

5. UK health and social care spending

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Key findings

The period between 2009–10 and 2014–15 saw historically slow increases in UK public spending on health, averaging 1.1% per year.

This was the lowest five-year growth rate since a consistent time series of health spending began in 1955–56. However, due to cuts to other services, health spending continued to increase as a share of public service spending.

NHS spending in England is set to increase by £11.6 billion between 2014–15 and 2020–21: more than the £7 billion increase pledged.

However, Department of Health (DH) spending – a wider measure of health spending in England – will increase by only £8.4 billion. This is because the non-NHS part of the DH budget (which includes the funding of education and medical research) will be cut by 20.9%.

Over the decade from 2009–10 to 2019–20, the population is growing and ageing, placing additional pressure on the health care system.

The extra NHS spending is enough to compensate the NHS for pressure created by a growing and ageing population over the next few years, but it does not account for other cost and demand pressures.

But looking at all DH spending rather than the NHS only, after adjusting for the ageing of the population, per-capita real spending will be lower in 2019–20 than in 2009–10. An additional £1.3 billion of DH spending would be required in 2019–20 just to maintain 2009–10 levels.

Real public spending on social care organised by English local authorities fell by 1.0% between 2009–10 and 2015–16. Within this, spending on adult social care fell by 6.4%, during a period when the population aged 65 and above grew by 15.6%.

Looking forward, the ability of councils to maintain 2015–16 levels of social care will depend on how much revenue is raised through council tax, and whether they want and can continue to protect social care relative to other services. Overall, it looks very challenging for councils to maintain per-adult social spending at current levels over the next few years.

The latest projections from the Office for Budget Responsibility (OBR) indicate substantial long-run spending pressures in health and long-term care. They suggest spending could rise from 8.0% of national income in 2021–22 to 14.7% by the mid 2060s.

These new estimates take account of both the ageing of the population and other cost pressures, and are more realistic than previous OBR projections which accounted only for demographic change. We have some big choices to make about how we deliver health and social care, and about the size and shape of the state.

5.1 Introduction

In 2015–16, the UK public sector spent £220.2 billion (2016–17 prices) on health, social care, and benefits to support people with disabilities and health conditions. This is equivalent to 11.5% of UK national income and 28.7% of total public spending. The majority, £140.6 billion (63.9%), of this was spent on health; £49.7 billion (22.5%) was spent on benefits¹ and £29.9 billion (13.6%) was spent on social care. While Chapter 6 looks at spending on disability and incapacity benefits, this chapter describes spending on health and social care.

The last six years have seen health spending rise slowly by historical standards. Despite this, the share of public service spending accounted for by health is at a historical high of 29.7% in 2015–16. This share has also increased at the same rate over the past few years as it did during the 2000s, when health spending was growing at a historically high rate. This is because the health budget has been protected from the cuts to public spending implemented since 2010. This is especially the case in England, where Department of

¹ This is broader than incapacity and disability benefits. It includes carer’s allowance, industrial injuries benefits, and associated housing benefit.

Health (DH) spending grew by 9.0% in real terms between 2009–10 and 2015–16. The increase in health spending in England is larger than that seen in Scotland, Wales and Northern Ireland, where the respective devolved administrations made different decisions about health spending, resulting in real-terms growth between 2009–10 and 2014–15 of only 4.5% in Northern Ireland, and a real-terms freeze in health spending in Scotland and Wales over this period.

The National Health Service (NHS) settlement in the 2015 Spending Review was (and continues to be) surrounded by a great deal of debate. English NHS spending is set to increase in real terms by 11.6% between 2014–15 and 2020–21. This is more than is required to meet the government's commitment to provide the £7 billion (2016–17 prices) requested by NHS England Chief Executive Simon Stevens in 2014. The estimates below indicate that these increases should just about meet the additional spending required to meet demographic pressures. However, given increasing demand and cost pressures from other sources faced by NHS providers, it seems likely that calls for further funding increases (such as those seen at the time of the 2016 Autumn Statement) will continue.² It is also noticeable that NHS funding – to which the government's £7 billion commitment applies – will increase at the cost of other parts of Department of Health spending. As a result, the non-NHS part of the DH budget will fall by £3.2 billion (or 20.9%) between 2014–15 and 2020–21.

If the NHS has struggled with modest budget increases, the experience of social care funding has been markedly different over the last six years. In England, real-terms public spending on local-authority-organised social care has fallen by 1.0% since 2009–10. Some of this burden has been transferred to the NHS, with a growing share of spending funded by transfers from the NHS to local authorities (these made up 7.5% of public spending on social care organised by local authorities in 2015–16, and come at the cost of reducing NHS spending on other services). Ignoring these transfers, social care spending by local authorities from their own revenues has fallen by 8.4% in real terms over this period, with substantially bigger falls for adult social care.

While pressures exist for both health and social care funding in the short run, the long-term forecasts suggest that a steadily increasing share of national income will need to be spent on providing these services. New forecasts from the Office for Budget Responsibility (OBR), released in January 2017, indicate that rising demographic and cost pressures could result in 14.7% of national income needing to be spent on health and long-term care by 2066–67. This is around a third higher than the previous estimates, published in June 2015, though the reported increase reflects better recognition of likely cost pressures rather than any substantive change. As a result, policymakers must consider whether, and if so how, to fund these future increases, either through increased taxes or cuts to other spending.

In this chapter, we examine recent trends in health spending in the UK and social care spending in England. In Section 5.2, we set out trends in UK health spending and compare recent changes in spending with historical spending growth. We also compare spending since 2009–10 across England, Scotland, Wales and Northern Ireland. Sections 5.3 and 5.4 describe recent health and social care spending in England, respectively. For health

² See, for example, Nuffield Trust, Health Foundation and King's Fund, 'The Autumn Statement: joint statement on health and social care', November 2016, <http://www.health.org.uk/sites/health/files/AutumnStatementHFKFNT.pdf>.

spending, we examine the implications of the 2015 Spending Review for the DH and NHS England budgets and discuss short-term pressures on these budgets. Section 5.4 examines past and forecast changes to social care spending in England and considers how much additional spending would be required to meet demographic pressures. Section 5.5 sets out recent long-term forecasts from the OBR for spending on health and long-term care. Section 5.6 concludes.

5.2 UK public spending on health

The vast majority of public spending on health goes on medical services (95.2% in 2015–16).³ This includes expenditure on the everyday running costs of the NHS, such as staffing costs and paying for drugs. It also includes expenditure on capital investments in NHS hospitals and technology. The remaining spending funds medical research (1.5% in 2015–16) and broader health services (3.2%), including training, education and public health initiatives. A more detailed breakdown of DH expenditure is presented in Section 5.3. It is important, however, to note that public health spending is a different measure from DH spending or NHS spending (see Box 5.1 later for a discussion on the differences between UK health spending, DH spending, and NHS England spending).

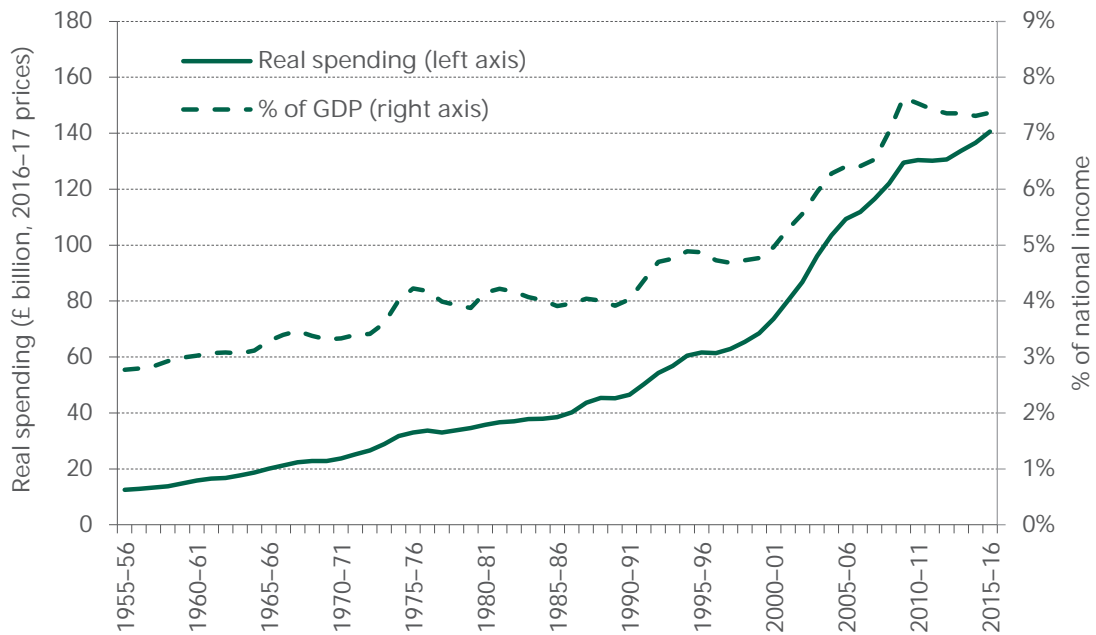
Figure 5.1 shows UK public health spending in each financial year between 1955–56 and 2015–16, both in real terms (after taking into account economy-wide changes in price levels over time) and as a share of national income. Real health spending has hugely increased over time, rising from £12.5 billion in 1955–56 to £140.6 billion in 2015–16 (2016–17 prices). This real increase has also easily outstripped growth in national income: health spending as a share of national income has risen from 2.8% to 7.4% over the same period. Spending peaked at 7.6% of national income in 2009–10, having increased sharply following the financial crisis and subsequent recession as national income fell (as opposed to a particularly large increase in health spending in absolute terms). Spending then fell back to its current level of 7.4%, despite real increases in health spending, following a recovery in national income.

Growth in spending has varied over time. Figure 5.2 shows the annual real growth rate in each financial year (deflating using a measure of economy-wide inflation). Real changes varied across individual years, ranging from an increase of 10.6% in 2003–04 to a cut of 1.8% in 1977–78. There have been only four years in the last 60 in which real cuts took place (1977–78, 1989–90, 1996–97 and 2011–12). With the exception of 1977–78, when health spending fell by 1.8% as part of widespread cuts to public expenditure (total managed expenditure fell in real terms by a total of 4.3% between 1976–77 and 1978–79⁴) following a loan from the International Monetary Fund (IMF), no annual cut in UK health spending has exceeded 0.5%.

³ Percentages do not add to 100% due to rounding. Authors' calculations using table 5.2 of HM Treasury, *Public Expenditure Statistical Analyses 2016*, <https://www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2016>.

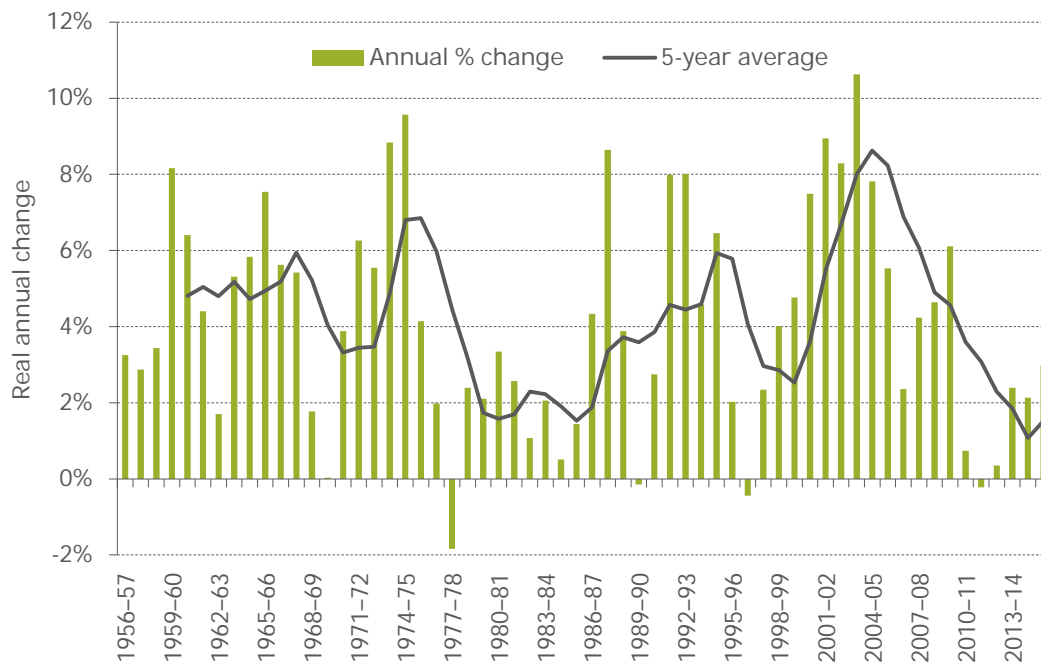
⁴ Calculated using 2016–17 prices. GDP deflator and total managed expenditure series from HM Treasury *Public Expenditure Statistical Analyses 2016*.

Figure 5.1. Annual UK public spending on health in real terms (2016–17 prices) and as a percentage of national income, 1955–56 to 2015–16



Source: Nominal health spending data from Office of Health Economics (1955–56 to 1990–91) and HM Treasury *Public Expenditure Statistical Analyses* (1991–92 to 2015–16). Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016.

Figure 5.2. Annual real growth rate in UK public spending on health, 1956–57 to 2015–16



Source: Authors' calculations using data from Figure 5.1. See Figure 5.1 for further details.

Table 5.1. Average annual real change in UK public spending on health

Period	Financial years	Average annual real growth rate
Whole period	1955–56 to 2015–16	4.1%
Pre 1979	1955–56 to 1978–79	4.4%
Thatcher and Major Conservative governments	1978–79 to 1996–97	3.4%
Previous Labour government	1996–97 to 2009–10	5.9%
Coalition government	2009–10 to 2014–15	1.1%

Source: Authors' calculations using data from Figure 5.1. See Figure 5.1 for further details.

