

Securing the future: funding health and social care to the 2030s

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In association with

NHS CONFEDERATION



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This is a chapter from IFS report ‘Securing the future: funding health and social care to the 2030s’

Published by

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With support from

The Economic and Social Research Council (ESRC)
through the Centre for Microeconomic Analysis of Public Policy
(CPP, reference ES/M010147/1)

Website: <http://www.esrc.ac.uk>

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ISBN: 978-1-911102-98-4

4. Options for funding health and social care

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Key findings

The pressures – from a growing and ageing population, from rising expectations and from increasing cost pressures – facing the NHS over the next 15 years are substantial.

Meeting the pressures under the Health Foundation’s ‘modernised NHS’ scenario, which allows for modest improvements in NHS services, would increase expenditure on health by an estimated 2.6% of GDP by 2033–34. This is equivalent to £56 billion in today’s terms, or £2,000 per year for each household in the UK. These figures are substantially larger than recent political pledges to the NHS.

Just maintaining services at their current level is deemed to require a substantial increase in funding, much of which would need to be found in the next five years.

Meeting the Health Foundation’s less generous ‘status quo’ scenario, which is deemed sufficient to maintain services at current levels, would require an estimated additional 1.6% of GDP by 2033–34, with 0.9% of GDP of this required by 2023–24. This increase is equivalent to £20 billion, or £700 per year per household in the UK, in 2018–19 terms.

On top of this, meeting the needs of an ageing population and a growing number of younger adults living with disabilities would require a considerable increase in social care funding.

If the current funding system is maintained, meeting the pressures on social care would require an estimated increase in funding of 0.4% of GDP by 2033–34, equivalent to around £8 billion in today’s terms, or £280 per year for each household in the UK. If the system is reformed to increase the generosity of the public offer, spending on social care would need to increase by even more.

In the past, rising health spending has effectively been paid for through reductions in spending on other services, particularly defence. It is difficult to see how this could be continued going forward.

Meeting the scale of the expected pressures while keeping public spending as a share of GDP constant would be difficult to achieve, not least because many other areas of government have been cut substantially since 2009–10.

There are signs that there is now an increased willingness from the public to pay more in tax.

The revenue needed to fund the ‘status quo’ scenario over the next five years is equivalent to the amount that would be raised by increasing all rates of income tax by around 5 pence, or increasing the main rate of VAT from 20% to 24%, or increasing all main rates of NICs, including employer NICs, by 2–3 pence.

Even eliminating the defence budget entirely would still not free up sufficient resources to fund the ‘modernised NHS’ scenario. Reducing defence spending at all as a share of national income may not be an option if the government is to continue to meet its international commitments.

Meeting the pressures under the ‘modernised NHS’ scenario while keeping overall public spending unchanged as a share of GDP would require cuts to non-NHS spending of 10%. Even meeting just the ‘status quo’ scenario would require average cuts of 6.7%. Achieving these would be made harder by the fact that other spending on pensioners is subject to similar demographic pressures to health and social care.

Nearly two-thirds of tax revenue is raised by the three largest taxes: income tax, National Insurance contributions (NICs) and VAT. Given the scale of the funding challenge facing health and social care, meeting the pressures through increased tax revenue would likely involve an increase in at least one of these taxes.

These changes are merely illustrative and, in practice, some combination of tax increases would most likely occur. Other options include the reversal of tax cuts made since 2010 or changes to taxes that could raise revenue from particular groups – such as richer or older individuals – or ones that make the overall tax system more efficient.

Relying solely on increased taxation to pay for a 'modernised NHS' would increase the UK tax burden as a share of GDP to historically high levels.

The UK tax burden is already at a high level by historical standards. But further tax increases of this scale are economically feasible. Even if the UK raised an additional 3.0% of GDP in tax, the tax burden would remain well below that in other European countries. It is notable that the UK already spends a high fraction of tax revenues on health relative to comparable European countries. Tax-funded increases in health spending, while maintaining spending in other areas, would increase this fraction further.

The public may prefer that any tax increase should be hypothecated for the NHS. However politically attractive, there remain strong economic arguments against such an approach.

There is no reason why we would want any particular tax to rise over time in line with health spending, nor any reason why we would want to tie health spending to the revenues from any one tax, which are likely to rise and fall over time. There are possible ways around this, but they risk introducing additional complexity, inefficiency and inequity into the tax system.

The NHS makes limited use of user charges compared with health systems elsewhere. There is little public appetite for increased charges, though the exemption criteria are in need of review.

In particular, the exemption of those aged between 60 and the state pension age from NHS charges seems difficult to justify when the state pension age – and retirement ages – are rising alongside increasing longevity at older ages. However, refining current eligibility criteria is unlikely to raise a substantial amount of money.

There are unique challenges around social care. Unlike the NHS, publicly funded social care is heavily means-tested and many people face substantial costs for their care. And, unlike the NHS, social care is a local responsibility with no national budget.

The government needs to think not just about the overall level of public spending on social care, but also how that funding is structured, who qualifies for public support, and how much those who do not qualify should be expected to pay. This is an area where setting out a clear direction of reform would help individuals to plan.

4.1 Introduction

The difficulties faced by the NHS and social care this winter have been a focus of much public and political discourse. Surveys of public opinion suggest that the public perceive that the NHS has a funding crisis, and the majority are prepared to pay more tax to fund increased NHS spending.

Since the beginning of austerity in 2010, NHS spending has grown at the slowest rate in its history, while social care spending in England has fallen in real terms and failed to keep pace with demand. Over the same period, NHS performance against its own targets has deteriorated, and over 400,000 fewer older people accessed publicly funded social care in 2016–17 than in 2009–10.

Chapter 3 of this report quantifies the additional funding that would be required to meet the expected pressures on health and social care. In order to deliver the Health Foundation's 'modernised' scenario, with modest improvements to NHS services and higher pay for staff, spending on health would need to rise from its current level of 7.3% of GDP to 9.9% of GDP in 2033–34. This increase is equivalent to an estimated £56 billion in 2018–19 prices, or an additional £2,000 extra per household per year. Of this, an estimated £34 billion or an additional £1,200 per household per year would be required just to maintain the 'status quo', including missed performance targets and slower pay growth for staff. On top of any additional funding for the NHS, meeting the needs of an ageing population and an increasing number of younger adults living with disabilities would require spending on social care to increase by an estimated 0.4% of GDP by 2033–34. This is equivalent to an additional £8 billion in today's terms, or an extra £280 per year for each household in the UK.

These figures are substantially larger than previous political pledges to the NHS, in terms of either claims about the potential 'Brexit dividend' or small increases in income tax to fund more NHS spending. The Health Foundation projections outlined in Chapter 3 are, however, relatively similar to other forecasts of funding pressures. In particular, OBR forecasts of spending in 2033–34 are broadly in line with the 'status quo' scenario,¹ while the 'modernised NHS' looks similar to the figures from the interim report of the Lord Darzi Review of Health and Care, convened by the IPPR.²

This chapter lays out how these sums of money could be raised if the public and politicians decide that the pressures should be met. Section 4.2 takes the cost pressure projections in Chapter 3 and quantifies the estimated deficit in funding in today's terms. Section 4.3 provides some evidence on public attitudes to NHS funding and taxation to gauge the public's appetite to pay for increased funding. Section 4.4 considers the potential for raising funds by cutting spending in other areas, by comparing levels and trends in areas of public spending since 2007–08 and over the longer term. Section 4.5 describes options for raising money through the existing tax system, including a discussion of hypothecation. Section 4.6 considers additional ways of raising money, including user charges, charging migrants and raising money from NHS estates. Section

¹ Office for Budget Responsibility, *Fiscal Sustainability Report: January 2017*, <http://obr.uk/fsr/fiscal-sustainability-report-january-2017/>.

² *The Lord Darzi Review of Health and Care: Interim Report*, Institute for Public Policy Research, April 2018, <https://www.ippr.org/publications/darzi-review-interim-report>.

4.7 focuses on the particular challenge of social care, where the debate is not just about how much additional funding is needed, but also about the organisation and scope of the service. Section 4.8 concludes.

4.2 What do these pressures mean for funding?

The Health Foundation analysis in Chapter 3 estimates that in order to meet the pressures on health and continue to modernise the range and quality of services provided, spending would need to increase over the next 15 years by £124 billion in today's prices. Of this total, more than three-quarters (£95 billion) is estimated to be required to maintain current service levels. On top of that, spending on social care would need to increase by around £18 billion to meet growing pressures.

These figures sound large, and they are. However, it is important to remember that we also expect the economy and therefore tax revenues to grow over that period, even if the current tax system is left unchanged. What really matters is how much of our national income (measured by gross domestic product, or GDP) we would have to spend on health in order to meet projected pressures. This will determine how much more the government would need to find by adjusting taxes, borrowing more or cutting other areas of spending.

We use the term 'GDP funding gap' to refer to the difference between the share of GDP we spend on health now and the share we would spend if we met the pressures outlined in Chapter 3. We then express this gap in 2018–19 terms to give an indication of the scale of the tax or spending changes that would be required if they were implemented today – in other words, how much it would cost today to meet the estimated GDP funding gap.

Table 4.1 shows projected spending levels under each of the scenarios laid out in Chapter 3. These projected levels are also expressed as a share of estimated GDP based on OBR growth forecasts.³ The estimated GDP funding gap is then calculated by comparing the predicted health and social care shares with their shares in 2018–19 (7.3% for the NHS and 1.1% for social care). The difference is then quantified in terms of 2018–19 GDP. These figures for the GDP funding gap, given in bold, will be used as a reference for Sections 4.4 and 4.5, which consider how much money could be raised by cutting spending elsewhere and by raising taxes.

Under the 'modernised' scenario, forecast NHS spending would grow from £154 billion in 2018–19 to an estimated £195 billion by 2023–24, and to £278 billion in 2033–34. Given projected growth, this implies that spending on the NHS would rise as a share of GDP throughout the period, reaching an estimated 9.9% in 2033–34. Given the current level of NHS spending of 7.3% of GDP, this would imply an estimated health funding gap of £56 billion by the end of the period.

More than three-quarters of the projected increase in NHS spending under the modernised scenario is accounted for by funding that is estimated to be needed to maintain the 'status quo'. Under the status quo scenario, projected spending would reach

³ See Office for Budget Responsibility, 'Long-term economic determinants', *Economic and Fiscal Outlook: March 2018*, <http://obr.uk/efo/economic-fiscal-outlook-march-2018/>. Real GDP is projected to grow at an average real rate of 1.8% per year up to 2033–34. This means that the economy is expected to be more than a third larger in 2033–34 than in 2017–18.

Table 4.1. Projected spending and funding gap for health and social care

		NHS status quo	Modernised NHS	Social care
2023–24	Spending in £ billion (2018–19 prices)	186.0	195.4	28.8
	Spending as % of GDP	8.2	8.6	1.3
	Funding gap	£20 billion	£29 billion	£3 billion
2028–29	Spending in £ billion (2018–19 prices)	215.1	232.4	34.2
	Spending as % of GDP	8.6	9.3	1.4
	Funding gap	£28 billion	£43 billion	£5 billion
2033–34	Spending in £ billion (2018–19 prices)	248.7	277.6	41.5
	Spending as % of GDP	8.9	9.9	1.5
	Funding gap	£34 billion	£56 billion	£8 billion

Source: Authors' calculations based on spending projections in Chapter 3, OBR Economic and Fiscal Outlook March 2018 and HM Treasury Public Expenditure Statistical Analyses 2017. Funding gap is calculated as the increase in spending (relative to 2018–19) as a share of GDP, expressed in 2018–19 terms.

an estimated £249 billion by 2033–34. However, when expressed as a share of GDP, most of the increases in funding pressures under this scenario are expected over the next five years, partly because the OBR expects GDP to grow at an average rate of 1.4% per year up to 2023–24 and 2.1% per year thereafter. This implies an estimated funding gap of £20 billion in 2023–24, rising to £34 billion by 2033–34.⁴

Projected spending on social care assumes that current levels of service and eligibility are maintained. Under these assumptions, projected spending is estimated to reach £41 billion by 2033–34, with social care as a share of GDP rising from 1.1% to 1.5%. This implies an estimated social care funding gap of £8 billion.

Taking the NHS and social care together, meeting the pressures under the modernised NHS scenario would require the government to raise an estimated additional £32 billion by 2023–24, rising to an estimated £64 billion in 2033–34. The status quo scenario would require an estimated additional £23 billion by 2023–24, rising to an estimated £42 billion in 2033–34.

It is crucial to note the sensitivity of these estimates to the future path of GDP growth, and therefore their uncertainty. But whatever the exact outcome in terms of economic growth and demand for health and social care spending, there can be little doubt that, unless there is a dramatic change in either political preferences or health costs and technology, we will end up spending significantly more on health and social care in the future than we do now. It will be up to politicians to decide whether the expected pressures should be met from public spending and, if so, where the additional resources that would be needed should come from.

⁴ Note that these figures refer to the funding gap for health only, and do not include social care.

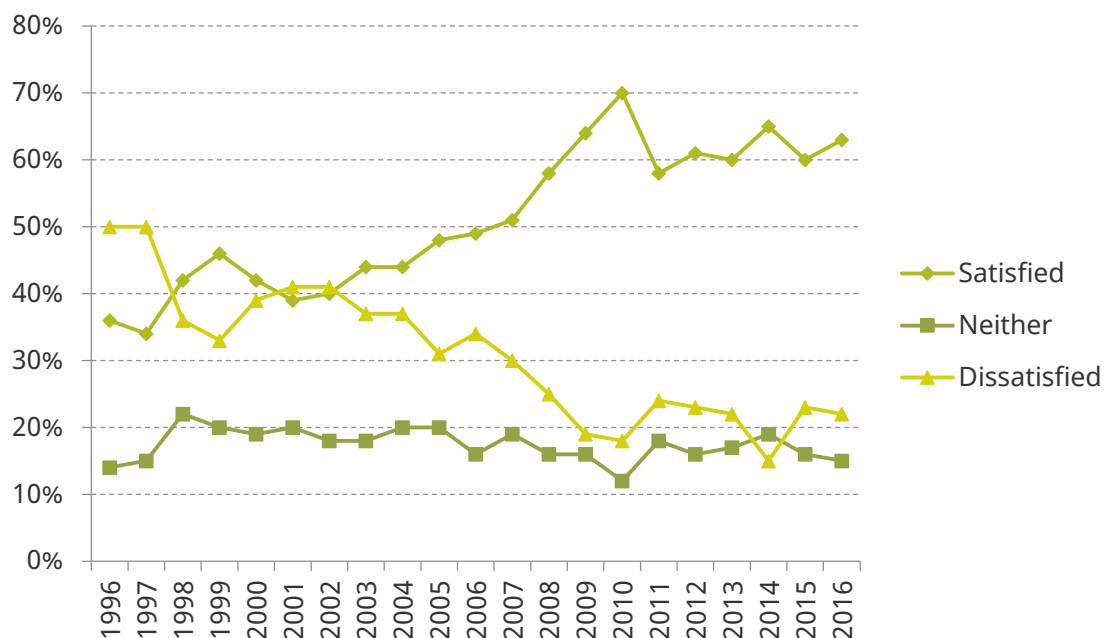
4.3 What are the public's views on NHS funding?

The public report high levels of satisfaction with the NHS, but are almost unanimous in believing that the NHS is in the midst of a funding crisis. Figure 4.1 shows levels of satisfaction with the NHS as recorded in the British Social Attitudes Survey. There was a large increase in levels of satisfaction between 2001 and 2010, from 39% to 70%, with a corresponding fall in the share reporting to be dissatisfied. This aligns with the period when NHS funding was increasing rapidly and waiting-time targets were introduced and then shortened. Satisfaction dropped to around 60% in 2011 and has remained stable since.

Using the most recent (2017) data, the King's Fund finds that those aged 65 and over were almost 10 percentage points more likely to report being 'quite' satisfied or 'very' satisfied with the NHS. It is unclear whether this reflects differences in contact with the NHS, differences in expectation or differences in quality of the services received.⁵ There are no statistically significant differences by household income or gender.⁶

While satisfaction has not fallen, Figure 4.2 shows that there has been an increase in the belief that the NHS is facing a funding problem. In 2014, 2015 and 2016, respondents to the British Social Attitudes Survey were asked whether they thought that the NHS had a funding problem. In all three years, over 90% responded that there was at least a minor funding problem. However, the share that claimed that the NHS had a severe funding

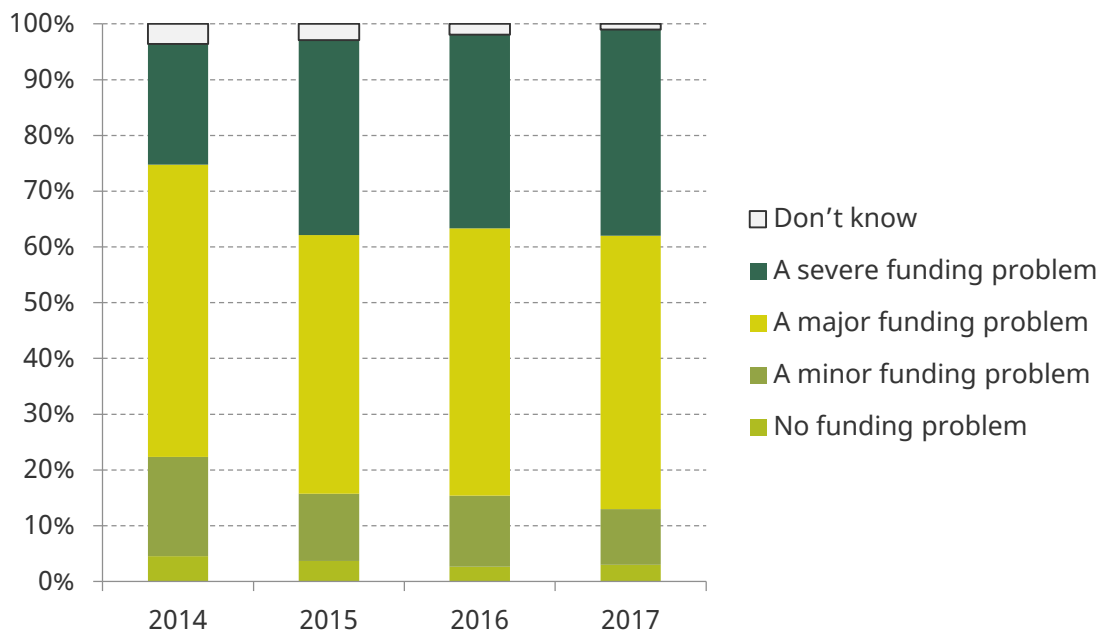
Figure 4.1. How satisfied or dissatisfied are you with the way the National Health Service runs nowadays?



