Health spending accounts for a third of the total Scottish budget. This paper looks at how this money is allocated, discusses some of the main areas of spending and considers the main cost pressures facing the NHS in Scotland.
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EXECUTIVE SUMMARY

In 2011-12, health spending accounts for just over a third (33.8%) of the total Scottish budget. Between 2005-06 and 2010-11, the health budget rose in line with the overall Scottish budget, with both increasing by 28% in cash terms. However, in the latest budget, health spending continued to grow in cash terms, while the overall Scottish budget was reduced. This reflected the Scottish Government’s decision to pass on the Barnett consequentials resulting from increased health spending in England.

Illustrative budget figures published by the Scottish Government for the period to 2014-15 indicate that the Scottish Government intends to continue to pass on Barnett consequentials from health spending in England, which would mean that the health budget would continue to rise in cash terms, while other budget lines would receive flat cash settlements. Actual plans for this period will be published in September 2011 in the Spending Review that will accompany the 2012-13 Draft Budget.

Around three-quarters of the total health budget is allocated to Health Boards, who determine spending in order to reflect local priorities and/or specific remits. The Health Board allocations are determined by the NHSScotland Resource Allocation Committee (NRAC) formula, which reflects factors such as the age/sex distribution of the population, geographic factors and other health-related indicators. In practice, actual allocations can differ from the implied NRAC allocations. This is because the Scottish Government is managing the transition to NRAC allocations so as to ensure that no individual Board faces a real terms reduction in its allocation in any year.

The capital budget for health has fallen in recent years, with the result that there is increasing use of revenue financing for capital projects. In the past, this has been through PFI/PPP projects, although this has now been replaced with a non-profit distributing (NPD) model of financing. Up to £750m of health capital projects are planned to be financed via NPD, including the Royal Sick Children’s Hospital and Department of Clinical Neurosciences in Edinburgh.

The hospital sector accounts for over half of all NHSScotland expenditure. Within this, the largest areas of spending are staff costs and pharmacy costs, which together account for over three quarters of all spending in the hospital and community sectors.

Cost pressures in the NHS result from increasing demand for services and increasing costs of delivery. Rising demand is largely the result of an ageing population, with the population aged 75+ forecast to expand by 84% over the period to 2033. Over the last decade, increasing staff costs have put upward pressure on health service costs, although this has moderated in recent years. The influence of other costs, such as drugs and utilities, has been more volatile.

The efficiency savings target for the Scottish public sector, including NHSScotland, was increased from 2% to 3% in 2011-12, implying savings of £257m across all territorial and special health boards in 2011-12. This compares with achieved savings of £208m in 2009-10.
THE HEALTH BUDGET

In the 2011-12 Draft Budget (Scottish Government, 2010a), the Scottish Government allocated £11,359.8m to health. This represented just over a third (33.8%) of the total Scottish budget for 2011-12. Within this total, £10,784.2m (95%) has been allocated to resource spending, with £488.2m (4%) allocated to capital spending.

Between 2005-06 and 2010-11, the health budget rose in line with the overall Scottish budget, with both increasing by 28% in cash terms. However, in the latest budget, the health budget was protected to an extent as a result of the Scottish Government’s decision to pass on Barnett consequentials resulting from health spending in England (see below for further discussion relating to Barnett consequentials). As a result, the health budget increased by 2% in cash terms, compared to a 3% cut in the overall Scottish budget. In real terms, this equates to a cut of 1% in the health budget and a 6% cut in the total Scottish budget.

BARNETT CONSEQUENTIALS

The Scottish Budget is determined through use of the ‘Barnett formula’. This means that when the UK Government decides to alter spending in an area of devolved responsibility (such as health), the Scottish Government’s budget is altered by a proportional amount (the ‘Barnett consequentials’). In the 2010 UK Spending Review, the UK Government announced plans to increase health resource spending in 2011-12 by £2.8bn (HM Treasury, 2010). The Barnett consequentials resulting from this decision increased the 2011-12 Scottish budget by £280.2m. The Scottish Government is not required to allocate Barnett consequentials to the area of spending from which they resulted, and can allocate any increased funds to any area of spending of its choice. However, the SNP Government had committed to allocating any Barnett consequentials from UK health spending to the Scottish health budget. This was reflected in an increase of £280m in the health resource DEL budget in 2011-12. As a result, health and wellbeing was the only portfolio to receive an increased resource DEL budget in cash terms, with all other spending areas experiencing reductions in their cash resource DEL budgets.