While there have been annual fluctuations in growth, health spending has been characterised by prolonged periods of strong growth followed by periods of weaker growth. This is demonstrated by the cyclical pattern of the five-year average real growth rate shown in Figure 5.2. Table 5.1 also shows the average annual real growth rate during specific periods. Over the entire period since 1955–56, the average annual real growth rate was 4.1%. In the period between 1955–56 and 1978–79, annual real growth averaged 4.4%. This was followed by a period of lower growth, with an average real growth rate of 3.4% between 1978–79 and 1996–97 during the Conservative governments of Margaret Thatcher and John Major. Spending grew at a much quicker pace during the Labour governments of Tony Blair and Gordon Brown. This was in part due to explicit policies aimed at increasing health spending as a proportion of national income towards the average levels of health spending in other western European countries, following a statement by Mr Blair in 2000.⁵ The Wanless Report in 2002 also recommended significant increases in health funding.⁶ As a consequence, health spending grew by an annual average of 5.9% between 1996–97 and 2009–10 (a rise from 4.7% to 7.6% of national income), and an even stronger 6.6% in the decade following Mr Blair's pledge to increase spending (1999–2000 to 2009–10).

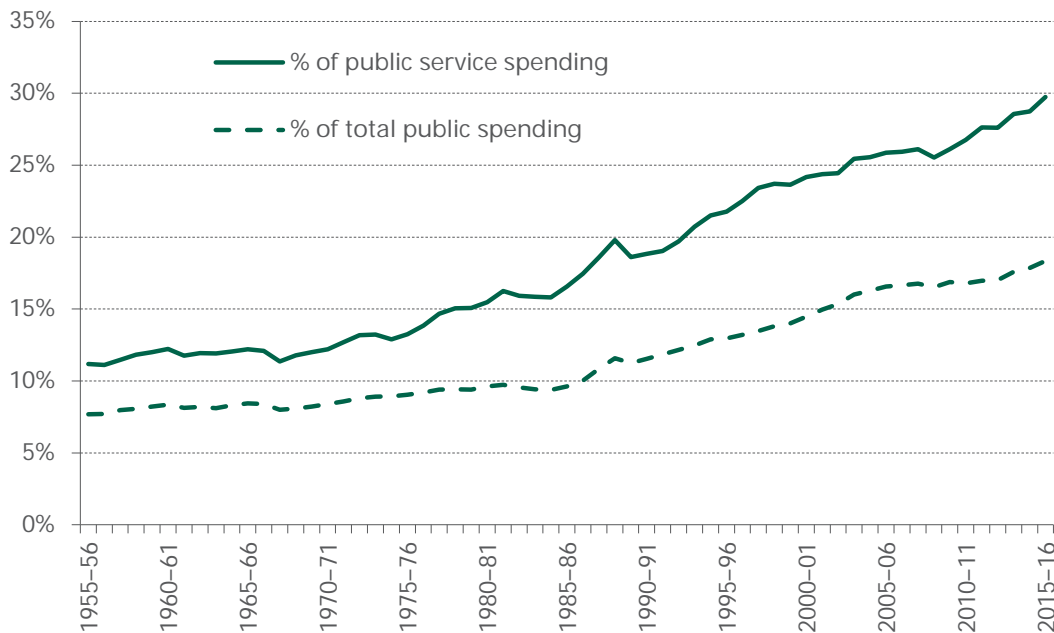
This period of large increases in health spending was followed by a period of relative budget restraint. Under the coalition government (2009–10 to 2014–15), health spending grew in real terms at an average annual rate of 1.1%. This was the lowest five-year growth rate since a consistent time series of health spending began in 1955–56 (the previous low being an average real growth rate of 1.5% between 1980–81 and 1985–86). However, these more modest increases occurred during a period in which large cuts were made to the spending of most other government departments, with health one of only three main areas of spending (along with overseas aid and schools) whose budget was protected from cuts.

The large real increases in health spending over time, and its relative protection during the recent period of austerity, have resulted in health accounting for an increasing share of public spending. Figure 5.3 shows UK health spending as a proportion of total public spending and public service spending (i.e. excluding spending on social security and debt

⁵ Mr Blair initially made these comments when interviewed on the BBC in January 2000. The aim was then repeated in parliament on 19 January 2000 (*Hansard*, 19 January 2000, column 837).

⁶ D. Wanless, *Securing Our Future Health: Taking a Long-Term View*, HM Treasury, London, 2002, <http://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf>.

Figure 5.3. Annual UK public spending on health as a percentage of total public and public service spending, 1955–56 to 2015–16



Note: Public spending is total managed expenditure. Public service spending is defined as total public spending less spending on gross debt interest and less spending on benefits and tax credits.

Source: Health spending data as for Figure 5.1. Public spending and public service spending calculated from OBR Public Finances Database and Department for Work and Pensions Benefit Expenditure Tables.

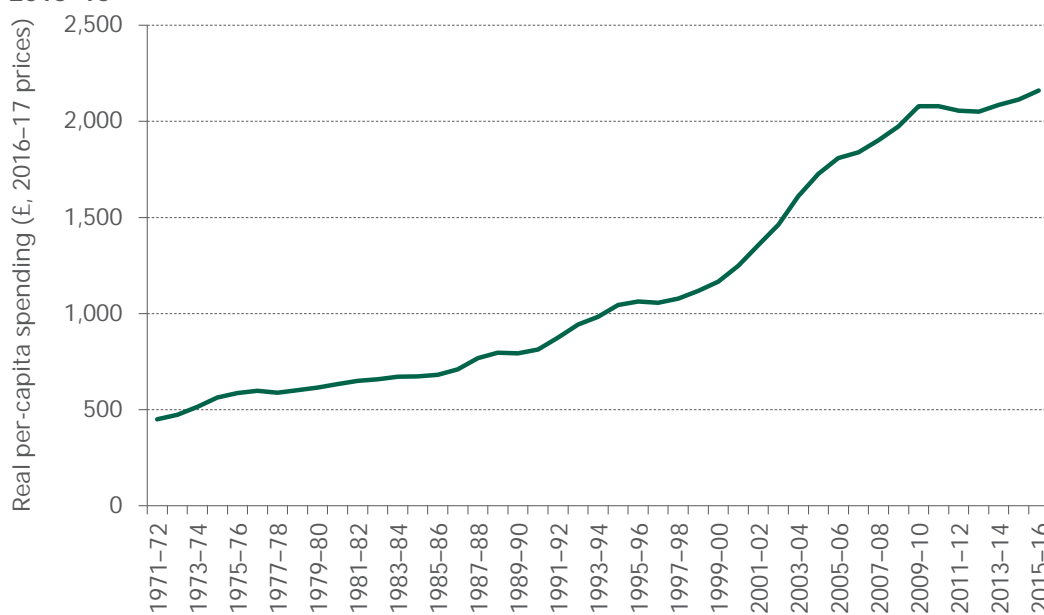
interest payments) in each year between 1955–56 and 2015–16. In 1955–56, health spending accounted for 7.7% of total public spending and 11.2% of public service spending. In 2015–16, these shares had increased to 18.4% and 29.7% respectively.

The 2010 Spending Review period witnessed a continued growth in these shares despite low real increases in health spending by historical standards. Between 2010–11 and 2015–16, health spending rose as a share of total public spending by 1.6 percentage points (or by 9.3%) and as a share of public service spending by 3.0 percentage points (11.1%). This means that, as a result of cuts to other departments and services, health spending now accounts for a greater share of government spending than ever before.

While health spending has increased over time, so have demand pressures for health services. In particular, the UK population, and therefore the potential number of users of the services, has increased. For example, between 1971 and 2015, the UK population grew by 16.4%, or 0.3% a year. This means that although health spending has increased by an annual average of 4.0% over this period, real spending per capita increased by an average of 3.6%.

Figure 5.4 shows real per-capita spending on health in the UK between 1971–72 and 2015–16. The pattern of growth is similar to that of overall growth shown in Figure 5.1, with sharp increases under Labour governments between 1996–97 and 2009–10 (5.4% on average), followed by a slower growth rate between 2009–10 and 2015–16 (0.6% on average). Population growth has been very strong in recent years, with 0.7% annual

Figure 5.4. Real per-capita public spending on health (2016–17 prices), 1971–72 to 2015–16



Source: Nominal health spending data from Office of Health Economics (1971–72 to 1990–91) and HM Treasury *Public Expenditure Statistical Analyses* (1991–92 to 2015–16). Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016. UK population data available on an annual basis (but not financial year) from the Office for National Statistics (ONS) mid-year population estimates (June 2016 release) <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/timeseries/ukpop/pop>.

growth between 2010 and 2015. Partly as a result of this, per-capita spending growth was weak, rising by only 0.6% per year on average between 2009–10 and 2015–16 (and actually falling between 2009–10 and 2012–13, before recovering in subsequent years).

In addition to population growth, the demographic composition of the population has also changed over time. Between 2009 and 2015, the share of the population aged 65 and over has grown by 10.0% (1.6 percentage points).⁷ Older individuals require more health services than younger individuals, so an ageing population will also have led to increased use of services. This means that although per-capita spending was at a historical high of £2,160 per head in 2015–16 (2016–17 prices), on average individuals will be older and therefore likely to require more health services than ever before. Given a strong expected increase in the size of the older population in the coming years, this issue will continue to be of great importance. We discuss this, and its consequences for health spending in England, in more detail in Section 5.3.

A comparison of health spending in England, Scotland, Wales and Northern Ireland

Health spending has been the responsibility of the devolved administrations of Scotland, Wales and Northern Ireland since 1999 and spending and policy decisions have diverged since then.

⁷ Office for National Statistics mid-year population estimates, 2009 and 2015. Accessed through NOMIS on 17 January 2017.

Table 5.2. Health spending and population growth in England, Scotland, Wales and Northern Ireland, 2009–10 and 2014–15

	% of identifiable UK health spending		% change between 2009–10 and 2014–15		
	2009–10	2014–15	Real health spending	Population	Real per-capita health spending
England	82.8	83.6	6.9	4.1	2.7
Scotland	9.1	8.6	0.0	2.2	–2.1
Wales	5.1	4.8	0.0	1.7	–1.7
Northern Ireland	3.0	2.9	4.5	2.6	1.8
UK	100.0	100.0	5.5	3.8	1.7

Note: Population data from Office for National Statistics mid-year population estimates, 2009 and 2014; accessed through NOMIS on 17 January 2017. Nominal health spending from HM Treasury *Public Expenditure Statistical Analyses 2016* and *2015*. Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016. The changes in UK real health spending and real per-capita health spending include UK health spending that takes place outside of the UK. If we exclude this spending, real health spending and real per-capita health spending changed by 5.8% and 2.0% respectively between 2009–10 and 2014–15.

Table 5.2 shows the proportions of UK health spending that took place in England, Scotland, Wales and Northern Ireland in 2009–10 and 2014–15.⁸ It also shows the total percentage changes in health spending, in the population of each nation and in per-capita spending over this period. In 2009–10, England accounted for the majority (82.8%) of UK health spending. Between 2009–10 and 2014–15, spending increased at a quicker rate in England than in the other nations. In particular, spending fell in real terms in Wales between 2009–10 and 2013–14 (before increasing in the final year). As a result, England accounted for a larger proportion of UK health spending in 2014–15 than in 2009–10.

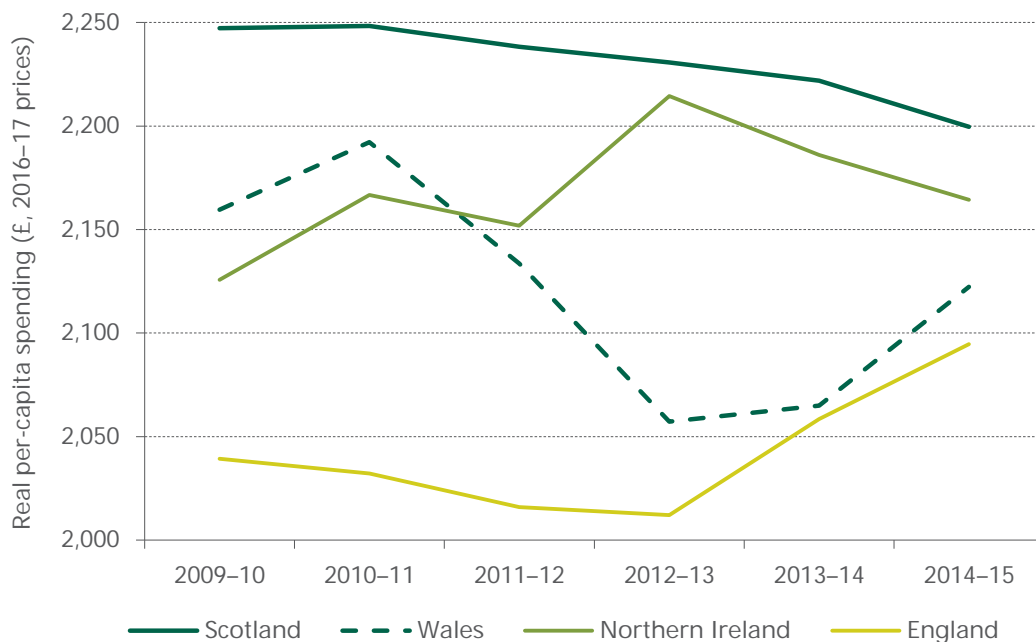
The demands for health services also increased over this period, with growth and ageing of the population. Between 2009–10 and 2014–15, the UK population grew by 3.8%. However, Table 5.2 shows that there was significant geographical variation, with population growth in England (4.1%) more than double growth in Wales (1.7%). This variation in demographic change will therefore have affected changes in per-capita spending over this period.⁹

Figure 5.5 displays real per-capita spending in England, Scotland, Wales and Northern Ireland for each financial year between 2009–10 and 2014–15. The final column of Table 5.2 also shows the percentage change in real per-capita spending over this period. England

⁸ Separate figures for health spending in England, Scotland, Wales and Northern Ireland are not included in HM Treasury PESA 2016.

⁹ The demographic composition, and changes to this composition, also vary across the nations. For example, the percentage of the population aged 65 and over is highest in Wales (19.9% in 2014), followed by Scotland (18.1%), England (17.6%) and Northern Ireland (15.5%). These population shares have also changed at different rates, growing by 1.9 percentage points in Wales between 2009–10 and 2014–15, 1.5 percentage points in England and Scotland and 1.4 percentage points in Northern Ireland. To our knowledge, there are no available data on differences in age-specific health care service use across the UK and so we have not compared age-adjusted per-capita spending figures.