Source: British Social Attitudes Survey, <http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-34/key-findings/context.aspx>.

⁵ A third of the sample are asked about their contact with inpatient services. However, the smaller sample means that differences are not statistically significant.

⁶ R. Robertson, J. Appleby and H. Evans, 'Public satisfaction with the NHS and social care in 2017', King's Fund, 2018, <https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-2017>.

Figure 4.2. Is the NHS facing a funding problem?

Source: British Social Attitudes Survey, <http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-34/key-findings/context.aspx>. 2017 analysis from the King's Fund, <https://www.kingsfund.org.uk/publications/does-public-see-tax-rises-answer-nhs-funding-pressures>.

problem increased from 22% to 35% between 2014 and 2015. Recent analysis from the King's Fund suggests the share who thought the NHS had a severe funding problem had increased further in 2017⁷.

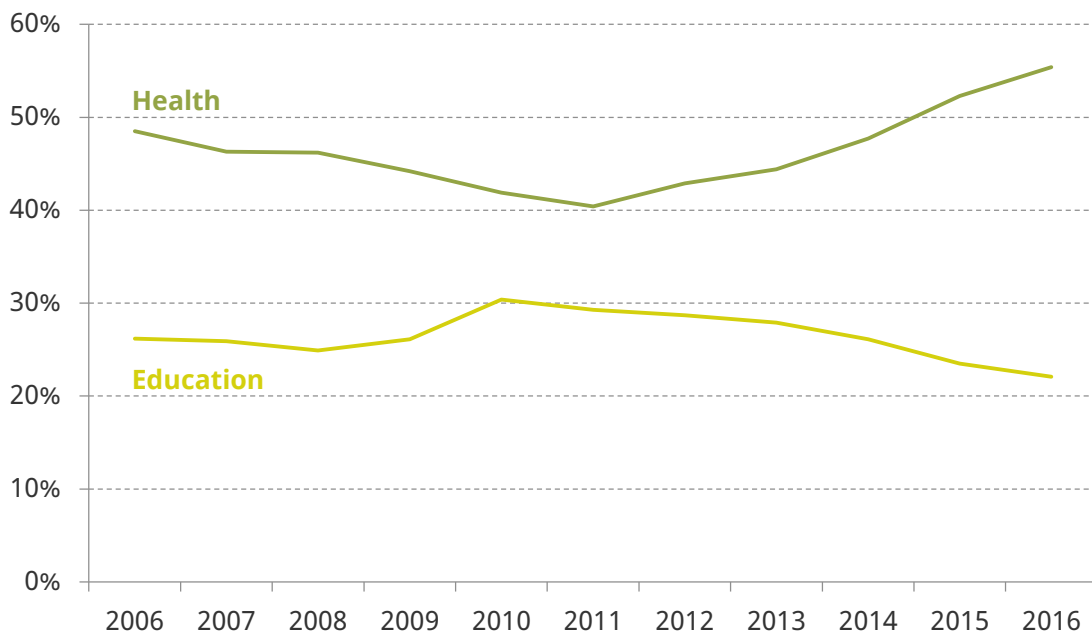
All public services have seen either spending cuts or a slower rate of growth in recent years. However, it does appear that concerns about NHS funding extend beyond a general concern about public services. The British Social Attitudes Survey has asked those polled their highest priority for extra public spending since the mid 1980s. Figure 4.3 shows the share choosing health and education as their highest priority, from 2006 to 2016. Together, these categories of spending accounted for three-quarters of responses in 2016. All other areas of public spending – including housing, defence, police and prisons, and public transport – are reported as being the highest priority by fewer than 10% of respondents.⁸ In all years, health is the most favoured option. However, between 2006 and 2011, the share reporting health as the first priority fell from 49% to 40%, while the share reporting education as the first priority increased from 26% to 29%. However, since 2011, the trends have reversed. In 2016, 55% reported health as the top priority, while the share opting for education fell back to 22%.⁹

⁷ H. Evans, 'Does the public see tax rises as the answer to NHS funding pressures?', King's Fund, 2018, <https://www.kingsfund.org.uk/publications/does-public-see-tax-rises-answer-nhs-funding-pressures>.

⁸ In 2016, the third-highest-rated area of public spending was housing, which was reported as the priority of 7.2% of those polled.

⁹ Further analysis of recent trends in public attitudes was published by the King's Fund in February 2018 (J. Cream, D. Maguire and R. Robertson, 'How have public attitudes to the NHS changed over the past three decades?', King's Fund, 2018, <https://www.kingsfund.org.uk/publications/how-have-public-attitudes-to-nhs-changed>).

Figure 4.3. Which, if any, area of public spending would be your highest priority for extra spending? Shares reporting health and education



Source: British Social Attitudes Survey, <http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-34/key-findings/context.aspx>.

There is much less information available about public opinion on social care, in terms of current quality, funding requirements or proposed reforms. This is partly because the issue is less salient for most people at any given point in time; it may also be that it is harder to explain what social care constitutes.

4.4 Paying for increased spending using the existing funding system

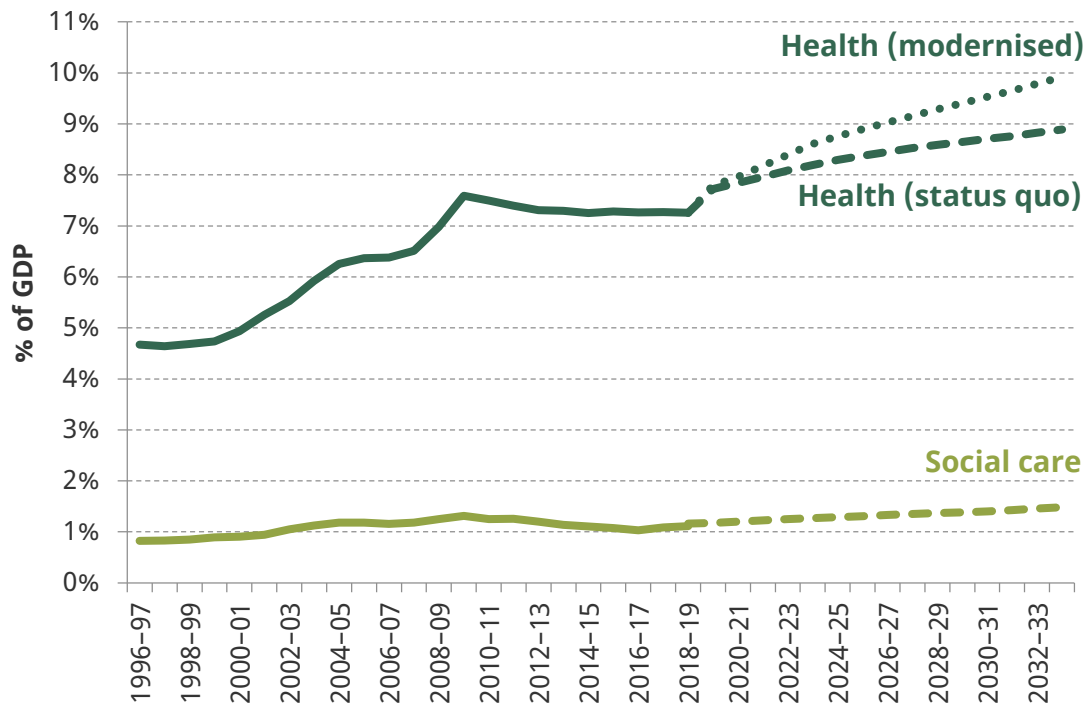
Taken at face value, most people seem to think that additional funding for the NHS is a priority. To accommodate additional funding would require reductions in other areas of public spending, increases in general taxation or increases in borrowing. Here we look at options for securing additional funding via spending cuts elsewhere. We examine the options via tax increases and via increases in borrowing in Sections 4.5 and 4.6 respectively.

Meeting projected pressures within current levels of public spending

This section analyses what the implications would be if the government decides to meet the projected pressures on health and social care spending by reducing spending on other areas (i.e. without spending more overall and holding the size of the state constant¹⁰).

Chapter 3 sets out projections for public spending on health and social care over the next 15 years. Figure 4.4 shows spending on health and social care as a share of GDP from 1996–97 to 2018–19, and spending projections to 2033–34 under the ‘modernised’

¹⁰ Total managed expenditure was equivalent to 38.8% of GDP in 2017–18. Source: OBR Public Finances Databank.

Figure 4.4. Projected spending on health and social care as a percentage of GDP

Source: Authors' calculations based on spending projections in Chapter 3, real GDP growth forecasts published in OBR Economic and Fiscal Outlook March 2018, OBR Public Finances Databank and various HM Treasury Public Expenditure Statistical Analyses.

scenario outlined in Chapter 3. Under this scenario, the government aims to achieve modest improvements in the range and quality of services provided while meeting demographic and cost pressures.

In 2018–19, UK health spending amounts to 7.3% of GDP and spending on social care amounts to an additional 1.1% of GDP. Under the modernised NHS scenario, health spending would need to increase to 9.9% of GDP and social care spending to 1.5% of GDP. That means that we would need to spend an extra 3.0% of national income, equivalent to more than £64 billion in today's terms. £42 billion of this is required just to keep the NHS at the same standard it is today.

If total managed expenditure (TME) is kept constant as a share of GDP, spending on other areas would need to be reduced to accommodate higher health and social care spending. This implies that health and social care spending would grow to account for a greater share of public spending, as summarised in Table 4.2.

In 2016–17, for every £1 the government spent, 18.7p went on health¹¹ and 2.6p on social care. That is, of the £798.9 billion the government spent in 2016–17, £149.2 billion went on health and £21.2 billion went on social care, leaving £628.5 billion for everything else. In our status quo scenario, in which there is no improvement in the range and quality of NHS services, spending on health is projected to increase to 21.1p in every £1 by 2023–24, 22.1p in 2028–29, and 22.9p in 2033–34. At the same time, social care spending is expected to rise from 2.6% to 3.8% of TME by 2033–34. Under the modernised scenario, in which the

¹¹ This is relatively high by international standards – see Figure 4.8.

Table 4.2. Projected health and social care spending as a percentage of TME

	Spending as % of TME		
	NHS status quo	Modernised NHS	Social care
2016–17 spending	18.7	18.7	2.6
2023–24 spending	21.1	22.2	3.3
2028–29 spending	22.1	23.9	3.5
2033–34 spending	22.9	25.6	3.8

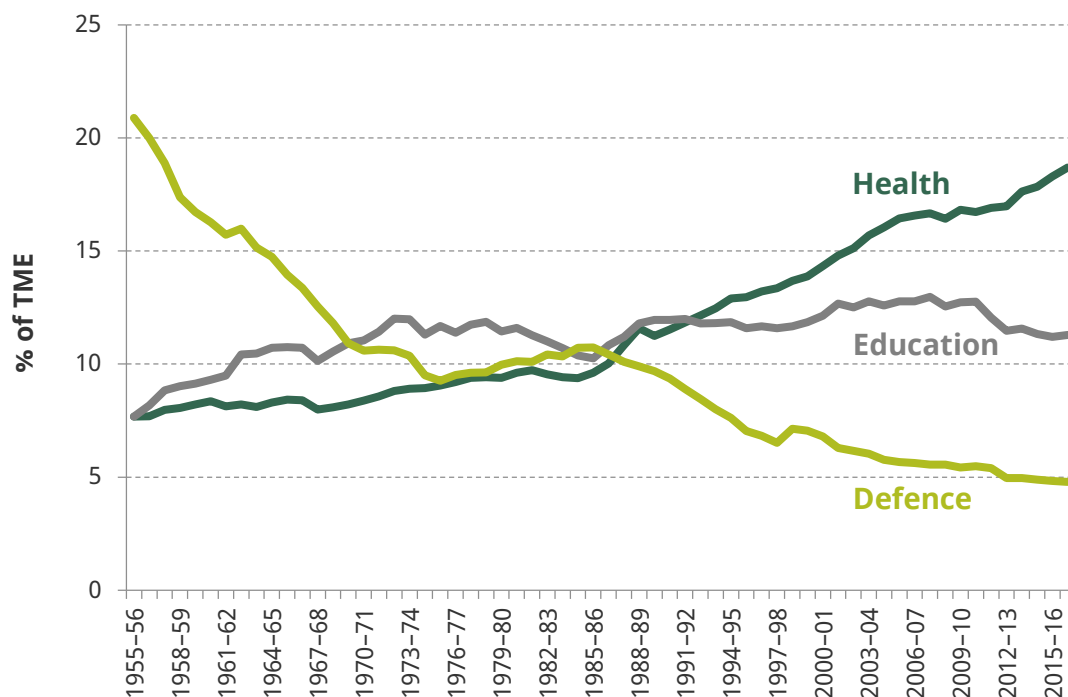
Source: Authors' calculations based on spending projections in Chapter 3 and OBR Public Finances Databank. Analysis assumes that total managed expenditure remains at its 2017–18 level of 38.8% of GDP.

government pursues modest improvements in the range and quality of NHS services, health spending is projected to reach 25.6p in every £1 by 2033–34.

The status quo scenario would require savings of around £42 billion in today's terms by 2033–34. That would mean cutting non-health-and-social-care spending by 6.7%. To meet the pressures in the modernised scenario, the government would need to find savings of £64 billion. That would require reducing spending on all other areas by 10% by 2033–34.

How much scope is there for reducing public spending in other areas?

Figure 1.5 in Chapter 1 illustrates how spending on health has increased both as a share of total public spending and as a share of spending on public services. Figure 4.5 shows how historical trends in health spending compare with those seen for education and defence.

Figure 4.5. Health, education and defence as shares of total spending


Source: Authors' calculations based on various HM Treasury Public Expenditure Statistical Analyses, UK National Accounts and OBR Public Finances Databank.

Health has steadily increased as a proportion of public spending, rising from 7.7% of all spending in 1955–56 to 18.7% in 2016–17, with most of the increase occurring since the mid 1980s. Over the whole period, this has been more than compensated for by falls in defence spending, which fell from 21% of spending in 1955–56 to just 4.8% in 2016–17. In the more recent past, the shares of government spending accounted for by health and defence spending were approximately equal in 1986–87. Since then, the health share has increased by 8.7 percentage points, while the defence share fell by 5.6 percentage points. This means that two-thirds of the increase in health spending since the mid 1980s has been compensated for by falls in defence spending.

Falls in defence spending cannot continue to compensate for increases in health spending. Current defence spending is 4.8% of total spending. Just to stop the NHS from getting any worse, the government would need to find savings of 4.2% of TME by 2033–34: that would mean eliminating almost 90% of the defence budget. Spending more money to improve the NHS and meet pressures on social care would require even larger cuts. Reducing defence spending may also not be an option if the government is to meet its commitment to spend 2% of national income (around 5% of TME) on defence every year of this decade.¹²

More generally, it looks like there is limited potential elsewhere for making cuts that could compensate for rises in health spending. Table 4.3 summarises how spending by function has evolved since 1978–79, both as a share of national income and in real terms after accounting for economy-wide changes in prices (expressed in 2018–19 prices). Changes in spending as a share of national income can come through changes in the level of cash spending (the numerator) and the level of GDP (the denominator). So, a fall in GDP during a recession means a given level of cash spending increases as a share of national income.

The table shows the same trends of increases in health spending, reductions in defence spending and largely stable education spending. Spending on health as a share of GDP increased steadily over the period, rising particularly quickly between 1996–97 and 2007–08, and increasing both in real terms and as a share of GDP between 2007–08 and 2016–17. Social security spending on pensioners and on non-pensioners increased in both real terms and as a share of GDP over the period, but the increase in spending on pensioners has been more pronounced since 2007–08. Long-term care spending doubled in real terms between 1996–97 and 2007–08, but fell between 2007–08 and 2016–17 both in real terms and as a share of national income. Spending on public order and safety ended the period much where it started as a share of national income, but fell by half a per cent of GDP between 2007–08 and 2016–17. Spending on defence, net debt interest, and housing and community amenities has fallen considerably since 1978–79.

Changes since 2007–08 are particularly relevant when thinking about the scope for further cuts. Amidst a wide-ranging austerity programme, health spending has been protected while many other areas have experienced considerable cuts in funding. Figure 4.6 shows the real-terms change in spending by function since 2007–08 in absolute terms.

¹² Source: Paragraph 1.84 of HM Treasury, *Summer Budget 2015*, <https://www.gov.uk/government/publications/summer-budget-2015>.

Table 4.3. Total spending and spending by function, as a percentage of national income and in £ billion (2018–19 prices)

		1978–79	1996–97	2007–08	2016–17
Total managed expenditure	% of GDP	41.5	35.4	39.0	38.9
	£ billion	374.9	482.6	730.9	798.6
Health	% of GDP	3.9	4.7	6.5	7.3
	£ billion	35.3	63.8	121.9	149.2
Education	% of GDP	4.9	4.1	5.1	4.4
	£ billion	44.5	56.3	94.9	90.2
Defence	% of GDP	4.0	2.4	2.2	1.9
	£ billion	36.1	32.9	40.6	38.3
Social security (pensioners)	% of GDP	5.0	5.2	5.5	6.1
	£ billion	45.0	71.6	102.9	125.6
Social security (working-age and children)	% of GDP	3.1	4.4	4.5	4.8
	£ billion	27.9	60.6	84.5	99.1
Public order and safety	% of GDP	1.4	1.8	2.0	1.5
	£ billion	12.2	24.4	38.2	31.1
Transport	% of GDP	1.5	1.0	1.3	1.5
	£ billion	13.5	14.2	24.8	30.6
Housing and community amenities	% of GDP	2.6	0.6	0.8	0.5
	£ billion	23.7	8.5	15.7	11.0
Overseas aid	% of GDP	0.4	0.2	0.3	0.7
	£ billion	3.9	3.1	6.4	14.4
Net debt interest	% of GDP	3.5	2.6	1.6	1.7
	£ billion	31.3	35.4	29.2	34.7
Long-term care	% of GDP	-	0.8	1.2	1.0
	£ billion	-	11.2	22.1	21.2

Source: Authors' calculations based on OBR Public Finances Databank (accessed February 2018), various HM Treasury Public Expenditure Statistical Analyses, DWP Benefit Expenditure Tables 2017, OBR Economic and Fiscal Outlook March 2018. Overseas Aid figure for 2016–17 is calculated based on the assumption that the government meets its target to spend 0.7% of GDP. Spending on long-term care excludes social services spending on families and children and spending on unemployment. Note that these spending functions do not align with the official Classifications of the Functions of Government (COFOG) used in HM Treasury PESA documents.

