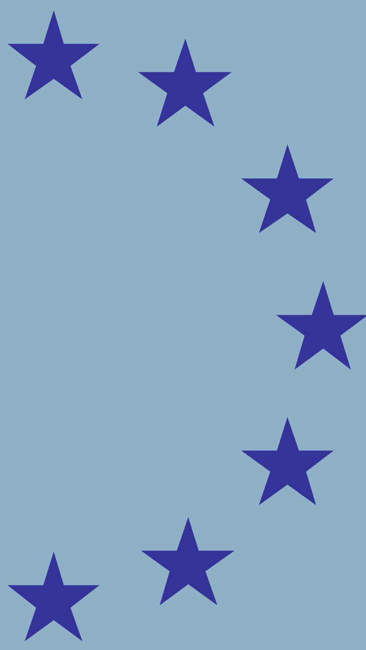
The United Kingdom

Health Care & Long-Term Care Systems



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Economic and Financial Affairs
Economic Policy Committee

The United Kingdom

Health care systems

1.28. UNITED KINGDOM

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, the UK had a GDP per capita of 27.3 PPS (in thousands), below the EU average of 27.9 PPS. Growth finally took hold in the UK in 2013. UK GDP grew by 2.9% in 2014. 2015 recorded a lower, but positive 2.3% and growth is projected to continue through 2016 and 2017 at 2.1%. ([334]) Population was estimated at 63.9 million in 2013. According to Eurostat 2013 projections, total population in the United Kingdom is projected to increase from around 64.1 million in 2013 to 80.1 million in 2060, with an increase of 25%, well above EU average level of 3.1%.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (9.1% in 2013) has fallen since the 2009 peak of 9.7%, due to tight post-crisis budget constraints, and is currently slightly below the EU average of 10.1%. Public expenditure is at 7.6% of GDP, in line with the EU average (7.78%) and similarly has fallen since its peak of 8.1% in 2009.

When expressed in per capita terms, total spending on health at 2,734 PPS in the UK is below the EU average of 2,988 PPS in 2013. So is public spending on health care: 1,927 PPS vs. an average of 2,208 PPS in 2013 in the EU.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 1.3 pps of GDP, above the average growth expected for the EU (0.9 pps) ([335]), according to the "AWG Reference Scenario". When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 2.0 pps of GDP from now until 2060 (EU: 1.6 pps).

([334]) European Commission (2016), European Economic Forecast Winter 2016.

([335]) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report at http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

Sustainability risks emerge in the medium term due to the high initial debt-to-GDP ratio, the projected cost of ageing and the unfavourable initial budgetary position. Over the long run, the projected increase of age-related public spending (notably pensions, healthcare and to a lesser extent long-term care), compounded by the unfavourable initial budgetary position, determine medium fiscal risks ([336]).

Health status

Life expectancy at birth (82.9 years for women and 79.2 years for men in 2013) is, respectively, below and above EU averages (83.3 for women and 77.8 for men in 2013) ([337]). In the same year, healthy life years, at 64.8 years for women and 64.4 years for men, are both above to the EU average of 61.5 and 61.4. The infant mortality rate of 4.2‰ is higher than the EU average of 3.9‰ in 2011, having gradually fallen over the last decade (from 5.3‰ in 2003).

As for the lifestyle of the UK population, the proportion of regular smokers of 20.0% is below the EU average (22.4% in 2011 and 22% in 2013). Obesity rates in the population are, at 24.9%, also well above the EU average of 15.5% in 2013. Alcohol consumption is, at 10.3 litres per capita, slightly higher than the EU average of 2011 (10 litres per capita) ([338]).

System characteristics

Coverage

Services are free at the point of need to all residents. Cost-sharing is limited and applies to some prescription drugs (90% of prescriptions are dispensed with no charge), optical and dental services. Cost-sharing schemes vary across the four countries (e.g. there are no prescription fees in Wales and reduced prescription fees in Scotland).

([336]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

([337]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

([338]) However the OECD reports the UK as characterised by levels of alcohol consumption to have increased during the last 30 years. http://www.oecd.org/unitedkingdom/Health-at-a-Glance-2015-Key-Findings-UK.pdf

Eyeglasses and contact lenses are mostly not funded or provided by the NHS. Children, elderly, pregnant women, those with certain medical conditions, those with an income below a certain threshold, beneficiaries of social benefits and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. In addition, dental charges are regulated to limit the overall cost of a course of treatment. As for prescriptions, these cost GBP 8.20 per item. It is however possible to purchase covering all such costs incurred over a 3-month o 12-month period.

In 2013, private and out-of-pocket expenditure were 16.5% and 9.3% of total health expenditure and therefore below the EU average (22.6% and 14.1%).

Current government policy is to increase access by increasing the choice of primary care physicians by extending service opening hours to evenings and weekends. This is seen as a means to improve access and reduce the waiting times for primary care visits. There are also targets to receive treatment following a GP referral (such as an 18-week target in England). Patients waiting longer than the target were sometimes referred for treatment to private hospitals or hospital abroad. Both inpatient and outpatient waiting time statistics are published across the four countries in the UK. In addition, public comparisons of different health services in terms of several performance indicators are available to help patients exercise choice and to encourage providers to improve their activities.

