



United Kingdom

Health Care & Long-Term Care Systems



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United Kingdom

Health care systems

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2.28. UNITED KINGDOM

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2015, the UK had a GDP per capita of 29,112 PPS (in thousands), slightly below the EU average of 29,610 PPS. Population was estimated at 64.9 million in 2015. According to Eurostat projections, total population in the United Kingdom is projected to increase from around 65.4 million in 2016 to 81 million in 2070, with an increase of 23.8%, well above EU average level of 2.0%.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (10.2% in 2015) has increased over the past decade (7.6% of GDP in 2005), and is currently in line with the EU average of 10.2% for the same year. Public (total) expenditure is at 8.1% of GDP, in line with the EU average (8.0% in 2015) and similarly it has increased throughout the past decade (6.1 % in 2005).

When expressed in per capita terms, total spending on health at 3,223 PPS in the UK was only slightly below the EU average of 3,271 PPS in 2015. The opposite applies to public spending on health care, which was above the EU average value in 2015, with 3,041 PPS vs. an average of 2,609 PPS. Looking at health care without long-term care⁽⁴¹⁶⁾ reveals a similar picture, with spending at the EU average (6.8% vs 6.8% in 2015).

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 1.4 pps of GDP, above the average growth expected for the EU (0.9 pps), according to the "AWG reference scenario"⁽⁴¹⁷⁾. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health

⁽⁴¹⁶⁾ To derive this figure, the aggregate HC.3 is subtracted from total health spending.

⁽⁴¹⁷⁾ See The 2018 Ageing Report at https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

care expenditure is expected to increase by 2.4 pps of GDP from now until 2070 (EU: 1.6 pps).

Sustainability risks emerge in the medium term, with the S1 indicator at 1.3 pps of GDP. These are primarily related to the current high level of government debt (contributing 1.7 percentage points of GDP) and projected ageing costs (0.7 percentage point of GDP). The long-term fiscal sustainability risk indicator S2 is at 3% of GDP. Compounding this result with the vulnerabilities linked to historical behaviour, captured by the DSA risk assessment, the United Kingdom appears to face high fiscal sustainability risks, also related to projected ageing costs, which contribute 3.3 percentage points of GDP⁽⁴¹⁸⁾.

Health status

Life expectancy at birth (82.8 years for women and 79.2 years for men in 2015) is, respectively, below and above EU averages (83.3 for women and 77.9 for men in 2015)⁽⁴¹⁹⁾. In the same year, healthy life years, at 63.3 years for women and 63.7 years for men, are slightly above the EU average for men, compared to, respectively, 63.3 and 62.6 for the EU in 2015. The infant mortality rate of 3.9‰ is higher than the EU average of 3.6‰ in 2015, having gradually fallen over the last decade (from 5.1‰ in 2005).

As for the lifestyle of the UK population, the proportion of regular smokers of 19.0% in 2014 is below the EU average (21.8% in 2013 and 20.9% in 2015). Obesity rates in the population are, at 19.8% (latest available figure for 2014), well above the EU average of 15.4% in 2015 (15.5% in 2013). Alcohol consumption is, at 10.7 litres per capita, slightly higher than the EU average of 2015 (10.2 litres per capita)⁽⁴²⁰⁾.

⁽⁴¹⁸⁾ European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

⁽⁴¹⁹⁾ 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.

⁽⁴²⁰⁾ 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>.

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). 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 £8.20 per item. It is however possible to purchase coverage for all such costs incurred over a 3-month or 12-month period.

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 and Social Care (DHSC) defines general policy guidelines and priorities for the NHS in England, to which it allocates the budget. DHSC 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 DHSC, 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. Based on the latest announcements in June 2018, a real terms increase of £20.5 billion will take place in NHS funding in England by the end of five years. This implies an average yearly increase in funding of 3.4 per cent in real terms. The funding will be

front-loaded, with an increase of £4.1 billion envisaged for 2019 (a steeper increase of 3.6% is planned in the first two years).

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 2015, private and out-of-pocket expenditure were 20.5% altogether and out-of-pocket alone represented 14.8% of total health expenditure, both below the EU average (21.6% and 15.9% in 2015).

