

Health and adult social care services

Extract from the July 2017 Fiscal risks report

- 6.47 Taken together health and adult social care are the largest single component of public services spending in the UK. Responsibility for delivering them is split between different levels of government: health care is a responsibility of central government and the devolved administrations, but adult social care is a responsibility of local government. While health care is funded mainly from general taxation, adult social care is currently funded from a combination of central and local taxation and payments by individual service users.
- 6.48 As regards provision, publicly provided health services are delivered by the NHS in England, while publicly provided adult social care is delivered (or commissioned) by local authorities. Scotland and Wales have relatively similar systems, but both have recently passed legislation to increase integration in delivery. Northern Ireland's system is more integrated.
- 6.49 As regards funding in England, treatment by the NHS is largely free at the point of delivery and financed from general taxation. Adult social care in England has to be paid for in full by the recipient until their income and capital falls below a means-tested threshold. When it does, the recipient may still need to pay a user charge based on their income, with the remaining cost met by the local authority. The system in the rest of the UK is somewhat more generous: in particular Scotland offers free personal care to older recipients of social care. Financial support is also provided through disability benefits and carer's allowance.
- 6.50 Public spending on health across the UK as a whole totaled £135.3 billion in 2015-16 (7.2 per cent of UK GDP) and on current plans is set to rise to £148.2 billion in 2019-20 (6.8 per cent).¹ Net adult social care spending local authorities in England was £14.1 billion in 2015-16 (0.9 per cent of English GDP) and is set to rise to £18.0 billion in 2019-20, thanks to recent increases in central government and council tax financing.² Spending through the Better Care Fund (BCF) – a joint programme spanning the NHS and local authorities to help join up services – is captured within health spending. It is worth around £2 billion a year, so if it was instead counted with net adult social care spending, that would be around 14 per cent higher, while health spending would be around 1½ per cent lower.
- 6.51 Chart 6.12 shows OECD estimates of public spending on health and adult social care as a share of GDP in the 'G7' major advanced economies. This excludes private sector spending

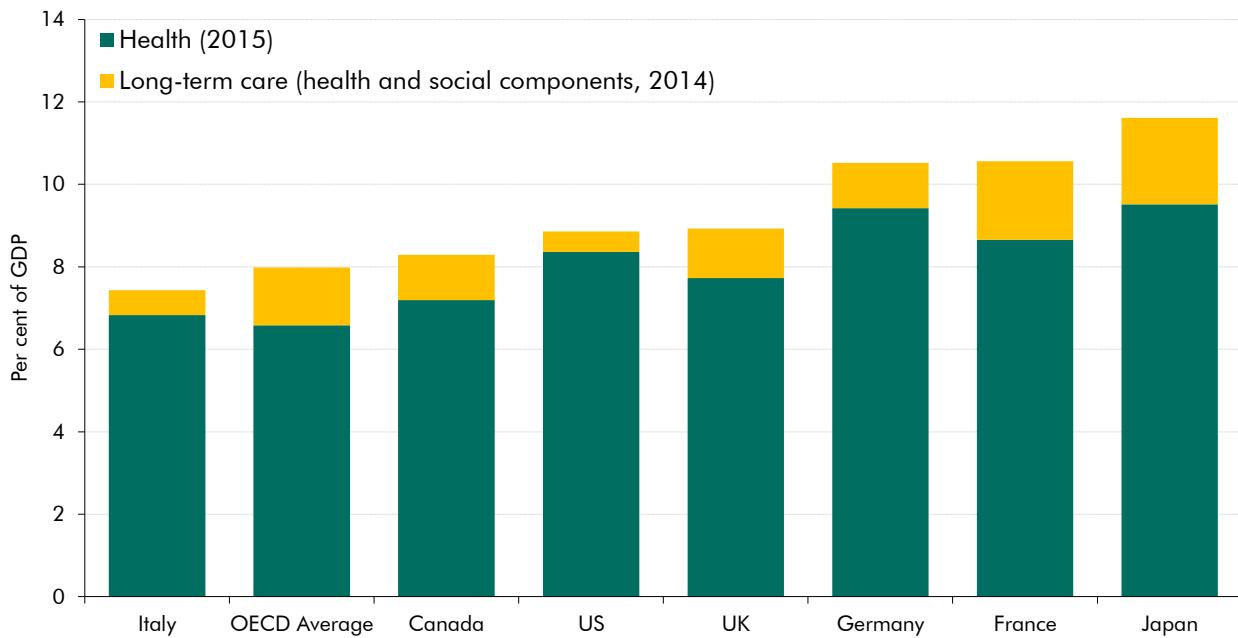
¹ Health spending on a 'functional' basis for the UK, covering both current and capital spending by central government only, taken from HM Treasury, *Public expenditure statistical analyses 2016*, July 2016. This differs from the outturn figures in Chart 6.13, which are for the public sector, i.e. they include local authority spending. Plans for future spending are only produced for central government.

² Outturn adult social care data are net current expenditure figures based on Department for Communities and Local Government (DCLG) local authority revenue expenditure and financing data. They exclude social care for children and families and all NHS income such as the Better Care Fund. As social care is delivered by local authorities, there is no equivalent to departmental plans for future years. The forecasts cited here were produced for us by the Department of Health.

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on these services, which is important in some countries – e.g. on health in the US. The chart shows that public spending on these services in the UK is in the middle of the pack among the G7 countries, but somewhat higher than the average across all OECD countries.

Chart 6.1: Public spending on health and adult social care in the G7



Source: OECD

6.52 We can think of the fiscal risks arising from this source as the possibility that the government and/or local authorities will decide to spend more than they currently plan to over the next few years and/or that spending will rise as a share of GDP over the longer term.

Drivers of health and social care spending

6.53 The amount of public money allocated to health and adult social care is ultimately a political choice, involving trade-offs with other spending priorities. But, viewed across time and countries, the amount governments choose to spend does seem to be driven by an identifiable set of factors, the importance of which varies from period to period:

- **Demographic factors** capture the effect of changes in the age structure of the population, including health status at given ages. The ageing of the population has not been a significant driver of spending in recent decades, but is expected to be more so in the future.³ As Chart 6.5 showed, the proportion of the population aged 85 or more, whose per capita consumption of health and social care spending is greatest, is set to rise sharply over the next half century. It should be noted, however, that the aggregate relationship between age and per capita health spending (shown in Chart 6.3) in part simply reflects the fact that spending rises very sharply in the last year of

³ De la Maisonneuve and Oliveira Martins, *Public spending on health and long-term care: a new set of projections*, OECD Policy Papers No. 06, 2013.

life ('death-related costs') and mortality rates are higher at higher ages. The number of deaths has recently been rising, after years of trending lower (see Chart 6.7).

- **Income-related drivers** reflect the fact that health and social care are 'normal' goods, which means that people generally demand more of them as their incomes rise. Studies suggest that income effects are an important driver of increases in real-terms health spending, but that they do not raise spending as a share of GDP.
- **Non-demographic cost pressures** come from various sources:
 - First, health and social care are **labour-intensive**, which leaves less scope for productivity growth than in the rest of the economy. But pay rates have to remain broadly in line with those elsewhere in order to recruit and retain staff, so relative costs rise in a mechanism known as 'Baumol's cost disease'.⁴
 - Second, **technological advances** (e.g. medical equipment, techniques and procedures) often increase rather than reduce spending, even when they reduce unit costs, because they result in treatments being used more widely.
 - Third, the rise of **chronic conditions** is likely to affect both health and social care, increasing the services that people consume before their final years of life.

NHS England estimated that, on average in 2015-16, these non-demographic cost pressures added 2.7 and 1.2 percentage points to growth in primary (GP) and secondary (hospital and community) care spending respectively.⁵

- 6.54** These drivers are not entirely independent of each other and in practice it is hard to isolate the individual contribution of each in explaining past trends. Estimates in studies that attempt to do so often differ in part because of the order in which they try to identify them.

