Modern Monetary Theory as Applied to NHS Budgeting

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LITERATURE REVIEW

Modern monetary theory for the post-pandemic NHS: why budget deficits do not matter

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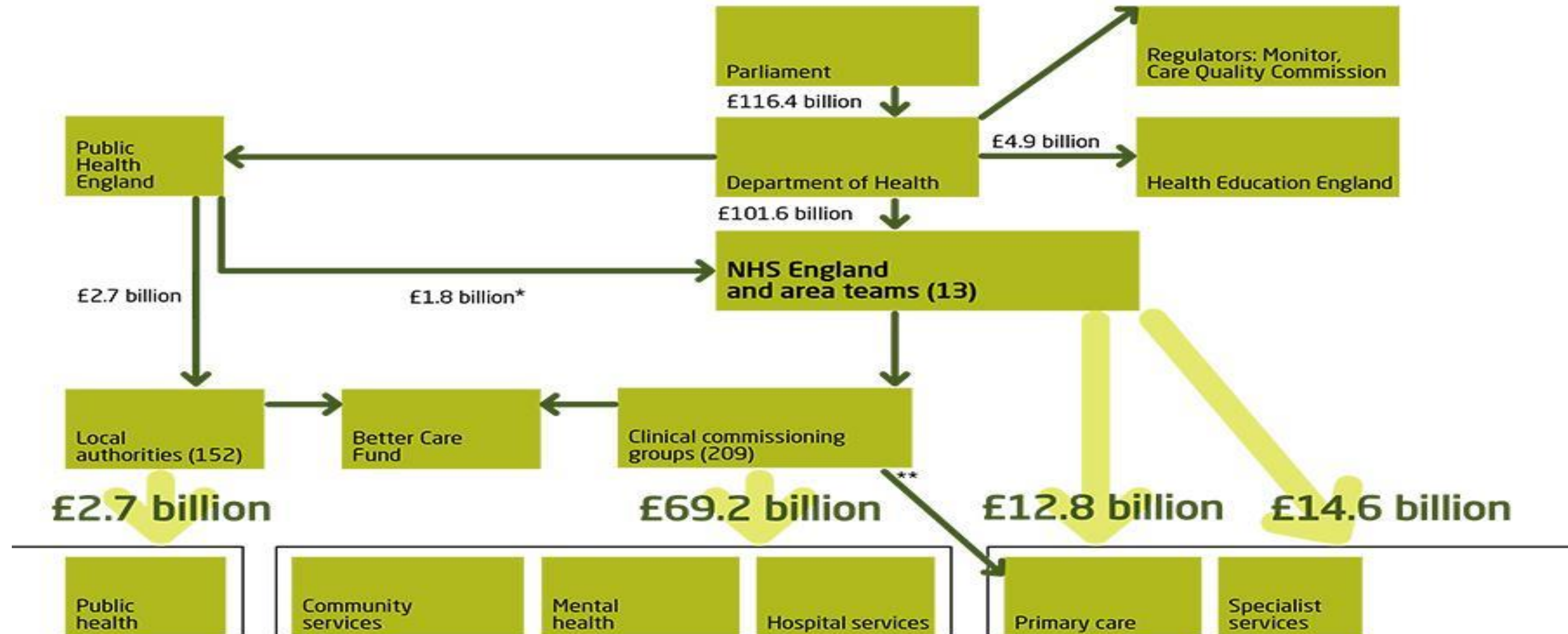
Abstract

NHS clinical directors are responsible for balancing departmental budgets, which can encompass staffing, equipment and operating theatres. As trust income is generally fixed, expenditure reduction is often attempted via recurrent cost improvement plans. In orthodox monetary theory, a departmental deficit contributes first to the hospital, then to the NHS, then to the national deficit. In the orthodox view, governments in deficit need