Surveys show that patients are generally satisfied with the NHS, especially those who have received NHS care.

Administrative organisation and revenue collection mechanism

The total budget of public funds to be allocated to the health sector is defined by the UK Parliament, the UK government and the Scottish, Welsh and Northern Ireland governments. Scotland, Wales and Northern Ireland receive a funding block from HM Treasury and are responsible for the resource allocation in their respective countries. The central government determines resource allocation across countries and regions based on demographic and mortality/morbidity data and historic costs. The funds to be allocated to each sector/ type of care are determined by the UK government and the Scottish, Welsh and Northern Ireland governments given their respective responsibilities. The Department of Health (DH) defines general policy guidelines and priorities for the NHS in England, to which it allocates the budget. DH uses part of the budget received by the Treasury to cover running costs, finance arms' length bodies and other issues of national relevance such as public health. The rest flows to NHS England, responsible for the national-level commissioning of a restricted set of services (specialised services, primary care, offender healthcare and some services for the armed forces) that allocates resources to Clinical Commissioning Groups (CCGS, formerly PCTs), responsible for the local commissioning of healthcare services.

The head of the DH, the Secretary of State for health responds to the UK Prime Minister. The basic benefit package is not explicitly defined but, through periodic assessments, the National Institute for Health and Care Excellence evaluates some interventions, medical devices and pharmaceuticals on the grounds of their clinical- and cost-effectiveness.

Although data is available on public/governmental spending on healthcare (both through the Estimates process, public expenditure transparency systems like OSCAR and through NHS England's Board papers), there is no Government information on total expenditure on health administration (incorporating both health insurance and public spending).

There is a strict health budget defined annually by country and for different health services. Overall health spending for England and the overall block grants to the Scotland, Wales and Northern Ireland are fixed in advance in spending reviews. The results of the most recent spending review, which covers the years 2016-17 to 2019-20, were announced on 25 November 2015 and define a real terms increase of GBP 10 billion in NHS funding in England.

Role of private insurance and out of pocket co-payments

9.9% of the population buys duplicative private insurance (to cover the same services that are

publicly provided/ funded). In 2013, private and out-of-pocket expenditure were 16.5% and 9.3% of total health expenditure and therefore below the EU average (22.6% and 14.1%) in 2013.

Types of providers, referral systems and patient choice

As care provision is defined at country level, there are some differences between England, Wales, Scotland and Northern Ireland in the way care is purchased and delivered.

In England, NHS Trusts (Acute Trusts, Foundation Trusts, Ambulance Trusts, Mental Health Trusts, and Care Trusts) are responsible for providing care to all residents. 209 Clinical Commissioning Groups are the local organisations in charge of ensuring residents are provided much of secondary care. Indeed CCGs control the large majority of the NHS budget by commissioning secondary care for their local population through contracts with Trusts and other providers. Primary care, commissioned by NHS England ([339]), is provided by independent general practitioners (GPs), dentists, or opticians working mostly in private group practices. NHS walk-in centres provide primary care during out-of-office hours as they have longer opening hours than most independent GPs, while the NHS Choices website and NHS 111 phone line provide information on health, allowing people to conduct an initial disease assessment and find information on health providers. 152 NHS Foundation Trusts in England (a type of hospital with large autonomy and run by local managers, staff and the public) and 88 NHS Trusts provide outpatient specialist care and day case and inpatient hospital care. Trusts oversee NHS hospitals and specialist care centres. Some of these are regional or national centres for more specialised care. The large majority of all acute care hospital beds are public. Private provision mostly relates to common, non-elective surgical treatments as well as dental and optical care. Salaried public hospital physicians are allowed to conduct private practice on a part-time basis but only under certain circumstances so as to reduce possible perverse incentives to reduce public sector activity and increase demand for their private practice.

([339]) CCGs are increasingly being delegated responsibility for this area.

Scotland, Wales and Northern Ireland have different models. In Scotland, 14 NHS Boards are responsible for the provision of health services by creating community health partnerships. Community health partnerships work with local authorities, clinical teams and the voluntary sector to support health improvement of local communities. In 2009, the Welsh Assembly launched a consultation to end the internal market in Wales and create a unified health system through the Public health Wales National Health Service Trust. This resulted in the redesign of healthcare delivery in Wales. The 22 Local health Boards who were responsible for commissioning health services for their residents were reduced to 7. The 13 NHS Trusts that provided hospital care were reduced to 3. In Northern Ireland, 4 Health and Social Services Boards are responsible for commissioning health services from a range of providers. 5 (formerly 19) Health and Social Services Trusts are the main service providers.

The number of practising physicians per 100,000 inhabitants (277 in 2013) is below the EU average (344 in 2013) though showing a consistent increase since 2003 (218). The number of GPs per 100,000 inhabitants (80 in 2013) is above the EU average (78.3 in 2013). The number of nurses per 100,000 inhabitants (818 in 2013) is below the EU average (837 in 2013), showing a consistent year-on-year reduction since the peak value of 1024 in 2005.