Medium-term spending risks

Recent trends in UK health and social care spending

- 6.55** As a result of these drivers – primarily the non-demographic cost pressures – health spending has grown faster than the economy on average over recent decades – 3.8 per cent a year in real terms versus 2.2 per cent a year since 1978-79.⁶ This trend is common to most advanced economies.⁷ Similarly, real terms net spending on adult social care in England has increased by an average of 3.3 per cent a year since 1994-95, while real GDP growth averaged 2.1 per cent a year over that period. This reflects spending by local

⁴ Baumol and Bowen, *Performing Arts: The Economic Dilemma*, New York: The Twentieth Century Fund, 1966.

⁵ NHS England, *NHS Five Year Forward View: Recap briefing for the Health Select Committee*, 2016.

⁶ Based on functional spending on health for the UK. Functional spending also includes spending on health by bodies other than the Department of Health, such as local authorities and devolved administrations.

⁷ See our Working Paper No. 9 on *Fiscal sustainability and public spending on health* and *Fiscal sustainability reports* for more detail.

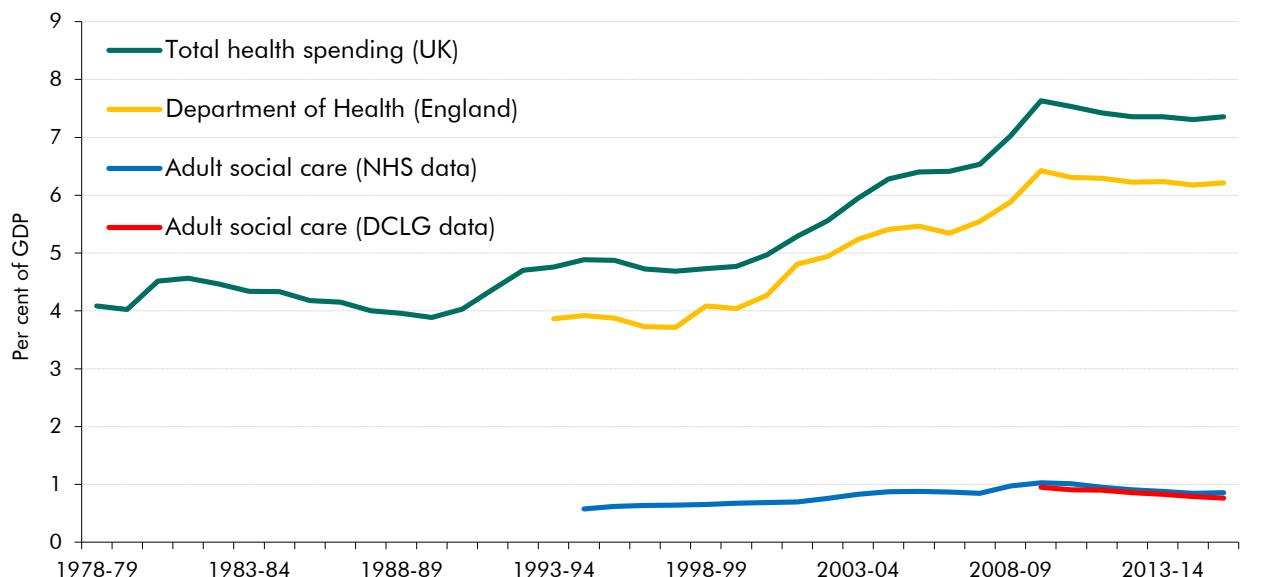
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authority social service departments. If spending through the BCF were included, the average real terms growth would increase to 3.8 per cent.

6.56 But the picture in recent years has been different. Governments have succeeded in squeezing spending on health and social care as a share of GDP to contribute to the deficit reduction programme put in place following the financial crisis (Chart 6.13). In comparison with the pre-crisis trend, the difference is most striking in health. Total health spending increased by 1.0 per cent of GDP in the five years to 2007-08, then by another 1.1 per cent of GDP in the two years to 2009-10 due to crisis-related drop in GDP. Between 2010-11 and 2015-16, the first five years of the deficit reduction programme, spending fell by 0.2 per cent of GDP. We estimate that:

- **pay restraint** more than explained the drop, as average pay and other staff costs increased more slowly than GDP per person;
- **workforce growth** contributed little to the change, as it increased only slightly more slowly than the population; but
- **non-pay costs** offset around half the contribution from pay restraint, as the number of interventions and their average cost increased.

Chart 6.2: Public spending on health and adult social care



Note: NHS data for adult social care is based on net current expenditure for England including the BCF and NHS transfers. DCLG data for adult social care is based on net current expenditure for England excluding the BCF and NHS transfers.

Source: DCLG, HMT, NHS

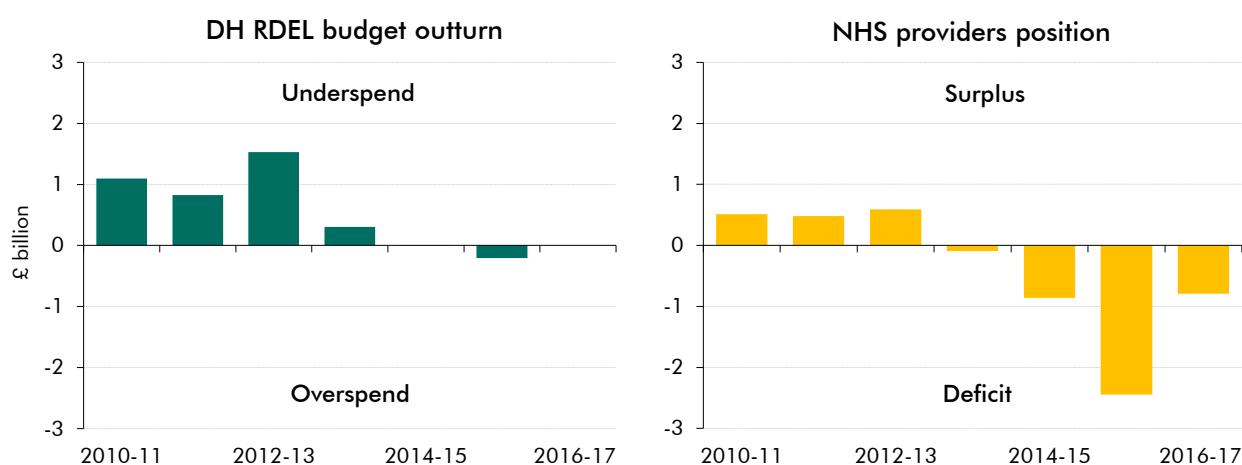
6.57 As the period of relative spending restraint has lengthened, so pressures have begun to emerge in both services:

- **Higher demand and longer waiting lists:** for example, accident and emergency (A&E) attendances and emergency admissions have been rising faster than population

growth, while the proportion of people being seen within four hours of admittance to A&E fell from 96.6 per cent in 2011-12 to 89.1 per cent in 2016-17.⁸

- **Knock-on pressures from social care:** the number of days during which beds in acute hospitals have been occupied due to delayed transfers of care increased by 37 per cent over two years. Social care was responsible for over half this increase, with the two main reported reasons being patients waiting for a care package in their home or a nursing home placement.⁹
- **Financial deficits and overspends:** NHS providers, which account for two-thirds of NHS spending, have been in deficit on average since 2013-14.¹⁰ This puts pressure on DH's DEL budget, requiring offsetting savings elsewhere in the departmental group to keep spending within the overall limit set by the Treasury. Despite making savings elsewhere, the department exceeded its total DEL budget by £0.4 billion in 2015-16. The department also overspent its RDEL (excluding depreciation) budget in 2014-15 by £0.2 billion, but this was more than offset by a capital underspend.