Although the result of health resource spending decisions by the UK Government resulted in positive Barnett consequentials for Scotland, the same was not true for capital spending. The UK Government announced plans to reduce the health capital budget and this change resulted

\[\text{Figure 1: Spending on health accounts for one third of the total Scottish budget} \quad \text{Figure 2: Health spending in cash terms has continued to rise while the overall budget has fallen}\]

\[\text{On the basis of the HM Treasury GDP deflator as at 28 June 2011. [Note: the GDP deflator is subject to periodic revision which can alter the resulting real terms calculations and direction of change]}\]
in negative Barnett consequentials for Scotland of £69.5m in 2011-12. These were also applied to the Scottish health budget.

The Barnett consequentials resulting from UK health spending decisions for the whole of the UK Spending Review period are shown in Table 1. If applied to the health budget, these consequentials would imply a steadily increasing health resource budget, growing by £250-300m per year in cash terms. Meanwhile, following a reduction of £69m in 2011-12, the capital budget would stabilise and then increase by £21m in 2014-15.

| Table 1: Barnett consequentials resulting from UK health spending decisions, £m |
|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Resource                    | 280.17   | 248.98   | 293.30   | 284.04   |
| Capital                     | -69.01   | -0.05    | 0.98     | 20.97    |
| Total                       | 211.17   | 248.93   | 294.28   | 305.01   |

**ILLUSTRATIVE BUDGET FIGURES FOR 2012-13 TO 2014-15**

In January 2011, the Scottish Government published illustrative budget figures for the period 2012-13 to 2014-15 (Scottish Government, 2011). In these figures, the health resource budget is the only area of spending showing an increase (in cash terms). In all other areas of spending, with the exception of the Scottish Government administration budget, a flat cash settlement is projected forwards, implying real terms cuts in these budget lines once inflation is taken into account. The Scottish Government administration budget shows cash reductions.

The rising health budget reflects the Scottish Government’s intention to pass on Barnett consequentials relating to health. In its illustrative figures, the SNP administration allocated the resource element of the Barnett consequentials to the health budget. However, the illustrative figures for the capital budget were not provided to the same level of detail and the health capital budget was not separately identified (it was included within the wider ‘health and wellbeing’ portfolio total) (Scottish Government, 2011).

| Table 2: Illustrative Budget Figures, £m (cash) |
|-----------------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Health resource budget                        | 10,772   | 11,021   | 11,314   | 11,598   | 7.7%               |
| Non-health resource budget                    | 14,629   | 14,622   | 14,616   | 14,609   | -0.1%              |

The Scottish Government stressed that these figures were purely for illustrative purposes but, if spending patterns were to follow the path set out in this document, the implication would be for health spending to rise by 8% in cash terms, while the non-health budget would remain static over the period 2011-12 to 2014-15. As a result of this, the proportion of the total resource budget accounted for by health spending would rise from 41% in 2010-11 to 44% in 2014-15. The capital budget is not shown separately for health in the illustrative figures. Actual planned health spending figures for the period to 2014-15 will be published by the Scottish Government in September 2011 as part of the Spending Review that will accompany the Draft Budget.