Changes in remuneration and wage increases have been used to attract licensed but not-practicing physicians back into the sector. In addition, authorities have hired foreign staff. They have used national procurement to have more GPs in areas where shortages were perceived. These suggests the need to continue a comprehensive human resources strategy to ensure that the skill mix goes in the direction of a primary care oriented provision, which authorities wish to pursue, that training, recruitment and attracting licensed staff back into the sector can compensate for staff shortages and losses due to retirement. Staff supply is regulated in terms of quotas for medical students but not by speciality or in terms of the location of physicians, which may explain some of the disparities in staff availability across geographic areas. Current government policy focuses on increasing access to primary care by

extending service opening hours to evenings and weekends.

Authorities have always strongly encouraged the use of primary care vis-à-vis specialist and hospital care. Patients are encouraged to register with a GP and there is a compulsory referral system to specialist and hospital care i.e. GPs are gatekeepers to most ([340]) specialist and hospital care. While choice of GP has been limited in the past, authorities (old and new) have made patient choice over primary care providers a priority and as a result patient choice of GP has been increasing though limited to a geographic area. Choice of specialist and hospital is allowed, and there is a large amount of information explaining to patients how to exercise their choice. From October 2014, GPs in England are able to register patients from outside of their practice area. Where they do so, they are not obliged to provide home visits, out of hours care. In these circumstances, responsibility for ensuring the patient has access to urgent care when away from the practice area, rests with NHS England.

The number of acute care beds per 100 000 inhabitants (228 in 2013) is below the EU average of 356 and has consistently decreased in recent times (312 in 2003). Authorities indicate that while there are no shortages of non-acute care beds, patients may at times create bed-blockages in acute care while awaiting appropriate follow-up care contributing to lengthen waiting times for elective surgery. It is for the central government to plan the opening of new public hospitals, but there appears to be no regulation in terms of the number of beds, the provision of specific specialised services or the supply of high cost equipment capacity. This has, however, not contributed to excessive capacity in terms of beds or high-cost equipment. Hospitals have autonomy to recruit medical and other health staff, while their pay scale is determined at national level.

Treatment options, covered health services

The basic benefit package is not explicitly defined but through clinical and cost-effectiveness assessments, the National Institute for Health and Care Excellence assesses some interventions, medical devices and pharmaceuticals on the grounds of their clinical- and cost-effectiveness.

([340]) There are some self-referring secondary services.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Primary care practitioners, grouped in primary care practices, are mostly independent contractors. Primary care practices are paid for a mix of capitation, additional funding for the provision of enhanced services, services related to preventive care, chronic disease management and patient satisfaction. For the provision of preventative care and patient satisfaction primary care practices are paid through the Quality and Outcomes Framework. This is a voluntary scheme in England, but the vast majority of practices in England take it up. It ensures that practices are rewarded for providing systematic quality of care for patients, not just for the number of patients on their list.

Outpatient and inpatient specialists working in the public sector are paid a salary but are also eligible to receive bonuses related to preventive care and chronic disease activities and targets.

Hospital doctor salaries are determined at hospital level. Private sector doctors are paid on a fee-for-service basis. Hospital doctors can carry out private professional services or fee-paying services, in line with the provisions governing the relationship between NHS work, private practice and fee-paying services in their terms and conditions of service. This means doctors are required to inform their clinical managers of any regular commitments in respect of private professional services or fee-paying activity. Where there is a conflict in scheduling work, NHS commitments must take precedence over private work.

An NHS GP is free to operate a private practice with private patients if they wish to do so. There are heavy restrictions on a GP's ability to charge fees to their NHS registered patients, but there are exceptions for procedures outside the General Medical Services Contracts Regulations such as signing passport applications and holiday insurance claims which GPs can issue a charge for.

When looking at hospital activity, inpatient discharges per 100 inhabitants are below the EU

average (12.4 vs. 16.5 in 2013) but are more than compensated by the very high number of day case discharges which is well above the EU average (15,607, more than double EU average of 7,031 in 2013). The proportion of surgical procedures conducted as day cases (55.8%) is considerably above the EU average (almost twice the EU level of 30.4% in 2013) and indeed one of the EU highest. Overall hospital curative average length of stay (6.6 days in 2011) is slightly above the EU average (6.2 days). These figures suggest that hospital throughput/efficiency is overall very high.

The market for pharmaceutical products

The Drug Tariff sets out what NHS dispensing contractors will be paid for the drugs supplied. There are controlled price amendments (increases/decreases). There is a list of products that cannot be supplied by prescribers as well as a list of products which will only be reimbursed if the listed conditions are fulfilled. Authorities promote rational prescribing by physicians through treatment and prescription guidelines (NICE guidance on clinical and cost-effectiveness effects of interventions, making prescribing measures available for primary care. Information is also available via NICE in the British National Formulary [BNF] and the BNF for Children) complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines.

These are coupled with pharmaceutical budgets. For example, CCGs commonly define local lists of recommended drugs which are considered sufficient to meet the needs of patients as cost-effectively as possible and prescribers (in the UK, nurses, pharmacists and other allied health professionals can, and have, trained to become prescribers) may be asked to justify prescribing outside the recommendations. There are also prescribing advisers employed at various levels of healthcare organisations to encourage rational and cost-effective prescribing and reviewing prescribing behaviour. Some CCGs also run prescribing incentives schemes with GPs so that they receive a (modest) bonus if they use cost-effective clinically appropriate prescribing.