Lecture outline

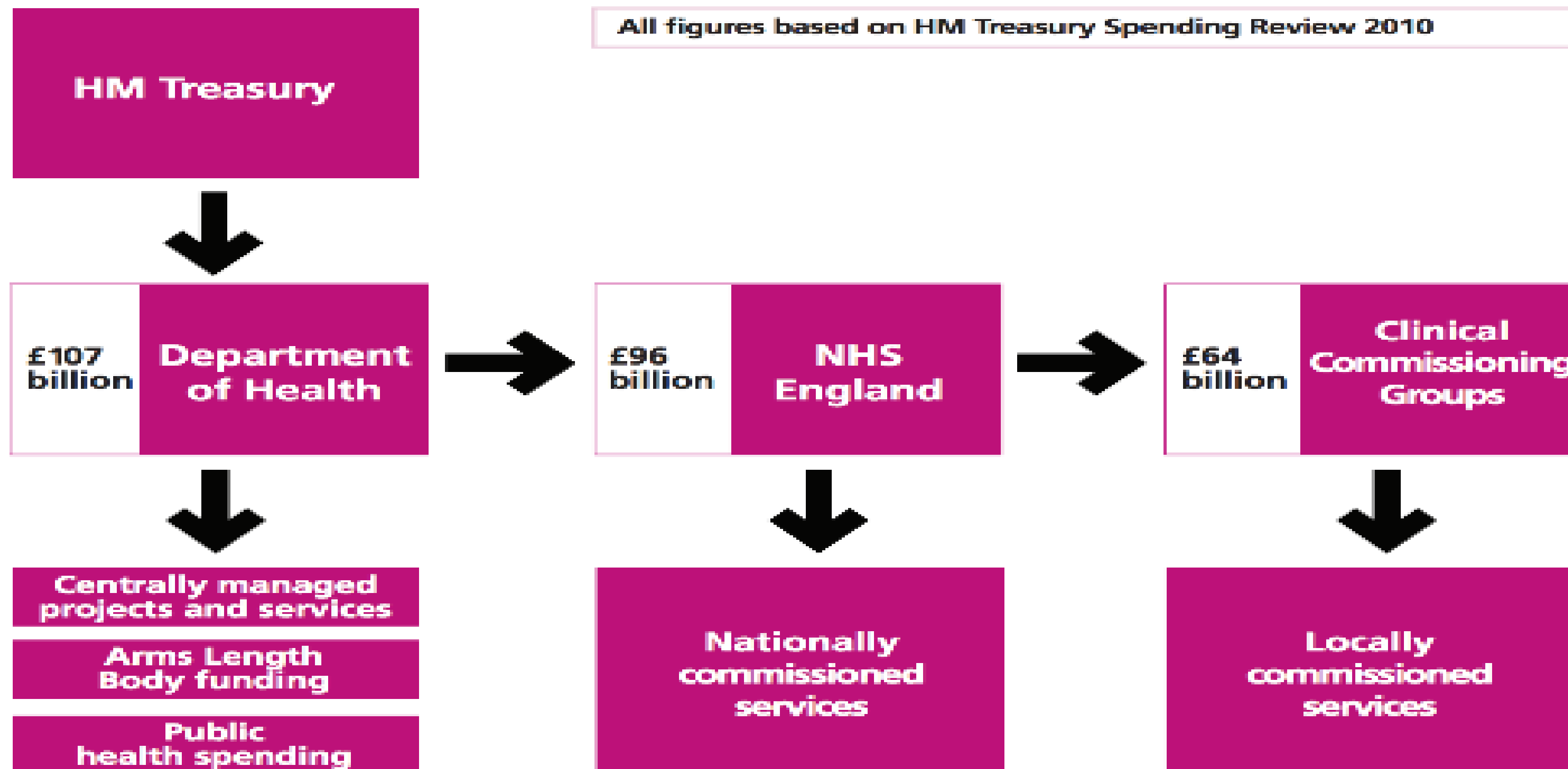
- How NHS depts and finances organised
- Conventional approaches to financial challenges
- The MMT approach
- The real reason why this may be beneficial (value)