Chart 6.3: Indicators of current health spending pressures



Source: Department of Health Annual Report 2015-16, NHS Improvement

- **Brexit-related uncertainties:** an estimated 5.5 per cent of the NHS workforce are EU nationals, including almost 10 per cent of doctors in England's hospital and community health services.¹¹ UCAS data published in March 2017 showed a 19 per cent fall in unique applicants to nursing and midwifery courses by the March 2017 deadline, compared to the same time point in 2016. Applications from other EU countries were down 25 per cent.¹² There was also a 96 per cent drop in the number

⁸ NHS, *A&E Attendances and Emergency Admission 2017-18*, April 2017.

⁹ NAO, *Health and social care integration*, HC 1011, 2017.

¹⁰ These providers are responsible for secondary (i.e. hospital and community) and tertiary (highly specialist) care.

¹¹ House of Commons Library, *NHS staff from overseas: statistics*, April 2017.

¹² UCAS, 2017 cycle applicant figures, 24 March deadline.

of nurses from the EU registering to practise in the UK in the year to April 2017.¹³

Given other policy changes, it is not clear how much of this relates specifically to Brexit.

- 6.58 In Spending Review 2015, the NHS was ‘protected’, with spending set to rise by 1.6 per cent a year in real terms on average between 2015-16 and 2020-21 and the increases frontloaded.¹⁴ Even so, the NHS has estimated that living within this settlement would require it to make £22 billion of efficiency savings by 2020-21.¹⁵
- 6.59 Comparing the five years to 2020-21 with the five years to 2015-16 (described in paragraph 6.56) is instructive. Spending is set to fall by 0.4 per cent of GDP in the five-year period in progress, up from 0.2 per cent of GDP in the past five years. Pay restraint continues to contribute to the fall, with the 1 per cent ceiling on cash pay rises in place until 2019-20. The effect of this on staff costs per employee is partly offset by a number of new policy-related pressures, the biggest of which are the apprenticeship levy (from 2017-18) and the expected effect of the ongoing pension revaluation (that will take effect in 2019-20). The new immigration skills charge and levy for pension administration costs also hit from 2017-18. Despite these pressures, staff costs per employee are still expected to rise a little more slowly than nominal GDP per person. Unlike the past, it is non-pay costs that are expected to deliver most of the fall in spending as a share of GDP – hence the large efficiency savings the NHS deems necessary. This would require it to overcome both demographic and other cost pressures that have historically led to health spending rising faster than GDP.
- 6.60 In the context of pressures on the NHS, the Government has injected additional funding in recent years and has allowed DH to use its budget allocation more flexibly. For example:
- **Announcements of additional funding:** on a number of occasions in recent years, governments have chosen to increase the health budget beyond the amount initially planned. The 2014 Autumn Statement set out £1.2 billion of additional funding from the reserve for frontline NHS services in 2015-16, raising the baseline for DH’s Spending Review settlement. Spring Budget 2017 also committed additional funding for ‘Sustainability and Transformation Plans’ ('place-based' local plans for the future of health and care services) and for A&E capital investment “*recognising the particular pressure in A&E*”. The Government has also put in place the ‘Better Care Fund’ to integrate health and social care services more effectively.
 - **Switching funds from capital to current spending:** the Treasury has allowed DH to move hundreds of millions of pounds from its capital budget to its resource budget to fund day-to-day spending (£640 million in 2014-15, £950 million in 2015-16 and £1.2 billion in 2016-17). The House of Commons Public Accounts Committee has

¹³ Health Foundation, *New data show 96% drop in nurses from EU since July last year*, 12 June 2017. Changes to language test requirements over this period may also have been a contributing factor to the drop in registrations.

¹⁴ The Department of Health budget did not increase by as much as that of the NHS, creating a squeeze on non-NHS elements of health spending. The Health Select Committee noted that reduced spending in some affected areas, such as funding for Public Health England, could create further knock-on pressures for the NHS. See House of Commons Health Committee, *Impact of the Spending Review on health and social care*, HC 139, 2016.

¹⁵ NHS Five-Year Forward View, *Recap briefing for the Health Select Committee on technical modelling and scenarios*, May 2016 and NAO, *Financial Sustainability of the NHS*, HC 785, 2016.

expressed concern and recommended that DH, NHS England and NHS Improvement should “call a halt to crisis driven transfers out of capital budgets”.¹⁶

Medium-term spending risks

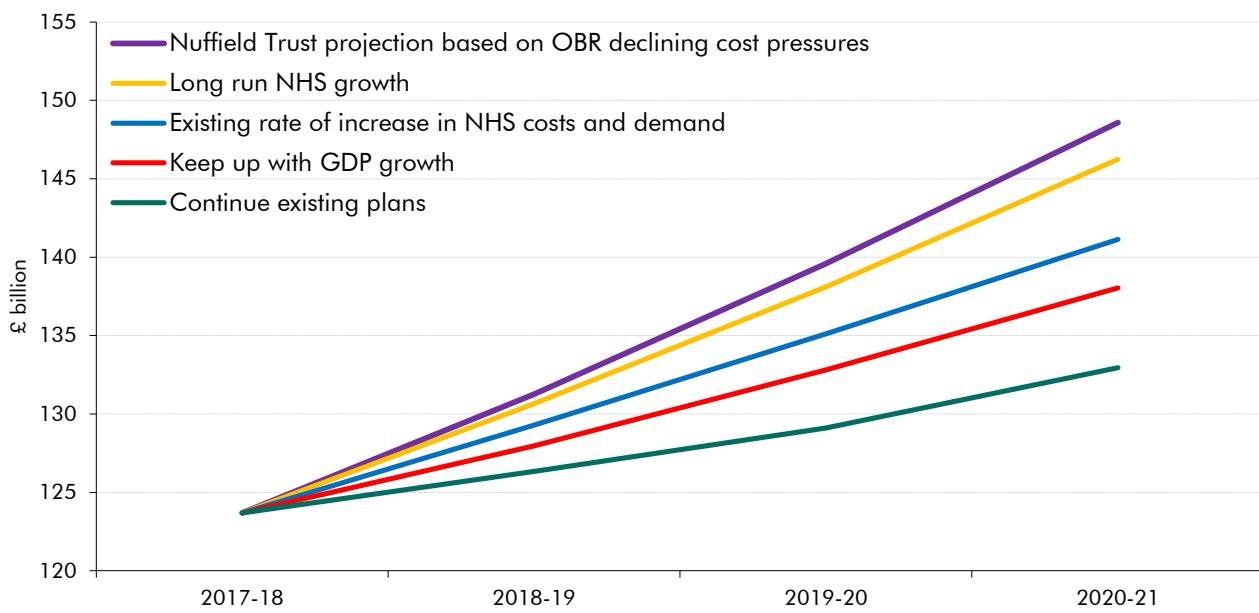
- 6.61 The combination of these emerging pressures and the willingness of successive governments to accede to the NHS’s periodic requests for more money – rather than imposing a hard budget constraint and requiring it to deliver the best service it can within its original allocation – implies a fiscal risk of further increases to current spending plans. The Conservative Party’s 2017 manifesto stated that “we will increase NHS spending by a minimum of £8 billion in real terms over the next five years”, implying further rises beyond those set out in current plans.
- 6.62 One way to assess the risk is to compare current plans to scenarios based on historical patterns or alternative demographic projections. Chart 6.15 shows four scenarios devised by the Nuffield Trust.¹⁷ All have spending higher than current plans, with the difference in 2020-21 ranging from £5.1 billion (to keep DH spending flat as a share of GDP) up to £15.6 billion (using the assumptions that underpin our long-term projections, but applying them from 2017-18 rather than 2022-23). Analysis by the Health Foundation (again based on our 2017 FSR health spending assumptions) suggested that there would be £15 billion (in 2017-18 prices) of spending pressures on top of pre-election spending plans by 2020-21.¹⁸ These top-down estimates do not allow us to identify where pressures are likely to be greatest. But combined with the NHS’s own estimate of necessary efficiency savings and our estimate of which broad categories are set to contribute to the fall in spending as a share of GDP, they suggest that the assumed path of unit cost growth is a key risk.