In England, patients pay a flat rate prescription charge for each item dispensed via an NHS prescription, unless one qualifies for exemption. There is an explicit generics policy although generic substitution cannot take place i.e. pharmacies are obliged to dispense the product prescribed by the doctor. However, prescribers are strongly encouraged to prescribe by their generic name for good professional practice (so pharmacists can provide the patient the cheapest product available) and for value for money reasons.

eHealth, Electronic Health Record

The Department of Health published an Information Strategy (May 2012) which set out a ten-year framework for transforming information for health and care. Working with stakeholders DH are in the process of implementing this vision and making progress. A key commitment was to give patients online record access to their GP record by March 2015.

In England resources have been made available to help the service accelerate progress towards a fully integrated health and care service- over GBP 500 m available to NHS trusts to accelerate progress to towards use of integrated digital care records by 2018, and over GBP 100 m to support nurses, midwives and health visitors to make better use of digital technology in all care settings. In addition, in 2013, the government allocated GBP 5.3 bn to support the transformation in integrated health and social care through the Better Care Fund.

NHS England’s Business Plan 2014/15 - 2016/17 outlined that by March 2015 patients would be able to order repeat prescriptions online, book appointments online and have online access to GP records available in 95% of GP practices.

Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis

A large amount of prescribing data is available, practice by practice, to prescribers and advisers to allow benchmarking and encourage improvement. There are also information and education campaigns directed at patients and cost-sharing to encourage a rational use of medicines on the patients' side. For many years, the DH published the share of generic prescribing as an indicator but

the focus has now developed in one of making the best use of medicines. This is called Medicines Optimisation and it works to make sure that the right patient gets the right choice of medicine at the right time. The Medicines and Prescribing Centre (part of NICE) provides a wide range of material and training to promote good quality prescribing. Prescribing advisers also encourage generic prescription.

Within the Quality Outcomes Framework, an annual reward scheme, detailed information is provided in the form of indicators to assess the performance of each GP at the national level. Capturing GPs' performance is also GPOS (general practice outcome standards).

The HS Outcomes Framework includes a set of system performance indicators that contribute to the evaluation of the performance of NHS England in managing the health care sector so that it generates improvements in health outcomes.

Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal identification system, improving remote diagnostics and telemedicine.

Healthy lifestyle and disease prevention activities have received a lot of attention mainly through programmes aiming at improving the health status and quality of life of the population.

Recently legislated and/or planned policy reforms

The NHS in England has undergone major changes in its core organisational and governance structure; most changes took effect on April 1 2013 (for an overview of the most important changes see http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx; accessed November 1, 2013). The Department of Health (DH) is still responsible for strategic leadership of both the health and social care systems, but is no longer the headquarters of the NHS, nor will it directly manage any NHS organisations. This responsibility has shifted to the new organisation NHS England.

NHS England is responsible for:

- Using its national remit to secure improvements in population health (variously improvements in NHS outcomes, and national priorities identified in the NHS Mandate),
- National commissioning of primary care (general practice, dentistry, community pharmacy, and ophthalmology) and specialised services,
- Allocation of funds between services and to local Clinical Commissioning Groups,
- Oversight of the activities of Clinical Commissioning Groups.

Primary care trusts (PCTs) and strategic health authorities (SHAs) have been abolished and new organisations, clinical commissioning groups (CCGs), were established. Primary care trusts (PCTs) used to commission most NHS services and controlled 80% of the NHS budget. On April 1 2013, PCTs were abolished and CCGs were established. All GP practices must now be a member of a CCG and the groups also include other health professionals, such as nurses. CCGs commission most services and can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers. A new regulator (Monitor) oversees and regulates these new arrangements (for more information on this new regulator see http://www.monitor-nhsft.gov.uk/about-monitor-0; accessed November 1, 2013). As of January 2016 the vast majority of hospitals and other NHS trusts have become foundation trusts ([341]); foundation trust will have more ‘freedom’ and a different structure than NHS trusts (for more details see http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/what-are-

([341]) 101 foundation trusts out of 154 acute trusts
43 foundation trusts out of 56 mental health trusts
3 foundation trusts out of 37 community providers
5 foundation trusts out of 10 ambulance trusts
http://www.nhsconfed.org/resources/key-statistics-on-the-nhs, accessed March 2 2016.

nhs-foundation-trusts; accessed November 1, 2013).

In addition, local authorities are tasked to take on a bigger role, which is in line with the political aim of greater overall responsibility at the local level. Local authorities are intended to assume responsibility for budgets for public health. Health and wellbeing boards have duties to encourage integrated working between commissioners of services across health, social care, public health and children's services. With the aim to support the joint effort of NHS and local government in working around people, placing their well-being as the focus of health and care services, the Better Care fund created a local single pooled budget. A new organisation, Public Health England (PHE), provides national leadership and expert services to support public health.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals. There are no separate pricing and reimbursement decisions for reimbursed medicines. The Pharmaceutical Price Regulation Scheme controls the price of branded medicines and the profits pharmaceutical companies can make on selling drugs to the NHS. If companies make too high a profit on NHS reimbursed drugs, they must either reduce the price or repay the NHS.