How the NHS money flows: national

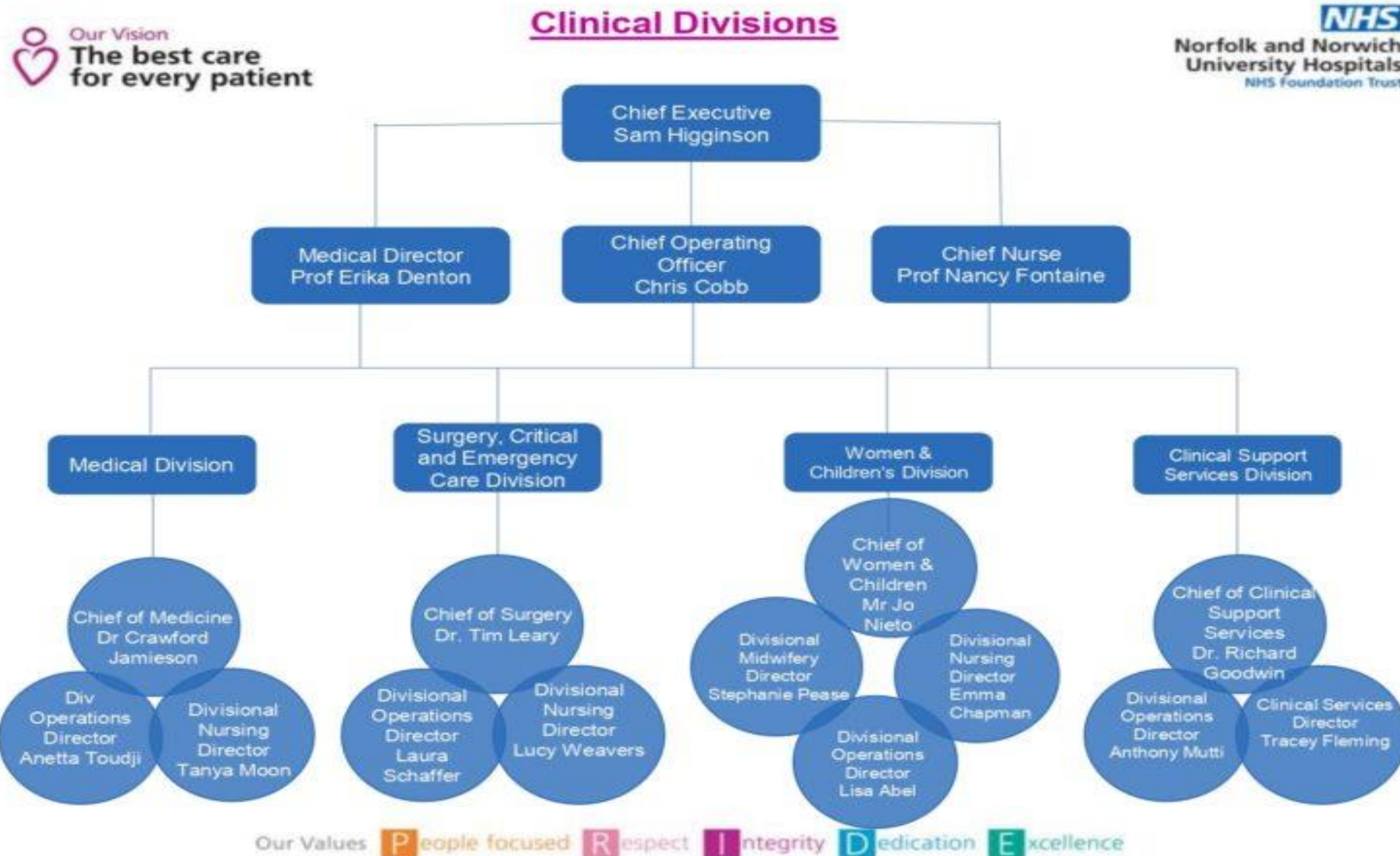


Simplified

- NHS (UK govt) allocates money based on ‘contracted’ activity

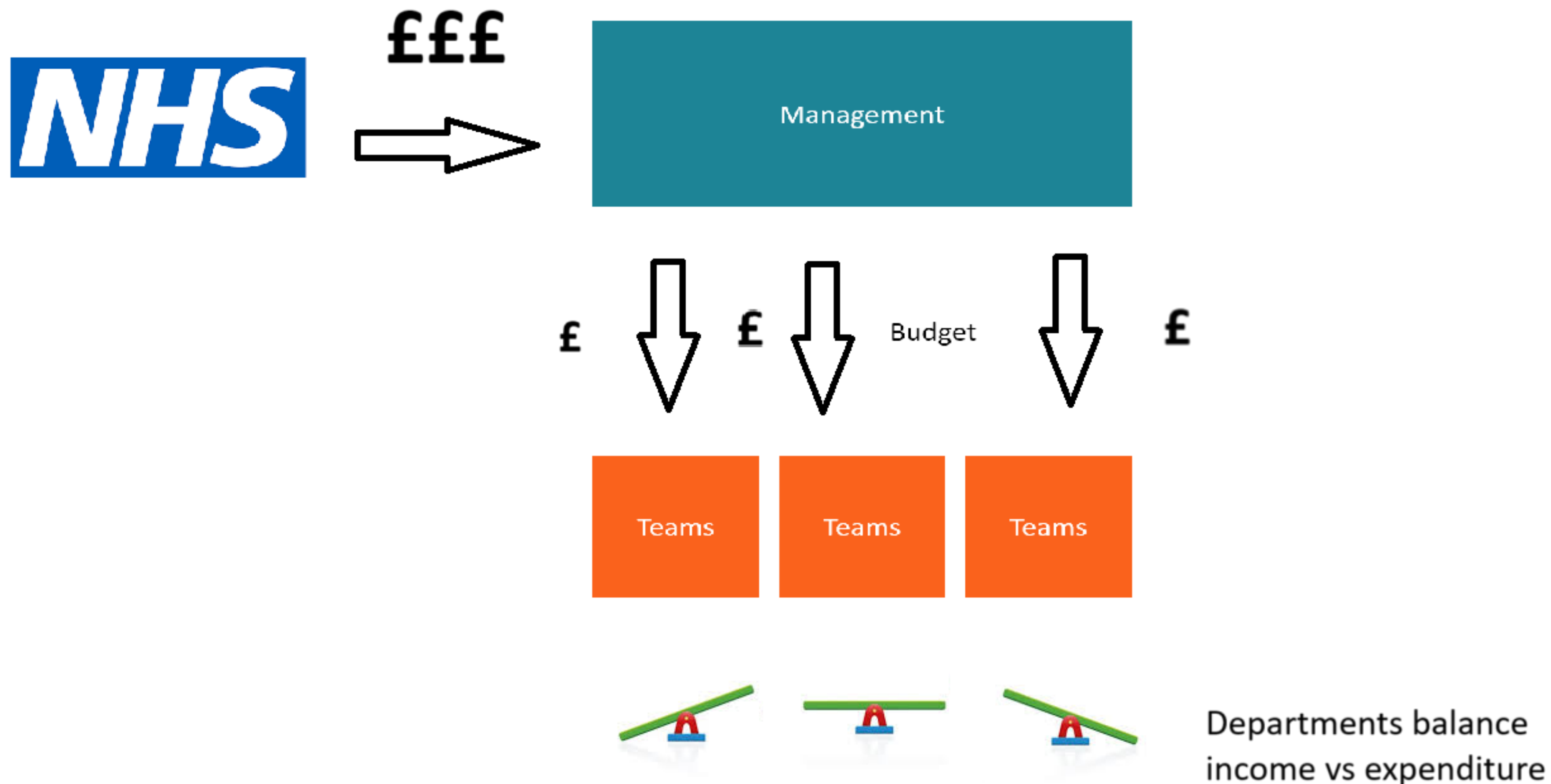


How NHS departments organised



But what happens within the hospital?