Figure 5.5. Real per-capita health spending in England, Scotland, Wales and Northern Ireland, 2009–10 to 2014–15



Source: Authors' calculations using HM Treasury *Public Expenditure Statistical Analyses 2016* (2010–11 to 2014–15 out-turns) and *2015* (2009–10 out-turn) and the November 2016 OBR GDP deflator.

had the lowest levels of real health spend per capita in all years, but this gap has narrowed over the five-year period. Between 2009–10 and 2014–15, real per-capita spending grew by 2.7% in England. This compares with weaker growth in Northern Ireland (1.8%) and falls in real per-capita spending in Scotland (–2.1%) and Wales (–1.7%).

5.3 Health spending in England

Health spending in England is primarily the responsibility of the Department of Health.¹⁰ Most of this funding is used to invest in and run the public health care system provided through the NHS, and the rest funds public health initiatives, health research and training for health care workers. In 2015–16, DH resource departmental limit (RDEL) gross expenditure was £124.3 billion. This includes income of £9.5 billion from other sources, specifically local authorities (£2.0 billion), private patients (£0.6 billion), prescribing and dental services (£1.9 billion) and other income (£5.0 billion). Net RDEL expenditure (that funded from central government revenue) in 2015–16 was therefore £114.7 billion.

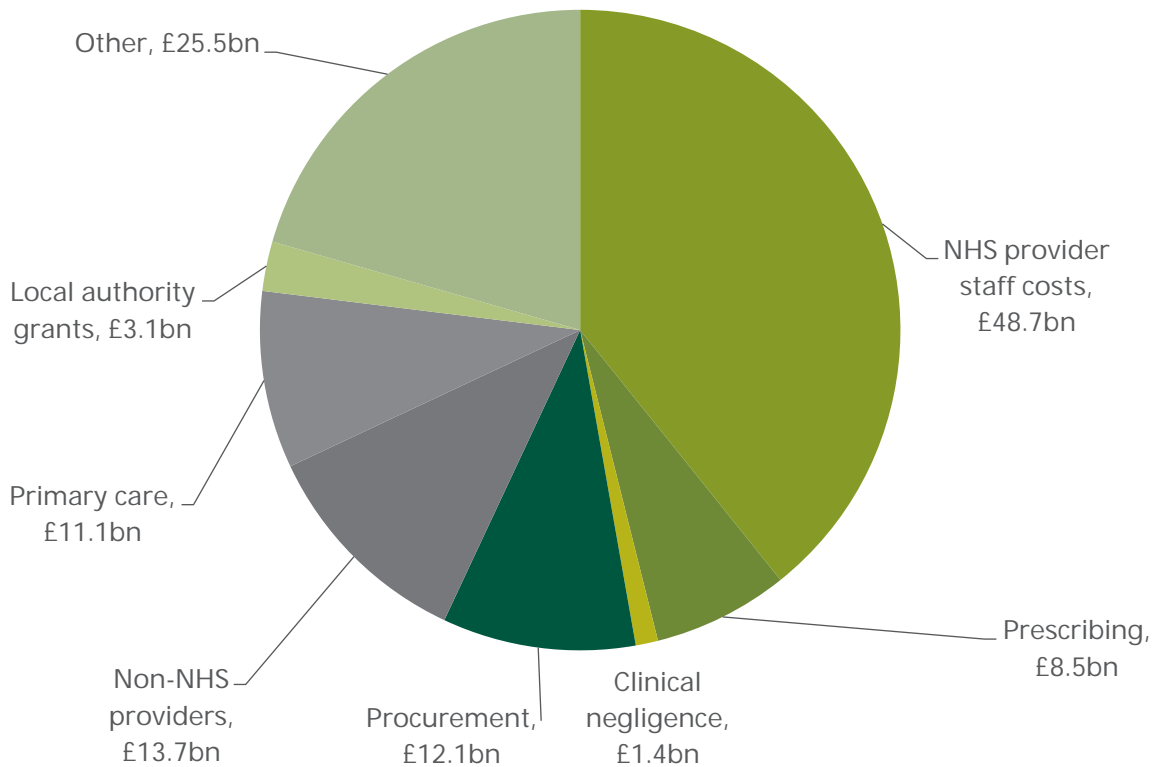
Figure 5.6 provides a breakdown of DH RDEL gross expenditure in 2015–16.¹¹ 57.0% is allocated directly to NHS providers. This funds the everyday running costs associated with providing NHS health care and includes staffing costs (39.2%), prescription drugs (6.8%), clinical negligence claims (1.1%) and procurement (9.8%). The remainder of the funds are

¹⁰ The DH accounted for 99% of health spending in England in 2015–16. The rest is accounted for by the Department for Culture, Media and Sport and the Department for Business, Innovation and Skills.

¹¹ All figures from Department of Health, *Annual Report and Accounts 2015–16*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/539602/DH_Annual_Report_Web.pdf.

allocated to other providers of health and social care and to administration costs. 11.0% of expenditure is allocated to non-NHS providers of health and social care. A further 8.9% is spent on providing primary care, including GP, dentistry, ophthalmology and pharmaceutical services, while 2.5% is allocated as local authority grants for public health spending. The remaining funds (20.5%) are allocated to administrative costs, stock consumed, depreciation and other costs.

Figure 5.6. Breakdown of Department of Health RDEL gross expenditure, 2015–16



Source: Figure 11 of Department of Health *Annual Report and Accounts 2015–16*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/539602/DH_Annual_Report_Web.pdf.

Table 5.3. Department of Health budget, 2009–10 to 2015–16

	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Nominal out-turn, £bn	98.4	100.4	102.8	105.2	109.8	113.3	117.2
Real out-turn, £bn (2016–17 prices)	109.0	109.2	110.3	110.5	113.4	115.4	118.9
% real annual increase	–	0.2%	1.0%	0.2%	2.6%	1.8%	3.0%
Cumulative % real increase since 2009–10	–	0.2%	1.2%	1.4%	4.1%	5.9%	9.0%

Source: *Public Expenditure Statistical Analyses 2014* and *2016*. 2016–17 prices calculated with November 2016 OBR GDP deflator. All figures refer to total departmental expenditure limit (TDEL), which includes resource DEL (minus depreciation) and capital DEL.

Table 5.3 shows DH spending in each financial year between 2009–10 and 2015–16. Over this period, DH spending increased by £9.9 billion, or 9.0%, in real terms (2016–17 prices). This is equivalent to an annual average real increase of 1.5%. This figure is far below the average past growth rate in UK health spending over the 60 years to 2015–16 (4.1%). However, it is a much more generous settlement than most other government departments got, with other departments experiencing spending cuts over the same period.

During this period, cost and demand pressures have been building in the NHS. In 2013, NHS England estimated that the NHS in England would face a shortfall of approximately £30 billion (in 2020–21 prices) in 2020–21 if NHS funding did not rise from the 2014–15 level.¹² These pressures amount to £27 billion in 2016–17 prices. There was therefore considerable political and media debate, in the lead-up to the 2015 Spending Review, as to how these pressures could be met.

As part of its *Five Year Forward View* published in 2014, NHS England set out a range of scenarios under which these additional pressures could be met. These scenarios included different combinations of additional NHS funding and improvements in NHS productivity. The option championed by NHS England Chief Executive Simon Stevens, as reported widely in the press in October 2014, was to increase NHS funding in 2020–21 by £7 billion relative to the 2014–15 level (in 2016–17 prices).¹³ The then Prime Minister David Cameron then made a pre-election pledge to increase funding in line with these plans.¹⁴

The remainder of the ‘funding gap’ would be addressed by productivity increases within the NHS, at an average rate of 2.4% per year. This was an ambitious target for productivity gains when set beside historical NHS performance and wider international comparisons. For example, Office for National Statistics (ONS) estimates indicate that NHS productivity increased at an average rate of 0.9% between 1997 and 2014.¹⁵ Achieving these efficiency gains was always going to be a tough challenge for the NHS.

The 2015 Spending Review set out spending plans for the DH in each financial year between 2015–16 and 2020–21. It also set out specific plans for the NHS England budget (as a subset of the DH budget) for each of these years. This was the first time that a Spending Review explicitly set out spending plans for the NHS (and not DH), and was done because the £30 billion ‘funding gap’ referred specifically to NHS (and not DH or health) spending, and subsequent pledges to increase spending also referred specifically to the English NHS (see Box 5.1 for details about the differences between NHS and DH spending).

¹² The NHS England calculations give an exact figure of £29 billion in 2020–21 prices. A rounded version of £30 billion has been widely publicised. Source: NHS England, ‘The NHS belongs to the people: a call to action’, 2013, <https://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf> and NHS England, ‘The NHS belongs to the people: a call to action - the technical annex’, 2013, <https://www.england.nhs.uk/wp-content/uploads/2013/12/cta-tech-Annex.pdf>.

¹³ This was £8 billion in 2020–21 prices, and was widely reported in the press. See, for example, <http://www.telegraph.co.uk/news/nhs/11181496/NHS-needs-8-bn-funding-boost-and-major-reforms-says-health-chief.html>.

¹⁴ See, for example, <http://www.bbc.co.uk/news/uk-politics-32772548>.

¹⁵ Figure 7 of Office for National Statistics, ‘Public service productivity estimates: total public service, UK: 2014’, <https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/articles/publicservicesproductivityestimatetotalpublicservices/2014#healthcare>.

Box 5.1. Different measures of 'health' spending in England

There is considerable debate about how much 'health' spending is likely to change in the coming years. However, it is often unclear exactly which measure of spending is being referred to.

This chapter focuses upon three different measures of 'health' spending. First, 'health' spending is defined by the purpose, or function, of spending. HM Treasury classifies public spending by broad function as part of its Public Expenditure Statistical Analyses (PESA) publication. In 2016, the UK government spent £140.6 billion (2016–17 prices) on health.^a This funded a combination of medical services, medical research and broader health services. We document the growth of this spending over time, and variation across the nations of the UK, in Section 5.2.

In Section 5.3, we discuss spending by the Department of Health and by NHS England. The majority of health spending in England is the responsibility of the DH, which accounted for 99% of health spending in 2015–16 (the Department for Culture, Media and Sport and the Department for Business, Innovation and Skills accounted for the rest).^b In 2015–16, DH spending was £118.9 billion (2016–17 prices).

The NHS England budget is a part (though the majority) of the wider DH budget, accounting for 87.0% of the DH budget in 2015–16.^c Since 2012, NHS England has been responsible for all NHS services in England. Future spending plans for NHS England were explicitly published in a spending review for the first time in 2015, with planned spending of £102.7 billion (2016–17 prices) in 2015–16.

The majority of DH and NHS England spending would be classified as 'health' spending. However, they also provide funding for other, non-health spending. For example, NHS England spent £1.8 billion on local-authority-organised social care in 2015–16 (see Section 5.4 for more details).

Health spending, and the budget for DH and NHS England, also change at different rates over time. UK health spending may differ from health spending in England due to policy decisions by the devolved administrations. Under the latest plans, NHS England spending will also increase at a quicker rate than overall DH spending over the next five years. For example, the 2015 Spending Review plans set out an 11.6% (1.9% per year) increase in NHS England spending between 2014–15 and 2020–21. This compares with a planned 7.3% (1.2% per year) increase in DH spending set out in the Spending Review.

In summary, it is important to be precise about the numbers being used when looking at trends in health spending.

^a HM Treasury *Public Expenditure Statistical Analyses 2016*. Real spending refers to 2016–17 prices, using the GDP deflator from the OBR in November 2016.

^b Table 5.1 of HM Treasury *Public Expenditure Statistical Analyses 2016*.

^c 2015 Spending Review.

Table 5.4. Plans for Department of Health and NHS England real spending at the time of Spending Review 2015

	Out-turn	Forecast as of Spending Review (SR) 2015					
	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Real spending (£bn, 2016–17)							
DH latest plans	115.4	118.9	120.6	121.9	122.0	122.4	
DH SR 2015 plans	115.4	118.0	120.4	121.7	121.7	122.2	123.8
NHS England SR 2015 plans	99.9	102.7	106.8	108.6	108.8	109.8	111.5
NHS England as % of DH budget (as of SR 2015)	86.6%	87.0%	88.7%	89.2%	89.4%	89.8%	90.1%

Source: Department of Health latest plans from PESA 2016. Department of Health and NHS England Spending Review plans from the 2015 Spending Review. 2014–15 DH out-turns available from PESA 2016. 2014–15 out-turn differs from the published nominal figure in the Spending Review after subsequent upwards revisions (from £113 billion to £113.3 billion in nominal terms). NHS England figures are not published as part of PESA, and therefore cannot be updated from the Spending Review. As a result, SR 2015 figures are used to ensure consistency in comparisons between NHS England and DH spending over time. All real-terms prices are in 2016–17 prices. These are calculated using the November 2016 OBR GDP deflator.

Table 5.4 shows the plans for DH and NHS England real spending in each financial year between 2014–15 and 2020–21, as set out at the time of the 2015 Spending Review. Under the Spending Review plans, total DH spending was forecast to rise by £8.4 billion (in 2016–17 prices) between 2014–15 and 2020–21. These plans implied a larger increase in NHS England spending, with a real increase of £11.6 billion (in 2016–17 prices), or 11.6%, between 2014–15 and 2020–21.¹⁶ As a result, the NHS England budget would account for 90.1% of DH spending in 2020–21, compared with 86.6% in 2014–15.

The forecast rate of future economy-wide inflation has fallen since the 2015 Spending Review plans were made, and as a result, these real increases in spending are larger than those planned in the Spending Review. This means that the planned increases are greater than both those committed to by Mr Cameron, and the required increases set out under the best NHS productivity scenario (2.4% per year between 2014–15 and 2020–21) in the *Five Year Forward View* and subsequently requested by Simon Stevens in 2014.