The 2014 Pharmaceutical Price Regulation Scheme (PPRS) was introduced on 1 January 2014. The scheme will provide assurance on almost all the branded medicines bill for the NHS. The bill will stay flat over the first 2 years of the scheme and will grow slowly after that. The industry will make payments to the Department of Health if NHS spending on branded medicines exceeds the allowed growth rate.

The document "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21" sets out a clearly defined list of priorities for 2016/2017 for each health system and longer term challenges, summarised by nine must dos, supporting the planned delivery of the Forward View. The priorities focus on improvements that all components of the system should try to achieve, ranging from the aggregate financial balance, to quality improvements at all levels of care (primary, emergency and secondary care) and realising efficiency gains.

The Forward View itself focusses on three main key areas:

- prevention and public health in light of projected risk factors in the population;
- removing the barriers between different healthcare providers;
- efficiency in spending to ensure there is no mismatch between resources and need ([342]).

Challenges

The analysis above shows that a range of reforms have been implemented in recent years, for example, to ensure access to a wide range of care, to improve the quality of care, to increase patient choice, to reduce waiting times, to increase activity and efficiency and to control pharmaceutical expenditure. They were to a large extent successful and the UK should continue to pursue them. The main challenges for the UK health care system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated patient packages as well as a focusing on productivity and costs in order to avoid the mismatch between health care needs and resources and ensure consistency with a challenging overall budgetary framework, in view of the future projected increase in health care expenditure over the coming decades, due to population ageing and non-demographic factors.
- To continue to enhance primary care provision by increasing the numbers and spatial distribution of GPs and primary care nurses, investing more in training and developing options to increase retention as envisaged in the Forward View. Additional numbers of needed primary care staff can render the referral system to specialist care more effective and increase actual patient choice.
- To enact the commitment to remove the barriers between difference healthcare

([342]) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf, accessed March 3, 2016.

providers so that care is shifted towards community settings, care is delivered in an integrated way and patients, especially those with chronic conditions, are increasingly empowered. Consistently, to shift resources from acute to primary and community services to strengthen and further develop community-based care.

- To reinforce the existing human resources strategy to tackle current shortages in staff, including in primary care staff, and ensure sufficient numbers of staff in the future in view of staff and population ageing.

- To continue to monitor the coherence of resource allocation to different types of care across geographic areas following devolution and decentralised commissioning of care to CCGs, to avoid possible variations in care availability and quality.

- To further the efforts to improve information in a number of areas and further introducing ICT and eHealth solutions to allow for nationwide electronic exchange of medical data (including patient electronic medical records) to support choice, reduce medical errors and increase cost-efficiency such that general practitioners, municipalities and hospitals work closely together to give citizens a coordinated package of treatment.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school).

- To ensure equal access to health promotion and disease prevention activities to help reducing health inequalities between UK countries and regions.

Table 1.28.1: **Statistical Annex – United Kingdom**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	1720	1849	1946	2063	2169	1908	1668	1813	1866	2054	2043	9289	9800	9934
GDP per capita PPS (thousands)	31.9	32.9	33.2	33.4	32.9	31.0	28.2	27.4	27.0	27.4	27.3	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	3.5	2.7	2.6	2.2	2.7	-1.4	-5.8	0.9	0.4	-1.2	1.1	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	5.8	4.6	5.5	4.2	3.7	3.4	4.4	-2.8	-1.1	-0.8	-0.5	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	7.8	7.9	8.1	8.3	8.4	8.8	9.7	9.4	9.2	9.3	9.1	10.4	10.1	10.1
Total current as % of GDP	7.1	7.3	7.4	7.6	7.6	7.9	8.8	8.6	8.5	8.5	8.5	9.8	9.6	9.7
Total capital investment as % of GDP	0.7	0.6	0.7	0.7	0.7	0.9	1.0	0.8	0.8	0.8	0.7	0.6	0.5	0.5
Total per capita PPS	1707	1833	1984	2124	2246	2392	2573	2574	2619	2684	2734	2828	2911	2995
Public as % of GDP	6.2	6.4	6.6	6.8	6.7	7.2	8.1	7.9	7.7	7.8	7.6	8.1	7.8	7.8
Public current as % of GDP	6.0	6.3	6.4	6.6	6.6	7.0	7.8	7.6	7.4	7.3	7.3	7.9	7.7	7.7
Public per capita PPS	1306	1442	1550	1664	1750	1858	2028	2070	1997	1852	1927	2079	2218	2208
Public capital investment as % of GDP	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.3	0.2	0.2	0.1
Public as % total expenditure on health	79.3	81.4	81.3	81.7	80.5	81.5	83.2	84.0	83.4	84.0	83.5	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	15.1	15.7	15.7	16.1	16.2	15.7	16.3	16.2	16.5	16.6	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	11.1	10.0	9.6	9.9	10.1	8.9	8.7	8.8	9.3	9.0	9.3	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	59.8	59.8	60.2	60.6	61.1	61.6	62.0	62.5	63.0	63.5	63.9	502.1	504.5	506.6
Life expectancy at birth for females	80.5	81.1	81.3	81.6	81.8	81.8	82.4	82.6	83.0	82.8	82.9	82.6	83.1	83.3
Life expectancy at birth for males	76.2	76.8	77.0	77.3	77.6	77.7	78.3	78.6	79.0	79.1	79.2	76.6	77.3	77.8
Healthy life years at birth females	60.9	:	65.5	64.9	66.0	66.3	66.1	65.6	65.2	64.5	64.8	:	62.1	61.5
Healthy life years at birth males	61.5	:	64.2	64.8	64.6	65.0	65.0	64.9	65.2	64.6	64.4	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	77	72	68	63	60	58	54	52	105	104	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	5.3	5.0	5.1	4.9	4.7	4.6	4.5	4.2	4.2	4.1	3.8	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.30	1.29	1.37	1.22	0.83	1.40	1.24	1.14	1.00	1.06	0.98	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.00	1.00	1.00	1.00	1.00	1.00	:	:	:	:	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.31	0.31	0.32
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.25	0.25	0.24
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.73	0.74	0.74	0.70	0.67	0.68	0.72	0.79	0.79	0.81	0.80	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.25	0.20	0.19
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.28.2: Statistical Annex - continued – United Kingdom