- Little formal literature…



Some important details & questions

- Note that dept income fixed in advance for year
- But expense varies
  - Expense = activity (clinics, operations, equipment, consumables)
  - Expense >> income (see next slide): concept of 'overperformance'
- What about overheads?
  - Porters, shared equipment, heating, lighting….
- Anaesthetics & Theatres a dilemma

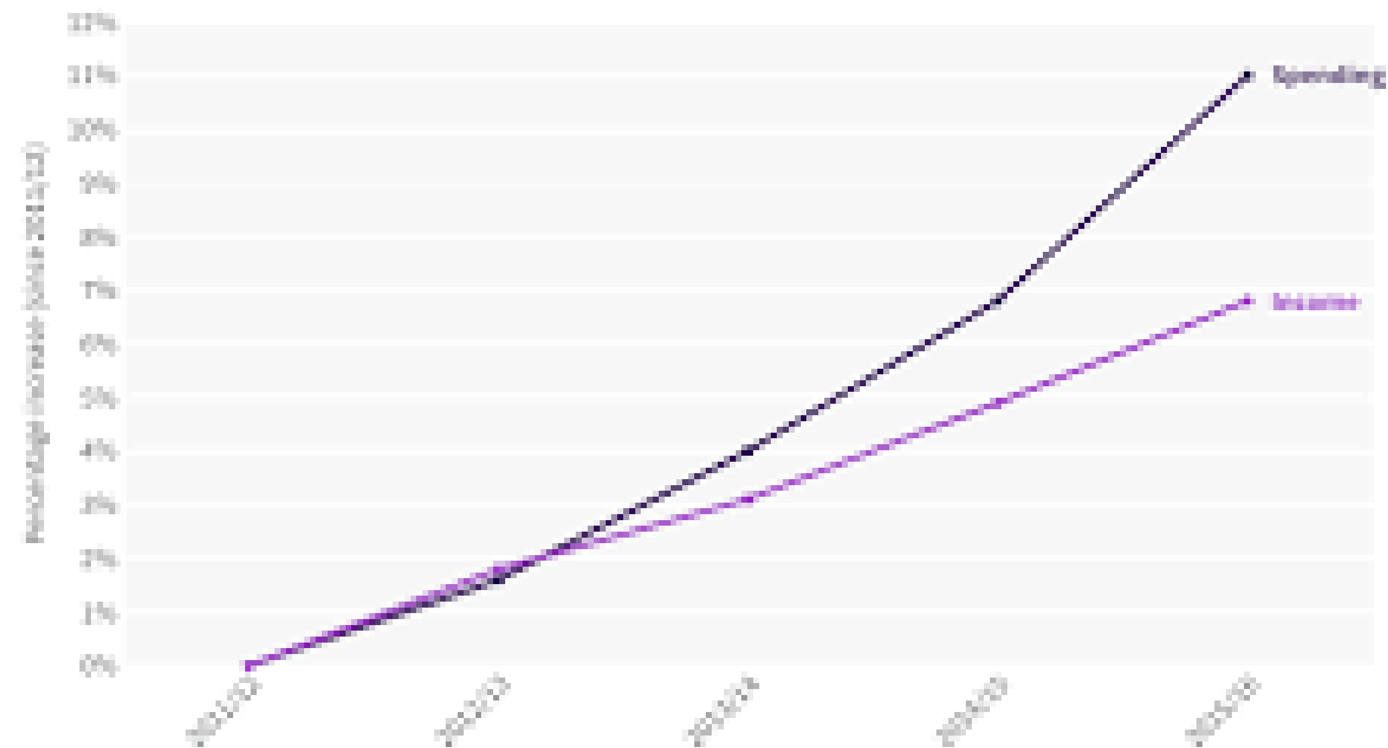
Dilemmas

- Anaesthetics expense (staff & drugs & equipment) is directly proportional to surgical activity
- So ‘efficiencies’ impossible
- Inefficiencies arise when cases cancelled: money already spent and cannot be recouped
- Theatres can be viewed as
- (1) within Surgery – (2) within Anaesthesia – (3) shared overhead – or (4) separate department
- Like Anaesthetics, expense (staff & drugs & equipment) is directly proportional to surgical activity

Dept deficits link to hospital and national deficit…

Figure 2 During austerity, NHS spending began to increase faster than NHS income

Trust spending and income before additional provider funding introduced*



Source: National Audit Office, Sustainability and financial performance of acute hospital trusts