¹⁶ House of Commons Committee of Public Accounts, *Financial sustainability of the NHS*, Forty Third Report, Session 2016–17, 2017.

¹⁷ Appleby and Gainsbury, *NHS funding choices and the 2017 General Election*, Nuffield Trust, May 2017.

¹⁸ Health Foundation, *General Election 2017: what the manifestos might mean for healthcare funding*, May 2017.

Chart 6.4: DH spending limits versus alternative Nuffield Trust scenarios



Note: Data has been converted from real into cash terms.

Source: Nuffield Trust

6.63 But there are a variety of ways that the Government could reduce spending as a share of GDP. Its focus is on delivering the same output for less by lowering costs and/or increasing productivity, but it could also choose to reduce provision. They all appear challenging:

- **Bearing down further on costs?** This could be done via pay, non-pay costs or a combination of the two. As noted above, pay restraint has been a significant contributor to the drop in NHS spending as a share of GDP in recent years. The 1 per cent cap on public sector pay increases – which applies to NHS staff – is set to continue until 2019-20. However, the NHS is reported to be facing difficulties in recruiting and retaining staff and shortages persist across some key staff groups,¹⁹ to which uncertainty has been added regarding the future rights and status of EU nationals working in the NHS. This has led several commentators to question the sustainability of pay restraint as a cost containment strategy.²⁰ The IFS estimates that every 1 per cent addition to NHS staffing costs would add around £0.5 billion a year to spending.²¹ Sources of potential non-pay savings include equipment, operations and the NHS estate. The NHS is relying more on these looking forward than was the case over the past five years.
- **Improving productivity?** The NHS has set itself a target of 2 to 3 per cent productivity gains a year through to 2020. Recent estimates suggest that productivity in the health care sector has been improving, with the ONS reporting average productivity growth of 2.0 per cent a year since 2012.²² But on the University of York measure productivity

¹⁹ NHS Pay Review Body, *Thirtieth Report*: 2017, March 2017.

²⁰ Royal College of Midwives, *Campaigning to End Pay Restraint in the NHS* submissions to NHS Pay Review Body, *Thirtieth Report*: 2017.

²¹ Stoye, *UK health spending*, IFS Briefing Note BN 201, May 2017.

²² ONS, *Public service productivity estimates: healthcare*, 2014, 2017.

growth has averaged only 1.0 per cent a year over the same period.²³ Over a longer period, productivity growth in the sector averaged 1.2 per cent a year between 1979 and 2014.²⁴ On this measure, it has not averaged more than 2 per cent a year for a period of more than three years.

- **Reduced health care provision?** Opinion polls identify the NHS (alongside Brexit) as the issue that matters most to the British public and find a majority worried that its performance will decline.²⁵ When the NHS England Chief Executive shares his views on the adequacy of health spending, it is often front-page news.²⁶ In this context, the recent General Election saw all the main parties' manifestoes promise to protect or increase NHS funding in some way. It therefore seems highly unlikely that health care provision will be rationed in a material way over the next five years.

6.64 On top of these 'business-as-usual' risks, there could be one-off events that generate demand for additional health spending, such as a large-scale outbreak of disease (e.g. an influenza pandemic, which the Cabinet Office considers to represent "*the most significant civil emergency risk*").²⁷ Long-term systemic cost pressures could also arise from sources such as an increase in antimicrobial resistance, which could greatly increase the costs associated with treating infections in all health care interventions.²⁸

6.65 When considering potential fiscal risks around health spending it is worth bearing in mind the size, complexity and opacity of the system that delivers public health care in the UK. The NHS is the world's fifth largest employer.²⁹ DH oversees nine non-departmental public bodies, including NHS England with its 209 clinical commissioning groups (CCGs). It also oversees three 'special health authorities', five other bodies, 153 NHS foundation trusts, 90 NHS trusts and NHS charities.³⁰ Several commentators have highlighted the challenge that this size and complexity creates for managing health care provision.³¹

Pressures on the adult social care budget and how Government has responded

6.66 As with health, there are visible signs of pressure on the adult social care system. In the past two years, governments have announced top up funding and delayed reforms that would increase costs further. This Government has stated that "*further reform is required to ensure that the system is prepared to meet the challenges of the increasing numbers of over 75s*"

²³ Grašič, Howdon, Santana and Street, *Productivity of the English NHS: 2014/15 Update*, CHE Research Paper 146, 2017.

²⁴ See our 2017 *Fiscal sustainability report*.

²⁵ Ipsos Mori, *Levels of pessimism for future of NHS, policing and education highest for 15 years*, April 2017.

²⁶ See, for example, reporting of Simon Stevens appearance at the House of Commons Health Select Committee in October 2016, where he was asked by the Chair if he felt that the "NHS has been given everything it has asked for" and answered that: "For years 1 and 5, yes, you could say that we were kind of in the zone, but for the next three years we did not get the funding that the NHS had requested. This is not a controversial statement. It is what I have already said to the Public Accounts Committee, so it is not a new statement. As a result, we have a bigger hill to climb. It is going to be a more challenging 2017-18 and 2019-20."

²⁷ Cabinet Office, *National Register of Civil Emergencies: 2015 edition*, 2015.

²⁸ Review on Antimicrobial Resistance, *Antimicrobial Resistance: Tackling a crisis for the health and wealth of nations*, 2014.

²⁹ Forbes, *The World's Biggest Employers*, 2015.

³⁰ Department of Health, *Annual report and accounts 2015-16*, July 2016.

³¹ See, for example, House of Commons Public Administration Committee, *Who's accountable? Relationships between Government and arm's-length bodies*, First Report of Session 2014-15, 2014 and PWC, *Redrawing the health and social care architecture*, 2016.

and that it will “work with partners at all levels, including those who use services and who work to provide care, to bring forward proposals for public consultation”.³²

6.67 Signs and sources of pressure on the adult social care budget include:

- **Pressure on local authority budgets has fed through to adult social care:** For those authorities in England with responsibility for adult social care, it is their largest item of discretionary spending. Local authority budgets have been squeezed by cuts to grant funding and limits on council tax rises. As a result, English local authorities’ total net current expenditure fell by 13.3 per cent in real terms between 2010-11 and 2015-16.³³ Within this, total spending on adult social care fell by less, but local authority spending on it still fell by 9.1 per cent over the same period, including transfers from the NHS. Spending on adult (and children’s) social care exceeded local authorities’ budgets in 2014-15 and, by a bigger margin, in 2015-16.³⁴
- **Reduced service delivery and spillover effects on the NHS:** spending cuts have not been offset by higher productivity – indeed, in a labour-intensive sector, the scope for such an offset is limited. The volume of services being delivered has therefore fallen with the decline in funding, with the Health Foundation estimating a fall of 25 per cent between 2009-10 and 2013-14 (with reductions in services for all disability types).³⁵ This has in turn increased pressure on the NHS, as noted above.
- **The National Living Wage:** in July 2015 the Government announced that the effective minimum wage for employees aged 25 and over – the ‘National Living Wage’ (NLW) – would rise significantly faster than expected earnings growth each year from 2016 to 2020. This will place significant pressure on the unit cost of social care because a high proportion of jobs in the sector are low-wage. Low Pay Commission (LPC) analysis suggests that around 40 per cent of care workers were legally affected by the introduction of the NLW. This generated a substantial compression effect in the bottom half of the wage distribution for care home assistants (including spillover effects for those under 25).³⁶ The LPC analysis found no clear evidence of NLW effects on employment, suggesting that profit margins and, perhaps, care quality were affected by higher labour costs. Our March 2017 EFO forecast implied that the NLW would rise by 17 per cent from its current level of £7.50 an hour to £8.75 an hour in 2020. This implies that much of the growth in adult social care spending in the coming years is required simply to meet faster growth in staff costs.