**BUDGET TIMELINE**

Figure 3 shows when information relating to the health budget is published during the year.
Figure 3
NHS Boards: Budget timeline

Document / event

Scottish Government Draft Budget

Information provided

Indicative NHS Board allocations

Timing (for 2012-13 financial year)

September 2011

Scottish Gvt announcement / letters to Boards

Final NHS board allocations

February 2012

NHS Board Local Delivery Plans

Spending plans submitted to SG by Boards

March 2012

Annual Accounts

Final outturn expenditure

December 2013
• **Draft Budget** – the Draft Budget is generally published in late September. This provides details of spending plans for the forthcoming financial year. The Draft Budget due for publication in September 2011 will outline spending plans for 2012-13. For health, the Draft Budget provides details of planned spending by the Scottish Government, as well as the total amount to be allocated to Health Boards. The Draft Budget also provides indicative allocations to individual Health Boards, but these are subject to change once final funding allocations are calculated (see below).

• **Spending Review** – in certain years (including 2011), the Draft Budget is accompanied by a Spending Review. The 2011 Spending Review document will set out spending plans for the period to 2014-15, but these will be at a less detailed level than the Draft Budget.

• **Health Board allocations** – the allocations to individual Health Boards are announced by the Scottish Government around February for the forthcoming financial year. The process for determining these allocations is described below.

• **Health Board spending plans** – once their allocations are finalised, Health Boards set out plans for how their allocation will be distributed. These are submitted to the Scottish Government in March.

• **Health Board accounts** – the final accounts of the individual Health Boards are published in the December following the end of the financial year.

## HEALTH BOARD ALLOCATIONS

Around three-quarters of the total health budget is allocated to Health Boards, which includes 14 territorial Health Boards and nine Special Health Boards. These Health Boards determine how to spend their allocation according to local priorities or their specific remit. In the 2011-12 Draft Budget, a total of £8,625.7m was allocated to NHS and Special Health Boards.

*Figure 4: Distribution of health budget, 2011-12, £m*

![Distribution of health budget, 2011-12, £m](image)

When the Draft Budget is published (usually late September, but this can be affected by the timing of UK Spending Reviews), Health Board allocations have not been finalised. The overall

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2 Special Health Boards deliver services to and on behalf of NHSScotland on a national basis and include, for example, the Ambulance Service and NHS24.
total to be allocated to Health Boards is announced in the Draft Budget, but the allocations to individual Health Boards are only indicative at this stage.

Final Health Board allocations are usually made available in February, informed by the NHSScotland Resource Allocation Committee (NRAC) formula. The NRAC formula was introduced in 2009-10 and is used to calculate target allocations for each Health Board area on the basis of factors such as the age/sex distribution of the population, geographic factors and other health-related indicators.

When the NRAC formula was first introduced, the implied distribution of funding differed markedly from the allocation that had been in place under the previous system (known as the Arbuthnott formula). In order to ensure that no individual health board faces a real terms reduction in its allocation, the Scottish Government has gradually been moving towards the NRAC allocation, by awarding a standard increase to Boards who are currently above their NRAC allocation and an additional uplift to those whose allocation falls short of the allocation implied by NRAC. By 2011-12, this process of alignment to NRAC had not yet been completed, meaning that some Health Boards continue to receive an allocation which is lower than their implied NRAC allocation and vice versa. The table below shows the 2011-12 allocations, along with the NRAC target allocations. Six health boards received an allocation lower than their NRAC target allocation in 2011-12 (NHS Fife, NHS Forth Valley, NHS Grampian, NHS Lanarkshire, NHS Lothian and NHS Orkney). The remaining eight health boards received allocations higher than their NRAC target allocation, with Greater Glasgow and Clyde the furthest above parity, receiving £63m more than its NRAC target allocation in 2011-12. The Scottish Government has not specified a deadline for achievement of the NRAC target shares. (Scottish Government, personal communication).

