2% |
| 2008/09 | | | 110,000 | | | 115,106 | | | +4.7% | | | 7.7% |
| 2009/10 | | | 118,700 | | | 122,220 | | | +6.2% | | | 8.5% |

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 1951/52 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 2011*

HMT, *GDP deflator consistent with March 2011 budget*

Table 2: NHS net expenditure in England: 1974/75 to 2014/15

| | Net NHS expenditure | | | Net NHS expenditure per household | |
|-------------------------------|----------------------------|-------------------------------|--------------------------|-----------------------------------|-----------------------|
| | Cash prices (£billions) | 2010/11 prices (£billions) | Real terms change (%) | Cash prices (£) | 2010/11 prices (£) |
| 1974/75 | 3.3 | 26.0 | 14.6% | 204 | 1,588 |
| 1975/76 | 4.4 | 27.4 | 5.4% | 268 | 1,663 |
| 1976/77 | 5.0 | 27.5 | 0.4% | 304 | 1,659 |
| 1977/78 | 5.6 | 26.7 | -2.9% | 333 | 1,600 |
| 1978/79 | 6.3 | 27.1 | 1.7% | 373 | 1,616 |
| 1979/80 | 7.4 | 27.6 | 1.5% | 440 | 1,628 |
| 1980/81 | 9.7 | 30.4 | 10.2% | 568 | 1,779 |
| 1981/82 | 10.9 | 31.0 | 2.2% | 625 | 1,788 |
| 1982/83 | 11.8 | 31.6 | 1.9% | 677 | 1,813 |
| 1983/84 | 12.5 | 32.0 | 1.1% | 710 | 1,818 |
| 1984/85 | 13.4 | 32.6 | 1.9% | 755 | 1,834 |
| 1985/86 | 14.2 | 32.6 | 0.1% | 790 | 1,818 |
| 1986/87 | 15.2 | 33.8 | 3.7% | 837 | 1,865 |
| 1987/88 | 16.7 | 35.1 | 3.9% | 909 | 1,917 |
| 1988/89 | 18.4 | 36.4 | 3.4% | 993 | 1,960 |
| 1989/90 | 19.9 | 36.6 | 0.7% | 1,058 | 1,949 |
| 1990/91 | 22.3 | 38.1 | 4.2% | 1,177 | 2,011 |
| 1991/92 | 25.4 | 40.9 | 7.2% | 1,323 | 2,133 |
| 1992/93 | 28.0 | 43.8 | 7.0% | 1,450 | 2,269 |
| 1993/94 | 28.9 | 44.1 | 0.7% | 1,492 | 2,272 |
| 1994/95 | 30.6 | 45.9 | 4.1% | 1,568 | 2,352 |
| 1995/96 | 32.0 | 46.6 | 1.6% | 1,630 | 2,377 |
| 1996-97 | 33.0 | 46.4 | -0.5% | 1,673 | 2,350 |
| 1997/98 | 34.7 | 47.5 | 2.4% | 1,749 | 2,396 |
| 1998/99 | 36.6 | 49.1 | 3.4% | 1,837 | 2,464 |
| 1999/00 | 39.9 | 52.5 | 6.8% | 1,989 | 2,616 |
| Stage 1 Resource Basis | | | | | |
| 1999/00 | 40.2 | 52.9 | - | 2,005 | 2,637 |
| 2000/01 | 43.9 | 57.0 | 7.9% | 2,172 | 2,820 |
| 2001/02 | 49.0 | 62.2 | 9.1% | 2,389 | 3,033 |
| 2002/03 | 54.0 | 66.5 | 6.8% | 2,608 | 3,209 |
| Stage 2 Resource Basis | | | | | |
| 2002/03 | 57.0 | 70.2 | - | 2,753 | 3,387 |
| 2003/04 ¹ | 64.2 | 76.8 | 7.3% | 3,070 | 3,673 |
| 2004/05 | 69.1 | 80.4 | 4.7% | 3,278 | 3,816 |
| 2005/06 | 74.4 | 85.0 | 5.8% | 3,494 | 3,995 |
| 2006/07 | 78.9 | 87.3 | 2.6% | 3,667 | 4,056 |
| 2007/08 | 85.8 | 92.3 | 5.7% | 3,945 | 4,242 |
| 2008/09 | 92.4 | 96.7 | 4.8% | 4,209 | 4,405 |
| 2009/10 | 99.8 | 102.8 | 6.3% | 4,511 | 4,511 |
| 2010/11 | 102.0 | 102.0 | -0.7% | 4,618 | 4,488 |
| 2011/12 ² | 105.9 | 102.9 | 0.9% | 4,656 | 4,440 |
| 2012/13 ² | 108.4 | 102.8 | -0.1% | 4,710 | 4,391 |
| 2013/14 ² | 111.4 | 102.8 | 0.1% | 4,784 | 4,347 |
| 2014/15 ² | 114.4 | 102.8 | 0.0% | 4,856 | 4,297 |

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 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 - 2010/11: HM Treasury *Public Expenditure Statistical Analyses 2011*, Table 1.8
2011/12 - 2014/15: HM Treasury *Spending Review 2010*
HMT, *GDP deflator consistent with March 2011 budget*

Table 3: NHS net expenditure, £m and per head, UK countries, 2005/06 to 2009/10

| Year | Total expenditure, £m | | | | Expenditure per head, £ | | | |
|---------|-----------------------|-------|----------|------------|-------------------------|-------|----------|------------|
| | England | Wales | Scotland | N. Ireland | England | Wales | Scotland | N. Ireland |
| 2005/06 | 73,203 | 4,649 | 8,562 | 2,630 | 1,451 | 1,574 | 1,681 | 1,525 |
| 2006/07 | 76,831 | 4,984 | 9,035 | 2,858 | 1,514 | 1,680 | 1,766 | 1,641 |
| 2007/08 | 83,223 | 5,255 | 9,727 | 2,955 | 1,629 | 1,763 | 1,893 | 1,678 |
| 2008/09 | 89,927 | 5,545 | 10,179 | 3,299 | 1,748 | 1,853 | 1,969 | 1,859 |
| 2009/10 | 97,130 | 5,922 | 10,616 | 3,959 | 1,875 | 1,975 | 2,044 | 2,213 |

Source: *Public Expenditure Statistical Analyses 2011*

Note: figures for England may not be consistent with those in Table 2 because they are calculated on a different basis (HMT Total Expenditure on Services aggregate, rather than Resource Accounting basis)