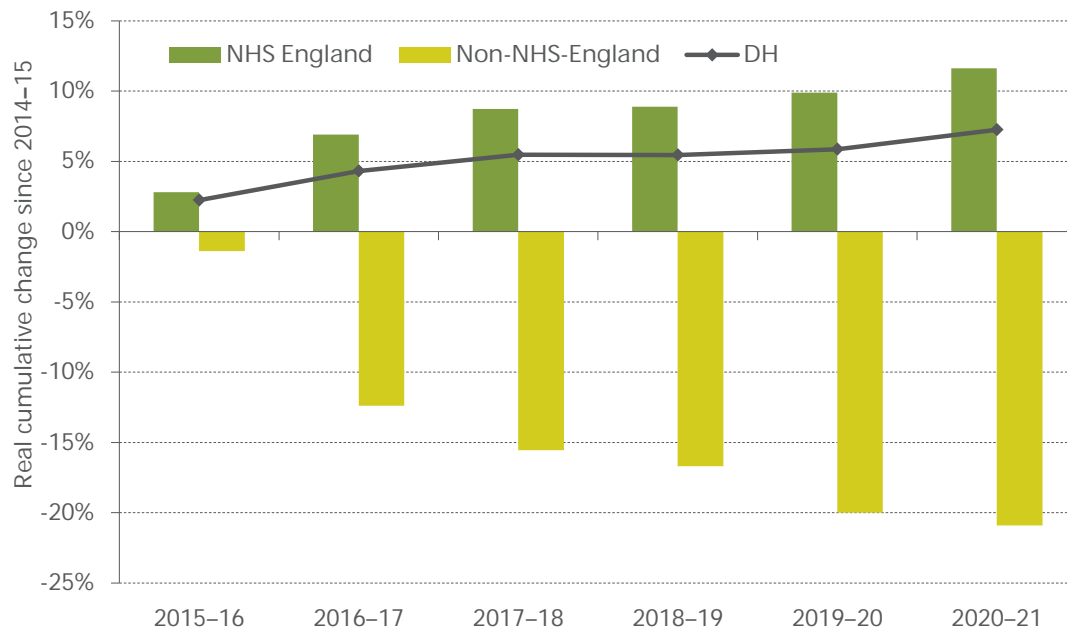
Table 5.4 also shows the latest planned DH spending up to 2019–20.¹⁷ The latest estimates indicate that DH spending was £0.9 billion higher in 2015–16 than initially set out in the 2015 Spending Review, and that spending will be marginally higher (£0.2–0.3 billion) in future years up to 2019–20.

It is important to note that the planned NHS spending increases are larger than the planned overall changes to the DH budget, as noted by the Health Select Committee in

¹⁶ This is an increase of £12.5 billion in 2020–21 prices, using the November 2016 GDP deflator.

¹⁷ Latest DH plans from PESA 2016. PESA 2016 includes forecast spending up to 2019–20. Plans for DH spending in 2020–21 are therefore not available. NHS England plans are not published separately, and it is unclear how changes to DH spending will affect NHS England planned spending between 2015–16 and 2019–20.

Figure 5.7. Cumulative real changes to Department of Health spending set out by the 2015 Spending Review, 2014–15 to 2020–21



Source: Spending Review 2015. NHS England figures are not published as part of PESA, and therefore cannot be updated from the Spending Review. As a result, SR 2015 figures are used to ensure consistency in comparisons between NHS England and DH spending over time. Real-terms changes are calculated using the November 2016 OBR GDP deflator.

July 2016.¹⁸ Figure 5.7 demonstrates this. It shows the cumulative increase in DH spending relative to 2014–15 for each year up to 2020–21, with real DH spending planned to increase by 7.3% over the period. It also shows the changes to NHS England and non-NHS-England spending within the overall DH budget. While the NHS England budget is set to increase by 11.6% over this period, the plans imply cuts to the remainder of the DH budget. Between 2014–15 and 2020–21, the non-NHS-England DH budget is set to fall by 20.9% in real terms, from £15.5 billion to £12.3 billion. This will have consequences for other activities carried out by the DH outside of NHS England, including the funding of education and medical research. Details of how these cuts will be distributed across services remain unclear. However, it is likely that the biggest impact will be in areas such as medical staff training and public health. Moving away from grants for student nurses towards student loans will reduce costs to DH, but could have consequences for the numbers of trainee nurses. Local authority public health budgets are also set to be cut in real terms going forward, and such reductions in public health spending may ultimately lead to greater demand for front-line NHS services.

Future pressures

The NHS faces many challenges in both the short and long runs. These arise from increasing demand for care and from pressures that increase the cost of providing a given level of care. In the remainder of this section, we discuss the likely impact of demographic

¹⁸ House of Commons Health Committee, *Impact of the Spending Review on Health and Social Care*, First Report of Session 2016–17, <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/139.pdf>.

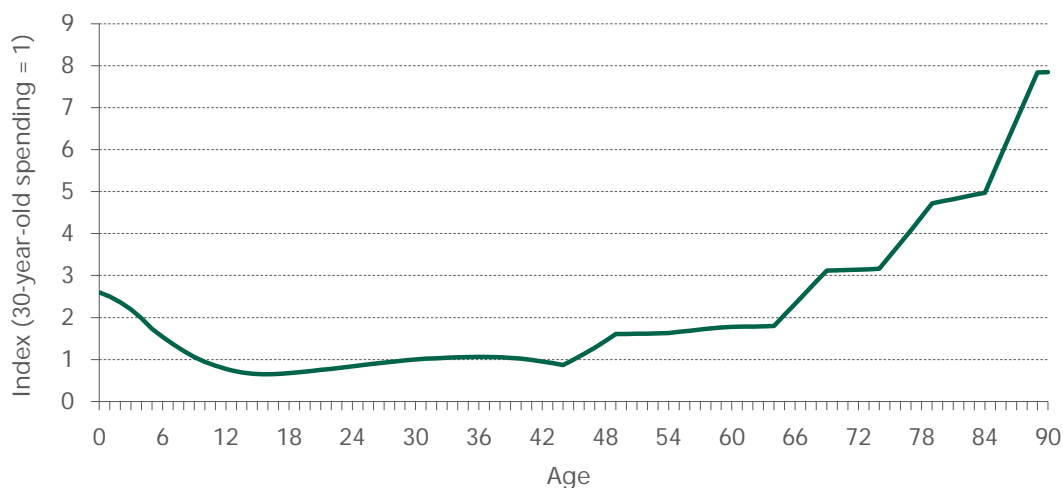
pressures on the demand for health care over the next five years. In Section 5.5, we will discuss longer-run demographic pressures and the impact of non-demographic cost pressures on long-run health spending.

Of course, the NHS is currently at the centre of a number of other fierce media and political debates. Plans for a ‘seven-day NHS’ have been controversial and will increase the responsibilities placed upon NHS providers by expanding the availability of elective and diagnostic services to weekends.¹⁹ There are also a number of issues relating to the training and pay of NHS staff. A dispute between the DH and the British Medical Association over the new junior doctor contract is ongoing, while there is concern about shortages of nursing and midwifery staff in many NHS hospitals.²⁰ How the NHS tackles these issues going forward is of great policy importance and will have implications for how health care is provided and funded in the future.

The first and most obvious pressure on demand for health care, in both the short and long run, comes from the growth and ageing of the population. A larger population will require more health services. For example, the English population increased by an average of 0.8% per year between 2009–10 and 2015–16. As a result, spending would be required to rise at this pace to keep up with population growth alone.

The ageing of the population is also important. Older individuals, on average, use more services than younger individuals. This means that as the size of the older population rises (or as an increasing proportion of the population is above a certain age), the average demand for health care will also increase. Figure 5.8 shows estimated annual public health spending on individuals of different ages relative to the annual spending on an average 30-year-old for the UK. It shows that average spending on someone aged 65 is double that

Figure 5.8. Age profile of public health spending in the UK (relative to 30-year-olds)



Source: Chart 3.7 of Office for Budget Responsibility *Fiscal Sustainability Report 2017*. Costs are reported for individuals of each age between 0 and 90 years, relative to the average cost of treating a 30-year-old in the UK.

¹⁹ For an example of reporting over concerns about the expansion of services, see <https://www.theguardian.com/society/2016/aug/22/secret-documents-reveal-official-concerns-over-seven-day-nhs-plans>.

²⁰ See, for example, <http://www.telegraph.co.uk/news/2017/01/19/96-per-cent-hospitals-have-nurse-shortages-official-figures/>.

Table 5.5. Spending increases required to keep up with demographic change

	Real increase in spending required to keep pace with:		Real increase in DH spending implied by out-turns and latest plans	Real increase in NHS England spending implied by out-turns and latest plans ^a
	population growth	population growth and changing age structure		
2009–10 to 2015–16	5.0% (0.8% per year)	8.1% (1.3% per year)	9.0% (1.5% per year)	–
2015–16 to 2019–20	3.1% (0.8% per year)	5.0% (1.2% per year)	3.0% (0.7% per year)	6.2% (1.5% per year)
2009–10 to 2019–20	8.2% (0.8% per year)	13.5% (1.3% per year)	12.3% (1.2% per year)	–

^a Spending Review 2015 shows real DH spending at £0.9 billion less than the latest spending plans in 2015–16 and £0.2 billion less in 2019–20. We assume that all additional DH spending is assigned to NHS England in both 2015–16 and 2019–20. This increases NHS England real spending to £103.6 billion in 2015–16 and £110.0 billion in 2019–20 (2016–17 prices). The change in real NHS England spending between 2015–16 and 2019–20 implied by the Spending Review 2015 plans is 6.9% (or 1.7% per year).

Source: Authors' calculations using ONS population projections (June 2014), mid-year population estimates (2009 to 2015) and age spending weights from the Office for Budget Responsibility Fiscal Sustainability Report 2017 (as shown in Figure 5.8).

on a 30-year-old. The ratio rises steeply at older ages, with spending on a 70-year-old three times, and spending on a 90-year-old almost eight times, that on a 30-year-old.

There is uncertainty about how much additional spending is required to treat a growing and ageing population. It is unclear whether individuals will spend extra years of life in good or bad health, so we cannot be sure whether the shape of the age profile of spending in Figure 5.8 will remain unchanged over time – although over short periods it is likely to be a good approximation. Under the assumption that this profile does not change in the short run, we can therefore combine Figure 5.8 with the latest population projections to estimate how much spending would need to increase by between 2009–10 and 2019–20 to account for a growing and ageing population. These estimates are shown in Table 5.5, where they are compared with the current real increases in DH and NHS England spending implied by the latest spending plans.

In order to keep pace with the growing size of the population, or in other words to keep real spending per capita constant, real health spending needed to increase by an average of 0.8% each year (or 5.0% in total) between 2009–10 and 2015–16. To maintain real spending per capita on people of each age required larger increases, of 1.3% per year (or 8.1% in total), due to our ageing population. Actual real spending by the DH just kept pace with this, increasing by 1.5% per year or 9.0% in total.

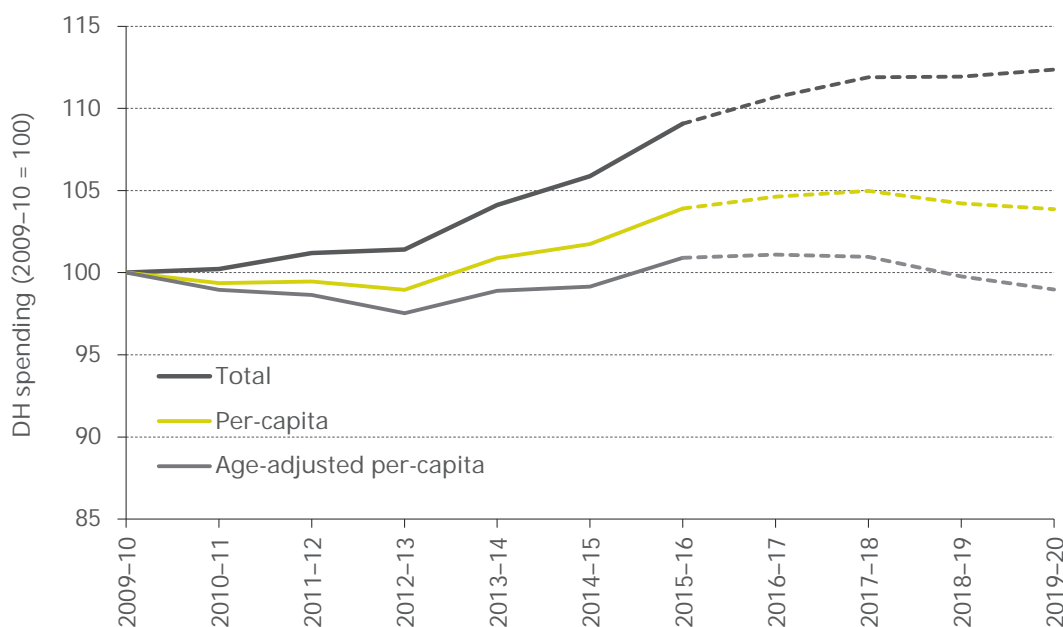
These changes can also be forecast going forward. The latest population projections imply that to keep real spending per capita constant, a real increase of 0.8% per year (or 3.1% in total) is required between 2015–16 and 2019–20. Accounting for the changing age structure as well requires real increases of 1.2% per year (or 5.0% in total). This compares with current planned increases in DH spending of 0.7% per year (or 3.0% in total) between

2015–16 and 2019–20. As a result, the planned increase in the DH budget over the next few years will fall short of that required to keep pace with the growing and ageing population by £2.4 billion.

As a result of planned spending, real increases in DH spending between 2009–10 and 2019–20 are set to be larger than the increases required to keep pace with population growth, with average growth of 1.2% per year (12.3% total, or £13.4 billion) rather than 0.8% per year (8.2%, £8.9 billion). However, this is below the spending increases required to keep pace with both population growth and changing age structure (1.3% per year, or 13.5% in total). This is clearly shown in Figure 5.9, which compares overall, per-capita and age-adjusted per-capita DH spending with their 2009–10 level in each financial year between 2009–10 and 2019–20 (forecast spending is shown by the broken line). This means that a real increase in DH spending between 2009–10 and 2019–20 of £14.7 billion will be required to keep pace with these changes. The current plans include growth of only £13.4 billion and, as a result, indicate a shortfall of £1.3 billion in DH spending by the end of the period.