Table 1: NRAC target and actual allocations 2011-12

<table>
<thead>
<tr>
<th>NHS Territorial Board</th>
<th>NRAC Target Allocation £m</th>
<th>2011-12 Allocation £m</th>
<th>Distance from Parity £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>559</td>
<td>575</td>
<td>16</td>
</tr>
<tr>
<td>Borders</td>
<td>158</td>
<td>167</td>
<td>9</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>227</td>
<td>242</td>
<td>14</td>
</tr>
<tr>
<td>Fife</td>
<td>519</td>
<td>507</td>
<td>-12</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>414</td>
<td>403</td>
<td>-11</td>
</tr>
<tr>
<td>Grampian</td>
<td>726</td>
<td>691</td>
<td>-34</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>1,833</td>
<td>1,896</td>
<td>63</td>
</tr>
<tr>
<td>Highland</td>
<td>477</td>
<td>485</td>
<td>8</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>827</td>
<td>816</td>
<td>-12</td>
</tr>
<tr>
<td>Lothian</td>
<td>1,113</td>
<td>1,054</td>
<td>-58</td>
</tr>
<tr>
<td>Orkney</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>Shetland</td>
<td>34</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>Tayside</td>
<td>593</td>
<td>596</td>
<td>3</td>
</tr>
<tr>
<td>Western Isles</td>
<td>46</td>
<td>58</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,557</strong></td>
<td><strong>7,557</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

Source: Scottish Government, personal communication
CAPITAL SPENDING

The Scottish Government and NHS Scotland fund capital projects either through traditional finance methods or revenue financed investment. Traditional finance methods involve funding projects upfront from the capital budget, while revenue financed investment (such as public private partnerships (PPP)/private finance initiative (PFI) or non-profit distributing (NPD) projects) involve private finance which is repaid over a number of years through ‘unitary charges’.

Traditional capital finance methods

The capital budget has fallen in recent years. The 2011-12 budget allocates £488.2m of the health budget to capital spending, compared with £577.7m in 2010-11 (Scottish Government 2010a). This represents a fall of 15% which, although significant, is smaller than the 21% reduction in the overall capital budget for the Scottish Government. The Draft Budget provides no further breakdown of capital spending. Initial NHS Board allocations are published later in the year and these show how the total capital budget is allocated across individual Boards. Individual Boards then set out their plans for capital spending in their annual spending plan documents. These have had to be reviewed in the light of the reducing capital budgets.

The system for allocating capital budgets across Boards changed recently, with a new system introduced for 2011-12 (Scottish Government, 2010c). A proportion of the capital budget is allocated using the ‘NRAC formula’, which is the same formula used to allocate the resource budget. The non-formula element of the capital budget is allocated to specific projects whose value is in excess of Board delegated limits. According to the Scottish Government, of the £491.5m capital allocation for Boards in 2011-12, roughly £90m was allocated using the formula and the remaining £400m to project specific funding. For 2011-12, the £400m project specific funding was fully accounted for by existing legal commitments. (Scottish Government, personal communication).

In the context of declining capital budgets, existing capital commitments are expected to absorb the non-formula element of funding. So, while in principle, new projects can bid for project specific funding, in practice new projects are more likely to be funded through non-traditional financing routes such as the non-profit distributing (NPD) model.

Revenue financing for capital projects

In part reflecting the reduced amounts available to finance capital projects through traditional finance methods, a number of health projects in recent years have used revenue financing. The unitary charges resulting from these projects come out of the resource budget. In 2011-12, estimated unitary charges for the 29 PPP/PFI/NPD projects in the health sector amount to £198m (HM Treasury, 2011a).

The 2011-12 Draft Budget stated that health projects with a capital value of up to £750m would be financed via the NPD model (Scottish Government, 2010a). The largest of these projects is the Royal Sick Children’s Hospital and Department of Clinical Neurosciences in Edinburgh (£250m). Smaller projects up to a total capital value of £500m will also be supported via NPD, including individual hospitals, health centres and mental health facilities. This includes projects valued at up to £200m in total to be financed through the ‘hub initiative’ which is led by the Scottish Futures Trust (SFT). Five hub territories have been established across Scotland. Public sector organisations across these hub territory will work in partnership with each other.

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3 For capital budgets the NRAC formula allocations are also adjusted to reflect cross boundary flows of patients and 10% is top-sliced and allocated to those Boards providing tertiary services.
and a private sector delivery partner in a joint venture delivery company called hubco. This delivery structure is likely to be the route for financing for smaller health projects, such as primary care facilities.

NPD financing is currently being used for the Mental Health Development project in NHS Tayside, with a capital value of £95m to be financed over 32 years.