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. Clinical Commissioning Groups (209) 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⁽⁴²¹⁾, 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. NHS Foundation Trusts in England (152) (a type of hospital with large autonomy and run by local managers, staff and the public) and NHS Trusts (88) 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.

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 twenty-two Local health Boards who were responsible for commissioning health services for their residents were reduced to seven. The thirteen NHS Trusts that provided hospital care were reduced to three. In Northern Ireland, four Health and Social Services Boards are responsible for commissioning health services from a range of providers. Five (formerly nineteen) Health and Social Services Trusts are the main service providers.

The number of practising physicians per 100 000 inhabitants (279 in 2015) is below the EU average (344 in 2015) though showing a consistent increase since 2005 (239). The number of GPs per 100 000 inhabitants (79 in 2015) is just above the EU average (78 in 2015). On the contrary, the number of nurses per 100 000 inhabitants (790 in 2015) is below the EU average (833 in 2015), 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 suggest the need to continue a comprehensive human resources strategy to ensure that the skill

⁽⁴²¹⁾CCGs are increasingly being delegated responsibility for this area.

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 ⁽⁴²²⁾ 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 (287 in 2006, latest available value) seems to be below the EU average, compared to the EU level of 416 in 2009). 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.

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.

⁽⁴²²⁾ There are some self-referring secondary services.

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 vs. 16 in 2015) but day case discharges, on the contrary, are more than double the EU average (16,636 vs. 7,635 in 2015). The proportion of surgical procedures conducted as day cases (57.5%) is considerably above the EU average (almost twice the EU level of 32.3% in 2015) and indeed one of the EU highest. Overall hospital average length of stay (7.0 days in 2015) is slightly below the EU average (7.6 days in the same year). 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 and Social Care published an Information Strategy (May 2012) which set out a ten-year framework for transforming information for health and care. Working with stakeholders DHSC 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 £500 million available to NHS trusts to accelerate progress to towards use of integrated digital care records by 2018, and over £100 million 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 £5.3 billion 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 DHSC 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⁽⁴²³⁾. The Department of Health and Social Care (DHSC) 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

⁽⁴²³⁾For an overview of the most important changes see <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>; accessed November 1, 2013.

Commission's (CQC) data about service providers. A new regulator (Monitor) oversees and regulates these new arrangements⁽⁴²⁴⁾. As of January 2016 the vast majority of hospitals and other NHS trusts have become foundation trusts⁽⁴²⁵⁾; foundation trust will have more 'freedom' and a different structure than NHS trusts⁽⁴²⁶⁾.

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 and Social Care if NHS spending on branded medicines exceeds the allowed growth rate.

The NHS Long Term Plan, released in January 2019, sets out a clearly defined list of ambitions up to 2028 to ensure the NHS can successfully improve quality and respond to the challenges in the decade ahead. The delivery of this plan will be supported by an increased funding (3.4% yearly vs. the 2.2% average over the past five years) that will total £20.5 billion by the end of the next five years.

The priorities focus both on the service model, with increased emphasis on "out-of-hospital" care, integrated care, personalised care and patient empowerment supported by digital solutions, reduced pressure on emergency hospital services; on increasing prevention and reducing health inequalities; on increasing the quality of care and improving care outcomes; on supporting NHS staff; on expanding the use of digital solutions to increase the effectiveness of the whole system and, in general, by maximising efficient spending. By focusing on these priorities for improvement, the aim to deliver to its citizens a stronger start of life, higher quality care to tackle major health problems and better support for a healthy ageing.

Following the publication of the NHS Long Term Plan, Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, will need to develop strategies to implement the national plan. Yearly strategic implementation plans will be available by April 2019, whereas five-year plans will be formulated by Autumn 2019.

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

⁽⁴²⁴⁾ For more information see <https://www.gov.uk/government/organisations/monitor/>; accessed April 12, 2019.

⁽⁴²⁵⁾ 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.

⁽⁴²⁶⁾ For more details see <https://www.mcht.nhs.uk/members/what-is-a-foundation-trust/>; accessed April 12, 2019.