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	EU- latest national data 2011	EU- latest national data 2013
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	18.3%	17.7%	18.4%	16.2%	10.9%	17.6%	14.2%	13.3%	11.8%	12.4%	11.6%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	14.1%	13.7%	13.4%	13.2%	13.1%	12.6%	:	:	:	:	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	2.6%	2.6%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	12.2%	11.8%	11.5%	10.6%	10.2%	9.8%	9.2%	10.4%	10.6%	11.0%	10.9%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	3.2%	2.7%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	EU- latest national data 2011	EU- latest national data 2013
MRI units per 100 000 inhabitants	0.46	0.50	0.54	0.56	:	0.55	:	0.63	0.66	:	0.61	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	0.1	0.1	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	0.7	0.7	0.7	0.8	:	0.7	:	0.8	0.8	:	0.8	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.1
Proportion of the population that is obese	23.0	23.0	23.0	24.0	24.0	24.5	23.0	26.1	24.8	24.7	24.9	14.9	15.4	15.5
Proportion of the population that is a regular smoker	26.0	25.0	24.0	22.0	21.0	21.0	21.0	20.0	20.0	20.0	:	23.2	22.4	22.0
Alcohol consumption litres per capita	11.6	11.7	11.5	11.3	11.5	10.7	10.8	10.5	10.3	9.7	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	218	231	239	245	249	258	267	272	276	275	277	329	335	344
Practising nurses per 100 000 inhabitants	1003	1016	1024	991	963	967	983	960	841	821	818	840	812	837
General practitioners per 100 000 inhabitants	:	58	60	60	60	59	58	80	81	80	80	:	78	78.3
Acute hospital beds per 100 000 inhabitants	312	308	299	287	275	272	268	241	237	231	228	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	5.2	5.3	5.0	5.1	5.0	5.9	5.0	:	:	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	12.8	12.8	12.7	12.5	12.5	12.6	12.7	12.7	12.5	12.4	12.4	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	10,253	10,653	11,667	12,358	13,152	14,009	14,487	14,826	15,059	15,086	15,607	6368	6530	7031
Acute care bed occupancy rates	84.0	84.0	84.0	83.0	84.0	84.8	84.2	84.4	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	7.1	6.9	6.7	6.4	6.3	6.2	6.1	5.9	5.9	5.9	5.9	6.5	6.3	6.3
Day cases as % of all hospital discharges	43.9	:	:	50.2	51.7	:	53.2	53.9	54.6	54.8	55.8	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	7.8	8.1	8.5	8.8	9.0	9.1	1.3	0.9
AWG risk scenario	7.8	8.2	8.8	9.4	9.7	9.8	2.0	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	64.1	66.9	70.6	74.0	77.3	80.1	25.0	3.1

Sources: EUROSTAT, OECD and WHO

The United Kingdom

Long-term care systems

2.28. UNITED KINGDOM

General context: Expenditure, fiscal sustainability and demographic trends

The United Kingdom has a population of around 63.9 million inhabitants, which is roughly 12.6% of the EU population. With a GDP of around EUR 2,043 bn, or 27,300 PPS per capita it is in line with the EU average GDP per capita of EUR 27,900. Public expenditure on long-term care is with 1.2% GDP ([471]), slightly higher than EU average in the previous years (around 1% in 2012). During the coming decades the population of the UK is set to increase, from 63.9 million inhabitants in 2013 to 80.1 million inhabitants in 2060. This 25% increase is well above the EU average change of 3%.

Health status

Life expectancy at birth for both women and men was, in 2013, respectively 82.9 and 79.2 years, respectively below and above the EU average (83.3 and 77.8 years, respectively, for women and men). However, the healthy life years at birth were 64.8 years (women) and 64.4 years (men) are both above the EU-average (61.5 and 61.4 respectively). The percentage of the UK population having a long-standing illness or health problem is in line with the EU average (32.5% like for the whole EU 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities is above the EU-average (10.2% against 8.7% in 2012).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 5.47 million residents living with strong limitations due to health problems in 2013, an increase of 49% is envisaged until 2060 to around 8.15 million. That is a steeper increase than in the EU as a whole (EU 40%). Also as a share of the population, the dependents are becoming a bigger group, going from 8.5% to 10.2%, with an increase of 19% (lower than the EU average of 36%).