Box 4.1. The impact of cuts to social care since 2009–10

In England, Wales and Scotland, local authorities (LAs) are responsible for organising and funding adult social care. Since 2009–10, these LAs have faced sizeable cuts in their funding from central government, which have been made in such a way as to vary substantially in size across different councils.^{a,b} The resulting cuts to social care spending have had a range of consequences for local services and the care sector more widely.

Many LAs have responded to squeezed budgets by tightening eligibility criteria and concentrating care and support on those with the highest needs. As a result, over 400,000 fewer people accessed publicly funded social care in 2016–17 than in 2009–10.^c This is likely to have led to an increasing level of unmet care need and increasing reliance on informal care from (unpaid) friends and family. For those still receiving publicly funded care, there may well have been deterioration in the quality of care provided and a scaling-back of preventative services.^d The NHS has borne some of the cost of these cuts to social care, whether through a rise in emergency admissions or through an increased number of delayed discharges from hospital due to lack of available social care packages.^{e,f}

Funding constraints have also led to a reduction in the fees paid to care homes for state-funded residents: according to LaingBuisson, LAs reduced fee rates by a national average of over 6% between 2010–11 and 2016–17.^g Care providers also offer care services to individuals who are not receiving LA support (i.e. they are self-funding). To compensate for the cuts to LA fees, these self-funders are charged 41% more on average than those with their places funded by LAs.^h This has introduced a substantial degree of cross-subsidisation and threatens the sustainability of parts of the sector that rely more heavily on LA funding.

^a N. Amin Smith, D. Phillips, P. Simpson, D. Eiser and M. Trickey, *A Time of Revolution? British Local Government Finance in the 2010s*, IFS Report 121, 2016, <https://www.ifs.org.uk/publications/8705>.

^b D. Phillips and P. Simpson, *National Standards, Local Risks: The Geography of Local Authority Funded Social Care, 2009–10 to 2015–16*, IFS Report 128, 2017, <https://www.ifs.org.uk/publications/9122>.

^c Nuffield Trust, Health Foundation and King's Fund, *The Autumn Budget: Joint Statement on Health and Social Care*, 2017, <https://www.kingsfund.org.uk/publications/autumn-budget-2017>.

^d R. Humphries, R. Thorlby, H. Holder, P. Hall and A. Charles, *Social Care for Older People: Home Truths*, King's Fund, 2016, <https://www.kingsfund.org.uk/publications/social-care-older-people>.

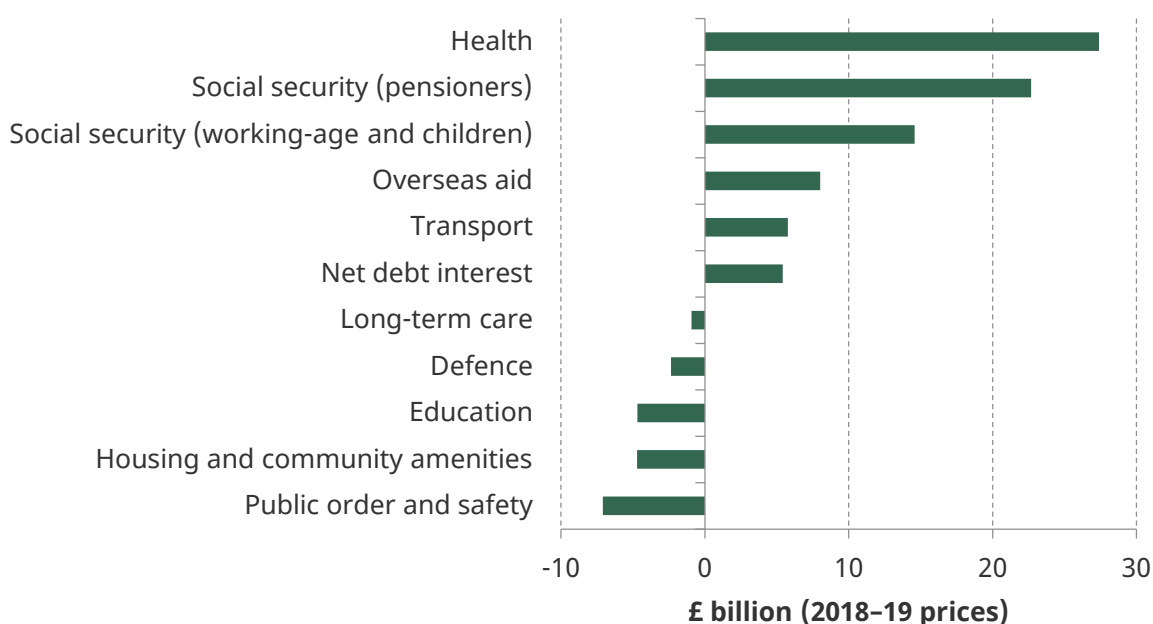
^e Communities and Local Government Committee, 'Oral evidence: adult social care, HC 47', Q258 and Q259,

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/adult-social-care/oral/44688.pdf>.

^f National Audit Office, 'Discharging older patients from hospital', 2016, <https://www.nao.org.uk/report/discharging-older-patients-from-hospital/>.

^g Cited by T. Jarrett, 'Social care: care home market – structure, issues, and cross-subsidisation (England)', House of Commons Library, Briefing Paper CBP-8003, 2018, <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8003>.

^h Competition and Markets Authority, *Care Homes Market Study*, 2016, <https://www.gov.uk/cma-cases/care-homes-market-study>.

Figure 4.6. Real-terms absolute change in spending by function, 2007–08 to 2016–17

Source: Authors' calculations based on data in Table 4.3.

Real spending on health increased by more than £27 billion between 2007–08 and 2016–17, a rise of 22.5%. Half of this increase came between 2007–08 and 2009–10, and health spending increased at a historically low rate after 2010–11. Public spending in a number of other areas fell over this period. For example, spending on public order and safety fell by more than £7 billion (a real-terms cut of more than 18%) and spending on housing and community amenities fell by £4.7 billion (a cut of almost a third). We can also see that while the increase in spending on overseas aid was not insubstantial, it was dwarfed by the increases in spending on health and social security.

Notably, while spending on health continued to rise between 2007–08 and 2016–17, UK spending on long-term care remained flat. In England, public spending on adult social care fell by 8% in real terms between 2009–10 and 2016–17,¹³ and the data suggest that the bulk of these cuts have fallen on those aged 65 and over.¹⁴ In recent years, as the impact of these cuts has become clearer, the government has transferred some NHS funding to social care via the Better Care Fund. The impact of social care cuts is explored in more detail in Box 4.1.

What does this mean for the potential for further spending cuts elsewhere?

This analysis presents a number of challenges for any government seeking to fund increases in spending on health and long-term care by making cuts elsewhere.

The first is one of simple arithmetic. To increase spending on health and social care to the level required under the 'modernised NHS' scenario without increasing TME, spending on everything else would need to be cut by 10% by 2033–34. To find savings of that scale, the

¹³ Source: P. Simpson, 'Public spending on adult social care in England', IFS Briefing Note BN200, 2018, <https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf>.

¹⁴ Source: D. Luchinskaya, P. Simpson and G. Stoye, 'UK health and social care spending', in C. Emmerson, P. Johnson and R. Joyce (eds), *The IFS Green Budget February 2017*, <https://www.ifs.org.uk/publications/8825>.

government would need to look to the larger budgets, such as those for education, defence and social security.

However, while social security is the largest area of government spending, more than half of the total goes to pensioners. Much of this spending is subject to similar demographic pressures to health as the older population grows. In its January 2017 Fiscal Sustainability Report, the OBR projected that spending on pensions would increase by 0.7% of GDP by 2033–34 as a result of demographic pressures.¹⁵ That is equivalent to an extra £15 billion in today's terms that the government would need to find, *on top of* the extra money needed for health and social care. This is not to say that savings could not be found in spending on pensioners, but indicates how difficult it would be to reduce the overall total by any sizeable amount.

Finally, many areas of public spending have already experienced severe real-terms cuts since 2010. Finding further savings in areas such as public order and safety (which includes the Home Office and Ministry of Justice) or housing would be challenging. Even areas such as education and defence, which have been (to an extent) ring-fenced and protected from the brunt of the cuts, have suffered real-terms cuts. Health is not the only budget under strain. Further prioritising health at the expense of other areas is likely to have far-reaching consequences, particularly for the quality of other public services and the generosity of the welfare system. This is important both because reductions in the quality and quantity of other public services may have an impact on individuals' health and therefore NHS and social care spending, and because the public value services other than the NHS.

In short, over recent decades we have been able to increase and protect NHS spending without much change in the overall size of the state, first by taking a big 'defence dividend' and then by implementing significant cuts to a wider range of public spending. It is hard to see that there is much scope to continue to find extra money for health and social care in this way.

4.5 Raising revenues through the tax system

If the government decides it wishes to meet the expected pressures on health and social care, an alternative to reducing other areas of public spending is to raise taxes in order to fund a higher level of public spending.

Public attitudes towards tax

There are signs that there is now an increased willingness from the public to pay more in tax. Each year, respondents to the British Social Attitudes Survey are asked whether they would like to 'keep taxes and spending the same', 'increase tax and spending' or 'reduce tax and spending'. Figure 4.7 shows that in the 1990s, support for raising taxes and spending often exceeded 60%. This followed a period of decreases in tax receipts as a share of GDP in the 1980s.¹⁶

¹⁵ Table 1.1 of supplementary data series, Office for Budget Responsibility, *Fiscal Sustainability Report: January 2017*.

¹⁶ H. Miller and B. Roantree, 'Tax revenues: where does the money come from and what are the next government's challenges?', IFS Briefing Note BN198, 2017, <https://www.ifs.org.uk/publications/9178>.

Figure 4.7. Percentage of people reporting different preferences for tax and spending, 1983–2016



Source: British Social Attitudes Survey, <http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-34/key-findings/context.aspx>.

Support for raising both taxes and spending fell sharply in the 2000s, reaching a low of 32% in 2010. This corresponds to a period when the Labour government spent more on public services through higher taxes and a period of high GDP growth. During the same period, there was a corresponding increase in the share of respondents who wanted to keep tax and spending the same. Since 2010, support for tax rises has risen, most sharply after 2014. In 2016, the share of respondents preferring tax and spending rises exceeded the share wanting to keep tax and spending the same for the first time since 2006. While the trend appears to be sharply upwards, it remains the case that support for additional tax and spending remains below its mid 1990s levels.

Since 2014, the British Social Attitudes Survey has asked respondents about how willing they would be to pay more for NHS service through increased taxes or user charges. The results are shown in Table 4.4.

In 2014, a total of 41% said they were prepared to pay more tax to fund NHS services, through either general taxation or a ring-fenced tax. By 2017, this had increased to 61%. The share prepared to accept user charges, either for non-medical costs in hospital and GP and A&E visits or by ending exemptions from existing charges, fell from 29% to 21%. However, because the question only allows respondents to choose one option, it is unclear whether this reflects a greater dislike for user charges or a greater tolerance of tax rises. The share who would not accept charges or tax rises fell from 27% to 15%, which is consistent with the public view that the NHS has a substantive funding problem.

At first sight, these trends in attitudes appear to suggest that there would be public support for increased taxation to fund the NHS. That said, there is a question over how big

Table 4.4. If the NHS needed more money, which of the following do you think you would be prepared to accept? (Single answer)

	2014	2015	2016	2017
Pay more through current taxes	17%	17%	21%	26%
Pay more through a separate tax that would go direct to the NHS	24%	24%	28%	35%
Pay for non-medical costs	12%	12%	11%	8%
Pay £10 for each visit to a GP or local A&E department	14%	15%	14%	11%
End exemptions from current charges	3%	3%	5%	2%
None of the above; NHS needs to live within budget	27%	26%	20%	15%
Don't know	3%	2%	1%	2%

Source: Figure 2 of King's Fund analysis of NatCen's British Social Attitudes Survey data, <https://www.kingsfund.org.uk/publications/does-public-see-tax-rises-answer-nhs-funding-pressures>.

an increase people would be prepared to pay. The tax rises that have been proposed in the past have been small, relative to the projected funding pressures over the next 15 years.¹⁷ Moreover, it is unclear how respondents believed the burden should be distributed. Would they personally be prepared to pay more tax or should tax rates in general be raised?

How much does the UK raise in tax compared with other countries?

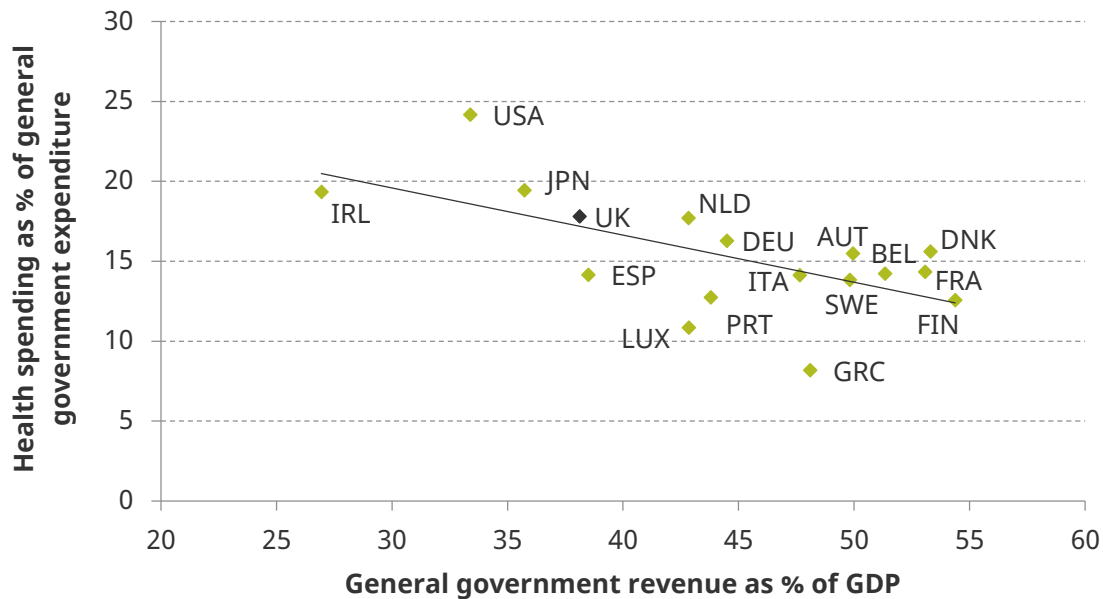
Figure 4.8 shows health spending as a share of general government expenditure plotted against general government revenue as a share of GDP, for EU-15 and G7 countries. At 38%, the UK is relatively low in terms of general government revenue as a share of GDP, between 5 and 15 percentage points lower than most EU-15 countries. However, tax as a share of GDP is high by historical standards in the UK, and we have experienced a net tax rise of 1.5% of national income since 2008.¹⁸ The UK share of government spending on health is relatively high at 17.8% in 2014–15 (the year shown in the figure).

The trend line in Figure 4.8 slopes downwards, suggesting that countries that have higher general government revenue spend a lower share of that revenue on health. Many of these high-revenue countries, such as Denmark or France, also spend more as a share of GDP on health. This suggests that higher levels of health spending in most other comparable EU countries reflect higher levels of overall government spending on all services, rather than differences in the prioritisation of health. If the UK spent the same share of government revenue on health as Denmark or France, but kept overall

¹⁷ For example, the Liberal Democrats proposed in their 2017 manifesto to put 1p on income tax. Adding 1p to all rates of income tax would raise an estimated £4.9 billion in 2018–19.

¹⁸ Source: T. Pope, 'Spring Statement 2018: the lost decade', presentation at IFS briefing on Spring Statement 2018, <https://www.ifs.org.uk/uploads/Spring%20Statement%202018%20-%20Tom%20Pope.pdf>.

Figure 4.8. The relationship between general government revenue as a percentage of GDP and health spending as a percentage of general government revenue, EU-15 and G7 (2015)



Note: Data for Canada were not available.

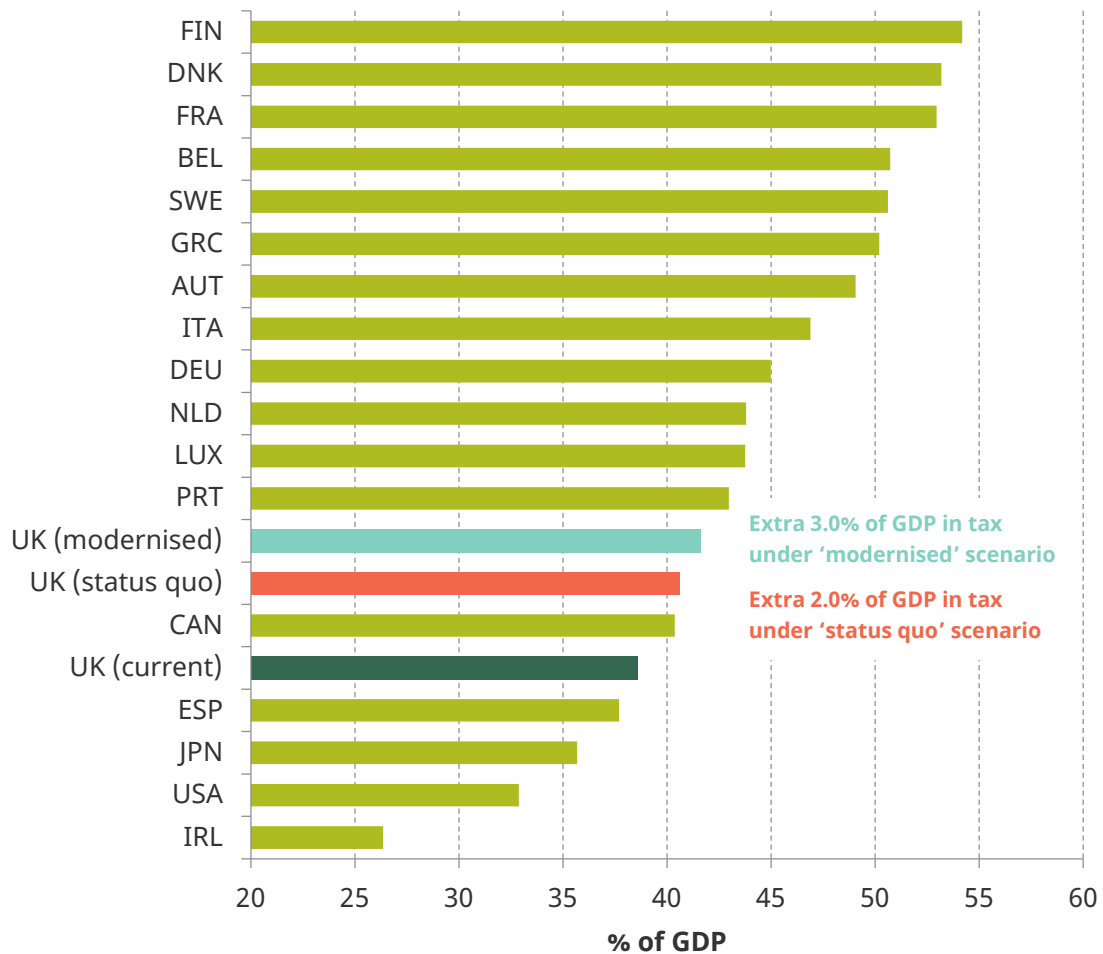
Source: OECD ('General government revenue', <https://data.oecd.org/gga/general-government-revenue.htm>; 'Health as a share of expenditure', Government at a Glance 2015, <http://dx.doi.org/10.1787/888933534784>).

government revenue as a share of GDP constant, UK public spending on health as a share of GDP would fall. Conversely, if the UK raised government revenue as a share of GDP to the levels of Denmark or France, but kept the share of that spending that went on health constant, public spending on health as a share of GDP would rise.