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 different healthcare 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 2.28.1: Statistical Annex – United Kingdom

General context												EU- latest national data			
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
GDP															
GDP, in billion Euro, current prices	2,027	2,147	2,245	1,975	1,717	1,842	1,884	2,078	2,064	2,279	2,602	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	30.9	31.1	30.8	29.5	26.7	27.4	27.1	27.5	27.4	27.9	29.1	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	2.3	1.8	1.5	-1.3	-4.9	0.9	0.6	0.8	1.4	2.3	1.5	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	3.7	4.5	2.0	4.9	-1.1	-1.0	1.4	16.5	1.7	2.7	3.7	0.2	0.2	4.1
Expenditure on health*															
Total as % of GDP	7.6	7.8	8.0	8.2	9.1	8.9	8.8	8.8	10.1	10.1	10.2	10.2	10.1	10.1	10.2
Total current as % of GDP	6.6	6.9	7.1	7.2	7.4	7.5	7.7	8.6	9.9	9.8	9.9	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	1.0	0.9	0.9	1.0	1.7	1.4	1.0	0.3	0.3	0.3	0.3	0.9	0.6	0.2	0.3
Total per capita PPS	2,399	2,567	2,743	2,472	2,353	2,457	2,452	2,701	3,061	3,339	3,827	2,745	2,895	2,975	3,305
Public total as % of GDP	6.1	6.3	6.3	6.7	7.5	7.4	7.3	7.2	8.1	8.1	8.1	8.0	7.8	7.8	8.0
Public current as % of GDP	5.9	6.1	6.1	6.4	7.2	7.1	7.0	6.9	7.8	7.8	7.9	7.7	7.6	7.6	7.8
Public total per capita PPS	1,934	2,089	2,175	2,006	1,950	2,043	2,026	2,201	2,445	2,676	3,042	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.25	0.24	0.23	0.30	0.37	0.35	0.26	0.25	0.26	0.28	0.24	0.2	0.2	0.2	0.2
Public as % total expenditure on health	80.6	81.4	79.3	81.1	82.8	83.2	82.6	81.5	79.9	80.1	79.5	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	16.5	16.2	14.4	14.6	16.7	15.6	17.4	15.7	18.3	17.0	17.3	14.8	14.8	15.2	15.0
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	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	9.5	9.9	10.0	9.0	8.9	9.6	9.3	10.6	14.8	14.7	14.8	14.6	14.9	15.9	15.9
Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.															
Population and health status															
Population, current (millions)	60.2	60.6	61.1	61.6	62.0	62.5	63.0	63.5	63.9	64.4	64.9	502.1	503.0	505.2	508.5
Life expectancy at birth for females	81.3	81.6	81.8	81.8	82.4	82.6	83.0	82.8	82.9	83.2	82.8	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.0	77.3	77.6	77.7	78.3	78.6	79.0	79.1	79.2	79.5	79.2	76.6	77.3	77.7	77.9
Healthy life years at birth females	65.5	64.9	66.0	66.3	66.1	65.6	65.2	64.5	64.8	64.2	63.3	62.0	62.1	61.5	63.3
Healthy life years at birth males	64.2	64.8	64.6	65.0	65.0	64.9	65.2	64.6	64.4	63.4	63.7	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	68	63	60	58	54	52	126	122	119	116	117	64	138	131	127
Infant mortality rate per 1 000 live births	5.1	4.9	4.7	4.6	4.5	4.2	4.2	4.0	3.9	3.9	3.9	4.2	3.9	3.7	3.6
Notes: Amenable mortality rates break in series in 2011.															
System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.8	1.8	1.8	1.8	2.1	1.9	1.9	1.9	2.3	2.3	2.3	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.5	0.5	0.5	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	2.4	2.4	2.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	1.2	1.2	1.2	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.3	0.3	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	:	:	:	:	:	:	:	:	0.5	0.5	0.5	0.3	0.2	0.3	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	0.3	0.2	0.2	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	2.2	2.2	2.2	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.4	0.4	0.4	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	2.1	2.1	2.1	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	0.8	0.8	0.8	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Prevention and public health services	:	:	:	:	:	:	:	:	0.4	0.4	0.4	0.2	0.2	0.2	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.28.2: Statistical Annex - continued - United Kingdom