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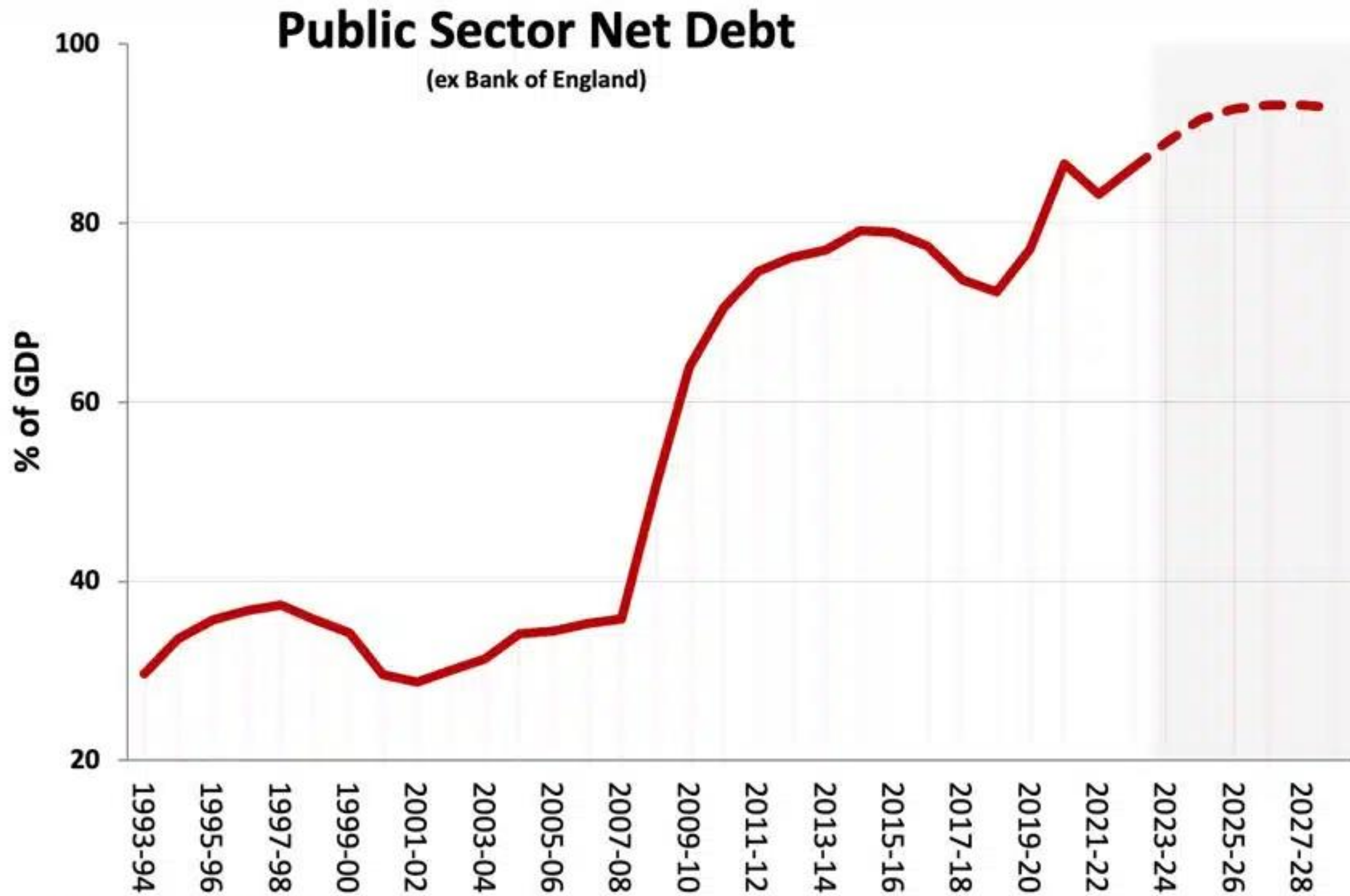


So what can NHS Clinical Directors do?

- Cannot set prices
- Cannot increase income in novel ways
- Cannot increase activity to increase income

- Could cut waste/improve efficiencies

- Mainly: reduce costs
- But only way to reduce costs is reduce activity
- Less activity is not the purpose of hospitals!