It is interesting to note that health spending as a share of government expenditure increased in the majority of countries between 2007 and 2015.¹⁹

If the government chose to raise taxes by the amount required to meet the pressures on health and social care, how would the UK tax take compare with those of other countries? Figure 4.9 shows how the UK compares internationally in terms of general government revenue as a share of GDP, and how it would compare if it met all pressures through additional tax under the 'status quo' scenario (extra 2.0% of GDP) and the 'modernised' scenario (extra 3.0% of GDP). The figure shows that if the UK were to raise an extra 3.0% of GDP in tax, it would move further from the USA and closer to the European average, but would still raise less in tax than countries such as France, Germany and the Netherlands. What this suggests is that it is quite possible to run an effective economy with higher levels of tax than we have in the UK. Of course, there are economically better and worse ways of doing this. And what is politically acceptable elsewhere may not be so in the UK.

¹⁹ The exceptions are southern European countries, including Greece, Italy, Portugal and Spain, where there have been particularly large increases in the share of spending accounted for by social protection as a result of the Great Recession (table 2.33 of OECD, *Government at a Glance 2017*, http://dx.doi.org/10.1787/gov_glance-2017-en).

Figure 4.9. General government revenue as a percentage of GDP, EU-15 and G7 (2016)

Source: OECD, 'General government revenue', <https://data.oecd.org/gga/general-government-revenue.htm>.

Note that this figure uses a different measure of the UK tax burden from that used elsewhere in the report, where OBR figures for National Accounts taxes and GDP are used.

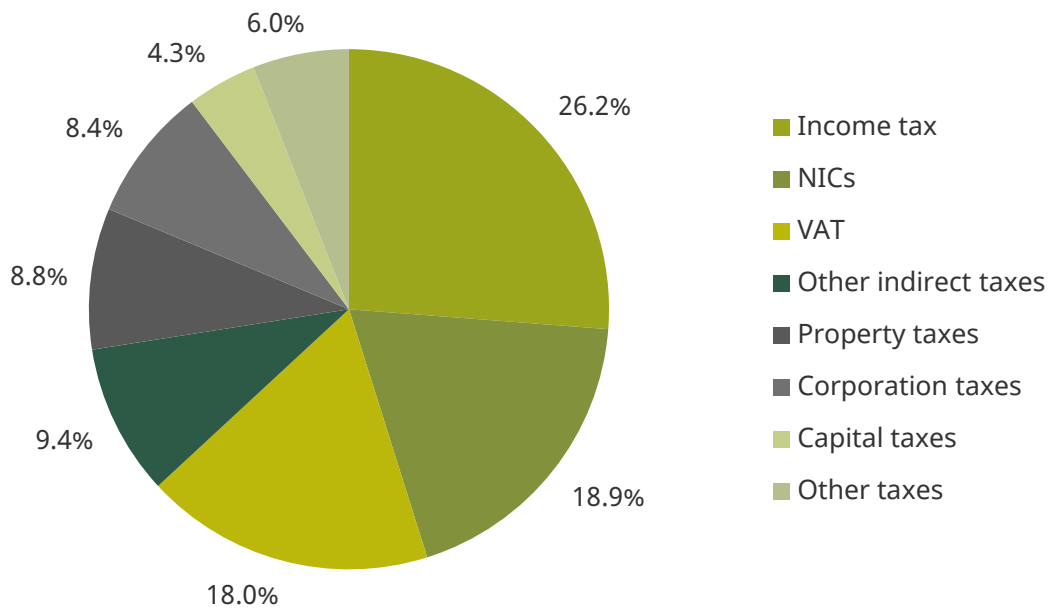
How could more tax revenue be raised?

Figure 4.10 shows the current make-up of total UK tax revenue by source. Nearly two-thirds (63.1%) of tax revenue is raised by the three largest taxes – income tax, National Insurance contributions (NICs) and VAT. Indirect taxes other than VAT, such as fuel duties and alcohol taxation, raise a further 9.4%, with property taxation and corporation taxation accounting for 8–9% each.

If the government decided that more money should be raised through taxes, there are at least three factors that it would need to consider when selecting which taxes to raise and by how much:

- *the amount to be raised*: if the sums involved are large, using taxes that raise relatively little money, or that are paid by relatively few individuals or firms, would require larger increases to generate the required revenue;
- *who pays the tax*: most governments have distributional goals, in terms of the income or other characteristics of taxpayers who would bear the burden of increased taxation;

Figure 4.10. Breakdown of UK tax revenues as a percentage of total taxation, 2017–18



Note: Total taxation is defined here as National Accounts taxes, which excludes non-tax public sector receipts.

Source: Authors' calculations based on OBR Public Finances Databank. Total taxation is defined here as National Accounts Taxes, which excludes non-tax public sector receipts.

- *possible distortions and disincentive effects*: almost all taxes generate potential distortions to behaviour. Taxes on earnings, such as income tax and NICs, create disincentives to work. Taxes on goods can distort the choices of consumers. An efficient tax system minimises the cost of these distortions for any given revenue requirement.

The remainder of this section starts by considering the estimated amounts that could be raised from the three big taxes, which constitute almost two-thirds of revenue. We then consider other potential changes, including reversing tax cuts since 2010, several of the tax changes that were proposed in the 2017 Labour party manifesto to raise money, and taxes that could be changed to improve the efficiency of the tax system.

We then consider three issues that have received high levels of public and political attention: raising money from advantaged groups, raising money from older people, and a hypothecated tax to pay for the NHS.

The three big taxes: income tax, NICs and VAT

Given the scale of the funding requirements outlined in Chapter 3, if the government wished to raise more in tax the obvious place to start is with the three main taxes – income tax, NICs and VAT.

Table 4.5 shows the estimated amount that the government could raise through increasing each of the three taxes. Raising all rates of income tax by 1p would raise an estimated £4.9 billion. The majority of this increase in revenue comes from raising the basic rate, which would yield around £4 billion. Raising the higher and additional rates by 1p would raise £0.8 billion and £0.1 billion, respectively. Alternatively, the government could reverse some of the recent increases to the personal tax-free allowance (PA), as this

Table 4.5. Summary of estimated revenue yield from possible reforms to income tax, NICs and VAT

	Revenue yield (2018–19)
Income tax	
- Increase basic rate by 1p	£4.0 billion
- Increase higher rate by 1p	£0.8 billion
- Increase additional rate by 1p	£0.1 billion
- Decrease personal allowance by £1,000 ^a	£5.8 billion
- Decrease basic-rate limit by £1,000 ^b	£0.4 billion
National Insurance contributions (NICs)	
- Increase main employee and self-employed NICs rates by 1p	£4.3 billion
- Increase employer NICs rate by 1p	£5.6 billion
- Increase additional NICs rates by 1p	£1.1 billion
Value added tax (VAT)	
- Increase main VAT rate by 1p	£6.0 billion

^a The personal allowance is the amount of income that individuals can earn without paying income tax. In 2018–19, this is set at £11,850.

^b The basic-rate limit is the amount of income above the personal tax allowance that is charged at the basic rate. In 2018–19, the basic-rate limit is £34,500, meaning that all income between £11,851 and £46,350 is taxed at a rate of 20%. Note that income tax bands are different in Scotland. This figure assumes that the upper earnings limit is reduced in line with the basic-rate limit.

Source: HMRC, 'Direct effects of illustrative tax changes', January 2018, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/680941/AB17_Direct_effects_of_illustrative_tax_changes_bulletin_Final.pdf.

would reduce the amount of income that people do not have to pay tax on. Decreasing the PA by £1,000 (from a starting point of £11,850 in 2018–19) would raise around £5.8 billion. Decreasing the basic-rate limit (BRL) by £1,000 (reducing the threshold at which income becomes subject to 40% income tax from £46,350 to £45,350) would raise £0.4 billion.²⁰ Reducing both the PA and the BRL by £1,000 would therefore raise around £6.2 billion.

Despite common belief, the revenues from NICs are not earmarked and instead contribute to general government revenues in the same way as income tax. Increasing the main rates of employee and self-employed NICs, along with the employer rate of NICs, by 1p would raise roughly £9.9 billion. Increasing the additional rate of NICs by 1p would raise a further £1.1 billion.

Increasing the main VAT rate by 1p would raise approximately £6 billion in additional revenue. Alternatively, the government could raise more money from VAT by widening the tax base, i.e. the set of goods on which VAT is charged. A range of goods are zero rated, which means that no VAT is charged on their final sale and that any VAT paid on inputs to the final product or service can be reclaimed. This includes food (worth £18.1 billion in 2017–18), the construction of new dwellings (£13.7 billion), domestic passenger transport

²⁰ This assumes that the upper earnings limit (UEL, the threshold at which the employee NICs rate drops from 12% to 2%) moves together with the BRL.

(£5.1 billion), books, newspapers and magazines (£1.7 billion), and children's clothes (£2.0 billion).²¹ In addition, VAT is paid on domestic fuel and power at a reduced rate, at an estimated cost of £4.7 billion in 2017–18.

Applying VAT to all goods at the standard rate would raise substantial sums and remove the distortions to consumption decisions, but is likely to prove unpopular as poorer households would see a larger loss as a proportion of disposable income. However, the Mirrlees Review illustrated how a move to uniform VAT rates could be packaged with other compensatory reforms in such a way as to leave the poor better off and – importantly – lead to a net increase in tax revenue.²² It would be possible to improve the progressivity and efficiency of the tax system, and raise tax revenue in the process.

In addition to zero and reduced rates of VAT, some goods and services are VAT exempt. This means that no VAT is charged on the final product or service, but the firm or organisation cannot reclaim VAT charged on the final product or service. Examples include finance and insurance, rent on domestic dwellings, education and health services. This is typically because there is no transparent price for the final good or service in question. Most education and health is free at the point of use, and most financial firms make money from interest rate spreads rather than a specific charge for a service. However, VAT exemption can cause distortions in production decisions, as inputs produced in-house are exempt from VAT but VAT would be payable on the same inputs sourced elsewhere. The largest exempt category is financial services, where the estimated revenue loss is £11.1 billion (though this estimate is subject to considerable uncertainty).²³

Table 4.6. Minimum required tax changes to meet pressures on health and social care by 2023–24 in the status quo scenario

	Required change to raise £23 billion (2018–19)
Broad-based taxes on income and spending	
- Increase in all rates of income tax	5p
- Decrease in personal allowance and basic-rate limit	£3,900
- Increase in all employee and self-employed NICs rates	4.5p
- Increase in employer NICs rate	4.5p
- Increase in main VAT rate	4p

Source: Authors' calculations based on spending projections in Chapter 3 and HMRC, 'Direct effects of illustrative tax changes', January 2018, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/680941/AB17_Direct_effects_of_illustrative_tax_changes_bulletin_Final.pdf.

²¹ Source: HMRC, 'Estimated costs of principal tax reliefs', December 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675345/Dec_17_Main_Reliefs_Final.pdf. Note that these figures are expressed in 2018–19 prices using March 2018 GDP deflators.

²² See pages 301–303 of I. Crawford, M. Keen and S. Smith, 'Value added tax and excises', in J. Mirrlees et al. (eds), *The Mirrlees Review: Dimensions of Tax Design*, Oxford University Press for IFS, 2010, <https://www.ifs.org.uk/uploads/mirrleesreview/dimensions/ch4.pdf>.

²³ For a description of how VAT could be levied on financial services, see pages 306–309 of I. Crawford, M. Keen and S. Smith, 'Value added tax and excises', in J. Mirrlees et al. (eds), *The Mirrlees Review: Dimensions of Tax Design*, Oxford University Press for IFS, 2010, <https://www.ifs.org.uk/uploads/mirrleesreview/dimensions/ch4.pdf>.

Recall that in order to maintain the status quo in the face of demographic and cost pressures (i.e. maintain 2018 levels of performance) and meet pressures on social care, we would need to raise an additional 1.1% of GDP by 2023–24, equivalent to £23 billion in 2018–19. To illustrate the magnitude of the changes required, Table 4.6 shows how much each tax rate or threshold would need to change by 2023–24 to raise that amount if the required revenue were raised from that tax alone. These can be thought of as the minimum changes required to avoid deterioration in the range and quality of services provided.

For each of the three taxes, rates at all levels would need to rise by 4–5p by 2023–24 to raise the revenue from that tax alone. In the case of income tax, a 5p increase would mean an additional tax payment of £48 per month for a worker on median earnings (£23,474) and £71 per month for a worker on average earnings (£29,009).²⁴ The personal allowance and basic-rate limit would both need to be reduced by almost £4,000 to generate £23 billion in today's prices.²⁵ The government could, of course, spread the burden across any combination of these taxes (or these and other taxes), and the changes could be made gradually over the next five years.

It is crucial to note that these are the estimated tax rises over the next five years that would be needed to keep the NHS in the state it is now. If the government wants to bring an end to missed waiting-time targets and annual winter crises, and to expand the quality and range of services on offer, even more money would be required. Under our modernised scenario, the government would need to raise an extra 1.5% of GDP by 2023–24, equivalent to £32 billion in 2018–19. A back-of-the-envelope calculation suggests that the scale of the tax rises would be roughly a third as large again (e.g. 6.5p on income tax or 6p on employer NICs). Thinking further ahead, under our modernised scenario, the government would need to find an additional £64 billion by 2033–34. The estimates above suggest that all rates of income tax would need to rise by 13p, or VAT by 10p, to raise that amount. However, the estimates in Table 4.5 (taken from the HMRC 'ready reckoner') are not designed to be accurate for tax changes of this magnitude and it would be inadvisable to scale up by that much. This is because the 'ready reckoners' do not take into account potential behavioural changes, which are more likely to accompany very large tax rises.

In short, the tax rises required to raise £64 billion in today's terms are substantial. Such increases could be spread across multiple taxes, and made gradually over time, but taxes would need to be considerably higher by 2033–34 to plug the funding gap. The scale of the additional revenue required means that relying on small taxes or an extremely narrow group of taxpayers is not a viable option.

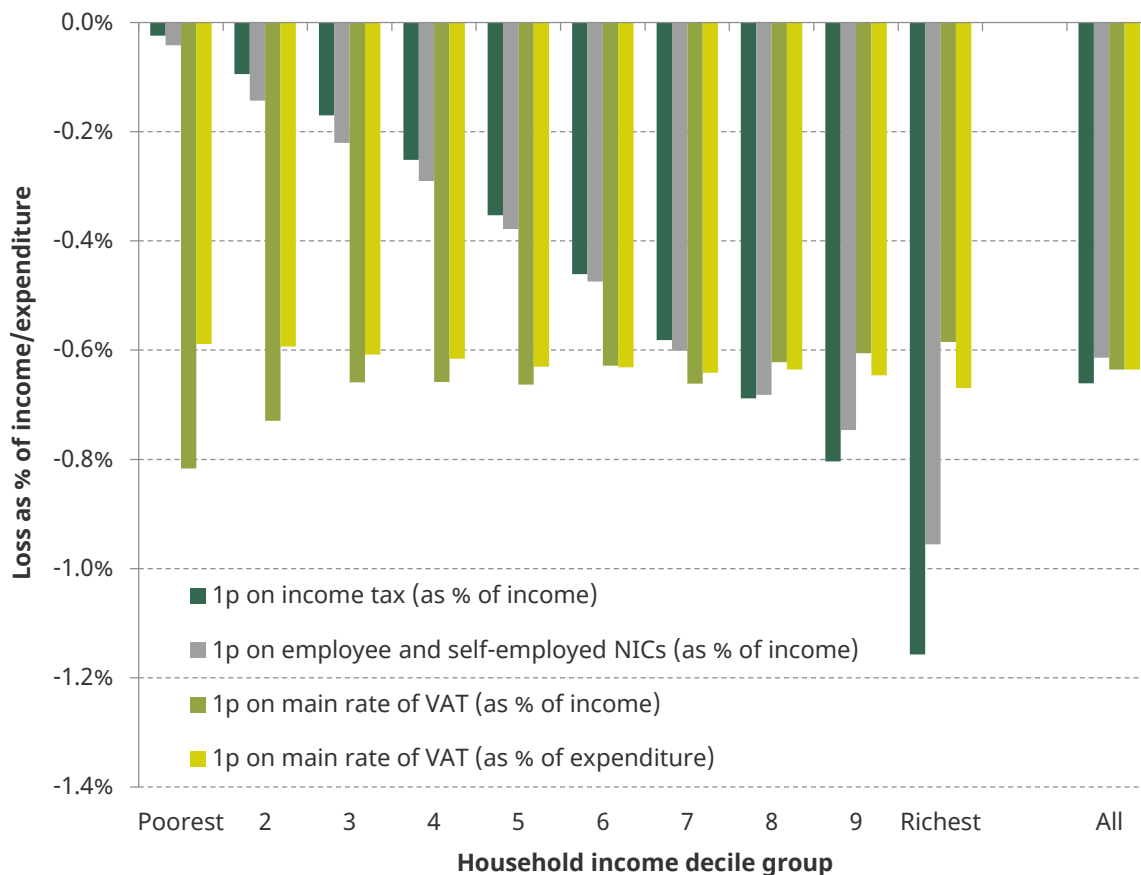
Distributional impact of increases in income tax, NICs and VAT

In addition to the amount that each tax would raise in revenue, the government may also wish to consider the distributional impact of any tax changes. Figure 4.11 shows the impact of a 1 percentage point rise in each of these three taxes, by household income decile (where households are divided into 10 equally sized groups based on income).

²⁴ Median and average earnings are for 2017. Source: Table 1.7a (annual gross pay for all employee jobs) of Annual Survey of Hours and Earnings, <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/all-employees> table1.