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU - latest national data			
	2009	2011	2013	2015											
Inpatient curative and rehabilitative care	26.8%	26.5%	24.7%	25.2%	28.2%	25.9%	24.4%	21.8%	23.6%	23.5%	23.7%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	4.8%	4.9%	5.0%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	24.8%	24.8%	25.3%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	12.2%	12.0%	12.0%	13.1%	12.6%	14.7%	14.6%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	2.7%	2.7%	2.4%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	:	:	:	:	:	:	:	:	5.0%	5.1%	5.2%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	:	:	:	:	:	:	:	:	2.5%	2.4%	2.2%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	27.8%	27.7%	28.0%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	5.2%	5.3%	5.3%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	26.8%	26.9%	27.2%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	10.2%	10.1%	10.2%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.5%	0.5%	0.5%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	:	:	:	:	:	:	:	:	5.0%	5.0%	5.1%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	:	:	:	:	:	:	:	:	1.8%	1.7%	1.5%	4.1%	4.0%	3.6%	3.4%
Expenditure drivers (technology, life style)															
MRI units per 100 000 inhabitants	0.54	0.56	:	0.55	:	0.66	0.70	0.72	0.72	0.72	:	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	:	0.1	:	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	0.8	0.8	:	0.7	:	0.8	0.9	0.9	0.9	1.0	:	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.1	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.2	0.2
Proportion of the population that is obese	23.0	24.0	24.0	24.5	:	:	:	:	:	19.8	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	24.0	22.0	21.0	21.0	21.0	20.0	20.0	20.0	19.0	19.0	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	12.1	11.6	11.8	11.5	10.8	10.9	10.7	10.4	10.3	10.4	10.7	10.4	10.3	10.1	10.2
Providers															
Practising physicians per 100 000 inhabitants	239	245	249	258	267	272	276	275	277	279	279	324	330	338	344
Practising nurses per 100 000 inhabitants	1024	991	963	967	983	960	841	821	818	819	790	837	835	825	833
General practitioners per 100 000 inhabitants	72	73	73	75	79	80	81	80	80	80	79	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs															
Doctors consultations per capita	5.0	5.1	5.0	5.9	5.0	:	:	:	:	:	:	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	13	12	12	13	13	13	13	12	12	12	12	17	16	16	16
Day cases discharges per 100 000 inhabitants	11,667	12,358	13,152	14,009	14,487	14,826	15,059	15,086	15,607	16,155	16,636	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	84.0	83.0	83.7	84.8	84.2	84.4	:	:	:	:	:	77.1	76.4	76.5	76.8
Hospital average length of stay	6.9	6.6	8.1	8.0	7.8	7.7	7.3	7.3	7.2	7.1	7.0	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	:	50.2	51.7	:	53.2	53.9	54.6	54.8	55.8	56.6	57.5	28.0	29.1	30.9	32.3
Population and Expenditure projections															
Projected public expenditure on healthcare as % of GDP*	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps.		
AWG reference scenario	7.9	8.1	8.2	8.4	8.6	8.8	8.9	9.1	9.2	9.2	9.3	9.4	UK	EU	
AWG risk scenario	7.9	8.1	8.4	8.7	9.0	9.3	9.6	9.8	10.0	10.1	10.2	10.3	2.4	1.6	
Note: *Excluding expenditure on medical long-term care component.															
Population projections	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in %		
Population projections until 2070 (millions)	65.4	67.2	69.5	71.6	73.4	75.0	76.4	77.6	78.5	79.3	80.1	81.0	UK	EU	
													23.8	2.0	

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

United Kingdom

Long-term care systems

3.28. UNITED KINGDOM

General context: Expenditure, fiscal sustainability and demographic trends

In 2016, the United Kingdom had a population of around 65.6 million inhabitants, which is roughly 13.0% of the EU population⁽⁶⁰⁵⁾. With a GDP of around €2,602 billion, or 29,112 PPS per capita, it is slightly below the EU average GDP per capita of €29,610. Public expenditure on long-term care (health)⁽⁶⁰⁶⁾ is 1.2% GDP, 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 65.6 million inhabitants in 2016 to 81 million inhabitants in 2070. This 24% increase is well above the EU average change of 2%.