The problem of deficits(orthodox monetary theory; OMT)

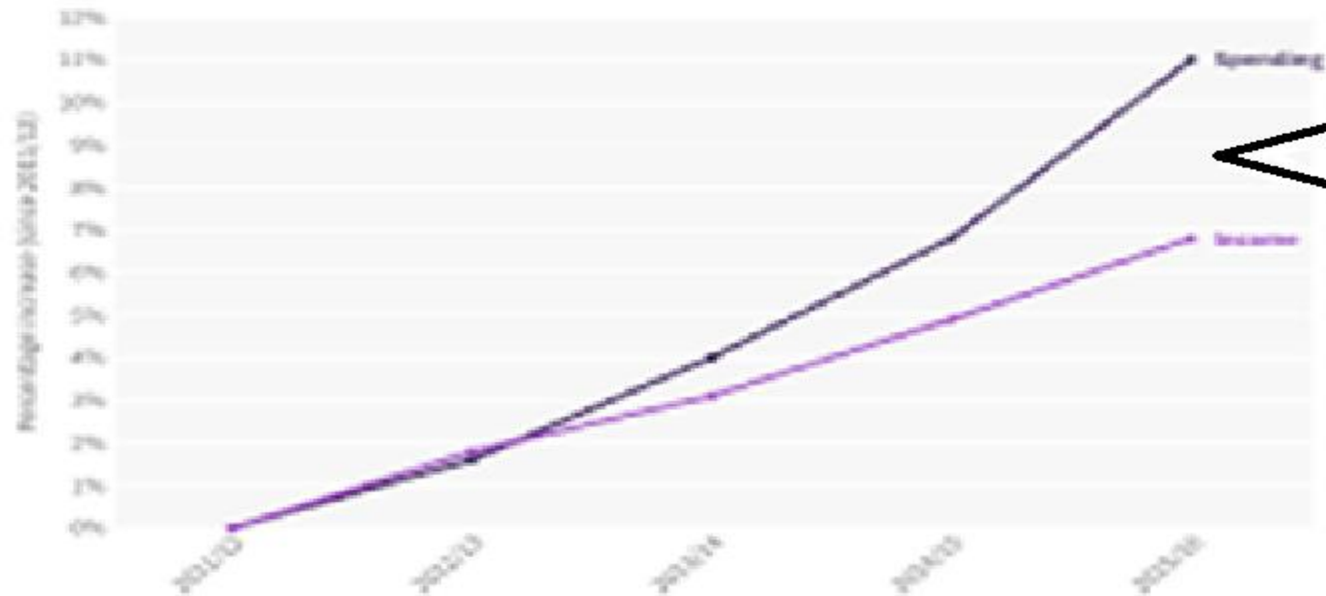
- *"...the state has no source of money other than money which people earn themselves. If the State wishes to spend more it can do so only... by taxing you more... People talk about a "free" health service. It is not free. You have to pay for it."* (Margaret Thatcher, 1983)

- OMT: deficit means
  - Highers taxes
  - Or bonds (gilts) issued at higher interest rates

- Both have consequences for inflation and unemployment...

MMT: a solution?

- Rather than pay £x and spend £y and call y-x the ‘deficit’…
- Why not just pay £y…?



why not just pay the higher amount in the first place?

Possible reasons for ‘preferring’ a deficit (OMT)

- By limiting funding, acts as driver for cost containment?
- Even national ‘deficit thinking’ helps create fiscal discipline?
- Allocating bigger budgets in the first place is akin to ‘printing money’ and hence could be inflationary?