²⁵ This assumes that the UEL is lowered in line with the basic-rate limit, which would cost the exchequer around £300 million in 2018–19 for each £1,000 reduction.

Figure 4.11. Distributional impact of a 1 percentage point increase in all rates of income tax, all rates of employee and self-employed NICs, and the main rate of VAT, 2017–18



Source: Authors' calculations using Family Resources Survey, 2015–16, and TAXBEN, the IFS tax and benefit microsimulation model.

An increase in income tax is the most *progressive* of the three – in other words, those with the highest incomes would pay the greatest proportion of their income extra in tax. In 2017–18, the first £11,500 of income was exempt from income tax, and a quarter of households did not contain any individuals who earned enough to pay any income tax.^{26,27} These households would therefore not pay any more tax if income tax rates rose. Of those households that do contain an income tax payer, those with higher incomes would lose a larger share of their income, because a higher share falls above the tax-exempt threshold and because a higher tax rate applies for those earning over £45,000.²⁸ A 1p rise in all rates of income tax would mean the poorest decile group losing 0.02% of its income, rising to 1.2% for the top decile.

²⁶ T. Pope and T. Waters, 'A survey of the UK tax system', IFS Briefing Note BN09, 2016, <https://www.ifs.org.uk/bns/bn09.pdf>.

²⁷ As deciles are defined at the household level, those in lower income deciles may still be paying income tax.

²⁸ HM Government, 'Tax and tax credit rates and thresholds for 2017–18', Policy Paper, 2016, <https://www.gov.uk/government/publications/tax-and-tax-credit-rates-and-thresholds-for-2017-18/tax-and-tax-credit-rates-and-thresholds-for-2017-18>.

Increasing NICs has a similar distributional effect, but is slightly less progressive than increasing income tax. This is, first, because only the first £157 per week is free of NICs. This is lower than the income tax exemption over the course of 52 weeks of the year (£8,164), and means that NICs may be payable on temporary work that leads to income above the weekly NICs threshold, even if annual earnings are low. Second, NICs are levied on employment income and not other income sources – in particular, savings income, which is disproportionately found in the top half of the income distribution. The result is that a 1p increase in all rates of employee and self-employed NICs would reduce the income of the bottom decile by 0.04% but the income of the top decile by 0.96%. A NICs rise may also generate debate about the generational distribution of tax rises. Not only are NICs only payable on employment income, but employees cease to pay NICs when they reach the state pension age. This means that the burden of increased NICs falls solely on individuals of working age.

VAT rises look regressive as a percentage of income: the bottom decile would lose 0.82% of its income from a 1p rise in the main VAT rate, compared with 0.64% for the population as a whole. However, this impression is misleading, as it mainly arises because, at a given point in time, low-income households typically spend more relative to their income. This is because these very low-income households are often experiencing temporary drops in income, and are either borrowing or running down savings to maintain their expenditure at a level which reflects their lifetime resources. For example, students have temporarily low incomes and relatively high consumption, but would expect to have much higher earnings in future.

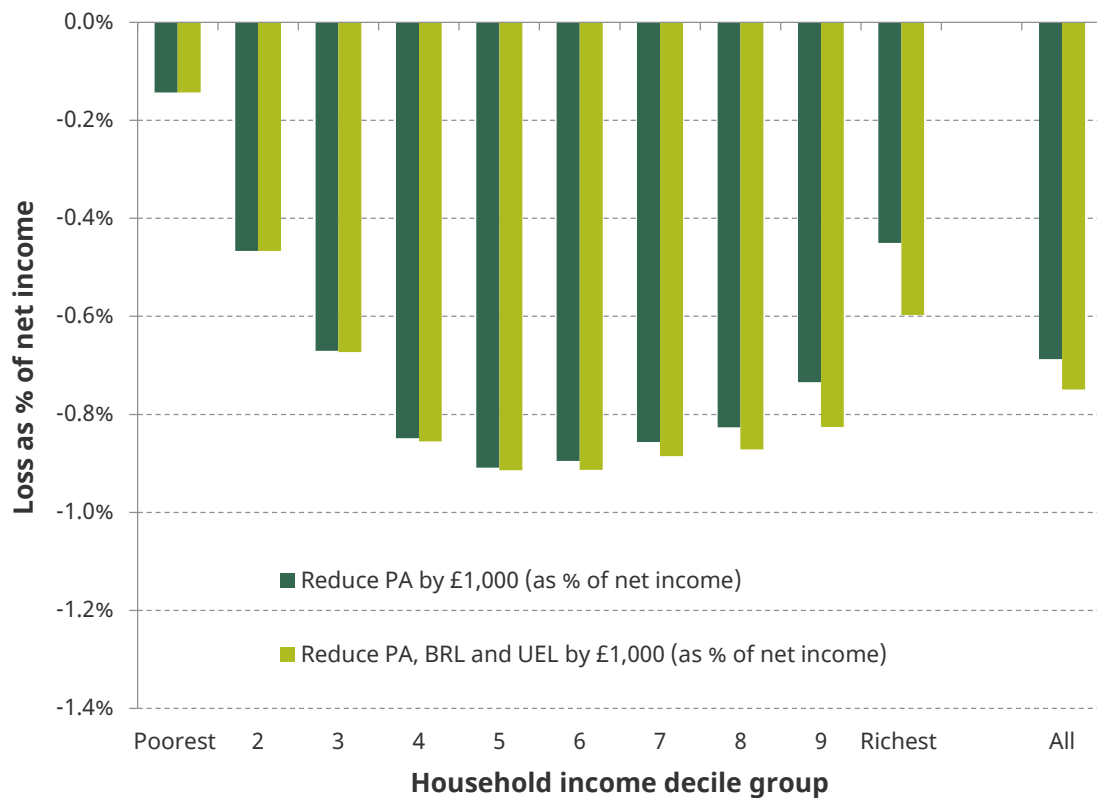
We can get a clearer picture of the distributional impact of VAT by considering the burden as a share of expenditure, which should more closely reflect lifetime resources. On this measure, VAT looks slightly progressive, with the impact of a 1p increase rising from 0.59% of expenditure for the lowest expenditure decile to 0.67% for the highest expenditure decile. This is because poorer households spend a larger share of their income on zero- or reduced-rate VAT goods, principally food. However, a rise in VAT is much less progressive than either increases in income tax or increases in NICs.

The higher share spent by poorer households on zero- or reduced-rated goods (such as food, children's clothing and fuel) means that imposing the standard VAT rate on them would be regressive in proportional terms. However, it is important to note that, in absolute terms, richer households spend far more on reduced- or zero-rated goods than poorer households, and therefore benefit more in cash terms from the lower rates. The structure of VAT is therefore not an effective way of redistributing income to poorer households. Applying VAT to children's clothing and distributing the proceeds uniformly across households with children would be more progressive than zero-rating children's clothes.²⁹ More progressive still would be to use the proceeds to increase child benefit, which richer households are not eligible for.

We can also examine the distributional impact of changes to tax allowances and thresholds. Figure 4.12 illustrates the impact across income deciles of a £1,000 reduction in the personal allowance (PA) and a £1,000 reduction in the PA, basic-rate limit (BRL) and

²⁹ T. Crossley, D. Phillips and M. Wakefield, 'Value added tax', in R. Chote, C. Emmerson, D. Miles and J. Shaw (eds), *The IFS Green Budget: January 2009*, <https://www.ifs.org.uk/budgets/gb2009/09chap10.pdf>.

Figure 4.12. Distributional impact of a £1,000 reduction in the personal allowance, basic-rate limit and upper earnings limit, 2017–18



Source: Authors' calculations using Family Resources Survey, 2015–16, and TAXBEN, the IFS tax and benefit microsimulation model.

upper earnings limit (UEL). Reducing just the PA would raise an estimated £5.8 billion, while reducing all three would raise around £6.2 billion (after accounting for the £0.3 billion revenue loss from the reduction in the UEL).

Reducing the personal allowance is less progressive than changes to the rates of income tax or NICs. The poorest decile is the least affected (losing 0.14% of net income), but the losses are concentrated in the middle of the income distribution rather than at the very top. Reducing the BRL and UEL as well as the PA is more progressive, as the additional change affects only those in the top half of the income distribution, but households in the fifth and sixth deciles would still lose the most from such a change.

The richest would lose most in cash terms from a reduction in the PA, BRL and UEL. But they would lose less as a percentage of net income than those in the third decile. This is because the PA starts to be withdrawn from individuals earning over £100,000, and those earning more than £123,700 in 2018–19 (or £123,000 in 2017–18) have a personal allowance of zero. These extremely high-income individuals are therefore unaffected by a reduction in the personal allowance.

Incentives and distortions

Raising any of the three main taxes, either through increased rates, reduced thresholds or reduced exemptions, would weaken work incentives, reducing the reward for working in terms of the amount of goods and services that additional earnings can purchase after

tax. A rise in NICs would typically be the most damaging to work incentives (per pound raised) as it would increase the difference in tax treatment of earned versus unearned income (dividends, pensions etc.) and in tax rates paid by employees and others. A rise in income tax is also expected to weaken work incentives, but only applies to income above the basic-rate threshold. An increase in VAT reduces the actual goods and services individuals can purchase with their wages, reducing incentives to work. However, as VAT would reduce the value of out-of-work incomes as well as in-work incomes, the relative attractiveness of working would not be reduced as much as by an increase in income tax or NICs raising a similar amount of revenue.

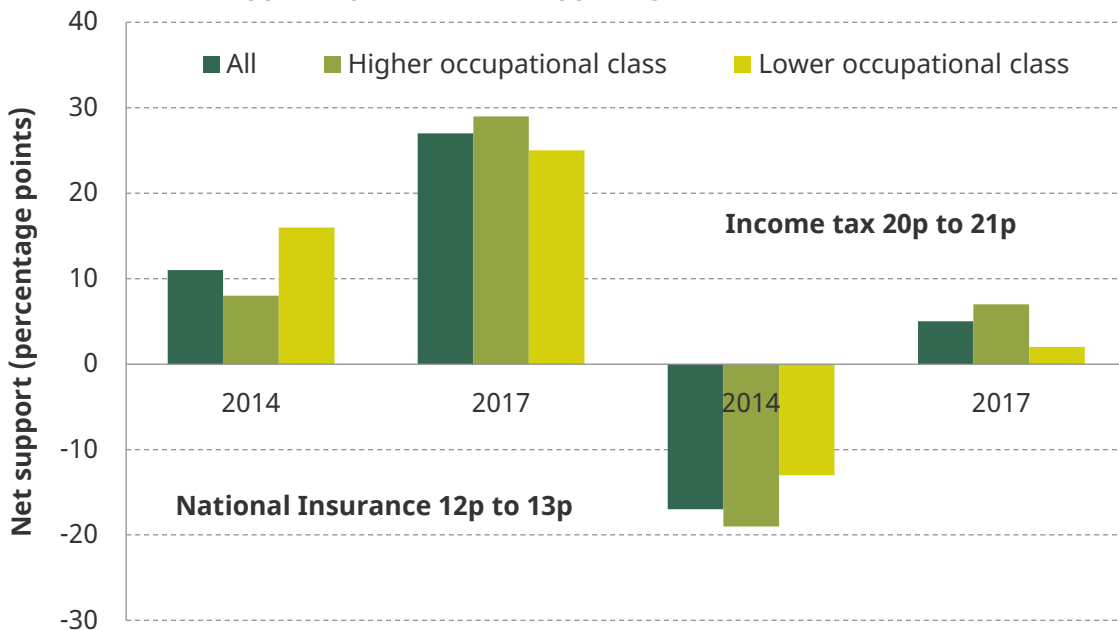
Public preferences on tax rises

In addition to the relative economic merits of raising each tax, it is also important to take public opinion into account.

When polled, the electorate tend to prefer increases in NICs to increases in income tax for funding additional NHS spending. In 2014 and 2017, YouGov polls asked respondents whether they supported or opposed a 1p increase in NICs and a 1p increase in income tax to raise money for the NHS. Figure 4.13 shows net support (percentage supporting minus percentage opposing) by year and by socio-economic classification.

The figure reveals two important features. First, in both 2014 and 2017, there is more support for an increase in NICs than for an increase in income tax. One possibility is that the public still regard the tax as contributory social insurance, where individuals would

Figure 4.13. Net support for National Insurance and income tax increases to pay for the NHS (share supporting minus share opposing)



Note: 'Higher occupational class' has social status classification ABC1. 'Lower occupational class' has social status classification C2DE.

Source: YouGov, 2014, https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/katz91y88e/YG-Archive-140422-TheTimes.pdf; YouGov, 2017, <https://yougov.co.uk/news/2017/01/12/majority-people-would-support-raising-national-ins/>.

later benefit from earlier payments, rather than an additional payroll tax. The lower NICs rate of 12p, versus 20p for income tax, may play some role. It is notable that those over 60 show a particularly strong preference for increasing NICs (net 54 points). Most of this group would not be directly affected by an increase in NICs, as employees cease to pay NICs when they reach state pension age. However, older people also have high levels of net support for income tax rises (32 points), which many do pay.³⁰

Second, there was an increase in support for both tax rises between 2014 and 2017, with net support for both increases in 2017. The largest shift in attitudes has been by those in higher occupational classes.³¹ In 2014, this group were less likely to support NICs rises and more likely to oppose income tax rises than those of lower occupational classes.³² By 2017, those of higher occupational classes were more likely to support tax rises than those of lower classes.

There is net support for NICs rises across all age groups and irrespective of the party an individual voted for in the 2015 general election. There is net support for income tax rises among those who voted Labour or Liberal Democrat in 2015 and among those aged over 40.

Other tax options

Although the three main taxes are likely to form the starting point for a government that wishes to increase tax revenue, there is scope for the government to look at other existing taxes and the reversal of recent tax cuts.

Reversing recent tax cuts

Although we have experienced a net tax rise since 2008, there have been a number of tax giveaways that could be reversed by a government seeking to increase revenue. Of particular note are the above-inflation increases in the personal allowance. The previous subsection discussed the scope for raising revenue through reductions in the PA and the distributional impact of doing so. Such a reduction would reverse some of the large increases in the PA made since 2010. The personal tax allowance is £11,850 in 2018–19, whereas had it been uprated in line with the Consumer Prices Index (CPI) since 2010 (the default) it would be £7,750. This policy, combined with changes to the higher-rate threshold, has been expensive, representing a net tax giveaway of £12 billion in 2017–18.³³ Reversing these increases might be politically difficult, and in any case the Conservative government has pledged to increase the PA to £12,500 by 2020. Nonetheless, reversing the increases in income tax thresholds – or at the very least bringing an end to above-inflation increases – would be one way of raising extra revenue for the exchequer.

Embedded within the public finances is an assumption that fuel duties will be uprated each year in line with the Retail Prices Index (RPI). However, fuel duty has been frozen for the past eight years. Revenues in 2018–19 will be around £6.2 billion lower than they

³⁰ There is net support for both NICs (35 points) and income tax (13 points) rises among the 40–59 age group. Those aged 18–24 and 25–39 have net support for NICs rises but not for income tax increases.

³¹ Social status classification ABC1.

³² Social status classification C2DE.

³³ C. Emmerson and T. Pope, 'Autumn 2017 Budget: options for easing the squeeze', IFS Briefing Note BN135, 2017, <https://www.ifs.org.uk/uploads/publications/comms/BN135.pdf>.

would have been had duties risen in line with RPI each year, rather than being frozen.³⁴ It is unlikely that any government would want or be willing to raise duties by enough to reverse this. Instead, bringing an end to the annual ritual of announcing a one-year freeze, or perhaps moving to CPI indexation, might raise more revenue than is the case under the current state of affairs.

Finally, cuts to corporation tax have represented a major tax giveaway since 2010. For instance, cuts to corporate tax rates announced between 2010 and 2016 were estimated to have reduced revenues by around £16.5 billion in 2017–18.³⁵ Accounting for measures that raise revenue (including anti-avoidance measures), the cost is estimated to be £12.4 billion. There is scope to raise revenue by reversing some (or all) of these changes; this is discussed below in the context of the Labour party's 2017 manifesto proposals.

Labour manifesto proposals on corporation and income tax

The 2017 Labour manifesto proposed corporation tax rises from 19% in 2017–18 to 26% in 2020–21. This would reverse the cuts since 2010 and return rates to their 2011 level. HMRC estimates that a 1 percentage point increase in the corporation tax rate would raise £2.7 billion per year in 2020–21 (£2.6 billion in 2018–19 prices).³⁶ A back-of-the-envelope calculation therefore suggests that an increase from 19% to 26% would raise £18.6 billion per year in 2020–21 (£18.0 billion in 2018–19 prices). However, this is likely an overestimate of how much revenue would be raised in the medium to long term, because higher tax rates would lead to companies investing less in the UK.

Even at a rate of 26%, the UK would still have the lowest rate of corporation tax in the G7. The UK would, however, be less competitive overall, because we have a less competitive tax base than other countries, as a smaller share of capital expenditure can be deducted from revenues each year.

Finally, while it may seem attractive to place more of the tax burden on corporations rather than individuals, in reality all taxes are paid by people and corporation tax is no different. While the direct impact of a corporation tax rate rise would be to reduce returns to company owners (shareholders), evidence suggests that a significant share of the increased tax burden is passed on to workers through lower wages.

The manifesto also proposed an increase in income tax for people with taxable income exceeding £80,000 per year, with a new marginal rate of 45% starting at £80,000 and a new marginal rate of 50% starting at £123,000.³⁷ The tax revenue that the proposal would raise is highly uncertain: Labour expected to raise around £4.5 billion a year, but the policy

³⁴ Source: Authors' calculations based on IFS Autumn 2017 pre-Budget analysis, <https://www.ifs.org.uk/uploads/publications/comms/BN135.pdf> and table 2.1 of HMT Autumn Budget 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/661480/autumn_budget_2017_web.pdf.

³⁵ H. Miller, 'What's been happening to corporation tax?', IFS Briefing Note BN206, 2017, <https://www.ifs.org.uk/publications/9207>.

³⁶ HMRC, 'Direct effects of illustrative tax changes', January 2018, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/680941/AB17_Direct_effects_of_illustrative_tax_changes_bulletin_Final.pdf.