If we consider only NHS England spending between 2015–16 and 2019–20, the current plans imply real increases in spending between 2015–16 and 2019–20 of 6.2% (1.5% per year) or £7.1 billion, which is sufficient to meet the annual 1.2% spending increases required to keep pace with both population growth and the changing age structure. In monetary terms, the plans indicate a real increase of £7.1 billion in NHS England funding, compared with funding pressure of £5.1 billion. In other words, three-quarters of the

Figure 5.9. Real-terms Department of Health spending (2009–10 = 100), 2009–10 to 2019–20



Note: Total, per-capita and age-adjusted per-capita spending in 2009–10 each take the value 100.

Source: Authors’ calculations using DH spending from HM Treasury PESA 2016 for all years between 2009–10 and 2019–20, ONS population projections (June 2014), ONS mid-year population estimates (2009 to 2015) and age spending weights from the Office for Budget Responsibility *Fiscal Sustainability Report 2017* (as shown in Figure 5.8).

increase in the NHS England budget over the period from 2015–16 to 2019–20 will be taken up by the expected costs of a growing and ageing population.

It is important to acknowledge that these estimates only account for demographic pressures on health care going forward. NHS England calculates that there are additional cost pressures that add to the cost of providing health care in England in each year.²¹ Substantially larger increases than 1.2% per year would therefore be required to meet these costs fully (in addition to the demographic pressures). We discuss the implications of these costs for long-run health spending in Section 5.5.

While funding for health care has grown over time, the level of health care services in the UK has also increased over time. To some extent, this increase in activity is driven by input growth, with health care inputs increasing by 93.6%, or 4.0% per year between 1997 and 2014.²² Health care productivity also increased over this period. This means that the NHS has been able to produce a greater (quality-adjusted) level of output with a given level of inputs over time.²³ ONS estimates indicate that productivity grew at an average rate of 0.9% per year between 1997 and 2014.²⁴

As a result of both an increased level of inputs and a more productive use of these inputs, health output has increased over time. Figure 5.10 shows how quality-adjusted output in the UK has changed between 1997 and 2014 (relative to the 1997 level).²⁵ Health care activity has increased by 126.8% over this period, or 4.9% per year on average. This increase in activity is not driven simply by increased demand arising from population growth (0.6% per year on average over the same period) and the ageing of the population. Thus demand for health care has increased over and above what would be required by demographic pressures, and this is likely to continue in the future.

How well the NHS meets future demand pressures will have important implications for the quality of health care services that it provides. However, measuring service quality is difficult. There are a myriad of indicators that are used to measure the performance of the NHS. These include waiting times for a range of services, patient satisfaction and death rates.²⁶ One indicator of NHS performance that has attracted much attention in recent years is waiting times in NHS accident and emergency (A&E) departments. From 2010–11,

²¹ NHS England, 'NHS Five Year Forward View: recap briefing for the Health Select Committee on technical modelling and scenarios', May 2016, <https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf>.

²² Figure 7 of Office for National Statistics, 'Public service productivity estimates: total public service: UK: 2014', <https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/articles/publicservicesproductivityestimatesoftotalpublicservices/2014>; last accessed on 20 January 2017.

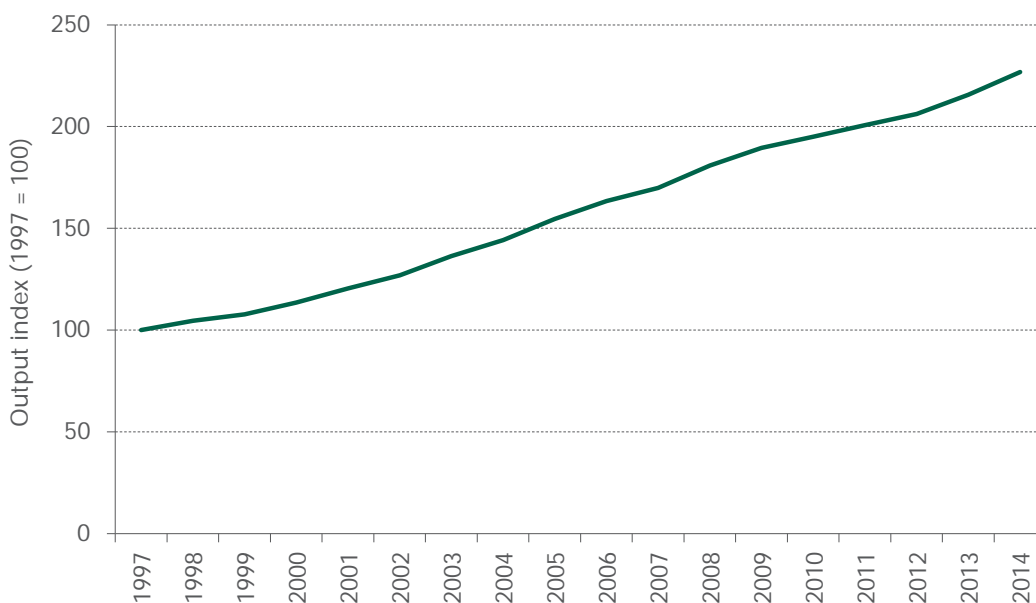
²³ For more details on quality adjustments for health care outputs, see Office for National Statistics, 'Sources and methods for public service productivity estimates: healthcare', available at <http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/guide-method/method-quality/specific/public-sector-methodology/articles/index.html>.

²⁴ Source as in footnote 22.

²⁵ Health care output or activity is measured using a cost-weighted activity index. This combines estimates of the health care output – e.g. the number of consultations, procedures, or products such as drugs – with the unit costs for each unit of output. Estimates include outputs from Hospital and Community Health Services, Family Health Services, drugs prescribed by GPs and NHS-funded services provided by non-NHS bodies (non-NHS services are not cost-weighted). See reference in footnote 23 for further details.

²⁶ 'QualityWatch', run by the Nuffield Trust and the Health Foundation, tracks a range of these indicators. See <http://www.qualitywatch.org.uk/>.

Figure 5.10. Quality-adjusted health care output (1997 = 100), 1997 to 2014



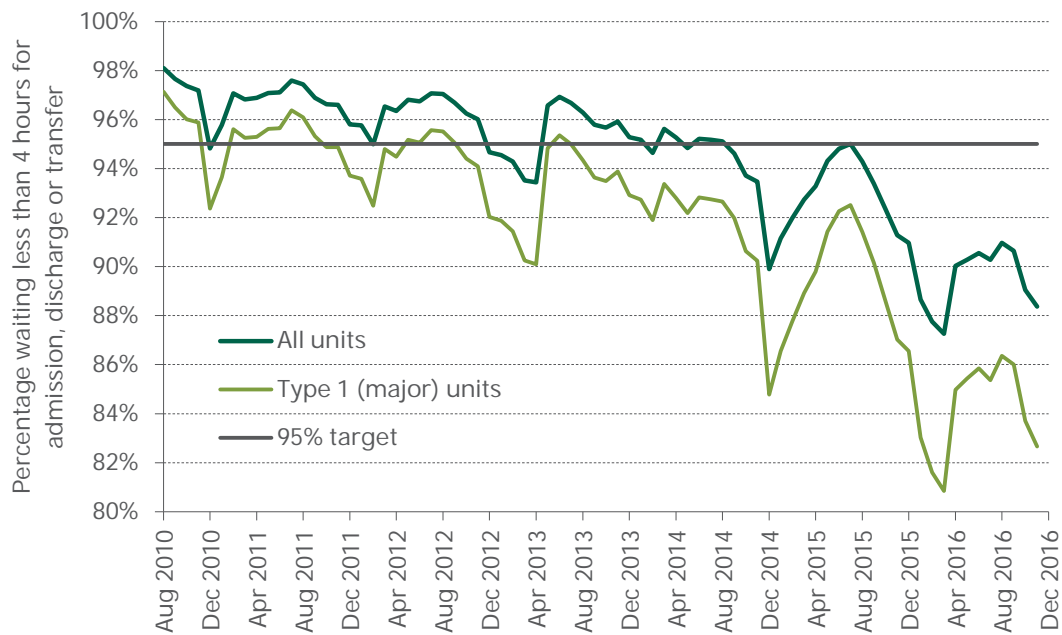
Source: Figure 7 of ONS, ‘Public service productivity estimates: total public service: UK: 2014’, <https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/articles/publicserviceproductivityestimatestotalpublicservices/2014>; last accessed on 20 January 2017.

the target for this measure has mandated that 95% of patients should be admitted, discharged or transferred to another hospital within four hours of arriving at an NHS A&E department.²⁷

Figure 5.11 shows how NHS hospitals performed against this target on a monthly basis between August 2010 and November 2016. It shows performance for all units (including walk-in centres and urgent care centres), and separately for major hospitals (‘Type 1 units’). Hospitals achieved the target level in most months prior to December 2012. However, during the 2012–13 winter season, performance dipped substantially, falling to only 90.1% of patients being treated within four hours in major hospitals in April 2013. Performance subsequently improved before falling again the following winter, and it fell to a low of 84.8% in major hospitals in December 2014. This seasonal pattern was repeated, with improvements in performance in Summer 2015, although the target level was only achieved in one month (July 2015) and performance levels were much lower in major units. The last year has then seen a marked decline in performance against the target, with only 88.4% patients, or 82.7% of patients in major hospitals, seen within the four-hour target in November 2016. This decline in performance has led to the temporary suspension of the target in some hospitals and to substantial debate over the future of the target.

²⁷ When first announced in the NHS Plan in 2000, the target level was 100%. This was reduced to 98% upon implementation in 2005, to allow for a small number of patients with clinical needs that required additional treatment time. This target was further reduced to 95% by the incoming coalition government in 2010. For more information on the target, see <http://www.nhs.uk/NHSEngland/thenhs/nhshistory/Pages/NHShistory2000s.aspx>.

Figure 5.11. Percentage of patients who are admitted, discharged or transferred within four hours of arrival at an A&E department, by unit type, August 2010 to November 2016



Note: All NHS hospitals and walk-in centres that provide emergency care are subject to the 95% target. Type 1 units are 24-hour consultant-led emergency departments with full resuscitation facilities and designated accommodation for the receipt of A&E patients.

Source: Data from NHS England, 'A&E attendances and emergency admissions' (accessed 9 January 2017), <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areas-ae-waiting-times-and-activity-ae-attendances-and-emergency-admissions-2016-17/>.

Of course, general NHS performance cannot be measured by a single indicator. However, there has also been a general decline in performance against targets for elective waiting times, cancer referral times and trolley waits in hospitals.²⁸ Taken together, these indicators suggest that NHS hospitals may already be finding it hard to meet rising demand pressures.

A final, important factor that is likely to influence the pressures faced by the NHS is the future organisation and funding of the social care system. Social care has traditionally been provided in England by local authorities, with the NHS responsible for some health-related long-term care. With large reductions in local authority funding since 2009–10, NHS funds have been increasingly diverted to fund traditional social care activities (as part of the Better Care Fund). Such a decision on the one hand increases the responsibilities of the NHS and reduces resources in other areas of NHS activity. However, the boundary between health and social care is often blurred, with many individuals requiring both acute health care and longer-term social care, and the reduced availability of social care is likely to lead to more use of NHS hospitals in the longer run. Understanding the role of social care, and how funding has evolved in this area in recent years, is therefore important. We turn to these issues in detail in the next section.

²⁸ <http://www.qualitywatch.org.uk/latest-data/combined-performance-summary-november-2016-0>.

5.4 Social care spending in England

Social care covers a wide range of non-medical services provided to individuals and families in order to help them carry out routine activities in their daily lives. It includes the provision of community and residential care for adults with physical and cognitive disabilities and mental health needs, in addition to services for looked-after children, children 'in need' and those on the child protection register.

Children's and adults' social care services are predominantly the responsibility of local authorities (LAs) in England.²⁹ For children, eligibility does not take into account the ability of the child or their parents to pay. However, LAs do have some discretion to charge fees for the services they provide.³⁰ By contrast, LAs only have a duty to provide and contribute to the cost of social care services in England for adults who are deemed sufficiently in need and unable to fund their own care. In the past, eligibility criteria and service coverage varied considerably across the country, but recent policy has aimed to reduce this variation through the introduction of national eligibility criteria as part of the Care Act 2014.³¹

In 2015–16, public spending on LA-organised care was £24.4 billion. One-third (£8.0 billion) of this was spent on children's services and two-thirds (£16.4 billion) on adult social care. These figures are based on LA net expenditure on social care (a measure that excludes any income LAs receive from providing services). They also include £1.8 billion from the Better Care Fund, a new pooled budget between Clinical Commissioning Groups (CCGs) and LAs to provide integrated care and social care services benefiting health. These figures do not include direct spending by the NHS on social care for which LAs have no responsibility.³²

Unlike health care, the majority of social care in England is either paid for privately or provided informally on a voluntary basis (e.g. by a partner or child). The largest source of care is relatives who provide informal care. Estimates from the National Audit Office (NAO) indicate that the replacement cost of all informal care could be as much as six times public spending on care.³³ Recent estimates, using the English Longitudinal Study of Ageing from 2014–15, also indicate that around a quarter of individuals aged 65 years and above received some informal help.³⁴

²⁹ The duties of LAs and the eligibility criteria for public assistance (which differ between children and adults) are defined in the Children Act 1989 and the Care Act 2014.

³⁰ No charge may be made to individuals in receipt of certain income-related benefits, including universal credit, income support and working tax credit.

³¹ Under the new law, LAs must assess separately an individual's care needs and financial situation. An adult is considered in need of care if they are unable to achieve two or more outcomes (such as maintaining personal hygiene) without assistance, distress or danger to their health. If they have assets over £23,250, they automatically have to pay the full cost of their care. However, if their savings are less than this, they will receive a contribution to the cost of their care from the LA, depending on their income and savings.

³² NHS social care spending primarily covers care services for individuals with severe and complex care needs who are considered to have a 'primary health need for care'. These services are counted in our measures of NHS spending in Section 5.3.

³³ NAO, *Adult Social Care in England: Overview*, 2014, <https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf>.