**DISTRIBUTION OF SPENDING**

The hospital sector accounts for over half of all NHS Scotland expenditure (£5.6bn in 2009-10, see Figure 5). The next biggest sector, in terms of spending, is the family health sector which accounts for around a quarter of all spending. This sector includes GP practices, general dental services and general ophthalmic services as well as the pharmaceutical costs associated with these services. The community sector (which includes district nursing as well as community midwifery, community dentistry, child health, home dialysis and GP out of hours services) accounts for 15% of costs. (ISD, 2010)

Analysis of hospital and community sector expenditure by category of spending shows that staff costs account for over two-thirds of all expenditure (Figure 6). Pharmacy services, which includes the cost of drugs, account for a further tenth of all spending (£0.8bn in 2009-10), although this figure does not include the pharmacy services of the family health sector, which totalled £1.1bn in 2009-10. Administrative costs accounted for a further tenth of spending, with facilities costs and teaching and research costs account for the remainder. (ISD, 2010)
BUDGETARY PRESSURES

Although health spending has been protected from the cuts being experienced in other areas of Government spending, NHS Scotland still faces considerable cost pressures and is also required to find efficiency savings, along with the rest of the Scottish public sector.

COST PRESSURES

There are a number of reasons why the costs of health service delivery might be expected to rise at a faster rate than costs elsewhere in the public sector. These cost pressures fall into two broad categories:

- Those which result from rising demand for services e.g. due to demographic factors or changing expectations about standards of care
- Those which result from rising costs of delivery e.g. as a result of increasing drug costs or higher wages for staff

Rising demand

The forecast growth in the number of older people in Scotland has significant implications for health spending. Between 2008 and 2033, the population of working age is expected to grow by 2.2%. Over the same period, the population of pensionable age is forecast to expand by almost a third (31.4%), meaning that almost one in four people will be of pensionable age (even after the planned increases to the pension age are taken into account). The most dramatic increase in both absolute and percentage terms is in the population aged 75+. The population in this age group is expected to expand by 330,000 or 84%.

The Scottish Government estimates that around £4.5bn is spent on health and social care services for those aged over 65, equivalent to more than a tenth of the Scottish budget (Scottish Government, 2010c). If services continue to be delivered on the same basis, this spending is forecast to rise to £8bn by 2031. The impact on spending will depend on the extent to which ‘healthy life expectancy’ keeps pace with overall life expectancy. To date, healthy life expectancy has grown at a slower rate, meaning that people are living longer lives but are not enjoying good health in later life, with resulting cost pressures on the acute and primary health sectors. Long-term conditions, such as dementia and diabetes, from which older people often suffer, account for 80% of GP consultations and 60% of hospital bed days. (Audit Scotland, 2009). (For further discussion of integrated health and social care and analysis of spend on older people, see Payne (2011)).
Rising Costs

Health service inflation is often cited as a reason why health budgets need to rise faster than other budgets, the argument being that because the costs faced by the health service are rising at a faster rate than prices more generally, budgets must also rise faster if the same standards of service are to be maintained. Staff costs and prescribing costs account for around three quarters of all expenditure in the health service.

The issue of rising costs in the health service was highlighted in reports undertaken by Sir Derek Wanless on behalf of the UK Government and the King’s Fund (Wanless, 2002 and 2007). These reports compared movements in the gross domestic product (GDP) deflator with movements in the ‘Hospital and Community Health Services pay and prices index’ (HCHS). The GDP deflator is produced by HM Treasury and is used to measure price movements across the whole economy, while the HCHS index is produced by the Department of Health and looks at the movement in health sector pay and the prices of goods and services purchased by the health sector. The HCHS index is weighted to reflect the relative importance of various items in the health budget (so, for example, changes in the costs of drugs will have a greater impact on the index than changes in the price of staff uniforms as drugs account for a far larger proportion of overall expenditure). In total, 42 different items of expenditure are covered by the index.