([471]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term care expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.3 pps of GDP by 2060. ([472]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. Sustainability risks appear over the long run due to the projected increase in age-related public spending, although the latter is driven primarily by pensions and health care, with a weaker contribution from long-term care. ([473])

System Characteristics

Public spending on LTC reached 1.2% of GDP in 2013 in the UK, below the EU average of 1% of GDP. Around 1.06% of GDP was spent on in-kind benefits in 2013 with 0.14% being spent on cash-benefits. ([474])

In the United Kingdom, 50.6% of dependents are receiving formal in-kind LTC services or cash benefits for LTC. Overall, 4.3% of the population receive formal LTC in-kind and/or cash benefits. ([475]) Low shares of coverage may indicate a situation of under-provision of LTC services. However higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 47.4% of public in-kind expenditure (EU: 60%), 52.6% being spent for LTC services provided at home. With more than a half spent on

([472]) The 2015 Ageing Report.
([473]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.
([474]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([475]) The 2015 Ageing Report.

home care, the United Kingdom appears to be more focussed on home care than the average, which may be more efficient, as institutional care is relatively costly with respect to other types of care.

The United Kingdom has a devolved long-term care (LTC) system where Wales, England, Scotland and Northern Ireland manage their LTC systems separately. Considering that 83% of the United Kingdom's elderly, representing, though not the only one ([476]), a very important source of long-term care expenditure, reside in England, the majority of service use and expenditure relates to England. A large part of the fiscal responsibility for LTC used to lie with the individual; but there is also considerable public support for the financing of LTC and the provision of LTC services([477]). Scotland has introduced a free and universal system in 2002. ([478]) The Department of Health, Social Services and Public Safety in Northern Ireland has recently carried out a consultation on adult social care reform. ([479])

Administrative organisation

Unlike health care in England and Wales, adult social care is strictly means-tested by local authorities. Care support is provided only for those with the high needs and the lowest means. In Scotland care is provided free to everyone in need ([480]), while Northern Ireland is considering the introduction of free care.

Types of care

Home care: In order to receive home care the elderly or those with qualifying care needs have to request this kind of service from the council, which will proceed to verifying entitlement and, upon confirmation, would make the necessary arrangements.

Institutional care: Most institutional care facilities, not unlike in the case of non-institutionalised care, are privately run with only a few being entirely publicly run. Private institutions nevertheless are in most cases commissioned through the local authorities. There are three types of institutional care in the United Kingdom, residential care homes, nursing homes and long-stay hospital provision.

Private Sector

According to the OECD Fact Sheet, May 2011 most services are provided by the private sector however, in the private services have clients which are separated in two distinct categories. Publicly funded clients and privately funded clients. Since the majority of the clients are classified as publicly funded clients this means that the private sector is financed to a great extent by the public sector.

Eligibility criteria, co-payments, out of the pocket expenses and private insurance

Local authorities receive a finite amount of funding from central Government but may also raise their own revenue through business rates and council tax. They determine how to distribute and set budgets for expenditure on adult social care. Funding comes from a combination of central taxation (formula and specific grant to local authorities-block grants), local taxation (council tax and business rates) and user charges for social care services. The majority of central government grants received are not earmarked for particular services and local authorities can decide how to allocate the overall budget to various public services including social services.

Health services provided under the National Health Service (NHS) are free at the point of delivery, irrespective of the financial means of the user. Social services arranged by local authorities attract user charges depending on the user's financial means. The means-test takes account of the person's assets (including in some cases, the total value of the persons' home). The assets of spouses, children and other relatives are not taken into account. Those with assets below this level will get help to cover LTC costs mainly according to their

([476]) Working age population with chronic conditions, including learning disabilities, represent an important source of non-age-related spending.
([477]) OECD Fact Sheet, (May 2011)
([478]) For details of the legislation see http://www.scottish.parliament.uk/visitandlearn/Education/15870.aspx, accessed Oct 18, 2013.
([479]) For further details see http://www.dhsspsni.gov.uk/showconsultations?txtid=58501, accessed Oct. 18, 2013
([480]) (further information about the Scottish system is available at http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/Free-Personal-Nursing-Care, accessed October 18, 2013).

incomes. In response to the Royal Commission, the Government funds a part of the nursing home fees that is meant to reflect the nursing input in the care provided. In the United Kingdom, private long-term care insurance is minimal. ([481])

Institutional care

In the United Kingdom, local authorities negotiate the fees that are paid to the providers of publicly subsidised residential care and home-care services. As local authorities are in many areas the main purchaser of care from local providers, they have considerable market power to negotiate fees at relatively low levels. Along with a general policy shift towards maintaining people's independence in the community, these fee levels seem to be one of the reasons for the decline in around 1998 to 2000 in the numbers of residential care and nursing home places. As well as low fees, the reimbursement and contract arrangements, which consist of a lot of spot contracts, can present a problem for providers. Private residential care and nursing home providers often charge higher fees to individuals who fund their own care. This means that, effectively, privately funded residents may be subsidising the care of publicly funded residents. ([482])

Formal/informal caregiving

In terms of financial eligibility for residential care, for example, currently an individual must have assets less than £118,000 in England to qualify for local authority placement into a care home that is fully funded by the local authority and partial financial help may be provided also above the threshold. Still, much of the needed care is provided informally. There are approximately six million unpaid carers in the UK with important variations among this dedicated group of people. 1.5 million are themselves over 60, 60% are women, and there are particularly high instances of caring in some black, minority and ethnic communities (twice as many Pakistani women, for example, are carers compared to the national average). ([483])

([481]) OECD Fact Sheet, May 2011.
([482]) OECD Fact Sheet, May 2011.
([483]) Centre for Social Justice (2010).