³⁴ R. Crawford and G. Stoye, *The Prevalence and Dynamics of Social Care Receipt*, IFS Report, forthcoming, 2017.

Some adults entirely procure and self-fund their own care. The NAO estimates that the value of this care in 2010–11 was roughly half that spent on LA-organised care (and this share is likely to have increased in recent years given public sector spending cuts).³⁵ In addition to this private funding, individuals may also co-fund receipt of LA-organised care (in 2015–16, these individuals contributed on average 16.5p for every £1 of public funding).³⁶

In this section, we look at how public spending on social care organised by LAs has changed since 2009–10, and how it may evolve up to 2019–20. Looking forward, we compare public social care spending for a scenario in which LAs do not prioritise social care services over the other services they provide and the spending that would be necessary to keep per-capita spending at a constant level for children and adults (a rough guide to the spending required to maintain current service levels with current eligibility thresholds).

Our analysis focuses on the period up to 2019–20. This means we do not consider the impacts of planned reforms after 2020, including the set of reforms that were planned for April 2017 but whose implementation was delayed until (at least) 2020. These reforms, which include a lifetime cap on care costs and an increase in the upper income limit for means-tested care, were estimated by the government before the delay to cost £2.5 billion per year by 2025–26.³⁷ Given the wider fiscal context of continued austerity (see Chapter 3), it would not be surprising if reform were delayed further.

Public spending on social care

Figure 5.12 shows public spending on social care organised by English LAs in each financial year between 1977–78 and 2015–16, in real terms and as a percentage of UK national income. These services have traditionally been funded by local government. In recent years, additional money from NHS transfers have accounted for a small but increasing share of spending. The figure shows spending with (solid line) and without (broken line) spending funded by NHS transfers to LAs.

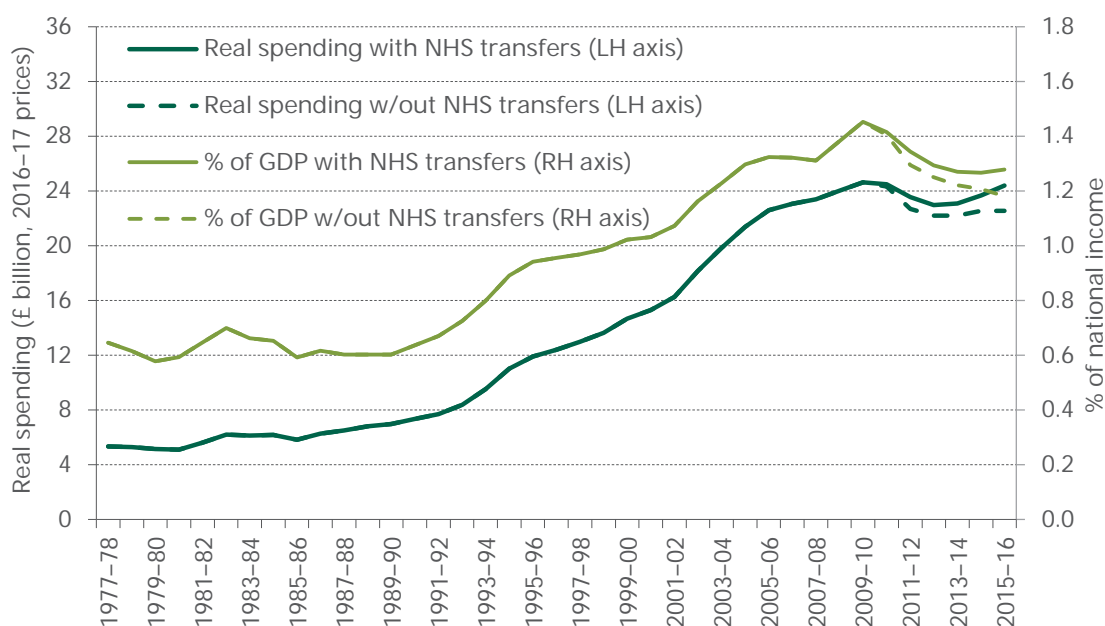
Public spending on social care has grown substantially over time both in real terms and as a share of national income. Growth in spending was particularly rapid in the first half of the 1990s and the first half of the 2000s. Between 1977–78 and 2009–10, spending grew on average by 4.9% per year. This is even faster than the 4.4% growth in UK health spending over the same period (see Figure 5.1). However, between 2009–10 and 2015–16, public spending on social care decreased by 1%. This is in contrast to the 9.0% real increase in DH spending in England over the same period. Transfers from the NHS to LAs played a

³⁵ NAO, *Adult Social Care in England: Overview*, 2014, <https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf>. Estimates originally come from Skills for Care, *The Economic Value of the Adult Social Care Sector in England*, 2013, <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/SfC-Economic-Impacts-Report-FINAL.pdf> and are based on the assumption that 48% of residential care users and 20% of users of other care services are entirely self-funded.

³⁶ Ratio of local authority social care expenditure financed by fees and charges to sum of net revenue expenditure on social care (both from DCLG local government revenue expenditure and financing statistics) and NHS transfers.

³⁷ Department of Health, *Social Care Funding Reform Impact Assessment*, IA 9531, February 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401348/Social_Care_Funding_Reform_IA_FINAL_v2.pdf.

Figure 5.12. Social care spending by local authorities in England on a consistent basis in real terms (2016–17 prices) and as a percentage of national income, 1977–78 to 2015–16



Note: Public social care spending is defined as net expenditure on social care by local authorities, plus NHS transfers to local authorities to fund social care from 2010–11 onwards. It excludes any NHS spending on social care other than the transfers for local authorities (e.g. continuing health care arrangements, nurses in care homes etc.). We assume that the learning disability and health reform grant (which prior to 2011–12 was part of the NHS budget and is included in this figure) grew at the same rate as the rest of social care spending.

Source: DCLG local government budget data (2015–16), DCLG local government out-turn data (2014–15), CIPFA financial and general actuals (2007–08 to 2013–14) and adjusted CIPFA financial and general estimates (1977–78 to 2006–07).

significant role in reducing the cut to social care spending over this period. However, this does mean that a larger share of NHS spending is spent on social care rather than on traditional NHS services. The impacts of these transfers on social care are discussed further below.

Table 5.6 shows that social care spending funded solely from LA revenues fell by 8.4% between 2009–10 and 2015–16, from £24.6 billion in 2009–10 to £22.6 billion in 2015–16 (2016–17 prices).³⁸ The cut was front-loaded, with spending falling sharply over the first few years, before flattening out and recovering slightly in 2014–15 and 2015–16.³⁹

³⁸ Note that in 2015–16 LAs were given new legal duties under phase one of the Care Act 2014, including a requirement to assess and meet the eligible needs of carers, for which they received additional funding in this year. To the extent that these needs were not previously being met by other public services, this represents a genuine increase in spending.

³⁹ This series is adjusted to ensure a consistent set of LA responsibilities over time. In 2011–12, responsibility and funding for spending on adults with learning disabilities (the ‘Valuing People Now’ programme) was transferred from the NHS to LAs. We add around £1.3 billion to LA spending in 2009–10 and 2010–11 to reflect these changes retrospectively. This is consistent with the treatment of DH spending in HM Treasury PESA 2016. Without this adjustment spending was roughly flat in real terms between 2009–10 and 2012–13, while the demands on LAs had increased.

Table 5.6. Public social care spending, 2009–10 to 2015–16 (2016–17 prices)

	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	Real change
LA net expenditure on social care (£bn)	24.6	24.3	22.7	22.2	22.2	22.6	22.6	-8.4%
% of total local service spending	48.3%	50.4%	51.3%	52.4%	53.6%	54.4%	55.3%	+7ppts
Publicly-funded LA-organised social care (£bn)	24.6	24.5	23.6	23.0	23.1	23.7	24.4	-1.0%
<i>of which NHS transfers to local authorities</i>	– (0%)	£0.17bn (0.7%)	£0.86bn (3.6%)	£0.76bn (3.3%)	£0.89bn (3.8%)	£1.12bn (4.7%)	£1.84bn (7.5%)	

Note: 'NHS transfers to local authorities' also includes winter pressures funding and the Better Care Fund. £1.84 billion in 2015–16 is the portion of the Better Care Fund minimum allocation in that year that CCGs reported was spent on social care services and social care providers; for more information, see NHS England, *Meta-Analysis of Better Care Fund Plans for 2015–16*, <https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-meta-analysis-summary-feb-update.pdf>.

Source: DCLG local authority revenue expenditure and financing statistics, 2009–10 to 2015–16 for LA net expenditure on social care. Annex C table C1 of HSCIC *Personal Social Services: Expenditure and Unit Costs England 2015–16* for NHS transfers, Better Care Fund and winter pressures funding.

Councils have made wider cuts to spending beyond social care. Between 2009–10 and 2015–16, as a result of council tax freezes and cuts to central government grants for LAs, total local service spending by LAs fell by 20.0%.⁴⁰ Local authorities chose to cut social care less than other services, so it now accounts for a larger proportion of local service spending, growing from 48.3% in 2009–10 to 55.3% in 2015–16.

The majority of public spending on social care is funded by LAs from their own revenues. However, since 2010–11, a growing share of spending has been financed by transfers from the NHS budget to LAs for spending on social care services that benefit health.⁴¹ In 2015–16, the transfers became part of the new Better Care Fund, a pooled social care budget between CCGs and LAs. Table 5.6 shows that the value of these transfers has increased from £0.17 billion in 2010–11 to £1.84 billion in 2015–16.⁴²

⁴⁰ Local service spending is defined as net expenditure on services by LAs in England excluding police, fire and national park authorities, as per Department for Communities and Local Government (DCLG) local government revenue expenditure and financing statistics. This measure excludes spending on education, fire, police and public health as LA responsibilities in these areas are inconsistent over time.

⁴¹ This spending is not recorded in LA net expenditure due to accounting practices, and is instead included in spending by the Department of Health. We add it to LA net expenditure on social care to get our headline measure of publicly-funded LA-organised social care. For more detail, see appendix C of Health and Social Care Information Centre, *Personal Social Services: Expenditure and Unit Costs England 2011–12*, <https://catalogue.ic.nhs.uk/publications/social-care/expenditure/pss-exp-eng-11-12-fin/pss-exp-eng-11-12-fin-rpt.pdf>.

⁴² A lack of detailed data makes it hard to confirm how these transfers were spent. In theory, transfers were only to be used to fund adult social care services that also have a health benefit. Between 2010–11 and 2014–15, this condition applied to the entire NHS transfer. In 2015–16, under the Better Care Fund, it applied to only

Table 5.7. Public social care spending on children and adults, 2009–10 to 2015–16 (2016–17 prices)

	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	Real % change
LA-funded children’s social care (£bn)	7.1	7.2	6.9	6.9	7.1	7.8	8.0	+12.4%
LA-funded adult social care (£bn)	17.5	17.1	15.8	15.3	15.1	14.8	14.6	–16.8%
LA-funded adult social care plus NHS transfers (£bn)	17.5	17.3	16.7	16.0	15.9	15.9	16.4	–6.4%

Note: For consistency we add around £1.3 billion of learning disability and health reform funding to adult social care spending in 2009–10 and 2010–11. We also remove around £440,000 of spending on youth services from children’s social care spending in 2014–15 and 2015–16 as these responsibilities were not previously classed as children’s social care. We assume that all NHS transfers to local authorities to fund social care are used to fund adult social care services.

Source: DCLG local authority revenue expenditure and financing statistics, 2009–10 to 2015–16 for LA net expenditure on social care. Annex C table C1 of HSCIC *Personal Social Services: Expenditure and Unit Costs England 2015–16* for NHS transfers, Better Care Fund and winter pressures funding.

Taking NHS transfers to LAs into account, public spending on social care fell by 1.0% between 2009–10 and 2015–16 (and increased in real terms from 2012–13 onwards).

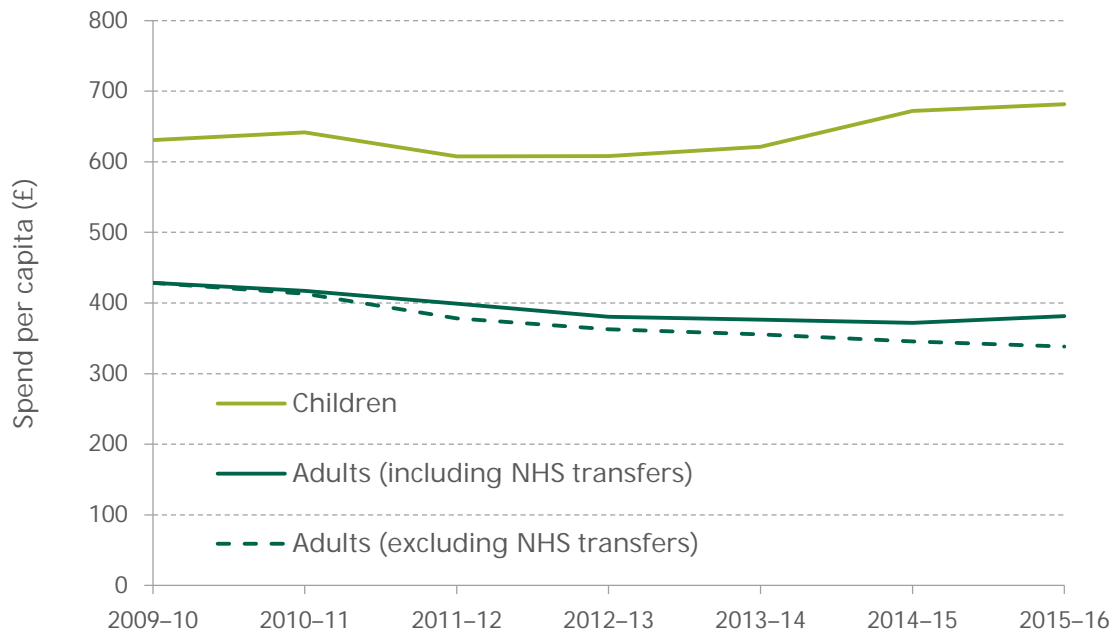
Public spending on LA-organised care for adults and for children have followed starkly different paths. Table 5.7 shows public spending on social care for children and adults in each financial year between 2009–10 and 2015–16. Public spending on children’s social care has increased in real terms by 12.4% over this period, whilst LA spending on adult social care (excluding NHS transfers) has fallen in real terms by 16.8%. If all NHS transfers contributed to adult social care, then the cut to adult social care has been a much smaller 6.4%.