Figure 8 shows the movement of these two indices over the last ten years and shows that, particularly in the earlier part of the period shown, inflation in the health sector was running at a far higher rate than in the economy more generally. However, this pattern is less clear in recent years, where movements of the two indices have been more closely aligned. Indeed in 2009-10, the HCHS pay and prices index grew at a slower rate than the GDP deflator (0.6% for the HCHS pay and price index, compared with 1.6% for the GDP deflator). The HCHS index for 2010-11 will be published in December.

The HCHS pay and price index can be split into its two constituent parts and these display quite different patterns, as shown in Figure 9. This analysis shows that, over the last decade, pay inflation has been the reason why health inflation has outstripped the GDP deflator. The HCHS price index has generally risen at a slower rate than the GDP deflator and has been negative in two of the years.
shown, including 2009-10, indicating falling prices for HCHS goods and services. More detailed analysis shows that there is considerable volatility in price movements. In 2009-10, particularly large falls in electricity, gas and rent costs contributed to falling prices. Drugs costs, although continuing to rise, grew at a modest rate of 1%. By comparison, in 2010-11, drug costs rose more sharply (4.1%) and the prices of medical and surgical equipment also showed strong growth (5.1%), while utility and property costs exerted less of a downward influence on overall price movements. (Department of Health 2010b and 2011).

**Staff costs**

Audit Scotland has highlighted that much of the increase in funding for the NHS in Scotland has been absorbed by rising staff costs (Audit Scotland 2010), as is reflected in the pay index shown in Figure 9. Pressures have arisen as a result of implementation of a range of commitments, including:

- The consultants’ contract (implemented in 2004)
- The new General Medical Services contract (introduced in 2004)
- Agenda for Change (implementation commenced in 2004)

The costs of implementing these contracts have been higher than anticipated, leading to higher-than-expected increases in staff costs. Audit Scotland also highlights the reliance on locum staff as a further factor leading to upward pressure on staff costs.

Along with other parts of the public sector, NHS Scotland has introduced a pay freeze in 2011-12 for all staff earning above £21,000 on a full-time equivalent (FTE) basis. Those earning less than £21,000 will receive an uplift of £250. At 30 September 2010, there were around 60,000 staff in NHS Scotland earning less than £21,000 on a FTE basis. This represented 37% of the 161,000 staff.

**Drugs costs**

Pharmacy services cost NHS Scotland £1.9bn in 2009-10. Within this total, drugs costs accounted for £1.3bn of pharmacy expenditure. This represented an increase of 4.4% on the equivalent expenditure in 2008-09 and, according to information provided to the Scottish Parliament’s Health and Sport Committee, health boards were expecting drugs costs to continue to rise at the same rate, or faster, in 2010-11. Combining GP prescribing and hospital prescribing, Boards were planning on the basis of cost increases of between 5 and 9 per cent. (Scottish Parliament Health and Sport Committee, 2010). Data from the HCHS price and pay index suggests that actual drugs costs have risen at a slower rate than this (4.1% in 2010-11) and grew by only 1% in 2009-10, but this UK-wide picture may not reflect the realities faced by individual Boards (not all of whom provided evidence for the Health and Sport Committee inquiry).

**EFFICIENCY SAVINGS**

Although the health budget has not faced the same budget reductions experienced elsewhere in the public sector, Health Boards have been asked to find efficiency savings along with the rest of the public sector.

The 2008-11 Efficient Government Programme included targets for 2% efficiency savings across the Scottish public sector, including Health Boards. The latest available data on reported efficiency savings across Health Boards are shown in Table 4.
### Table 4: NHS Board Efficiency Savings