³² Cabinet Office, *The Queen’s speech and associated background briefing*, 2017.

³³ This fall in local authority spending includes a large fall in education spending due to the ‘academisation’ of schools. When schools switch to become academies, their spending is classified to the central government rather than local authorities sector.

³⁴ See Chart 4.10 in our March 2017 EFO and associated discussion.

³⁵ NHS Digital, 2017.

³⁶ Giupponi and Machin, *The Impact of the National Living Wage on English Care Homes, analysis for the Low Pay Commission*, 2017.

- **Brexit-related workforce uncertainties:** 'Skills for Care' estimates that around 230,000 social care workers in England were born outside the country, one in six of the total; of these, around 90,000 were born in the EU.³⁷

6.68 While the introduction of the NLW has increased pressure on the social care budget, other Government decisions have postponed costs or increased funding. They include:

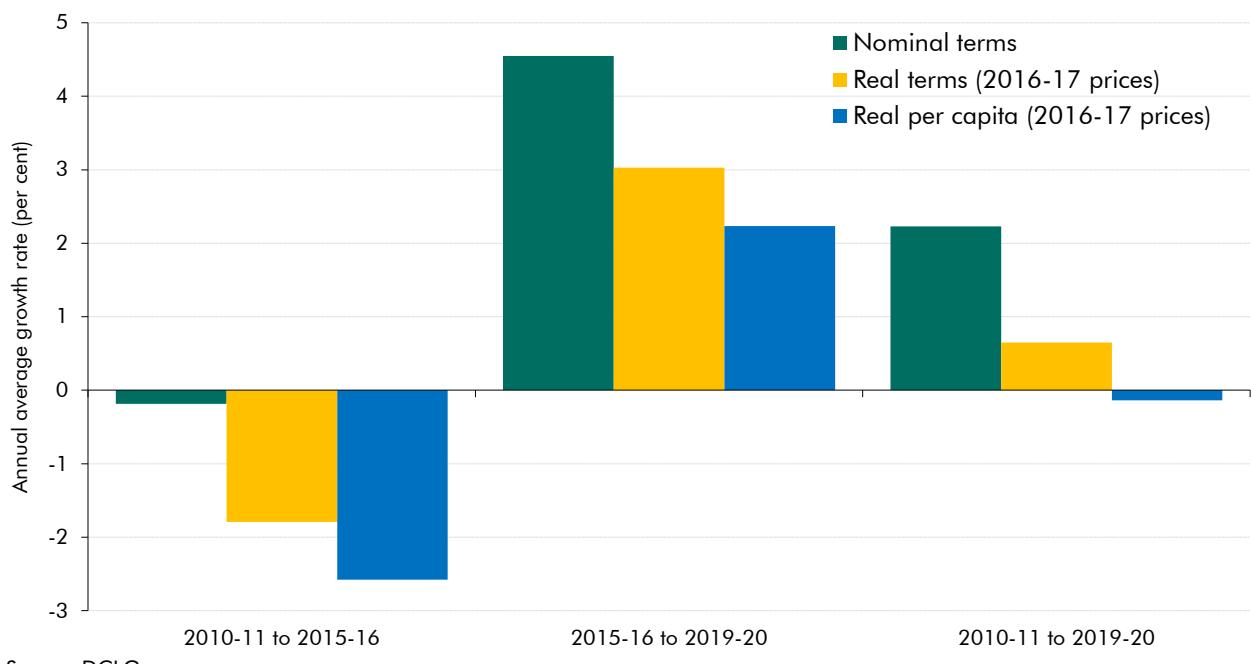
- **Delaying the Dilnot reforms:** the Coalition Government's plans to reform social care funding, informed by the 2011 Dilnot Commission, would have introduced a lifetime cap of £72,000 on certain expenses that individuals pay towards their long-term care, with the state meeting the remainder (bar up to £12,000 a year in 'hotel costs' if the individual is in a care home). This was due to commence in April 2016, at a UK-wide cost of around £6 billion over the first five years. In July 2015, the Conservative Government announced that the introduction would be postponed until April 2020. The new Government now plans to consult on further options for reform.
- **Additional council tax funding:** in Spending Review 2015, the Government announced that eligible councils would be allowed to increase council tax bills by 2 per cent a year beyond the existing cap for a period of three years, with the money raised dedicated to adult social care. In December 2016, it announced that councils would be allowed to raise bills by 3 per cent a year for two years, bringing forward the funding boost.
- **Additional central government funding:** in Spring Budget 2017, the Government announced £1 billion of additional grant funding for local authorities in England in 2017-18 and a further £1 billion spread over 2018-19 and 2019-20. It said that this would "*ensure councils can take immediate action to fund care packages for more people, support social care providers, and relieve pressure on the NHS locally.*"

6.69 The overall effect has been to put the adult social care budget on an upward path, reversing some of the real per capita reduction in spending over the five years to 2015-16 (Chart 6.16). This trend is strengthened further if spending through the BCF is included, to the extent that there is a small increase in real per capita spending of 0.6 per cent over the 10-year period. This would still be smaller than the rise in real staff costs generated by the NLW. In April 2017 a House of Lords committee stated that it "*remain[s] unconvinced that the amount allocated so far for the period to 2020 is sufficient to provide a stable platform of adult social care services on which to build a longer-term funding solution.*"³⁸

³⁷ Skills for Care, *National Minimum Data Set on Social Care (NMDS-SC) for England*, 2016.

³⁸ House of Lords Select Committee on the Long-term Sustainability of the NHS, *The Long-term Sustainability of the NHS and Adult Social Care*, HL Paper 151, 2017.

Chart 6.5: Adult social care spending in England



Source: DCLG

Interactions between health and social care

- 6.70 Health and social care services interact in a number of ways. First, they share a number of common drivers, although they may be sensitive to them in different ways. This means that pressures on both can build at the same time, but not necessarily at the same pace. Second, the services provided are substitutable, so pressures on one can spill over to the other.
- 6.71 In terms of common drivers, where the sensitivity of each form of care to them differs, the key issue is that trends in morbidity (i.e. the amount of time spent in ill health) and trends in disability do not necessarily run in parallel. The relationship between risk factors, morbidity incidence and prevalence, disability rates (at different intensities), mortality rates, healthy life expectancy and disability-free life expectancy is complex. For example:
- Incidence rates of **strokes** have been falling, but the proportion of the population that survives a stroke has been rising. This suggests that the need for acute hospital care for stroke has been falling (easing one source of pressure on health care), but that the need for social care for stroke has been rising (increasing pressure there).³⁹
 - Prevalence rates of **learning disabilities** have been rising due to improved survival, including survival into old age. Severe learning disability is a major driver of the need for social care, but is less important for health care.⁴⁰

³⁹ Lee, Shafe and Cowie, UK stroke incidence, mortality and cardiovascular risk management 1999–2008: time-trend analysis from the General Practice Research Database, 2011. See also Koton, Silvia and others, Stroke incidence and mortality trends in US communities, 1987 to 2011, *Jama* 312.3: 259-268, 2014.

⁴⁰ Emerson and Hatton, Estimating future need for social care among adults with learning disabilities in England: an update, Durham: Improving Health and Lives Learning Disability Observatory, 2011.