In addition to these changes in overall spending, demand for publicly-funded social care may have increased as the population has grown. Figure 5.13 shows that after taking into account age-specific population growth, spending per child has increased by 8.1% between 2009–10 and 2015–16. In contrast, spending per adult has fallen by 11.0% after taking NHS transfers into account (or by 21.0% if these transfers are excluded).

The care needs and financial situation (and therefore the ability to pay for care) of the adult population are diverse. Ideally, we would like to examine how LAs have prioritised social care services among different age groups during the period of cuts. Population growth has been strongest among the older population, with 15.6% more individuals aged 65 and over in 2015–16 than in 2009–10, compared with 2.6% more individuals aged 18–64.

some of the transfer. Consistent with the Health and Social Care Information Centre (and based on NHS England analysis), we assume that a little under half of the minimum funding was spent on adult social care services in 2015–16. In all other years, we include the entire transfer in the measure of social care spending.

Figure 5.13. Public social care spending per capita by age group, 2009–10 to 2015–16 (2016–17 prices)



Source: Spending from DCLG local government revenue expenditure and financing statistics. NHS transfers from annex C of HSCIC *Personal Social Services: Expenditure and Unit Costs England 2015–16*. Population statistics from ONS estimates.

This suggests that total care needs (regardless of how they are financed) probably rose more quickly for older people than for younger adults over this period, and LAs may have chosen to target more resources to services for older people.

On the other hand, the public sector does not provide comprehensive funding for social care, and older individuals, having (potentially) saved over the course of their working lives, may have a greater ability to pay for care. Younger adults who require care will, on average, have had shorter working lives, have saved less and may have a stronger financial need for publicly-funded care. Local authorities may therefore have focused their limited resources on adults of working age.

The structure of the data – with substantial portions of funding unallocated to particular services – makes it hard to allocate spending to narrow age groups. However, with some assumptions, we can allocate spending between adults aged 18–64 and adults aged 65 and over.⁴³ On this basis, we estimate that public spending on social care for adults (excluding NHS transfers) aged 18–64 has been cut by 6.8% between 2009–10 and 2015–16, whilst spending on those aged 65 and over has fallen by 26.8%. The cut for older adults will be smaller if we have not allocated enough of the ‘unallocated’ funds to this age group. However, this would mean a correspondingly larger cut to spending on younger adults.

⁴³ We allocate any spending on adult social care that is not explicitly allocated to either age group (‘unallocated spend’) in proportion to the share of allocated spending that is labelled as benefiting a particular age group. We also assume that the learning disability and health reform funding added in for 2009–10 and 2010–11 is allocated to each age group in proportion to the share of adults with learning disabilities receiving LA-organised residential care in those years in each age group.

There are no available data that allow us to allocate NHS transfers to specific age groups in 2015–16, so these figures exclude the impact of those transfers. However, for the cuts to be larger among the younger age group than among those aged 65 and over, the latter group would have had to receive more than 97% of those transfers.

Pressures on future social care spending

Forecasting future social care spending is difficult. There are three main areas of uncertainty: demand for care services; cost pressures; and available funding.

First, it is unclear how demand for publicly-funded care will change over time. This depends both on overall demand for care services and on the share of these that the government undertakes to (co-)fund. Given forecast population ageing, demand will increase. However, this may not translate into higher demand for publicly-funded social care if the government responds to age-related increases in demand by tightening eligibility criteria. On the other hand, if the government does not further delay implementation of reforms to social care funding, then the share of social care expenditure covered by the public purse would increase.

Demand for publicly-funded care services may also be limited by the ability of individuals to substitute away from state-provided care, towards privately-funded and informal care. This substitution is possible to a much greater extent for social care than for health care, and it is likely that the ability to use informal and private care will be greater among individuals in the birth cohorts that are currently approaching old age than among individuals in previous, and potentially later, cohorts. Extended life expectancy, particularly for men, is likely to lead to a higher proportion of older people living in couples than before, and therefore increases the potential for (informal) spousal care.⁴⁴ Recent cohorts of older individuals are also substantially wealthier than their predecessors, and also than their children are likely to be.⁴⁵ As a result, they will have, on average, a greater ability to fund (or co-fund with local authorities) social care privately.

Secondly, even if demand is unchanged, the cost of providing social care services may change. For example, increases in the national living wage (NLW) for those aged 25 and over will increase social care provider costs. The forthcoming exit of the UK from the European Union may also make it harder to recruit staff from the EU and require more spending (through higher wages) to maintain the same level of service. If this is the case, government may choose to increase spending in response.

Finally, we do not know how much money will be available to LAs to fund social care. Local authority revenues, which provide the majority of social care funding, will depend upon both general economic conditions (e.g. how much is collected from business rates) and policy decisions in regards to changes to council tax and the local government funding system. How much of their revenues LAs decide to spend on social care depends not just on demand for social care services, but on demand for the other services LAs provide. The introduction of national eligibility criteria, in terms of both care needs and ability to pay, will limit the ability of LAs to reduce (or limit increases in) social care spending when faced

⁴⁴ C. Emmerson, K. Heald and A. Hood, *The Changing Face of Retirement: Future Patterns of Work, Health, Care and Income among the Older Population*, IFS Report R95, 2014, <https://www.ifs.org.uk/uploads/publications/comms/r95.pdf>.

⁴⁵ J. Cribb, A. Hood and R. Joyce, 'The economic circumstances of different generations: the latest picture', IFS Briefing Note BN187, 2016, <https://www.ifs.org.uk/uploads/publications/bns/bn187.pdf>.

with additional demand by tightening eligibility. As a result, LA spending on social care will be more sensitive to changes in demand for social care in future. Although the reforms to eligibility are desirable in the sense that they reduce variation in access to public social care across the country, they will have consequences for LA budgets, and LAs will have to seek cost reductions in social care or elsewhere.

Over the next few years, the government intends to make additional funding available for social care from the NHS budget and elsewhere. The Better Care Fund will continue, with the government pledging to maintain the mandated NHS contribution in real terms to the end of the parliament.⁴⁶ Local authorities will receive new funding from the improved Better Care Fund grant (to be spent as part of the joint budget) and have been allowed to make additional council tax increases from 2016–17 in order to fund adult social care (the so-called ‘social care precept’). A one-off grant for 2017–18 was announced in December 2016, but this redistributes, rather than adds to, overall LA revenues.⁴⁷

The revenues LAs receive from the improved Better Care Fund and the social care precept are ring-fenced for spending on adult social care. Together they equate to £3.1 billion of ‘extra’ funding for adult social care by 2019–20 (assuming LAs use the precept to the maximum and allocate all of this extra revenue to social care). However, the ring fence does not guarantee that LAs will increase social care spending by this amount. The following scenario illustrates this. A local authority initially plans to spend £300 million on social care in a given year. The government then allows it to raise a further £10 million through council tax increases, supposedly to fund additional social care services. This £10 million is reported as spent on social care, but £10 million of main LA budget is moved to fund another service (e.g. waste collection). As a result, the LA still spends £300 million on social care (£10 million of which is nominally funded by the social care precept) and is also able to increase spending elsewhere by the amount it raised. These new sources of funding therefore give councils greater total revenues, but in practice they can decide whether or not to spend them on social care.

Table 5.8 sets out two plausible scenarios for public spending on LA-organised social care from 2015–16 to 2019–20 using funding plans and revenue forecasts where available. Our assumptions in both scenarios include that all councils make full use of the social care precept and that the value of CCG payments into the Better Care Fund going to social care remains flat in real terms.⁴⁸

The scenarios differ only in the assumption about how LAs allocate their spending. In the first column (the ‘low spending’ scenario), social care spending by LAs made out of their own revenues (i.e. excluding NHS transfers) changes in line with their overall budgets. In other words, LAs do not continue to protect social care from spending cuts. Under these assumptions, real-terms spending on social care would fall by 7.2% between 2015–16 and

⁴⁶ Paragraph 1.111 of HM Treasury, *Spending Review and Autumn Statement 2015*, <https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents>.

⁴⁷ N. Amin-Smith, P. Johnson and D. Phillips, ‘How far do today’s social care announcements address social care funding concerns?’, IFS Observation, 16 December 2016, <https://www.ifs.org.uk/publications/8811>.

⁴⁸ See note to Table 5.8 for more detail. These assumptions differ from those of the OBR in its January 2017 Fiscal Sustainability Report, where all spending as part of the Better Care Fund is allocated to health, and not long-term care, spending. As a result, the OBR’s scenario gives a more pessimistic outlook for social care spending.

Table 5.8. Real social care spending required to keep per-capita total spending on social care constant (2016–17 prices), 2015–16 and 2019–20

	Plausible scenario for social care spending (low)	Plausible scenario for social care spending (high)	Per-capita spend held constant at 2015–16 level (incl. Better Care Fund)	Per-capita spend held constant at 2009–10 level
2015–16	£24.4bn	£24.4bn	£24.4bn	£25.8bn
2019–20	£22.6bn	£23.8bn	£25.1bn	£26.6bn
% change, 2015–16 to 2019–20	-7.2%	-2.4%	3.1%	9.2%
Potential spending gap in 2019–20 (low scenario)	–	–	£2.5bn (11%)	£4.0bn (18%)
Potential spending gap in 2019–20 (high scenario)	–	–	£1.3bn (6%)	£2.8bn (11%)

Note: We assume that revenues in 2016–17 are as set out in local authority budgets. The revenue support grant is as set out in the 2017–18 provisional local government finance settlement (December 2016). Any other government grants for which plans are not available (including special grants) are assumed to remain fixed in nominal terms at their 2016–17 level. Retained income from the business rates scheme changes in line with OBR forecasts. The business rates supplement changes at the same rate. All councils make full use of the updated social care precept, increasing council tax by an additional 3% in 2017–18 and 2018–19. We assume that the real-terms value of the Better Care Fund and the share of funding going to social care will remain constant over the entire period.

Source: Authors' calculations using DCLG local government revenue expenditure statistics.

2019–20, from £24.4 billion to £22.6 billion (including £1.84 billion of NHS Better Care Fund spending in each year).

In the second scenario (the 'high spending' scenario), we assume that in years when overall budgets are cut, councils protect social care to the same degree as they did over the period between 2009–10 and 2015–16. In all other years, we assume that social care spending rises in line with overall spending. Under these assumptions, spending on social care would fall by 2.4% between 2015–16 and 2019–20, from £24.4 billion to £23.8 billion (including £1.84 billion of NHS Better Care Fund spending in each year).

One obvious pressure on the demand for social care is population growth and the relative number of adults and children in the population. The third column in Table 5.8 shows how much spending would be required in 2019–20 to keep pace with the growth in the child and adult populations since 2015–16, and so maintain per-child and per-adult spending at the 2015–16 levels (£682 per child and £381 per adult). Taking into account growth in the number of adults and growth in the number of children, spending would need to increase by 3.1%, or 0.8% per year, to maintain per-capita spending for each group over this period. This is equivalent to an additional £753 million (2016–17 prices) of spending for social care in 2019–20 compared with 2015–16, £1.3 billion (6%) more than the 'high' potential

spending scenario in the second column and £2.5 billion (11%) more than the 'low' potential spending scenario set out in the first column.

The final column of Table 5.8 shows how much additional spending would be required to maintain per-capita spending on social care for children and adults at their 2009–10 levels. Given that per-capita spending on social care had already fallen substantially between 2009–10 and 2015–16, a 9.2% real increase in spending would be required between 2015–16 and 2019–20 to restore per-capita spending in the final year to 2009–10 levels. This is equivalent to an additional £2.2 billion (2016–17 prices) being spent on social care in that year compared with what was actually spent in 2015–16, £2.8 billion (11%) more than the 'high' potential spending scenario in the second column and £4.0 billion (18%) more than the 'low' potential spending scenario set out in the first column.

It is again worth noting that we cannot assign social care spending to narrow age groups (beyond children and adults). However, individuals aged 65 and over (and particularly those 85 and above) make up a large share of users of adult social care. Population growth has been particularly strong for this group. As a result of this, these figures are likely to underestimate demographic pressures on adult social care spending.

Demographic pressures mean that if eligibility criteria do not change, LAs must provide care for more people. In addition to demand pressures, the cost of providing care may also rise, reducing the quantity or quality of care that an LA can afford (given a fixed budget). The care industry, perhaps even more so than health, is labour intensive, with many care services involving one-to-one assistance. Labour costs are therefore a significant determinant of the overall cost of care. There are two high-profile pressures on labour costs on the horizon: the introduction of the NLW and the possible labour market implications of Brexit.

A new NLW for employees aged 25 and over of £7.20 an hour was implemented in April 2016. This is forecast by the OBR to increase by 15% to £8.30 in 2019 in nominal terms.⁴⁹ Social care is identified by the Low Pay Commission (LPC) as a 'low-pay sector' to which it pays particular attention, and it sees the risk to the sector from minimum wage increases as 'high'. In April 2015, 7.7% of jobs held by those aged 21 and over in social care were paid at the then national minimum wage (NMW) of £6.50 per hour,⁵⁰ though the LPC voices concerns that this may underestimate the extent of low pay in the sector given evidence of considerable non-compliance, particularly in the form of non-payment for travel time.⁵¹

Although the proportion of jobs at the NMW was lower than in other low-pay sectors in 2015, the ratio of the NMW to the median earnings of adults aged 22 years and above in

⁴⁹ Supplementary economic table 1.19 of OBR, *Economic and Fiscal Outlook – November 2016*, <http://budgetresponsibility.org.uk/efo/economic-and-fiscal-outlook-november-2016/>.

⁵⁰ LPC, *National Minimum Wage: Low Pay Commission Report Spring 2016*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571631/LPC_spring_report_2016.pdf.