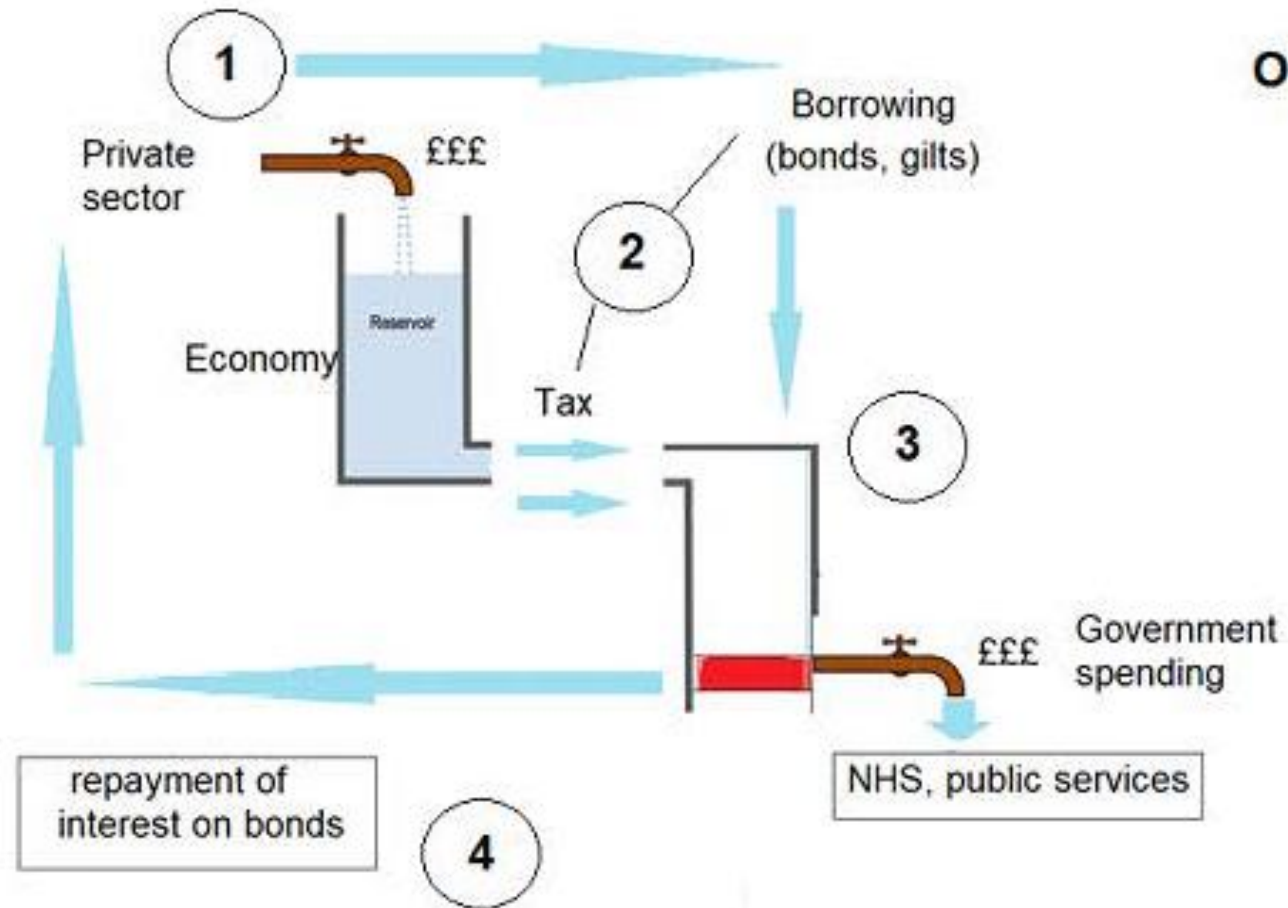
Alternative view: MMT

- The ‘deficit’ is a myth in the first place
- Govts can (and do) ‘print money’ by making spending commitments
- *“…the U.S. government has a printing press that allows it to produce as many U.S. dollars as it wishes at essentially no cost.”* – Ben Bernanke, Chair, US Federal Reserve
- *“…there’s nothing to prevent the federal government from creating as much money as it wants and paying it to somebody…”* – Alan Greenspan, Chair, US Federal Reserve

- *"It's not tax money…we simply use the computer to mark up the size of the account…more akin to printing money than it is to borrowing"* – Ben Bernanke, Chair of the US Federal Reserve (in answer to "Does the Federal Reserve (US government) use tax money to fund spending commitments?")

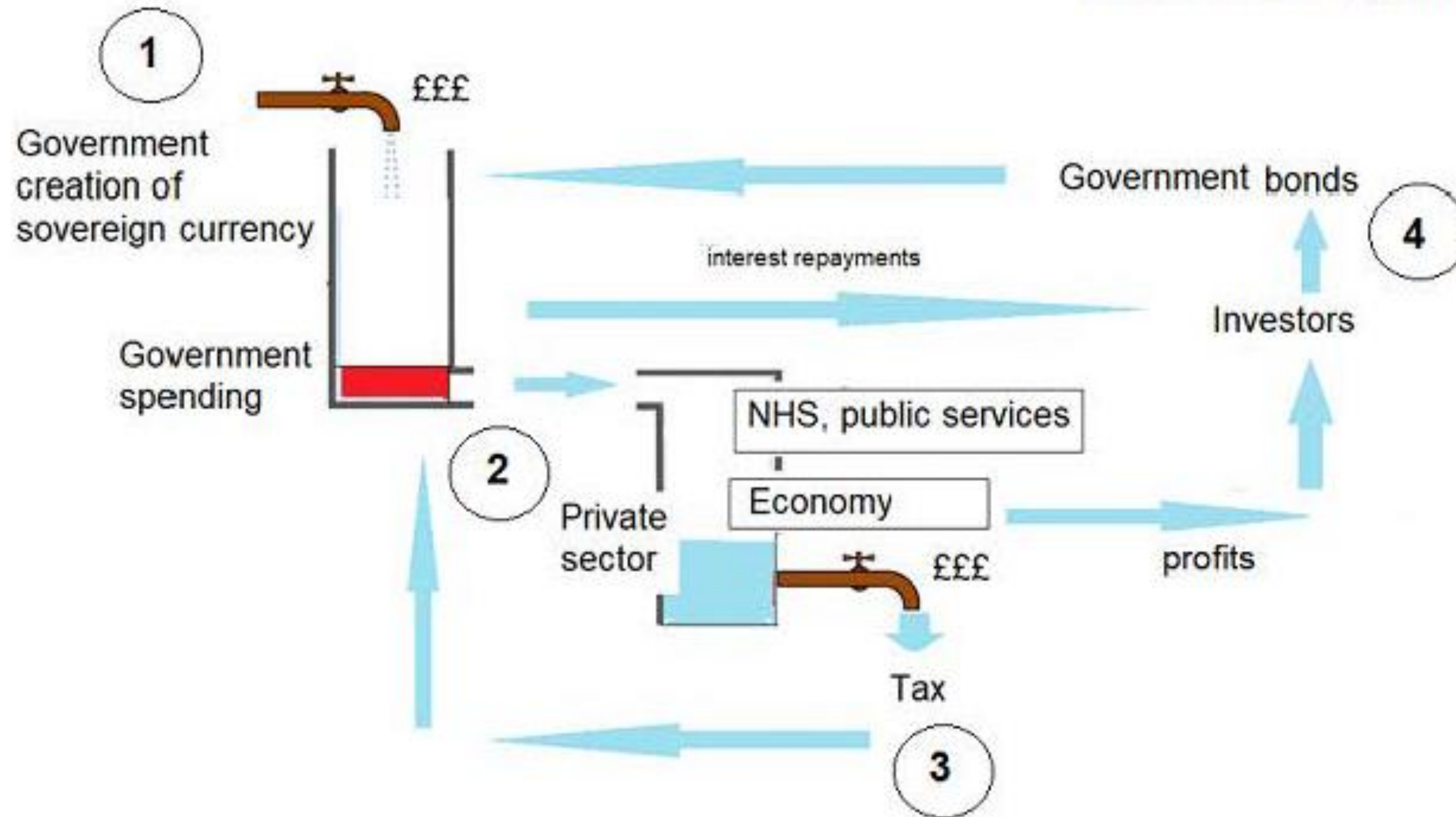
- *"As the sole manufacturer of $s, whose debt is denominated in $s, the U.S. government can never become insolvent, i.e., unable to pay its bills…the government is not dependent on credit markets."* - Federal Reserve Bank of St Louis