- **Dementia** is frequently cited as pressure on social care budgets. Incidence rates (the risk of getting the illness) and prevalence rates (the proportion of cases in the total population) have been falling, probably as a result of reduced smoking and other lifestyle factors. But whether this will continue is uncertain, especially since the prevalence of diabetes, an important risk factor, is rising. And even if age-specific incidence and prevalence rates do not increase, unless there is a breakthrough in treatment the number of sufferers is likely to rise as the population gets older and more people reach the average age of onset in the early-to-mid 80s. Dementia is not a major driver of hospital admissions, but it is a driver of the length and cost of stays (through admissions for other reasons) and a major driver of need for social care.⁴¹

6.72 In terms of how spending on health or social care can influence demand on the other service, NAO analysis suggests that around a fifth of emergency hospital admissions are for existing conditions that could be managed by primary, community or social care.⁴² It also estimated that delays in discharging patients increased by 37 per cent in the two years to November 2016, with the main reason being that patients were waiting for some form of care package, at home or in residential care.⁴³ The extra costs of keeping patients in hospital who no longer need to receive acute clinical care is around £820 million.⁴⁴ Longer stays are also likely to harm older people's health as they lose mobility and ability to do everyday tasks, potentially increasing future health and social care costs.

Long-term risks to fiscal sustainability

Risks factored into our central projections

6.73 The central projections in our latest FSR suggest that if governments choose to increase spending on health and social care to accommodate long-term cost and demand pressures – a plausible interpretation of unchanged policy – then spending would rise gradually but significantly over coming decades as a share of GDP. This would pose clear risks to fiscal sustainability if governments did not take action either to reduce the effects of these pressures or to offset them with lower spending elsewhere.

6.74 In our 2017 FSR, our central projections assumed that:

- **Spending on health care would rise from 6.9 per cent of GDP in 2021-22 to 12.6 per cent of GDP in 2066-67.** Population ageing contributed 1.3 percentage points of the 5.8 per cent of GDP rise, but other non-demographic cost pressures were the biggest factor accounting for 4.5 percentage points of the rise. In terms of the continuous long-term fiscal risks considered in this report, the pressure from ageing, technology and other factors on health spending is the biggest risk we see to fiscal sustainability.

⁴¹ Satizabal, Claudia et al., *Incidence of dementia over three decades in the Framingham Heart Study*, New England Journal of Medicine 374.6: 523-532, 2016.

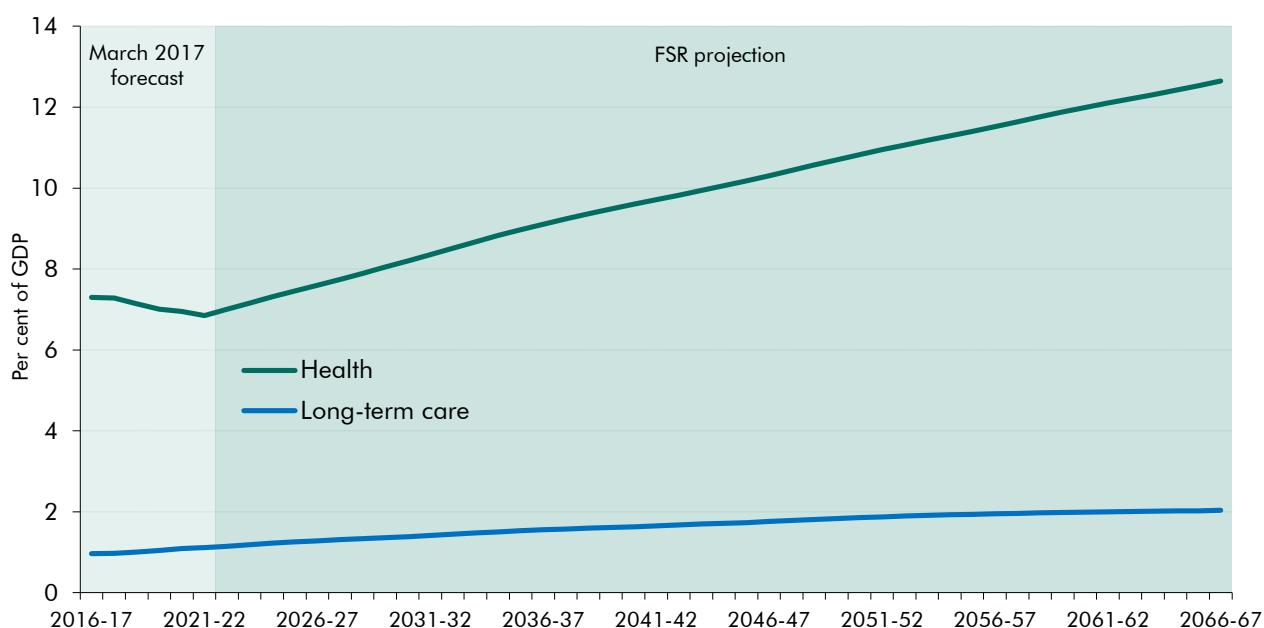
⁴² NAO, *Adult social care in England: overview*, 2014.

⁴³ NAO, *Health and social care integration*, 2017.

⁴⁴ NAO, *Discharging older patients from hospital*, 2016.

- Spending on adult social care would rise from 1.1 per cent of GDP in 2021-22 to 2.0 per cent of GDP in 2066-67. Similarly, the OECD has estimated that spending on long-term care will increase by 0.9 per cent of GDP between 2010 and 2060. It estimates that only around 10 per cent of the increase is due to demographic factors.⁴⁵

Chart 6.6: Long-term projections for health and adult social care spending



Source: OBR

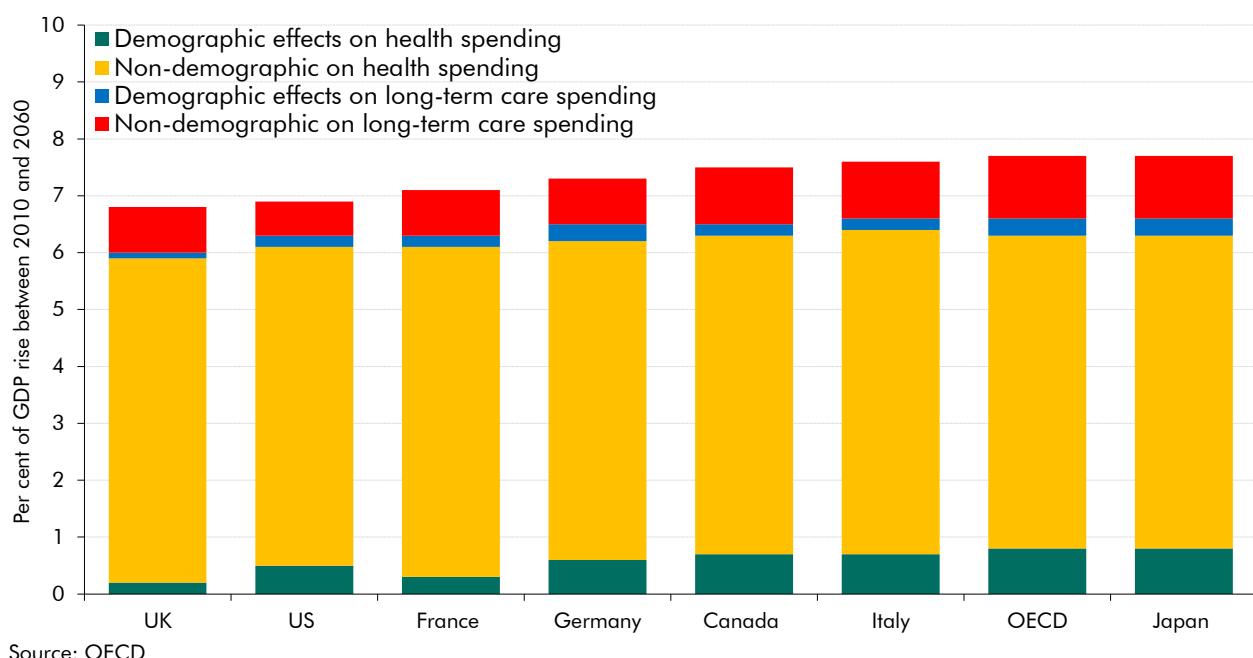
- 6.75** Upward pressure on health and social care spending is not a UK-specific phenomenon. The OECD projects that spending by its member governments will increase by an average of 7.7 per cent of GDP by 2060, from 6.2 to 13.9 per cent (Chart 6.18).⁴⁶ The projected rise in spending in the UK was the smallest among the G7 major advanced economies, although at 6.8 per cent of GDP it would still be equivalent to around £138 billion a year in today's terms. Non-demographic pressures are expected to be a more important driver than population ageing, a conclusion shared by the European Commission's 2015 projections for EU countries.⁴⁷ (As noted above, the precise contribution of each driver differs from study to study – the OECD attributes more of the pressure in the UK to non-demographic rather than demographic drivers than we do.)