³⁷ The proposals also retained the policy of withdrawing the personal allowance from those earning more than £100,000 which, combined with the increase in the headline rate from 40% to 45%, would mean a marginal tax rate of 67.5% for those earning between £100,000 and £123,700.

could raise more, or less, or nothing, depending on the size of the response from high-income individuals. The impact of the tax rise would be highly concentrated on those with the highest incomes, with about 1.3 million people affected – a relatively small group, but one that is already a very important source of revenue. A more detailed discussion of the proposals is available in IFS analysis published at the time of the election.³⁸

Wider tax reform

Considering the tax system more widely, the government has a vast range of available options for tax reform. Detailed consideration of these options is beyond the scope of this report. The interested reader should look to the Mirrlees Review for comprehensive analysis of the UK tax system and a set of proposals for tax reform.³⁹ For our purposes, the important thing to note is that there are a range of changes that the government could make to improve the efficiency of the tax system and potentially raise revenue in the process. No single one of those changes would be a panacea for the pressures on health and social care. But sensible reforms could increase people's welfare, improve the performance of the economy and, if designed appropriately, make a valuable contribution towards meeting the funding pressures described earlier in this report.

Taxing specific groups

If the government chooses to meet the pressures on health and social care through tax rises, it may also wish to achieve distributional objectives by designing tax changes to target particular groups. Two groups may be of particular interest. The first is those who are better off, who, it is sometimes argued, could afford to pay more tax. The second is people over the age of 65, who currently experience relatively generous treatment by the tax and benefit system, but are high users of health and social care.

Taxing the better off

The extent to which the tax and benefit system redistributes income is a political decision for governments and the public, which we take no stance on. However, both Labour and the Conservatives have expressed preferences for raising taxes from the 'well-off' and those with the 'broadest-shoulders'.⁴⁰ It is therefore likely that if taxes were increased to pay for additional NHS funding, the government in charge would be concerned about the distribution of the tax burden.

Before considering the options for raising tax from the 'better-off' or the 'rich', it is important to define who that group are. In particular, are individuals characterised based on their income or wealth? Those with high income and those with high wealth are distinct, albeit overlapping, groups. Also of crucial importance is how far up the income or wealth distribution the government wants to target. Are the better-off the top half of the income/wealth distribution, the top 10% or even just the top 1%?

Those with higher incomes already pay a high proportion of total tax revenues collected. For example, 28% of all income tax in 2017–18 was raised from the top 1% of income tax

³⁸ S. Adam, A. Hood, R. Joyce and D. Phillips, 'Labour's proposed income tax rises for high-income individuals', IFS Briefing Note BN209, 2017, <https://www.ifs.org.uk/publications/9229>.

³⁹ <https://www.ifs.org.uk/publications/mirrleesreview/>.

⁴⁰ The Labour party has a strong preference for raising more tax revenue from the rich, with the election manifesto of 2017 promising not to raise income tax on those earning less than £80,000.

payers, 59% from the top 10% and 90% from the top 50%.⁴¹ As three-fifths of the adult population in the UK are income tax payers, this means that these contributions are coming from the top 0.57%, 5.7% and 28.5% of the population, respectively.⁴² Increases in all rates of income tax, National Insurance contributions and, to a lesser extent, VAT would fall disproportionately on those in the top half of the income distribution.

The most obvious way to target a tax rise on the top 10% or higher is to increase the higher rate of income tax or the additional rate of NICs, which would concentrate losses on the top tenth of the income distribution.⁴³ However, focusing on these taxes, which are paid by relatively few tax payers, means tax rates would have to rise by more to generate a given amount of revenue. For example, assuming no behavioural changes, higher-rate income tax would need to increase by 5p to generate the same revenue as an additional 1p on the basic rate of income tax. This is likely to create greater disincentives to work.

Targeting higher-wealth individuals is much harder, and a specific wealth tax would have a number of economic and political disadvantages. For most households, their biggest source of wealth is their house, but housing taxation is not currently well structured. There are two ways in which housing is taxed. The first is through council tax, which is an annual charge levied by local authorities based on the value of the property. However, the current council tax system charges a lower percentage on high-value properties and tax rates are based on house values in 1991. This structure has no sensible justification. Council tax could be reformed in such a way as to make the system more efficient and raise more revenue from the rich. The second form of housing taxation is stamp duty, paid by buyers when properties are purchased. This is highly distortionary as it discourages people from moving. Increasing stamp duty is likely to increase this distortion further.

There are a number of smaller taxes that could be reformed to increase revenue while also improving the efficiency of the tax system. In particular, the forgiveness of capital gains tax (CGT) at death and the inheritance tax (IHT) reliefs for business assets, agricultural land and gifts made more than seven years before death are highly distortionary. The benefit of all of these reliefs falls disproportionately on the rich. The tax-free lump sum on private pensions is sizeable and badly targeted, and the NICs treatment of employer pension contributions looks unnecessarily generous. Reform in these areas could remove existing distortions and increase tax receipts by a considerable amount.

A detailed discussion of options for taxing the 'better-off' is provided in the IFS Green Budget 2013.⁴⁴

⁴¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/616440/Table_2.4.xlsx.

⁴² There were 30.4 million taxpayers in the UK in 2016–17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/610456/Apr17_Numbertaxpayerstraders_bulletin_Final.pdf), while the number of individuals aged 16 and over in 2016 is projected to be 53.3 million (<https://www.nomisweb.co.uk>).

⁴³ Increasing either by 1p would mean an individual earning £50,000 per year would pay an additional £36.50 in tax per annum while those earning £100,000 per year would pay an additional £536.50.

⁴⁴ S. Adam, C. Emmerson and B. Roantree, 'Broad shoulders and tight belts: options for taxing the better-off', in C. Emmerson, P. Johnson and H. Miller (eds), *The IFS Green Budget: February 2013*, https://www.ifs.org.uk/budgets/gb2013/GB2013_Ch9.pdf.

Taxing older people

The Dilnot Commission⁴⁵ proposed a more generous system of state support for social care costs. The beneficiaries of such a reform would be pensioners with higher levels of income and/or assets. The Commission therefore proposed that if taxes were to rise to pay for increased generosity, the burden of those taxes should primarily fall on older people.

Older people are also likely to receive a disproportionate share of any increase in NHS spending, as they suffer higher rates of ill health. However, this does not necessarily imply that older people should shoulder the cost. The UK does not link access to the NHS to either annual or lifetime tax payments. On one hand, cohorts, on average, pay more in tax than they receive in healthcare when they are working and they receive more in healthcare than they pay in tax once retired. The younger generation would benefit from any increased health spending later in their own lives.

That said, the current generation of older people would be the main immediate beneficiaries of any increase in spending. They have also done particularly well economically, are likely to be better off than succeeding generations and have been relatively protected from many of the effects of the recent austerity programme.

Pensioners have seen their incomes increase more rapidly than the working population since 1997. Between 1997 and 2010, tax and benefit changes introduced by the Labour government favoured pensioners, particularly those on lower incomes. Since 2010, pensioners have been largely protected from the tax and benefit changes introduced as part of fiscal consolidation. They have also benefited, relative to younger generations, from house price changes and many have access to generous occupational pension schemes not available to younger cohorts. It is also worth saying that, as the population ages, having a tax system that raises more money from the older part of the population is likely to be more sustainable.

Were the government to want to raise money specifically from older voters, it would have a number of options:

- The winter fuel payment (WFP), free TV licences and free bus passes are not well targeted. Tax treatment means that they increase the post-tax income of the richest and the poorest by the same amount. Total spending on WFP is forecast to be £2.0 billion in 2017–18, with an additional £641 million on free television licences.⁴⁶ Restricting eligibility to those on pension credit would realise an additional £1.7 billion. Applying income tax to these benefits would raise much less, at £0.2 billion.⁴⁷
- Improving the taxation of housing, as discussed above, would tend to raise more money from those who currently own expensive properties – largely older generations. The Intergenerational Commission, convened by the Resolution Foundation, recently

⁴⁵ Commission on Funding of Care and Support, <http://webarchive.nationalarchives.gov.uk/20130221130239/http://dilnotcommission.dh.gov.uk/>.

⁴⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/675359/outturn-and-forecast-autumn-budget-2017.xlsx.

⁴⁷ Source: Calculations using TAXBEN, the IFS tax and benefit microsimulation model, and the Family Resources Survey 2015–16.

recommended replacing council tax by a progressive property tax with surcharges on second and empty properties.⁴⁸ Such a change could eliminate a number of inefficiencies from the existing system and raise revenue from older generations.

- Pensioners currently pay no NICs on earned income, at an annual cost of approximately £1.1 billion.⁴⁹ The Intergenerational Commission concluded that charging NICs on the earnings of workers over the state pension age would raise £0.9 billion in 2020 and be strongly progressive within the pensioner population.⁵⁰
- While it is probably desirable for the government to encourage individuals to save for a pension, the 25% tax-free lump sum that can be drawn down from a pension pot in retirement seems excessively generous. It would be hard to withdraw it completely from those who have made pension contributions in the expectation of benefiting from it, but reform could raise additional revenue.
- Changes to inheritance tax could raise additional resources. One particularly anomalous part of the current tax system is the way in which pension pots can be left free of tax. Charging capital gains tax at death would make the current tax system both more equitable and more efficient.

Between them, changes such as these could raise perhaps a small number of billions of pounds per year, make the tax system more efficient and equitable, and make it more sustainable in the face of an ageing population. Of course, none would be straightforward or popular, and certainly they would not be enough by themselves to meet the funding challenge.

Raising revenues through a hypothecated tax

The debate around whether the NHS should be funded through a separate or hypothecated tax has resurfaced this year, with supporters including the economist Richard Layard and a cross-party backbench coalition of Nick Boles, Liz Kendall and Norman Lamb. ‘Hypothecation’ simply means earmarking tax revenues for specific, identified purposes. As with any other tax, the amount raised would depend on the rate and how many people would be liable to pay. The main argument for hypothecation is that the public would be more willing to pay more tax if they felt sure that the money would go to health and social care. The additional funding required to meet estimated pressures does not change.

When speaking about a hypothecated health tax, people often have quite different things in mind. Broadly, there are two types. ‘Pure hypothecation’ would see total health spending set exactly at the revenue raised by a particular tax or set of taxes. The most obvious existing example of this type of hypothecation is the licence fee used to finance

⁴⁸ Source: Resolution Foundation, *A New Generational Contract: The Final Report of the Intergenerational Commission*, 2018, <https://www.intergenerationcommission.org/publications/a-new-generational-contract-the-final-report-of-the-intergenerational-commission/>.

⁴⁹ Source: HMRC, ‘Estimated costs of principal tax reliefs’, December 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675345/Dec_17_Main_Reliefs_Final.pdf.

⁵⁰ Source: Resolution Foundation, *A New Generational Contract: The Final Report of the Intergenerational Commission*, 2018, <https://www.intergenerationcommission.org/publications/a-new-generational-contract-the-final-report-of-the-intergenerational-commission/>.

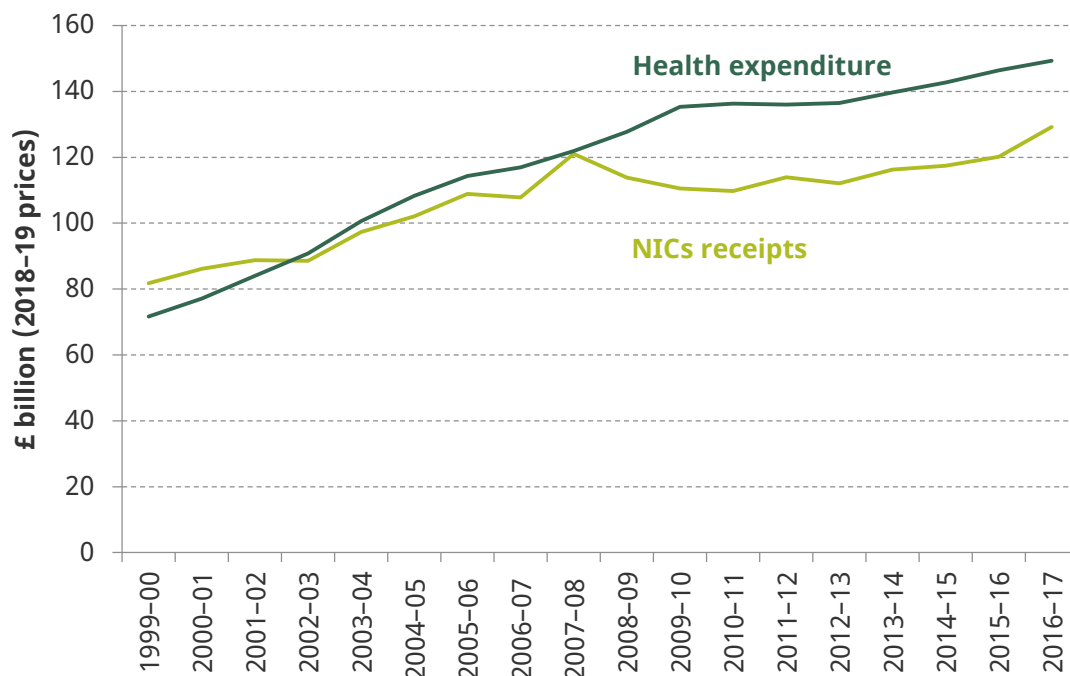
the BBC. Alternatively, we could design a system with ‘incremental hypothecation’, under which revenues raised from a health tax or taxes would be used to top up spending on health, with the remainder coming from general government expenditure. An example of this is net revenues from London’s congestion charge, which are spent on public transport in London.

Pure hypothecation of revenues in any one year to spending in the same year is almost certainly unsuited to the provision of healthcare. The revenue raised from taxes on income, earnings or spending would fluctuate with the business cycle. To illustrate this, Figure 4.14 shows NHS spending and National Insurance contributions from 1999–2000 to 2016–17.⁵¹ As now, the NHS was funded by general taxation throughout this period.

Between 1999–2000 and 2007–08, health spending grew faster than NICs receipts, but the two were always within £10 billion of one another. In 2007–08, the two series were only £0.8 billion apart. However, the start of the Great Recession led the two series to diverge substantially, as NICs receipts declined and NHS spending continued to increase. In 2008–09, NHS spending was £13.9 billion greater than NICs receipts, a gap that was equal to 11% of the NHS budget. By 2009–10, NHS spending exceeded NICs receipts by £24.8 billion, a gap equal to 18% of the NHS budget and 22% of all NICs receipts in that year.

Under incremental hypothecation, funds raised are used to top up funds from general taxation. This means that spending is not as responsive to tax receipts as under pure

Figure 4.14. NICs receipts and health expenditure



Source: March 2018 GDP deflators, various PESAs and

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/682281/Jan18_Receipts_Table_Financial.xlsx.

⁵¹ We use NICs in this example, as most proposals for hypothecation reference NICs or a reformed version of NICs. It would, in theory, be possible to hypothecate other types of tax.

hypothecation. However, the difficulty with this form of hypothecation is that it is impossible to verify that the government's promises have actually led to any changes in the allocation of spending. Priorities change and money may, over time, be reallocated to other areas. National Insurance contributions are, in theory, hypothecated to fund social security benefits and the NHS. However, the supposed hypothecation has never imposed any constraint on those budgets, in good times or bad.

The 1p increase in all rates of National Insurance announced by Gordon Brown in 2002 was done on the promise it would be used to boost health spending, but the resulting revenue was soon dwarfed by the overall increase in health costs that were financed through general tax revenues. In addition, the same Budget increased spending on tax credits and pension credit hugely; one could just as easily have said that the additional NICs revenue funded these items. A more recent example is the council tax Social Care Precept, with councils allowed to increase council tax by up to 3% in 2017–18 and 2018–19 to spend money on social care. Early evidence suggests that there has been an associated increase in adult social care spending. Whether this continues to be the case is less certain. This is because there is no way of verifying that additional funding would not otherwise have been allocated to adult social care from other sources, such as central government grants or the Better Care Fund.

Recent proposals on hypothecation have suggested ways of avoiding the funding volatility of pure hypothecation. For example, a proposal from the LSE economist Richard Layard has the following three features:⁵²

- At the beginning of each parliament, an independent body would advise on the level of NHS spending that would be needed to meet predicted pressures over the next five years. We consider this proposal in more detail in the 'Long-term planning ...' section below.
- The government would set the rate of a National Health Insurance Tax (NHI) to meet expected NHS spending, based on OBR growth forecasts. This NHI could be based on a revised form of National Insurance contributions, extended to cover the over-65s and income from sources other than employment.
- Health spending would be based on the spending plans set out at the beginning of parliament, not on the NHI revenue in a given year. Any debts (when NHI revenue was below planned spending) or surpluses (when NHI revenue exceeded health spending) would be assumed by the Treasury at the end of each five-year period.

A cross-party group of Nick Boles, Liz Kendall and Norman Lamb has outlined 10 principles of long-term funding for health and social care, which included a proposal for a similar system of hypothecation.⁵³ These proposals are a clear improvement on pure hypothecation. However, there are a number of problems, common to all proposals for hypothecation, that must be acknowledged and addressed.

⁵² Source: R. Layard and J. Appleby, 'Head to head: is it time for a dedicated tax to fund the NHS?', *BMJ*, 2017, 356, j471.

⁵³ N. Boles, L. Kendall and N. Lamb, 'Ten principles of long-term funding for NHS and social care', 2018, <https://www.facebook.com/notes/nick-boles-mp/ten-principles-of-long-term-funding-for-nhs-and-social-care/1522885904504144/>.

How would shortfalls be addressed?

The recent example of the Great Recession shows that Richard Layard's proposal could result in a rapid accumulation of debt when the hypothecated tax revenues fall short, as illustrated clearly by Figure 4.14. The accumulated shortfall between NICs and health spending over the 2010–15 parliament would have amounted to an additional £111 billion of debt for the Treasury.⁵⁴ An alternative would be to increase NHI though the forecast period if shortfalls occurred. Covering the shortfall from 2010–11 would have required a

Box 4.2. Hypothecation and social insurance in other European countries

Many countries in Europe fund health insurance through social insurance models, with a smaller number of countries opting for forms of hypothecated tax. Each system has a different mechanism for addressing shortfalls during recessions.

For example, in Estonia, which operates a hypothecated tax system, the Great Recession led the revenues of the Estonian Health Insurance Fund to fall by 11% in 2009 and 5% in 2010. As the recession continued, the Fund's accumulated reserves were run down to compensate for the falls. This action was accompanied by increases in user charges, increased official waiting times and reductions in the generosity of benefits.^a

In Germany, which operates a social insurance system, falls in employment are partially compensated for by the federal government paying for insurance for those who are not working. In addition, competing social insurance funds are able to charge an additional (capped) premium to employees if revenues fall short. However, as the funds are competing, there is an incentive for them to avoid increasing charges in an effort to retain customers.^b

It is also important to remember that the issue of how money is raised is typically of secondary importance to how much is raised and who is liable for tax payments or insurance levies. In France, healthcare was traditionally funded through social insurance. However, since 1998, employee payroll contributions have been gradually phased out and replaced by a hypothecated tax – the 'general social contribution' (*contribution sociale généralisée*, CSG). Unlike the previous social insurance model, the CSG is placed on total income rather than just earned income. This change aimed to widen the revenue base. The rate depends on the level of earned income. Employers' contributions continue to be determined by gross income. Although this reform has taken France away from a social insurance system and towards a tax-funded system, the bigger change for the population is the alteration of the tax base, and therefore how much can be raised and from whom.