Health status

Life expectancy at birth for both women and men was, in 2015, 82.8 and 79.2 years, respectively below and above the EU average (83.3 and 77.9 years for women and men). Healthy life years at birth were 63.3 years for women and 63.7 years for men, again above the EU-average for males (63.3 and 62.6 respectively in 2015). The percentage of the UK population having a long-standing illness or health problem is above the EU average with 35.3% vs. 34.2% in 2015. Also the percentage of the population indicating a self-perceived severe limitation in its daily activities is above the EU-average (10.6% against 8.1% in 2015).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming decades. From 6.67 million residents living with strong limitations due to health problems in 2015, an increase of 47% is envisaged until 2070 to around 9.84 million. That is a steeper increase than in the EU as a whole (EU 25%). Also as a share of the population, the dependents are projected to become a bigger group, going from 10.2% to 12.1% by 2070, with

an increase of 19%, which is however lower than the EU average of 21% over the same period.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is projected to steadily increase. 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 1.3 pps of GDP by 2070⁽⁶⁰⁷⁾. The "AWG risk scenario", which also 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 1.8 pps of GDP by 2070. Overall, the projected long-term care expenditure increase is expected to add to budgetary pressure. Fiscal sustainability risks as captured by S1 are medium over the medium term, linked to the current high level of government debt and projected ageing costs. Overall, given the high risks to debt sustainability, fiscal sustainability risks over the medium-term are high. In the long term, the UK appears to face high fiscal sustainability risks, also related to projected ageing costs⁽⁶⁰⁸⁾.

System Characteristics

Public spending on long-term care in the UK reached 1.2% of GDP in 2015, in line with the EU average for the same year (1.2%). Around 75% of total long-term care public spending was spent on in-kind benefits in 2016 (EU average 84.4%) with 25% being spent on cash-benefits (EU average 15.6%)⁽⁶⁰⁹⁾.

In the United Kingdom, 52.3% of dependents are receiving formal in-kind long-term care services or cash benefits for long-term care (EU average 50% in 2016). Overall, 5.3% of the population receive

⁽⁶⁰⁵⁾ Based on Eurostat projections.

⁽⁶⁰⁶⁾ Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with tasks linked with Activities with Daily Living).

⁽⁶⁰⁷⁾ The 2018 Ageing Report:

https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

⁽⁶⁰⁸⁾ European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

⁽⁶⁰⁹⁾ The 2018 Ageing Report.

formal long-term care in-kind and/or cash benefits, which is above the EU average of 4.6% ⁽⁶¹⁰⁾. 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 services makes up 56.8% of public in-kind expenditure (EU: 66.3% in 2016), 43.2% being spent for long-term care services provided at home in the same year. The United Kingdom appears to be more focussed on home care than the average (EU 33.7%), which may be more efficient, as institutional care is relatively costly with respect to other types of care. While the share of expenditure on institutional care is relatively low, unit costs of this type of provision, measured as a share of GDP per capita, appear to be above average, pointing to scope to further rationalise spending in this area. Lower than average unit costs for the provision of cash benefits also suggest that this area could be strengthened with potential gains from a cost-efficiency perspective, subject to a rational allocation and well-regulated use of additional resources.

The United Kingdom has a devolved long-term care system where Wales, England, Scotland and Northern Ireland manage their systems separately. Considering that 83% of the United Kingdom's elderly reside in England, the majority of service use and expenditure relates to England, even though the elderly are not the only source of long-term care expenditure ⁽⁶¹¹⁾. A large part of the fiscal responsibility for long-term care used to lie with the individual, but there is also considerable public support for the financing of long-term care and the provision of services ⁽⁶¹²⁾. In Scotland, a contribution of £177 a week to a care provider is available to anyone assessed as needing personal care services, and is not means tested. Additional payments are available to people needing nursing care. This is known as 'free personal care', though doesn't cover the full cost of care for most and is only available in certain circumstances ⁽⁶¹³⁾. The

Department of Health, Social Services and Public Safety in Northern Ireland has recently carried out a consultation on adult social care reform ⁽⁶¹⁴⁾.