⁴⁵ Unlike our long-term methodology based on PSSRU modelling, the OECD's projection equation allows for easy isolation of the demographic drivers in long term care spending, such as care dependency ratios and life expectancy. For this reason the OECD projection has been sampled for an indication of the level of demographic change.

⁴⁶ De la Maisonneuve and Oliveira Martins, *Public spending on health and long-term care: a new set of projections*, OECD Policy Papers No. 06, 2013.

⁴⁷ European Commission, *The 2015 Ageing Report: Economic and Budgetary projections for the EU 28 (2013-2060)*, 2015.

Chart 6.7: OECD projections for rise in health and long-term care spending



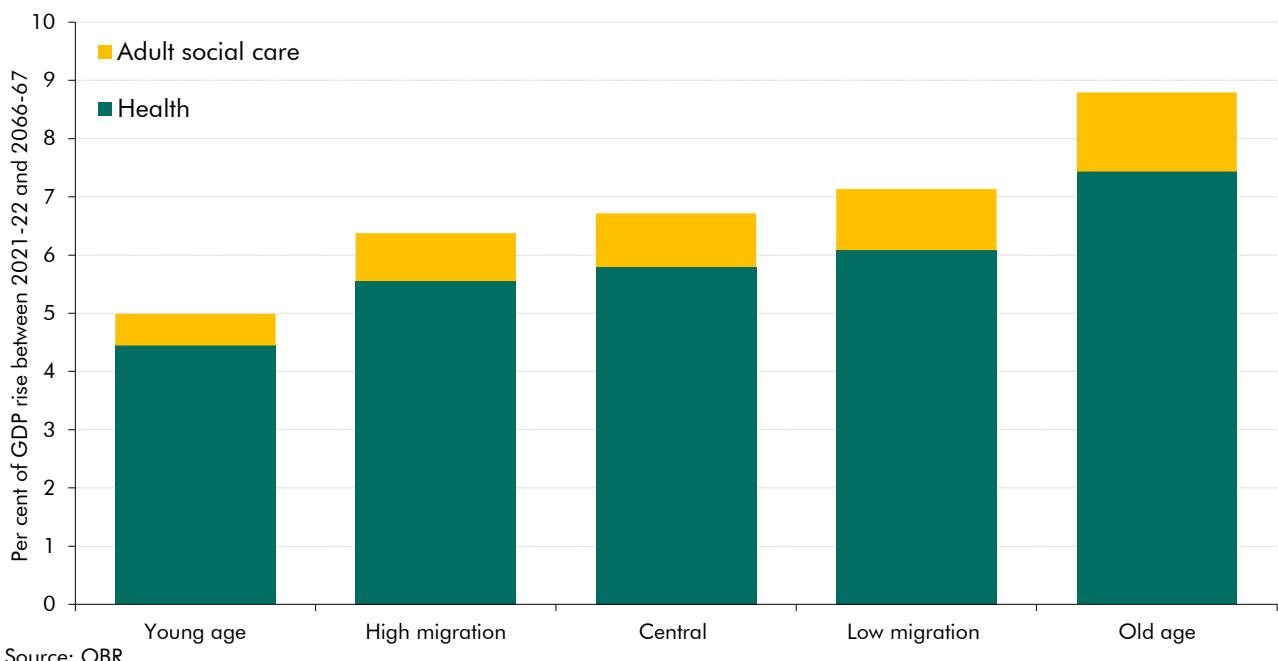
Source: OECD

- 6.76 The scale of the long-term fiscal risk posed by health and adult social care spending depends crucially on the assumptions that we make about the various drivers of spending. There is considerable uncertainty around these, including policy uncertainty around adult social care. We therefore undertake sensitivity analyses to illustrate how our results change under different assumptions. But none of the sensitivities we have tested would see spending flat or falling as a share of GDP, so the uncertainty is over the size of the challenge they pose, not whether there is one. There are, of course, many other potential sources of uncertainty beyond those that we have tested.

Demographic trends

- 6.77 Chart 6.19 shows how sensitive our projections of the rise in spending between 2021-22 and 2066-67 are to demographic assumptions. These use four variants of the ONS population projections: the old age, young age, high migration and low migration variants. The biggest long-term risk would be associated with the old age variant, in which fertility and net inward migration are assumed to be lower, but life expectancy higher, than in the central projection. This means a higher old-age dependency ratio, which feeds through to lower GDP per person and higher spending per person on health and adult social care. In total, public spending on health and adult social care is projected to increase by 2.1 per cent of GDP more by 2066-67 in the old age variant than in our central projection.

Chart 6.8: Change in spending under different demographic assumptions



Trends in health status

6.78 A further age-related sensitivity relates to health status at specific ages:

- **For health spending, the key assumption relates to morbidity** at specific ages when longevity rises. There is significant uncertainty over the relationship between life expectancy and morbidity rates, which could increase, decrease or remain constant as life expectancy rises.⁴⁸ If we see more years spent in *ill* health (an expansion of morbidity), pressure on health spending would rise – especially relative to GDP, since individuals in ill health are also likely to contribute less to GDP. If we see more years spent in good health (a compression of morbidity), GDP could rise by more than any age-related increase in health spending. In our 2017 FSR, we moved from assuming full expansion of morbidity (as in previous FSRs) to slower expansion (so that increases in life expectancy are split between extra time spent in good health and in ill health). The effect was to reduce the rise in health spending by around 0.7 per cent of GDP by 2066-67 relative to an assumption of full expansion of morbidity.
- **For adult social care spending, the key assumption relates to the prevalence of disability** at specific ages. Again, there is considerable uncertainty around the likely impact of rising longevity on disability rates. Some studies have suggested that specific causes of disability may become more prominent with increasing longevity, raising demand for care services.⁴⁹ Others have argued that as life expectancy increases, the incidence of severe disability is delayed, reducing prevalence for some age-groups.⁵⁰ A

⁴⁸ See our Working paper No.9 'Health spending and fiscal sustainability' for a fuller discussion.

⁴⁹ For example, the number of people with a dementia (Alzheimer's disease) is expected to increase, becoming a major public-health problem worldwide. See OECD, *Addressing dementia, The OECD response*, March 2015.

⁵⁰ Fries, *The compression of morbidity: near or far?*, Milbank Memorial Fund Quarterly, Vol 67(2): 208-232, 1989.

third set of studies suggest a dynamic equilibrium, with increasing periods of life spent needing care but the severity of conditions decreasing.⁵¹ Our central projection assumes that the age-specific prevalence of needing care is constant (the ‘base case’). Sensitivity analysis published by PSSRU looks at alternative assumptions for trends in functional disability.⁵² In the scenario that considers ‘continued current trends’, disability prevalence increases among older people. In the base case, the projections show that there would be 2.0 million older people with an ‘activities of daily living’ disability in 2035. This would rise to 2.6 million if current trends continued. This would add around 0.1 per cent of GDP to spending on social care for older people.

The income elasticity of demand for services

- 6.79 In our long-term health spending projections we have assumed that the income elasticity of demand for health care is one, which means that rising incomes put neither upward nor downward pressure on spending as a share of GDP. Using an income elasticity of 0.8 and 1.2 (in both cases gradually converging to one at the end of the projection period) would add or subtract around 0.5 per cent of GDP to health spending in 2066-67 relative to our central projection. Adult social care is likely to be subject to the same uncertainties.