^a *Eurohealth – Quarterly of the European Observatory on Health Systems and Policies*, 2012, 18(1), http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/EuroHealth_V18n1_WEB_110412.pdf.

^b 'Identifying options for funding the NHS and social care in the UK: international evidence', 2018, Health Foundation Working Paper.

⁵⁴ This is calculated as the accumulated shortfall between (nominal) NICs receipts and health spending between 2010–11 and 2014–15.

3p increase in both employee and employer NICs.⁵⁵ However, such an increase would have further depressed living standards and the labour market in the aftermath of a severe economic downturn. Whether such a move would have been economically or politically feasible is open to question. It is also possible that an unforeseen health shock (such as a major flu pandemic) could necessitate a large increase in spending, which hypothecated tax receipts may not be able to cover.

In theory, variation in the funds available from year to year due to wider economic conditions could be smoothed through a system of top-ups and reductions. This would complicate the system, however, and obscure the link between tax revenues and spending on health. Box 4.2 gives more details on how shortfalls in spending have been addressed in other European countries that operate hypothecated taxes or social insurance.

Tying health spending to a particular tax could make raising tax more costly

Spending on health is expected to rise as a fraction of national income. So any tax hypothecated to health would need to rise over time. Where significant increases are required, we might want a broader tax base than a single tax. At the very least, we would want to be confident that any tax hypothecated to paying for health could be increased without causing much more economic harm than would be caused by alternative methods of raising tax. One problem with a National-Insurance-type tax on earnings is that it would increase the differences between the taxation of earned and unearned income, increasing incentives to incorporate for example. This is in fact an economically serious issue and could lead to significant tax-incentivised behavioural change as well as unfairness between employees and others. If the hypothecated tax were not charged on pension income, then it would also exacerbate intergenerational inequalities.

What does hypothecation mean for devolution, and vice versa?

Devolution introduces additional complications for a hypothecated tax. Current NHS funding comes from UK taxation. The devolved administrations in Scotland, Wales and Northern Ireland are allocated a block grant based on the Barnett formula. They can then make their own decisions about how much to spend on the NHS.

Under the current system, an NHS hypothecated tax could be implemented in two ways. A hypothecated tax could be applied to a UK-wide tax, such as National Insurance. However, under pure hypothecation, this would mean fixing health spending in the devolved administration to a tax set at the UK level. This could remove the power devolved administrations have over their single biggest item of expenditure. Alternatively, administrations could choose how to spend the funds they were allocated from the hypothecated tax, but this would move away from the objective of introducing the tax. Nick Boles has suggested separate National Health Funds should be established in England, Scotland, Wales and Northern Ireland with the proceeds of a UK tax based on some form of needs-based formula.⁵⁶ The question is, however, whether any devolved administration could choose to raise more for health. They could, of course, top up spending from other revenues, but again this would weaken the link between health spending and the hypothecated tax.

⁵⁵ Source: Authors' calculations based on HM Treasury and HM Revenue & Customs, 'Tax ready reckoner and tax reliefs', December 2009.

⁵⁶ N. Boles, 'Square deal on the NHS', 2018, <https://www.nickboles.co.uk/news/square-deal-nhs>.

The alternative is that each country within the UK could have its own hypothecated tax, and these could potentially be set at different levels. This, however, would require substantially higher tax rates in Wales and Northern Ireland than in the rest of the UK because they have a lower tax base. This does not seem like a plausible option.

Ultimately, it would probably be possible to implement some form of hypothecated tax within the devolved structure of the UK. However, any model would have to trade off the extent to which health spending was hypothecated (the strength of the link between the revenues of a hypothecated tax and health spending), the discretion that devolved administrations have over how much they spend on health, and fiscal equalisation, where tax revenues are smoothed across the nations of the UK.

Long-term planning for health and social care spending

One feature of many proposals to introduce a hypothecated tax is to introduce an independent body to assess pressures on health and social care and to provide evidence on the level at which the tax rate might need to be set to meet those pressures. Such proposals often also feature methods to ensure that funding is set for a period of years in order to provide certainty and aid planning. However, it is important to note that there is no necessary link between hypothecation and such a body or between hypothecation and funding certainty. Each could exist without the other. There may be reasons to support an independent body to monitor long-run demand pressures, even for those sceptical about the merits of hypothecation.

In April 2017, the House of Lords Select Committee Report on the Long-Term Sustainability of the NHS and Social Care criticised the culture of short-termism in the determination of health and social care spending.⁵⁷ The report finds that from the Department of Health downwards, those involved in the health and social care system have been absorbed in day-to-day struggles rather than undertaking long-run strategic planning. The report recommends the establishment of an Office for Health and Care Sustainability, which should report to parliament on spending requirements over the next 15–20 years. This body would be entirely separate from the health and social care system and play no role in its operation. It should be independent and able to speak freely within its remit. Its initial focus could include the following:

- monitoring demographic trends and their potential impacts on spending;
- assessing workforce needs and required skill mix;
- monitoring the stability of health and adult social care funding allocations, and how those allocations compare with demand.

The principal aim is to provide independently established benchmarks against which NHS planning and investment decisions could be measured. Almost all areas of the NHS have to make decisions about investments in the equipment they purchase and the staff they employ or train. These investments have pay-offs that extend years into the future. Reducing uncertainty about future levels of funding could therefore make it easier for policymakers to make investment decisions.

⁵⁷ House of Lords Select Committee on the Long-Term Sustainability of the NHS, *The Long-Term Sustainability of the NHS and Adult Social Care*, Report of Session 2016–17, <https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf>.

One symptom of a lack of long-term planning, identified in the same report, has been the absence of any comprehensive long-term workforce planning until a draft workforce strategy was published in late 2017.⁵⁸ This lack of planning places pressure on NHS providers and represents a significant threat to the long-run sustainability of the NHS. The proposed Office for Health and Care Sustainability would both take a longer-term view and integrate finance planning with workforce planning.

The counter-argument is that this type of long-term planning could and should already be happening. The information could be produced by the Department of Health, NHS England, Pay Review Bodies or other arm's length bodies. In addition, there are many other areas of public spending that have similar issues with short-termism and it would be expensive to establish an independent body for every government department. There is also a case to be made that the level of spending on health is inherently a political decision on which it is possible to reasonably disagree, and so should not be removed from the democratic process. The argument for an independent Office for Health and Care Sustainability is therefore based on the assumptions that: (i) existing bodies do not and cannot have the expertise or right incentives to make independent recommendations on long-term planning; (ii) there are reasons that health needs such a body but other government departments do not; and (iii) the appropriate level of health spending should be determined independently, rather than by democratically elected politicians.

4.6 Alternative proposals for raising revenue for the NHS

Increasing borrowing to enable increased spending

If the government chooses to spend more on health and social care, but neither reduces other areas of spending nor raises additional revenues, it would need to fund that extra spending through borrowing. In order to fully meet the pressures outlined in Chapter 3, this would mean additional borrowing equivalent to 3.0% of GDP in 2033–34 to plug the funding gap.

Government borrowing is far from unusual: the UK has run a budget deficit in 43 of the last 50 years.⁵⁹ There are numerous economic arguments why governments should borrow at certain times, particularly in response to negative shocks. It certainly would not be desirable to balance the books in every period. There may be a case for borrowing to invest in capital projects, such as new hospitals or medical technology. However, one cannot simply borrow more every year in the face of growing and sustained needs for spending. Borrowing can smooth a transition to a higher spending equilibrium. It cannot be the long-term solution.

User charges

The NHS makes limited use of user charges relative to health systems in comparable countries, and there is generally little public support for increasing charges.⁶⁰ Figure 4.15

⁵⁸ Health Education England, *Facing the Facts, Shaping the Future: A Draft Health and Care Workforce Strategy for England to 2027*, 2017, <https://hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf>.

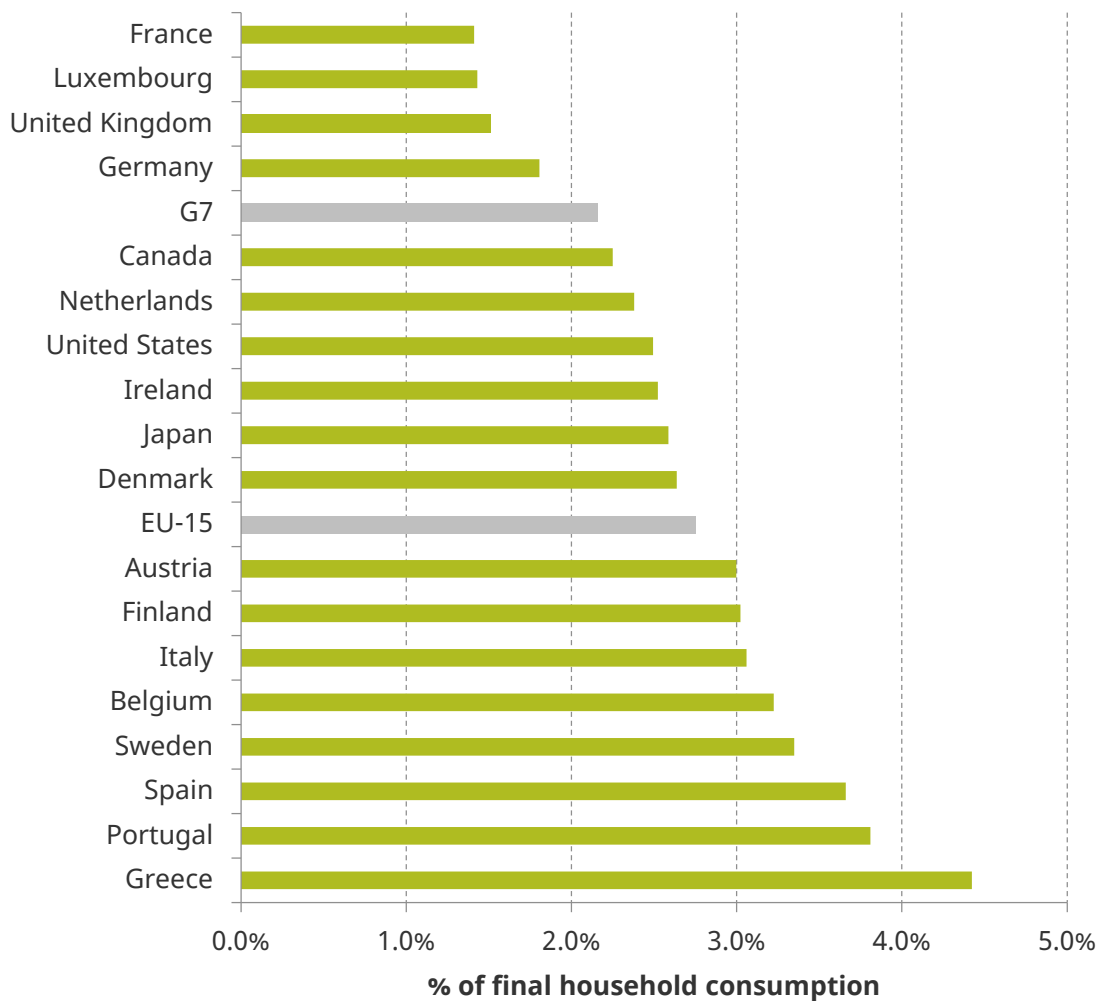
⁵⁹ Source: Office for Budget Responsibility, Public Finances Databank.

⁶⁰ User charges for social care are discussed in Section 4.7.

shows 'out-of-pocket' medical spending as a share of final household consumption in EU-15 and G7 countries. This out-of-pocket spending is defined as expenditure paid directly by private households and does not depend on whether the spending was initiated by a medical profession or the patient. Examples include over-the-counter medicines and any co-payments not covered by insurance. France has the lowest out-of-pocket cost share, at 1.4%. The share in the UK is only slightly higher, at 1.5%, substantially lower than the EU-15 and G7 averages. Greece has the highest share of out-of-pocket spending, at 4.4%.

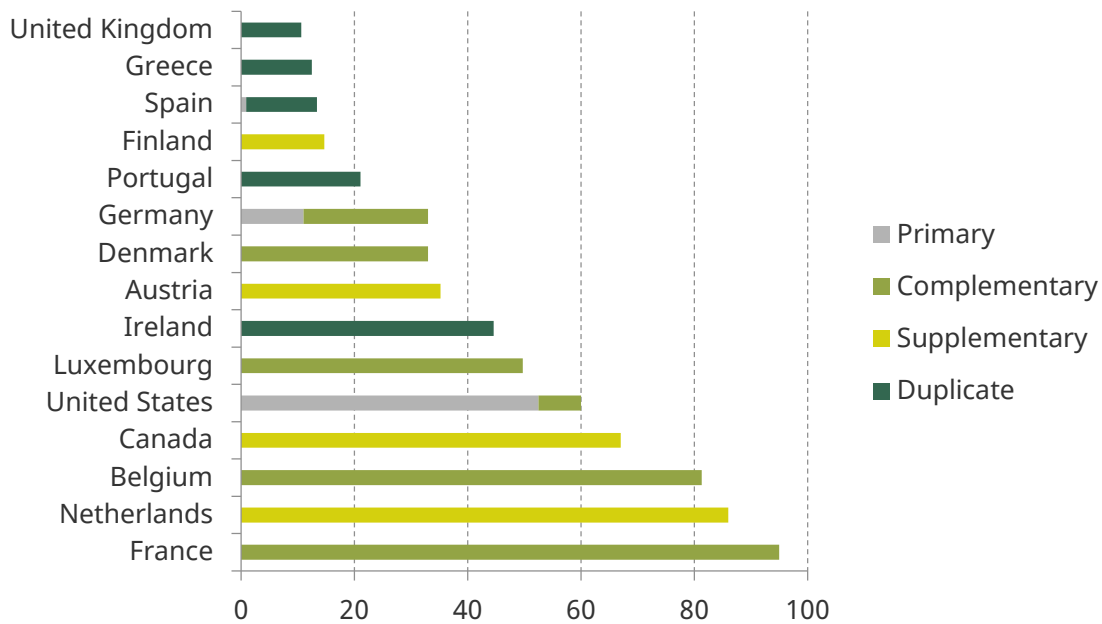
Direct out-of-pocket spending does not, however, fully reflect what individuals in different countries pay for healthcare in addition to taxes or social insurance contributions. In particular, many countries operate systems of private insurance. This may be primary (instead of public insurance), complementary (covering co-payments not covered under public insurance), supplementary (covering services not covered by public insurance) or duplicate (covering the same services as public insurance). Rates of coverage for each type of insurance are shown in Figure 4.16.

Figure 4.15. Out-of-pocket medical spending as a share of final household consumption, EU-15 and G7, 2015 (or nearest year)



Source: OECD Health Statistics 2017, <http://www.oecd.org/els/health-systems/health-data.htm>.

Figure 4.16. Private health insurance coverage by type, 2013 (or nearest year), selected EU-15 and G7 countries



Source: Figure 7.2 of OECD Health Statistics 2015, <http://dx.doi.org/10.1787/888933281052>.

The UK has duplicate insurance rates of around 10% – that is, about 10% of people have private health insurance in addition to the rights they have to NHS treatment. There is no other type of insurance, as there are very few services that the NHS does not cover. By contrast, France, which has a very similar level of out-of-pocket spending to the UK, has almost complete coverage of complementary insurance. Under the French system, social insurance covers 80% of the cost of health services.⁶¹ In addition, French people buy separate complementary insurance that covers almost all of the remaining 20%. In countries with high levels of private insurance, the dominant types are either complementary or supplementary. The exceptions are the United States, where just over half have private primary insurance, and Ireland, where more than two-fifths of the population have duplicate insurance.

There are two important points to note from Figures 4.15 and 4.16. First, there is no one-for-one relationship between the type of health system and out-of-pocket spending. Denmark and Sweden, like the UK, have a Beveridge-style model, with healthcare funded through general taxation, but have relatively high out-of-pocket spending. By contrast, France and Germany have much lower out-of-pocket costs than Japan, even though all three operate some form of social insurance model. Second, out-of-pocket spending is only one element of additional individual healthcare spending.

Economic arguments for and against charging

Most health systems in comparable countries make limited use of user charges. As with all goods and services, applying or increasing prices will tend to discourage use. In healthcare, that may raise the following concerns:

⁶¹ C. Gastaldi-Ménager, P-Y. Geoffard and G. de Lagasnerie, 'Medical spending in France: concentration, persistence and evolution before death', *Fiscal Studies*, 2016, 37, 499–526, doi:10.1111/j.1475-5890.2016.12107.

- delaying treatment could lead individuals to present later to the health system in a worse state of health, generating higher costs for the individual and the health system;
- delaying or avoiding treatment could have negative impacts on others, through, for example, the spread of infectious diseases;
- it is in some sense inequitable to link access to healthcare to ability to pay.

The low charges in the UK are driven by all three of these concerns. As result, the UK has much lower shares of the population that did not fill or skipped prescriptions, did not visit the doctor and did not get recommended care than in other OECD countries.⁶² These benefits of low charges must, however, be weighed against the need to raise more money through taxes or social insurance to achieve a given level of healthcare spending and against any benefit from discouraging excessive demand. All taxes also carry costs, by distorting people's decisions to work, invest and save. There may also be some health service use that the health system wishes to discourage through charges, such as overuse of prescribed medication.

In most countries, the health system is organised to ameliorate the potential negative effects of charging by providing exemptions for either groups of individuals or types of treatment. Categories of patients often exempt include the young, the old, those on low income and those with certain health conditions.⁶³

The trade-off with exemptions is that not all individuals in the exempt group would be deterred by charges. The exemptions are therefore a transfer from the health system to these individuals who would otherwise have had to pay, which again must be weighed against the cost of raising revenue from other sources. For example, exempting on the basis of age means that children from high-income families and high-income pensioners, who might not be deterred by a small user charge, do not pay charges.

In addition to exempting particular groups, health systems often exempt certain types of services, such as vaccines and contraception. These are typically services that the health system does not want to discourage, because there are significant spillovers to others from ill health or because the individual may require more costly treatment in the future if left untreated.

Charges in the NHS

There are three main areas where the NHS already charges some groups for the direct provision of healthcare: prescriptions issued in the community (principally by GPs), dentistry and general ophthalmic services (eye tests and glasses).

England makes the greatest use of charges. The total amount raised and the set of groups that are exempt in England are summarised in Table 4.7.