<table>
<thead>
<tr>
<th></th>
<th>2008-09 £'000</th>
<th>% of budget 1</th>
<th>2009-10 £'000</th>
<th>% of budget 1</th>
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<tr>
<td><strong>NHS Board</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>10,934</td>
<td>2.0%</td>
<td>11,284</td>
<td>2.0%</td>
</tr>
<tr>
<td>Borders</td>
<td>5,216</td>
<td>3.3%</td>
<td>4,804</td>
<td>2.9%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>4,764</td>
<td>2.1%</td>
<td>4,776</td>
<td>2.0%</td>
</tr>
<tr>
<td>Fife</td>
<td>10,201</td>
<td>2.1%</td>
<td>10,085</td>
<td>2.0%</td>
</tr>
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<td>Forth Valley</td>
<td>8,059</td>
<td>2.1%</td>
<td>10,219</td>
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<td>Grampian</td>
<td>14,222</td>
<td>2.2%</td>
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<td>Greater Glasgow and Clyde</td>
<td>54,700</td>
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<td>Highland</td>
<td>15,985</td>
<td>3.5%</td>
<td>14,310</td>
<td>3.0%</td>
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<td>Lanarkshire</td>
<td>19,307</td>
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<td>19,873</td>
<td>2.5%</td>
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<td>Lothian</td>
<td>19,141</td>
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<td>24,947</td>
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<td>Orkney</td>
<td>1,170</td>
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<td>2,459</td>
<td>8.0%</td>
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<td>Shetland</td>
<td>722</td>
<td>2.1%</td>
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<td>3.1%</td>
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<td>Tayside</td>
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<td>Western Isles</td>
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<td>2.9%</td>
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<td>NHS Ambulance Service</td>
<td>5,441</td>
<td>3.0%</td>
<td>6,813</td>
<td>3.6%</td>
</tr>
<tr>
<td>NHS Education for Scotland(^2)</td>
<td>724</td>
<td>2.0%</td>
<td>854</td>
<td>2.0%</td>
</tr>
<tr>
<td>NHS National Services</td>
<td>5,281</td>
<td>2.1%</td>
<td>4,944</td>
<td>1.9%</td>
</tr>
<tr>
<td>NHS State Hospital</td>
<td>759</td>
<td>2.2%</td>
<td>1,400</td>
<td>4.0%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>347</td>
<td>2.0%</td>
<td>404</td>
<td>2.3%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>4,809</td>
<td>9.0%</td>
<td>1,222</td>
<td>2.2%</td>
</tr>
<tr>
<td>Golden Jubilee National Hospital</td>
<td>1,027</td>
<td>2.6%</td>
<td>1,697</td>
<td>4.1%</td>
</tr>
<tr>
<td>QIS</td>
<td>539</td>
<td>3.3%</td>
<td>161</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>203,495</strong></td>
<td><strong>2.6%</strong></td>
<td><strong>207,692</strong></td>
<td><strong>2.5%</strong></td>
</tr>
</tbody>
</table>

1 Based on allocations on which original savings targets were based
2 NES baseline is adjusted for ACT payments and Training Grade salaries

Source: Scottish Government (2010b)

Overall, reported efficiencies have exceeded the 2% target in both 2008-09 and 2009-10, with 2.6% and 2.5% savings reported across the NHS Boards as a whole in 2008-09 and 2009-10 respectively. However, there is variation in reported efficiencies.

Alongside the Draft Budget 2011-12, the Scottish Government announced plans to raise the efficiency savings target from 2% to 3% for 2011-12. Four territorial NHS Boards and three Special Boards achieved this level of efficiency savings in 2009-10. On the basis of the 2011-12 draft budget for NHS Boards (excluding other income), a 3% efficiency target would imply savings of £257m across all territorial and special health boards in 2011-12.

In its report to the Finance Committee on the Draft Budget 2010-11, the Health and Sport Committee discussed its concern that the achievement of Boards in relation to efficiency savings may not be independently verifiable. It added that, whilst it welcomed the national Efficiency and Productivity initiative, it believed clarity was required in respect of the savings being counted as cash-releasing by NHS Boards. It recommended that NHS boards should “make public a description of each type of saving, how it was achieved, the amount saved and how the board checked that the service to patients did not suffer as a result and that savings were used to the clear benefit of patients” (Scottish Parliament Finance Committee, 2009).
SOURCES


RELATED BRIEFINGS

SB 11-40 The National Health Service in Scotland: Subject Profile
SB 11-43 Adult Community Care - Key Issues

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