Administrative organisation

Unlike health care in England and Wales, adult social care is strictly means-tested by local authorities. In Scotland care is provided free to everyone in need ⁽⁶¹⁵⁾, while Northern Ireland is considering the introduction of free care.

Types of care

Home care: Domiciliary care otherwise known as home care helps people who are frail or who have support needs live independently in their own homes. Personal assistants visit people to provide practical support with tasks including washing and getting dressed. People may also need other help with other practical household tasks. Those who believe they have care needs are entitled to a care assessment from their local authority. If the person has eligible needs the council will carry out a financial assessment to establish whether the person is entitled to help with the cost of their care.

Residential care homes: Most care homes, are privately run. Local authorities can commission care from either private care homes or their own facilities. There are three types of institutional care in the United Kingdom, residential care homes, nursing homes and reablement beds in a hospital.

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.

⁽⁶¹⁰⁾ The 2018 Ageing Report.

⁽⁶¹¹⁾ Working age population with chronic conditions, including learning disabilities, represent an important source of non-age-related spending.

⁽⁶¹²⁾ OECD Fact Sheet, (May 2011).

⁽⁶¹³⁾ For additional details on this topic see <https://www2.gov.scot/Topics/Health/Support-Social-Care/Support/Adult-Social-Care/Free-Personal-Nursing-Care>, accessed May 3, 2019.

⁽⁶¹⁴⁾ For further details see <http://www.dhsspsni.gov.uk/showconsultations?txtid=58501>, accessed Oct. 18, 2013.

⁽⁶¹⁵⁾ 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.

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 depending on local authority means test 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 care 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. As mentioned above, social care services arranged by local authorities attract user charges depending on the user's financial means. Whether or not a person qualifies for any financial support towards their care costs depends on the level of their assets. Local authorities provide means-tested financial help to pay for care and support where a person cannot afford the cost themselves. The financial assessment takes into account what a person can afford from both their income and their assets, for example savings or property. If a person has above the capital limit of £23,250 they pay the full costs of their care and support. If their assets are below the lower capital limit of £14,250, they pay what they can afford from income only. Anyone who falls between the capital limits will be expected to pay what they can afford from income plus a means tested contribution from assets. The value of a person's house is not included in the means test if they receive care at home, or if they enter a care home but a spouse or qualifying relative still lives at the house. These terms are known as means test disregards.

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 ⁽⁶¹⁶⁾.

Some people over the age of 18 with a 'primary health need' may be eligible for NHS Continuing Healthcare (CHC), a package of care that is arranged and funded solely by the NHS for people not in hospital.

CHC eligibility is not determined by age or clinical condition, but we know that the majority of those qualifying are the oldest in society with debilitating conditions such as dementia, or younger people with serious debilitating conditions such as spinal injury.

Individuals may receive CHC funding for any setting, including their own home or a care home.

If found to be eligible for CHC in an individual's own home, the NHS will pay for healthcare (e.g. services from a community nurse or specialist therapist) and associated social care needs (e.g. personal care and domestic tasks - help with bathing, dressing, food preparation and shopping).

In a care home, the NHS also pays for care home fees, including board and accommodation.

If an individual is not assessed as eligible for CHC but does have some nursing needs, and resides or needs to reside in a care home with nursing, they may be eligible for NHS-funded Nursing Care (FNC). If assessed as eligible, the relevant Clinical Commissioning Group will pay a flat rate payment to the care home to cover the reasonable costs of providing registered nursing care to FNC eligible residents.

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. Traditional models of residential and domiciliary care still dominate today's market. However over the last 30 years, the market has shifted from a focus on care homes

⁽⁶¹⁶⁾ OECD Fact Sheet, May 2011.

to more care provided at home. This is partly driven by a policy shift towards maintaining people's independence at home and in the community. The Competition and Markets Authority (CMA) published its market study into residential care homes for over 65s in the UK in November 2017. The scope of the market study was to understand 'why the care home market may not be working well for residents and their families and to develop proposals to make it better'. The report estimated that fees paid by local authorities to care home providers could be on average up to 10% below total cost, on the basis of historical fees data and analysis. The report concluded that this could present challenges to the longer term stability of the care market. 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

In 2014 the UK passed legislation which consolidated existing law in England 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 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).