Non-demographic cost pressures

- 6.80 Non-demographic cost pressures are the biggest driver of higher health spending in our central projections and an important factor in our adult social care projections. These assumptions represent key sources of uncertainty:

- **Health spending:** in order to include other cost pressures in our long-term health spending projections, we used the NHS England estimate of non-demographic cost pressures in 2015-16 as the starting point, then assumed that they would decline over time, as might be expected as health spending takes up an ever larger share of national income. Specifically, we assumed a linear convergence for both primary and secondary care to a 1 per cent a year increase from 2036-37 onwards. There is significant uncertainty over the level and speed at which other cost pressures will converge. This reflects significant uncertainty over how pharmaceuticals, medical procedures and technology might evolve over the future. Chart 6.20 shows the sensitivity of our central projection to different assumptions about these pressures.⁵³
- **Adult social care spending:** our projections assume no productivity growth in the social care sector, which means spending must rise as a share of GDP to maintain the volume of services provided. But, according to the ONS, productivity in the adult social care sector has been falling by 1.7 per cent a year on average since 1997, with only five years in which productivity increased. If this continues, unit cost pressures would

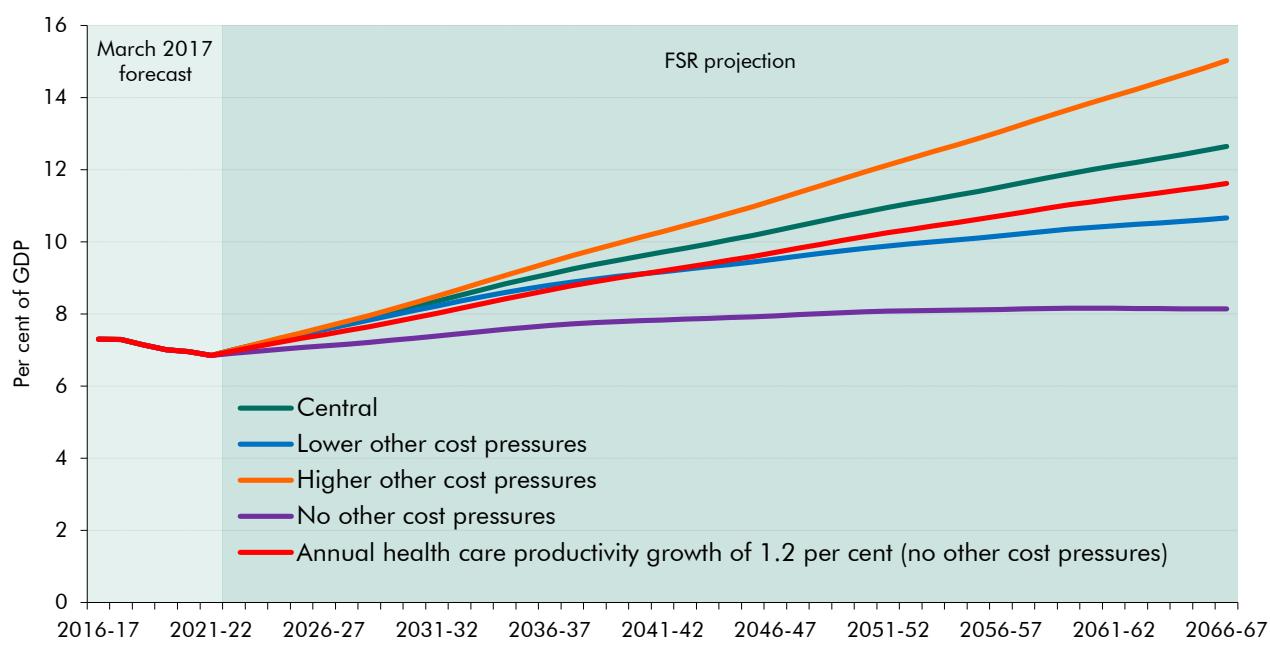
⁵¹ Jagger, *Trends in life expectancy and healthy life expectancy*, Foresight, Government Office for Science, March 2015.

⁵² PSSRU, *Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035*, 2015.

⁵³ Given the considerable uncertainty around estimates of demographic and income-related effects, estimates of other cost pressures that are typically calculated by residual are inherently sensitive to assumptions about other factors. Non-linear interactions are also possible, which adds further uncertainty. For example, high other cost pressures might well be partly driven by a high rate of technological advance. That would increase cost, but it could also increase productivity in the health care. These issues are discussed further in our 2017 FSR and in Licchetta and Stelmach, *Fiscal sustainability and public spending in health*, OBR Working Paper No.9, 2016.

increase relative to our central assumption to maintain the same level of care (although this measure of productivity is not quality-adjusted). The OECD's projections for advanced economies also assume that non-demographic cost pressures will be more important than ageing. The OECD produces a baseline 'cost containment' scenario and a 'cost-pressure' scenario that illustrates the sensitivity of spending to higher cost growth. It projects long-term care spending in the UK would increase by 1.8 per cent of GDP by 2060 in the 'cost pressure' scenario, relative to the 1.4 per cent in their baseline.⁵⁴

Chart 6.9: Health care spending under alternative cost pressure assumptions



Source: OBR

Other sources of risk

- 6.81 A number of other factors might affect demand for adult social care and the unit cost of providing it. On the demand side, expectations of care could increase or the supply of unpaid care from family or friends may not rise as fast as demand for it. On the unit cost side, the capital costs of residential care could increase if property prices continue to rise relative to incomes (as they have historically).
- 6.82 Finally, there are policy-related uncertainties affecting adult social care at the moment. In the last Parliament, the Government decided to delay until April 2020 the introduction of a cap on care costs that had been due to commence in April 2016. The precise details of how the policy would be implemented in 2020 were not specified, so we made some simple assumptions in order to estimate the long-term impact of the policy for our 2017 FSR. The new Government plans to bring forward proposals for public consultation on social care.

⁵⁴ De la Maisonneuve and Oliveira Martins, *Public spending on health and long-term care: a new set of projections*, OECD Policy Papers No. 06, 2013.

Conclusions

- 6.83 Over the medium term, demand and cost pressures in health and adult social care seem more likely to increase than to decrease as the pressures of ageing and other cost pressures continue. Given the propensity of past governments to top up initial spending allocations under such circumstances, and the Conservative Party's manifesto commitment to real terms spending increases over the next five years, this suggests that there is a significant fiscal risk of spending being increased again. This looks high in health, but medium in social care where recent policy decisions have already put funding on an upward trajectory. The potential impact is larger from health than from social care simply because the initial level of spending is much greater. A 1 per cent increase in NHS spending plans over the next four years would add £4.6 billion to PSND in 2020-21, whereas a 1 per cent increase in funding for social care, delivered through central government grants, would add £0.5 billion by 2019-20. Raising council tax to increase social care funding is fiscally neutral.
- 6.84 Over the long term, and on a plausible interpretation of 'unchanged policy', there seems a very high risk that health and adult social care spending will be on an upward trajectory as a share of GDP due to demographic and other cost pressures. In terms of magnitude, our latest long-term fiscal projections suggest that the combined effect – on the basis of policy as it stood prior to the election – would be to increase primary spending by 6.7 per cent of GDP in 2066-67, by far the biggest spending pressure in our projections. While these figures are clearly subject to great uncertainty, the direction of travel does not look in doubt.
- 6.85 In terms of the other characteristics set out in Chapter 1, the long-term risks here are generally gradual and continuous, implying that policy could also respond gradually. However, there is also scope for one-off pressures from time to time if either or both systems come under particular strain, say from a bad winter or if a private sector provider of social care were to fail and the public sector had to take on provision of those services. Health and social care spending risks do not seem correlated with many other fiscal risks.