OMT model



Orthodox money theory

MMT model



So, in relation to the NHS

- Government could (should) take the view that whatever is actually spends on NHS in a given year is the actual spend…and should set the budget for the following years
- This equates (in MMT) to a spending commitment (printing of money) without need for taxes, despite this being a public service
- In OMT terms this is 'borrowing' but in MMT this is spending denominated in own currency (£s) so should not be inflationary
- Plus: prevents cost-cutting and service-cutting so is an investment in better health (and hence, economic output)
- *"Why health care matters and the current debt does not."* - Federal Reserve Bank of St Louis The Regional Economist, 2011; Oct: 4-5.

Impact on Clinical Directors

- Stop asking *‘how do I balance the budget?’*

- instead ask *‘what investments of savings are necessary to enhance value and productivity?’*

- *‘…Cost-measurement approaches [have] obscured value in healthcare… cost-containment efforts are incremental, ineffective, and sometimes even counterproductive.’* (Porter, 2010)

- It is incorrect to believe that the allocated department budget represents what can be afforded; the NHS budget is what simply we, as a society, choose to afford

- The government puts financial constraints on NHS to engender management discipline

- However, financial balance can be a bad proxy for controlling behaviour, because what we as a society really want is good health

- Recognising this releases us all from artificial constraints to analysis and widens the range of policy options.

- It is important that currency-issuing states recognise that it is real resources that matter particularly labour, not just financial metrics

- A democratic state should decide on the amount of real resources it wishes to commit to healthcare

- The costs of that resource choice are real in this sense. To determine the cost of employing more nurses or healthcare staff, it is necessary to consider what they could have done if they had chosen another career path instead, or remained unemployed

- The immediate financial cost of such choices is borne by the current community. However, future generations will benefit economically and personally from established and continuing high standards of healthcare

- Cost is not irrelevant: no benefit from gold-plated equipment
- Focus on quality
- Examples:
  - ‘Lean’
  - In theatre, good scheduling to use capacity
  - Safety
- Do not confuse ‘value’ with ‘value-for-money’ (latter depends on current price, which can vary in future)

Suggestions for discussion & future developments

- **How do we harness the massive post-pandemic waiting list (8M patients) to drive investment?**
- Apple does not complain about demand for iphones – why do hospitals complain about demand?
- Privatising healthcare will make patients pay, and ensure capacity growth (Apple) but does not ensure equity (not everyone has an iphone)
- Taxation is unpopular, and those who need healthcare most are not always those who pay the tax
- Is there an insurance- or charity-based or alternative funding solution? (beyond MMT)?

- **How do we best ‘price’ the notion of ‘value’ in healthcare?**

- Could be done by measures of ‘use of resources’
  - If you are given 8 hours of surgery, how much (%) do you use?

- Could be done more easily in short-term outputs
  - How many (%) operations successful and do not need re-operations?

- But more difficult for long-terms sustained outputs
  - How many operations actually lead to sustained health and economic benefits?

- **Why does one public service (NHS) pay another (electricity’water/gas) for services?**

- Utility costs when rising fast impose direct costs on publicly funded healthcare

- **Currently private healthcare double-taxed**
  - Income tax and National Insurance tax on earnings (funding NHS)
  - VAT on private health insurance

- Would tax relief be a way of stimulating alternative healthcare to relieve NHS burden?

Conclusions

- The current focus on ‘deficits’ in departmental budgets (originating from an OMT view of economics) constrains Clinical Director thinking
- CDs are forced to make service cuts to balance budgets
- Regardless, more is always spent on NHS than is budgeted
- Why not simply fund it anyway, and abolish deficits?
- This would relieve pressure to balance budgets and permit focus on quality
- Consider other radical strategies

END – THANK YOU