Prevention and rehabilitation policies/measures

Some services which are preventative or rehabilitative in nature are fully funded by the state.

Recently legislated and/or planned policy reforms

The UK has recently passed legislation which consolidates existing law into a single, unified, modern statute. The legislation focuses on promoting people's well-being by enabling them to prevent and postpone the need for long term care and to pursue education, employment and other opportunities to realise their potential. The changes being made include:

- introduction of a new national minimum eligibility criteria, which defines the minimum level of need for support an individual should be assessed as having before they are entitled to publicly funded care, rather than allowing this to be set at the discretion of local government; (from April 2015);
- informal carers will be treated as equal to the person they care for, including the same rights to assessment and broadened entitlements to publicly funded support (from April 2015);
- rebalancing the focus of services to promote wellbeing and prevention or delaying of needs in order to reduce dependency, rather than only intervening at crisis point; (from April 2015);
- a new offer that the state will defer the costs of residential care in return for a charge against the person's house, so that no-one will be forced to sell their home in their lifetime to pay for residential care (from April 2015).

Challenges

The UK has a relatively fragmented system of LTC, with high costs and heavy reliance on informal care. As it stands, the main challenges of the system appear to be:

- **Improving the governance framework**: to define a comprehensive approach covering both policies for informal (family and friends)

carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** to foster pre-funding elements, which implies setting aside some funds to pay for future obligations.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage, to reduce the risk of impoverishment of recipients and informal carers.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers; to increase the retention of successfully recruited LTC workers, by further improving the pay and working conditions of the LTC workforce building on the horizontal improvements brought about for all categories by the National Living Wage, training opportunities, more responsibilities on-the-job, feedback support and supervision, to seek options to increase the productivity of LTC workers.

- **Supporting family carers:** to further the efforts on establishing policies for supporting informal carers, as envisaged by the future carers strategy, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Encouraging independent living**: to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring coordination and continuity of care:** to further the efforts towards better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; to create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.28.1: **Statistical Annex –United Kingdom**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	1,720	1,849	1,946	2,063	2,169	1,908	1,668	1,813	1,866	2,054	2,043	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	31.9	32.9	33.2	33.4	32.9	31.0	28.2	27.4	27.0	27.4	27.3	26.8	27.6	28.0	28.1	27.9
Population, in millions	59.5	59.8	60.2	60.6	61.1	61.6	62.0	62.5	63.0	63.5	63.9	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	:	:	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	:	:	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	:	:	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.5	81.1	81.3	81.6	81.8	81.8	82.4	82.6	83.0	82.8	82.9	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	76.2	76.8	77.0	77.3	77.6	77.7	78.3	78.6	79.0	79.1	79.2	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	60.9	:	65.5	64.9	66.0	66.3	66.1	65.6	65.2	64.5	64.8	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	61.5	:	64.2	64.8	64.6	65.0	65.0	64.9	65.2	64.6	64.4	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	37.4	38.0	35.8	33.9	35.8	34.5	36.0	32.9	32.5	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	9.4	9.2	9.0	8.8	9.6	9.2	9.1	10.6	10.2	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	318	288	259	230	234	238	243	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	847	899	951	1,003	1,017	1,032	1,020	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.9	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	5,550	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.28.2: **Statistical Annex - continued – United Kingdom**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	63.9	66.9	70.6	74.0	77.3	80.1	25%	3%
Dependency								
Number of dependents in millions	5.47	5.94	6.61	7.23	7.76	8.15	49%	40%
Share of dependents, in %	8.5	8.9	9.4	9.8	10.0	10.2	19%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.2	1.2	1.3	1.4	1.5	1.5	30%	40%
AWG risk scenario	1.2	1.3	1.5	1.7	2.0	2.3	97%	149%
Coverage								
Number of people receiving care in an institution	242,704	265,143	304,866	339,403	359,715	378,875	56%	79%
Number of people receiving care at home	1,020,055	1,107,112	1,264,021	1,422,183	1,533,700	1,605,348	57%	78%
Number of people receiving cash benefits	1,508,174	1,661,344	1,964,768	2,302,408	2,633,305	2,852,580	89%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	4.3	4.5	5.0	5.5	5.9	6.0	40%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	50.6	51.1	53.4	56.2	58.3	59.4	17%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	88.7	88.6	88.5	87.9	87.2	86.9	-2%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	11.3	11.4	11.5	12.1	12.8	13.1	16%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	47.4	47.5	47.1	46.5	45.3	45.6	-4%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	52.6	52.5	52.9	53.5	54.7	54.4	3%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	128.4	128.5	128.7	126.4	125.0	126.4	-2%	-2%
Unit costs of home care per recipient, as % of GDP per capita	33.9	34.0	34.9	34.7	35.3	35.6	5%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	5.6	5.5	5.5	5.5	5.5	5.6	0%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".