⁵¹ See LPC, *National Minimum Wage: Low Pay Commission Report 2014*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/288841/The_National_Minimum_Wage_LPC_Report_2014.pdf and HM Revenue & Customs, 'National minimum wage compliance in the social care sector', 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262269/131125_Social_Care_Evaluation_2013_ReportNov2013PDF.PDF.

the sector was 79.5%. As a result, increases in the minimum wage – and the new NLW – could bind for a very large number of workers, and the LPC reported in Autumn 2016 that coverage of the minimum (now living) wage in social care ‘more than doubled between 2015 and 2016 – the greatest percentage increase of any sector’.⁵² Increases in the NLW planned over the next few years could therefore affect a large proportion of the social care workforce and provide a significant challenge for public funders of social care trying to reducing spending.

A more uncertain risk to costs is the possible knock-on labour market impact of the UK’s exit from the EU. What impact this will have on labour costs for social care will depend in large part on the deal reached (in particular the agreement on freedom of labour movement) between the UK and the EU. However, it is worth noting that an estimated 6% of the adult social care workforce in 2015 was of EU (non-British) nationality. This is equivalent to 80,000 jobs.⁵³ There will also be substantial regional variation in these effects. The rates were 12% in London and 10% in the South East, compared with 1% in the North East. Replacing these workers or facing additional wage levies on employing them could add further to the cost pressures in social care.

5.5 Long-run spending on health and social care

In previous sections, we showed that public spending on health and social care has accounted for an increasing share of national income over time. This trend has been interrupted in recent years with more modest budget increases since 2009–10, and current spending plans indicate this will continue over the next five years. However, over the long term, a number of pressures suggest quicker growth in spending on health and social care than in the rest of the economy. In particular, demographic pressures, low productivity growth in health and social care, and new advancements in medical technology will increase spending in these areas. Understanding how these pressures are likely to affect future spending on health and social care is important when thinking about how care should be organised and funded in future. It also has important ramifications for the wider public finances (see Chapter 3 for more details).

The Office for Budget Responsibility projects spending on health and long-term care as a proportion of GDP over a 50-year period as part of its Fiscal Sustainability Report (FSR).⁵⁴ The most recent estimates, published in January 2017, forecast spending on health and long-term care up to 2066–67. Table 5.9 shows the OBR central forecast of health and long-term care spending in 2016–17, 2021–22, and in 10-year intervals between 2026–27 and 2066–67.

⁵² LPC, *National Minimum Wage: Low Pay Commission Report Autumn 2016*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575634/10583-LPC-National_Living_Wage_WEB.pdf.

⁵³ This excludes jobs funded by direct payment recipients and/or the NHS. Source: Skills for Care, ‘Nationality of the adult social care workforce, 2015’, 2016, <https://www.nmds-sc-online.org.uk/Get.aspx?id=/Research/Adult%20social%20care%20workforce%20reports/Reports/Nationality%20of%20the%20adult%20social%20care%20workforce%202015.pdf>.

⁵⁴ The FSR uses long-term care spending projections from the Department of Health Personal Social Services Research Unit. For more details, see Office for Budget Responsibility, *Fiscal Sustainability Report – January 2017*, <http://budgetresponsibility.org.uk/fsr/fiscal-sustainability-report-january-2017/>.

Table 5.9. OBR central forecasts for health and long-term care spending in 2016–17 to 2066–67, as a percentage of GDP

	Forecast spending as % of GDP						
	2016–17	2021–22	2026–27	2036–37	2046–47	2056–57	2066–67
Health	7.3	6.9	7.6	9.1	10.3	11.5	12.6
Long-term care	1.0	1.1	1.3	1.6	1.8	2.0	2.0
Combined	8.3	8.0	8.9	10.7	12.1	13.5	14.7

Note: 2016–17 and 2021–22 estimates are consistent with the November 2016 Economic and Fiscal Outlook. Projections for financial years between 2026–27 and 2066–67 are consistent with the central projection of the 2017 FSR. The OBR classifies all spending as part of the Better Care Fund (by both the NHS and local authorities) as health spending. This differs from our treatment of Better Care Funding in Section 5.4, where we apportion part of this funding (£1.84 billion in 2015–16) to spending on local-authority-organised social care.

Source: All projections taken from table 3.7 of OBR, *Fiscal Sustainability Report – January 2017*, <http://budgetresponsibility.org.uk/fsr/fiscal-sustainability-report-january-2017/>.

The forecasts indicate that health spending might fall from 7.3% of national income in 2016–17 to 6.9% of national income in 2021–22, in line with the health spending plans in the 2015 Spending Review and the November 2016 forecast for GDP growth. Health spending is then projected to increase steadily over time, rising by 5.7% of national income over 45 years to 12.6% of national income in 2066–67. Spending on long-term care is also projected to increase, doubling from 1.0% of national income in 2016–17 to 2.0% in 2066–67.

These increases are driven by a number of factors. Demographic pressures play an important role in increasing spending on both health and long-term care. The ONS forecasts that the proportion of individuals aged 65 years and over will increase from 18.0% of the population in 2016 to 26.1% in 2066. Growth is particularly strong among the oldest individuals, with the share of the population aged 85 years and above set to increase from 2.4% to 7.1% over the same period. As shown in Figure 5.8, older individuals use more health care, on average, than younger individuals. Long-term care is also disproportionately used by older individuals. As a result, the steady ageing of the UK population will increase the demand for both health and long-term care.

However, while demographic pressures account for the majority of the increases in long-term care spending, other non-demographic pressures (such as technological advances in medical equipment) play a larger role in the growth of health spending. For example, NHS England estimates that non-demographic cost pressures added 2.7% to primary care costs and 1.2% to secondary care costs in 2015–16.⁵⁵ This compares with demographic pressures of 1.3 percentage points in the same year (averaged across primary and secondary care). Estimates of non-demographic pressures from the International Monetary Fund (IMF) are also substantial, at an average of 2.2% per year between 1995 and 2008.⁵⁶ In the latest forecasts, the OBR assumes that non-demographic cost pressures contribute to the

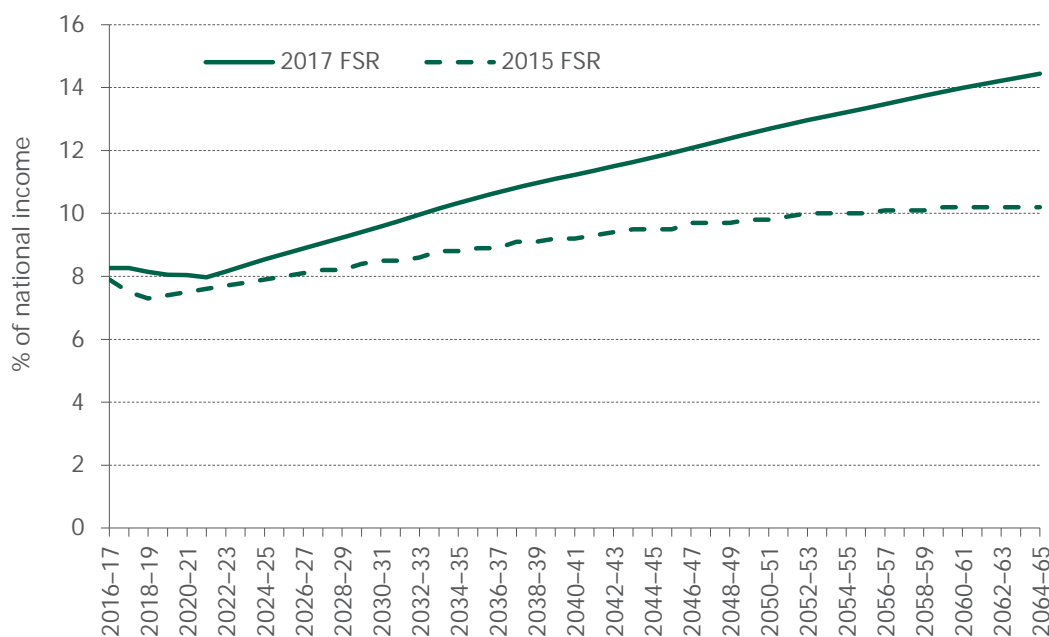
⁵⁵ NHS England, 'NHS Five Year Forward View: recap briefing for the Health Select Committee on technical modelling and scenarios', May 2016, <https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf>.

⁵⁶ International Monetary Fund, 'Macro-fiscal implications of health care reform in advanced and emerging economies', December 2010, <http://www.imf.org/external/np/pp/eng/2010/122810.pdf>.

increase in health spending up to 2066–67. These costs start at a level consistent with the NHS England cost estimates for 2015–16, before falling to a constant level of 1% per year between 2036–37 and 2066–67.⁵⁷

Forecasting spending over a 50-year period is clearly a difficult task, and the projections are extremely sensitive to the assumptions used. In particular, the assumptions around NHS productivity and non-demographic cost pressures drastically affect the forecasts of health spending. In previous FSRs, the forecasts did not include any non-demographic cost pressures. As a result, the latest forecasts indicate a much steeper rise in health spending than those set out by previous projections. This is demonstrated by Figure 5.14, which shows the combined projection for health and long-term care spending as set out in the 2015 and 2017 FSRs. The 2017 forecasts estimate combined spending at 4.2% of national income higher in 2064–65 than the level indicated by the 2015 forecast. This is due to the inclusion of non-demographic costs for health care, and is more than enough to outweigh new assumptions related to slower population ageing⁵⁸ and reduced

Figure 5.14. OBR central forecasts of combined public spending on health and long-term care as a percentage of GDP between 2016–17 and 2064–65, by year of forecast



Source: The 2017 projection combines the central projections of spending on health and long-term care from supplementary table 1.1 of OBR *Fiscal Sustainability Report – January 2017*. The 2015 projection combines the central projections of spending on health and long-term care from supplementary table 1.1 of OBR *Fiscal Sustainability Report – June 2015*.

⁵⁷ The 1% figure is consistent with the steady-state cost pressure used in the long-run projections of US health spending by the US Congressional Budget Office.

⁵⁸ The 2017 FSR uses population projections estimated by the Office for National Statistics in 2014. These differ from the 2012 estimates used in the 2015 FSR. The later set of population projections indicate stronger growth in the working-age population than first expected, increasing future GDP projections. The 2014 figures also have higher mortality rates for those aged 85 and over. As a consequence, there are fewer individuals aged 85 and over who demand health care in any given year. Both of these factors reduce the estimates of health spending as a proportion of GDP.

morbidity at older ages,⁵⁹ which would otherwise reduce projected health spending. It should also be noted that the projections are based on an assumption that productivity in the long-term care sector grows at the same rate as in the rest of the economy, and they take no account of the introduction of the national living wage (which, as discussed in Section 5.4, is expected to add significant costs to care providers). Hence there are good reasons to think that the risks around these projections for long-term care spending are skewed to the upside.

These projections indicate that, regardless of the funding decisions made over the next few years, spending on health and social care is likely to grow substantially going forward. Policymakers must therefore also consider long term solutions to funding these services in addition to the short term decisions currently being debated.

5.6 Conclusion

Since the inception of the publicly-funded health system, UK governments have spent a large and increasing amount on health and social care. However, spending on health and on social care have taken different paths since 2009–10. Health spending increased by 9.0% in real terms between 2009–10 and 2015–16. This is a considerably more generous settlement than most other services (including social care) got and, despite increases being very low by historical standards, the share of service spending accounted for by health spending has continued to rise.

The 2015 Spending Review plans indicate that real NHS spending will increase by £11.6 billion (2016–17 prices), or 11.6% (1.9% per year), between 2014–15 and 2020–21. This increase is larger than that requested by Simon Stevens in 2014. However, this has come partly at the cost of cuts to the wider Department of Health budget. Under the Spending Review plans, DH spending is set to increase by a smaller amount – 7.3% (1.2% per year) between 2014–15 and 2020–21 – implying a real-terms cut to non-NHS DH spending of 20.9%.

Current plans indicate that increases in NHS spending between 2015–16 and 2019–20 will exceed the additional funding required to meet demographic pressures by £1.2 billion (2016–17 prices) in 2019–20. However, these spending increases do not take into account any other cost pressures, and these are likely to be substantial. When considering plans for DH spending, spending in 2019–20 is set to be £1.3 billion below that required to meet the pressures since 2009–10 arising from a growing and ageing population. It is therefore not surprising that there remains pressure on the government to provide additional funding to the NHS (and the wider DH budget) on top of the Spending Review 2015 allocation.

While health spending has increased in England, local authority spending on social care has fallen by 1.0% in real terms between 2009–10 and 2015–16. In per-capita terms, the cut for adults has been 11.0%, and this is likely to be larger for adults over the age of 65.

⁵⁹ The 2015 FSR assumes that as life expectancy increases at older ages, individuals spend these additional years in poor health. This is known as ‘expansion of morbidity’ and increases the proportion of life spent in poor health. The 2017 FSR instead assumes that additional years of life are spent entirely in good health. This assumption is known as ‘compression of morbidity’ and acts to reduce the proportion of life spent in poor health. This is in line with other international forecasts and reduces projected health spending at older ages.

These cuts have come despite local authorities prioritising social care in their budgetary choices, and the increasing size of NHS transfers to local authority budgets. NHS transfers have helped to soften the cuts in the short term, but this means that NHS resources are stretched further and less is spent on traditional health services. Looking forward, though real-terms protection has been guaranteed for the NHS transfers until the end of the parliament, real budget cuts to local authorities will mean that the cumulative cut in social care funding between 2009–10 and 2019–20 is likely to increase.

This contrasting pattern of changes to health and social care spending may in part reflect the relative visibility of NHS funding numbers, but may also reflect the ability of individuals to substitute away from publicly-funded care to privately-funded or informal care, in a way that is much less possible for health care. A key policy issue going forward is whether this pattern will continue, and whether planned reforms to the social care system (such as a lifetime cap on the costs that private individuals face) will be implemented.

Regardless of the funding decisions made in the short term, substantial long-run pressures exist. The latest OBR forecasts make welcome changes in the assumptions about non-demographic costs faced by the NHS. However, this reveals that health and long-term care are projected to account for a huge proportion of national income in future. Making sensible decisions over how to organise and fund such a system in the long run are imperative for policymakers, and may involve difficult decisions over revenue raising and spending elsewhere in future.