The Government has committed to consult on options for reform of the social care sector, to put it on a more sustainable footing for the longer term.

Challenges

The UK has a relatively fragmented system of LTC, with above-average unit costs and average 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 3.28.1: Statistical Annex –United Kingdom

GENERAL CONTEXT															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP and Population															
GDP, in billion euro, current prices	2,027	2,147	2,245	1,975	1,717	1,842	1,884	2,078	2,064	2,279	2,602	12,451	13,213	13,559	14,447
GDP per capita, PPS	30.9	31.1	30.8	29.5	26.7	27.4	27.1	27.5	27.4	27.9	29.1	26.8	28.1	28.0	29.6
Population, in millions	60.2	60.6	61.1	61.6	62.0	62.5	63.0	63.5	63.9	64.4	64.9	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	:	:	:	:	:	:	:	:	1.2	1.2	1.2	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	334.5	339.5	355.0	264.1	283.2	352.1	373.6
As % of total government expenditure	:	:	:	:	:	:	:	:	2.8	2.7	2.8	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	81.3	81.6	81.8	81.8	82.4	82.6	83.0	82.8	82.9	83.2	82.8	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.0	77.3	77.6	77.7	78.3	78.6	79.0	79.1	79.2	79.5	79.2	76.6	77.3	77.7	77.9
Healthy life years at birth for females	65.5	64.9	66.0	66.3	66.1	65.6	65.2	64.5	64.8	64.2	63.3	62.0	62.1	61.5	63.3
Healthy life years at birth for males	64.2	64.8	64.6	65.0	65.0	64.9	65.2	64.6	64.4	63.4	63.7	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	38.0	35.8	33.9	35.8	34.5	36.0	32.9	32.5	34.4	35.3	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.2	9.0	8.8	9.6	9.2	9.1	10.6	10.2	10.5	10.6	8.3	8.3	8.7	8.1
SYSTEM CHARACTERISTICS															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Coverage (Based on data from Ageing Reports)															
Number of people receiving care in an institution, in thousands	:	:	318	288	259	230	234	238	243	246	249	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	847	899	951	1,003	1,017	1,032	1,020	1,030	1,040	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.9	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.2	2.2	2.2
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 3.28.2: Statistical Annex - continued – United Kingdom

PROJECTIONS									
	2016	2020	2030	2040	2050	2060	2070	MS Change 2016-2070	EU Change 2016-2070
Population									
Population projection in millions	65.6	67.5	71.8	75.2	77.7	79.4	81.0	24%	2%
Dependency									
Number of dependents in millions	6.67	6.97	7.78	8.49	9.09	9.45	9.84	47%	25%
Share of dependents, in %	10.2	10.3	10.8	11.3	11.7	11.9	12.1	19%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	1.5	1.6	1.8	2.1	2.4	2.6	2.8	83%	73%
AWG risk scenario	1.5	1.6	1.9	2.2	2.6	3.0	3.3	120%	170%
Coverage									
Number of people receiving care in an institution	644,163	685,067	831,859	1,008,108	1,182,738	1,302,625	1,389,748	116%	72%
Number of people receiving care at home	1,242,964	1,321,712	1,584,020	1,859,854	2,122,156	2,284,079	2,437,852	96%	86%
Number of people receiving cash benefits	1,604,522	1,699,848	2,015,483	2,349,049	2,664,252	2,869,875	3,049,085	90%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.3	5.5	6.2	6.9	7.7	8.1	8.5	59%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	52.3	53.2	56.9	61.5	65.7	68.3	69.9	34%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	97.7	97.7	97.7	97.8	97.8	97.9	97.9	0%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	2.3	2.3	2.3	2.2	2.2	2.1	2.1	-10%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	56.8	56.8	57.1	57.8	58.3	58.9	58.9	4%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	43.2	43.2	42.9	42.2	41.7	41.1	41.1	-5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	85.1	85.0	87.4	89.2	89.4	91.0	92.7	9%	10%
Unit costs of home care per recipient, as % of GDP per capita	33.5	33.5	34.6	35.3	35.6	36.2	36.9	10%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	1.4	1.4	1.5	1.5	1.5	1.5	1.5	8%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).