⁶² C. Schoen, R. Osborn, D. Squires and M. Doty, 'Access, affordability, and insurance complexity are often worse in the United States compared to 10 other countries', *Health Affairs*, 2013, 32, 2205–15, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0879>.

⁶³ V. Paris, M. Devaux and L. Wei, 'Health institutional characteristics: a survey of 29 OECD countries', OECD Health Working Paper 50, 2010, <http://dx.doi.org/10.1787/5kmfxfq9qbnr-en>.

Table 4.7. Summary of exemptions from user charges in England

	Prescriptions	Sight tests	NHS optical vouchers	Dentistry
Total cost (£ million)	9,518	300	Not available	2,738
Total charges (£ million)	1,034	-		810
% exempt	89.4	-		48.7
Exemptions:				
Aged 60+	Yes	Yes	No	No
Aged <16	Yes	Yes	Yes	Yes
Aged 16–18 and in full-time education	Yes	Yes	Yes	Yes
Low income / Means-tested benefits	Yes	Yes	Yes	Yes
Health	Yes	Yes	No	No
Maternity / Had a baby in past 12 months	Yes	No	No	Yes

Note: All figures are expressed in 2018–19 prices.

Source:

Prescriptions – NHS Digital, 'Prescriptions dispensed in the community: England 2006 to 2016', 2017, <https://files.digital.nhs.uk/publication/s/o/pres-disp-com-eng-2006-16-rep.pdf>.

Sight tests – NHS Digital, 'General ophthalmic services activity statistics: England, year ending 31 March 2017', 2017, <https://digital.nhs.uk/catalogue/PUB30012>.

Dentistry – NHS Digital, 'NHS dental statistics for England: 2016–17', 2017, <https://digital.nhs.uk/catalogue/PUB30069>.

Prescriptions

Prescriptions are the largest area of activity where user charges apply in England. Prescription charges were introduced in 1952. They were abolished in 1965 by the Wilson Labour government but reintroduced in 1968. Exemptions under the original 1952 charges were very limited (mainly to those on National Assistance, plus dependants). When prescription charges were reintroduced in 1968, exemptions were much more extensive and were defined on the basis of age, income and medical status.

The cost of prescription drugs dispensed in the community in England in 2016–17 was £9.5 billion in 2018–19 prices. However, as 89.4% of prescriptions are free through an extensive list of exemption criteria, only £1.0 billion was recouped through prescription charges. For those who are not exempt, the current charge in 2018–19 is £8.80 per item. Those requiring a high number of prescriptions, but who are not exempt from charges, can insure themselves by purchasing a prescription prepayment certificate (PPC). These

certificates allow an individual to fill as many prescriptions as they need for a set price. The cost of a PPC is £29.10 for 3 months or £104 for 12 months. An individual would be better off buying a PPC than paying on a per prescription basis if they expect to have more than three prescriptions over 3 months or more than twelve prescriptions over 12 months. Approximately half the revenue the NHS in England receives from prescription charges comes from PPCs.⁶⁴

It is worth noting that hospital prescribing has grown much faster than GP prescribing since 2010–11. In 2010–11, primary care prescribing cost £8.6 billion compared with £4.2 billion by hospitals. By 2016–17, GP prescribing had grown by 3.6% to £9.0 billion, while hospital prescribing had almost doubled to £8.3 billion. Prescriptions dispensed in hospitals are not subject to the prescription charge.⁶⁵

Prescription charges were abolished in Wales in 2007 and Scotland in 2011 after gradual price reductions, and in Northern Ireland in 2010. England had the lowest prescribing spending per head in 2013, followed by Scotland, Wales and Northern Ireland. However, this is similar to the pattern in 2006, before prescription charges in Wales, Scotland and Northern Ireland had been removed.⁶⁶

Dental

User charges recoup 30% of total NHS community dental costs in England (outside hospital). The major difference from prescription charges is that the over-60s are not exempt. Those who are not exempt can choose either to see an NHS dentist and pay a user charge based on the treatment they receive or to see a private dentist.

The other countries of the UK also continue to charge for dentistry in some form. Northern Ireland charges on the same basis as England. Wales offers free dental checks for the under-25s and over-60s, but patients must pay for treatment. In Scotland, patients must pay for 80% of dental charges up to a total of £384 for a course of treatment.

General ophthalmic services

General ophthalmic services are the smallest area where user charges apply. Free universal eye tests were abolished in 1988.⁶⁷ Patients are seen by private optometrists but their eye tests are paid for if they meet the exemption criteria. The over-60s had to pay for eye tests until 1 April 1999. Some individuals are also eligible for a voucher to help purchase their glasses or contact lenses. Notably, the over-60s are not eligible for NHS vouchers for glasses, although they are eligible for a free eye test.

Charges for eye tests and glasses are similar across the countries of the UK. The exception is in Scotland, where those aged 16–59 are entitled to a free eye test every two years. Groups exempt from paying for eye tests in the other countries of the UK are eligible for a free one every year.

⁶⁴ <https://files.digital.nhs.uk/publication/s/o/pres-disp-com-eng-2006-16-rep.pdf>.

⁶⁵ <https://digital.nhs.uk/catalogue/PUB30152>.

⁶⁶ <https://www.nuffieldtrust.org.uk/chart/annual-prescribing-spend-per-person-in-the-uk>.

⁶⁷ <https://publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/81506.htm#n84>.

Could more money be raised through user charges?

Additional funding could be raised by expanding the scope of user charges to more services, increasing the level of existing user charges or reducing exemptions. In each case, the additional revenue that could be raised must be weighed against the possible negative impacts of the charges on patients and the health system. Even if the revenue from increased charges did exceed the costs, there is likely to be considerable political resistance.

As noted by the Barker Commission, the current prescription charge is already relatively high compared with other countries, and there would be a concern that large increases might deter more people from filling their prescriptions.⁶⁸ There has been a reduction in the real value of payments to dentists and optometrists for treating NHS patients. Again, the revenue from increased costs must be weighed against the potential impacts of discouraging use.

There has been widespread agreement for at least a decade that the current system of health exemptions needs reform,⁶⁹ particularly in the case of prescription charges.

Table 4.8 shows the breakdown of prescriptions in England by exemption category for the years 2012 to 2016. Three-fifths of prescriptions are dispensed free of charge because the

Table 4.8. Percentage of items that were charged for or dispensed free, by exemption category (2016–17 prices)

	2012	2013	2014	2015	2016
Charged	9.4	9.3	9.4	9.7	10.0
Age 60+	58.3	59.5	60.0	60.4	61.0
Young	5.3	4.7	4.7	4.5	4.4
Maternity/Medical	8.0	8.1	8.1	8.1	8.2
NHS LIS	11.4	11.7	11.7	11.9	11.8
Contraceptives	0.8	0.6	0.6	0.5	0.5
Personally administered	1.9	1.8	1.8	1.7	1.7
Other	4.1	3.5	3.1	2.4	1.7
Not captured	0.8	0.7	0.7	0.6	0.7

Source:

2012 to 2015 – page 97 of ‘Prescriptions dispensed in the community, statistics for England – 2005–2015: report’, <http://www.content.digital.nhs.uk/pubs/presdisp0515>.

2016 data – page 25 of ‘Prescriptions dispensed in the community, statistics for England – 2006–2016: report’, <http://digital.nhs.uk/pubs/presdisp0616>.

⁶⁸ *A New Settlement for Health and Social Care*, Final Report of the Commission on the Future of Health and Social Care in England, 2014, <https://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>.

⁶⁹ I. Gilmore, *Prescription Charges Review: Implementing Exemption from Prescription Charges for People with Long Term Conditions*, 2009, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213884/dh_116367.pdf;
A New Settlement for Health and Social Care, Final Report of the Commission on the Future of Health and Social Care in England, 2014, <https://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>.

individual is over 60. This share has increased slightly over the past five years, from 58.3% in 2012 to 61.0% in 2016. The total net ingredient cost for prescription drugs for this group was £4.8 billion in 2016,⁷⁰ which is equivalent to more than half of total payments to GPs in 2016–17 (£8.9 billion).⁷¹ The next largest group is the NHS low income scheme (LIS), which covers just under 12% of prescriptions; 8% of prescriptions are exempt for medical or maternity reasons. The young (those under 16 or under 18 and in full-time education) account for a further 4.5%. Given these shares, any changes that reduced exemptions for groups other than the over-60s are unlikely to raise large sums of money.

There is a similar pattern for NHS eye tests. A total of 48.2% of free NHS eye tests were accounted for by those aged 60 and over in 2016–17, an increase from 44.4% in 2012–13.⁷²

It is notable that entitlements for most other financial and in-kind benefits have increased in line with the female state pension age, yet an individual becomes eligible for free prescriptions and eye tests once they turn 60. Retaining exemptions for 60- to 64-year-olds who do not qualify under health or low-income grounds seems hard to justify, given other NHS priorities.

Reform of the health criteria for exemption appears to be long overdue, although this is unlikely to raise any additional funds. With the exception of the introduction of exemption for cancer patients in 2009, the list of qualifying health conditions remains that drawn up in the mid 1960s.⁷³ The difficulty has been to develop criteria that are inclusive enough to take account of a long and ever-changing list of rare conditions, but not so broad that the definition is hard to interpret or could lead to large unwarranted variation in eligibility across regions and GPs.

The Barker Commission in 2014 recommended significantly reducing exemptions, but substantially reducing the prescription charge payment to £2.50.⁷⁴ This could be combined with a cap, based on the current annual prepayment certificate cost of £104. It is hard to estimate exactly how much this would raise, due to the lack of patient-level data on prescriptions, but the Barker Commission estimates that it would raise an additional £1 billion per year. Many Scandinavian countries operate a cap-based system, where there are few exemptions but individual payments are limited. For example, in Sweden, the annual cap in 2016 was just under £200 per adult and there was a cap of £200 for all children in the same family.⁷⁵

Raising money from the NHS estates

NHS provider trusts currently occupy over 1,200 sites, with a total gross internal area of 26 million square metres.⁷⁶ NHS estates therefore hold a huge capital value. At the same

⁷⁰ Table 8 of NHS Digital, 'Prescriptions dispensed in the community, statistics for England – 2006–2016: report', 2017, <http://digital.nhs.uk/pubs/presdisp0616>.

⁷¹ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/nhs-payments-to-general-practice-england-2016-17>.

⁷² <https://digital.nhs.uk/catalogue/PUB30012>.

⁷³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213884/dh_116367.pdf.

⁷⁴ *A New Settlement for Health and Social Care*, Final Report of the Commission on the Future of Health and Social Care in England, 2014, <https://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>.

⁷⁵ https://ec.europa.eu/info/sites/info/files/file_import/joint-report_se_en_2.pdf.

⁷⁶ Deloitte, 'Naylor Review: data analysis', 2016, <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>.

time, a significant proportion of the estate is not fit for purpose, or is in need of upgrading. In 2016–17, there was an estimated backlog in maintenance (i.e. work that should already have taken place) of £5.7 billion in 2018–19 prices, an increase of 9.1% on 2015–16, on the back of a 13.9% increase between 2014–15 and 2015–16.⁷⁷ In addition, new models of care set out in the five-year forward view⁷⁸ are likely to require £5 billion of capital investment. These capital requirements led the Department of Health commissioner Sir Robert Naylor to develop a new estates strategy that would allow some of this required investment to be paid for by the disposal of existing estate.

As part of his review, Naylor was asked to identify £2 billion of assets that could be released for reinvestment and to provide land for 26,000 new homes. Naylor recommended that an NHS Property Board should be established to support the delivery of Sustainability and Transformation Plans (STPs) and subsequent healthcare plans. The report identified gross risk-adjusted capital receipts of £2.7 billion from inefficiently used estate, with the potential for more given favourable planning permissions. Effective disposal of a small number of high-value assets in London could see this total rise significantly. It is important to recognise that all of these funds are one-off and therefore more suitable for funding the current need for capital investment rather than for supporting ongoing NHS spending. However, Naylor did also find that disposals could deliver ongoing annual revenue savings of £500 million per year.

Changes in models of care delivery over the coming years and decades, driven by medical advances and patient preferences as well as cost, will necessitate changes in the estate and facilities that the NHS needs. Disposing of property assets that are not suitable or required to deliver healthcare now or in the coming decade seems like one way of funding these reforms. However, it should be noted that the largest stream of revenue would be the one-off proceeds from disposal. The ongoing funding stream would be relatively small.

Recovering costs from visitors and migrants

Eligibility for free NHS care is based on normal residency rather than citizenship. The first legislation to introduce a statutory obligation for the NHS to charge visitors was introduced in 1977 and implemented in 1982. However, efforts to enforce these charges were limited until the early 2000s. Charges only apply to secondary care (hospital) services. There is no charge for primary care services, accident and emergency, family planning, testing and treatment for sexually transmitted diseases, treatment for physical and mental conditions caused by torture and sexual violence, and compulsory psychiatric services.

A review in 2013 suggested that in 2012–13 the NHS charged 65% of the potential amount for those outside the EEA and Switzerland (EEA&S), but only 16% of potential charges for

⁷⁷ <https://digital.nhs.uk/catalogue/PUB30096>;
R. Naylor, *NHS Property and Estates: Why the Estate Matters for Patients*, 2017,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607725/Naylor_review.pdf.

⁷⁸ NHS, *Five Year Forward View*, 2014, <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>.

EEA&S. In total, the NHS charged for just £89 million of the £367 million that could have been charged. Of this, £73 million was recovered.⁷⁹

An overseas visitor and migrant cost recovery programme was launched in England in July 2014, with the aim of increasing cost recovery from £73 million in 2012–13 to £500 million a year by 2017–18. Measures have included the following:

- *Introducing an immigration health surcharge for non-EEA&S temporary migrants of £200 per year, or £150 for students and those applying under the youth mobility scheme.* In the first year of the surcharge (2015–16), the National Audit Office estimated it would raise an additional £164 million.⁸⁰ In February 2018, it was announced that the health surcharge would rise to £400 per year (£300 for students) regardless of service use.
- *Financial incentives for trusts to recover costs.* Since October 2014, the European Health Insurance Card (EHIC) incentive scheme has provided an additional 25% on top of basic tariffs when costs were recovered on treatment for EEA&S citizens.⁸¹ This was in order to compensate for the additional administrative costs. Since April 2015, trusts have been able to charge non-EEA&S migrants 150% of the standard tariff.⁸²
- *Obligations to charge.* Since October 2017, providers must recover an estimate of the charges for care in advance, although this must not delay any urgent treatment. The obligation to charge patients was also extended to non-NHS providers. Payments for non-residents were also introduced for NHS 111 telephone advice services and palliative care services provided by charities or community interest groups.

Debts can be written off if recovery proves impossible because, for example, the patient has died and it is not possible to recover the charges from their estate, the patient has no assets, or reasonable steps have been made to recover the charges.

There is considerable variation in the amounts recovered from individual trusts. In 2015–16, 10 of the 154 trusts accounted for half of the revenue. Only around half of the differences in rates of charging can be explained by the size of the trust, the type of trust and the geographical location.⁸³

There has been an increase in the revenue raised for the healthcare of overseas visitors. However, most of that increase has come from changes in the charging rules and, in particular, the health surcharge, which is a fixed charge not related to actual healthcare

⁷⁹ National Audit Office, *Recovering the Cost of NHS Treatment for Overseas Visitors*, Report by the Comptroller and Auditor General, Session 2016–17, HC 728, 2016; as cited in House of Commons Committee of Public Accounts, *NHS Treatment for Overseas Patients*, 37th Report of Session 2016–17, HC 771, <https://publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/771/771.pdf>.

⁸⁰ National Audit Office, *Recovering the Cost of NHS Treatment for Overseas Visitors*, Report by the Comptroller and Auditor General, Session 2016–17, HC 728, 2016, <https://www.nao.org.uk/wp-content/uploads/2016/10/Recovering-the-cost-of-NHS-treatment-for-overseas-visitors.pdf>.

⁸¹ Department of Health, *EHIC Incentive Scheme: Frequently Asked Questions*, 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/634847/FAQs_EEA_Incentives.pdf.

⁸² NHS England, *Improving Systems for Cost Recovery for Overseas Visitors: Interim Guidance*, May 2015, <https://www.england.nhs.uk/wp-content/uploads/2015/05/guidance-chargeable-overseas-visitor.pdf>.

⁸³ Paragraphs 2.17 and 2.19 of National Audit Office, *Recovering the Cost of NHS Treatment for Overseas Visitors*, 28 October 2016, HC 728, 2016–17.

use. There has been less success in increasing revenue through improvements in how trusts implement existing regulations.

There are clear benefits to improving cost recovery, at least up to the level of other European countries. However, it should be noted that potential revenue is small relative to the total funding gap. The current government target is to raise £500 million.

Other UK countries

The other three countries in the UK have not increased charges in the same way as in England. In Scotland, non-EEA&S residents are exempt from NHS charges as soon as they commence employment or self-employment, or if they are enrolled in a full-time university course. Charges apply to non-EEA&S visitors who are staying for a short period or are not in education or employment.⁸⁴ In Wales and Northern Ireland, non-EEA&S patients are exempt from charges if they have been living legally in the UK for 12 months.⁸⁵

4.7 The social care challenge

There are considerable spending pressures on both the NHS and social care, and the discussion in previous sections applies to revenue that the government might wish to raise for either service. However, the two systems are organised very differently and there are a number of concerns specific to social care funding that are the focus of this section.

Why is social care different?

There are two key reasons why social care funding requires additional consideration beyond the wider question of how to raise more money.

Social care is a local, not a national, responsibility

There is no England-wide budget allocated to social care. Conditional on meeting their statutory requirements, local authorities can decide how much of their revenues to spend on adult social care services. Simply increasing the grants paid to LAs would not guarantee extra spending on social care: LAs are also responsible for providing other services, such as rubbish collection, road maintenance and local libraries. Given that social care has been relatively protected by local authorities until now,⁸⁶ any extra money might instead be used to reverse previous cuts to those other services. Even if the government sought to fund additional spending on adult social care services through *ring-fenced* grants, councils could implicitly use the money to fund other services by reducing the amount of their own revenue allocated to social care.

Additionally, previous IFS research has noted the tension between the government's desire to ensure consistent standards of social care in England and the government's

⁸⁴ http://www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf.

⁸⁵ <http://gov.wales/docs/dhss/publications/091209overseasguidanceversion6en.pdf>; <https://www.lawcentreni.org/component/content/article/63-policy-briefings/865-refused-asylum-seekers-and-access-to-free-secondary-healthcare.html>.

⁸⁶ Public spending on adult social care in England fell by 6% in real terms between 2009–10 and 2016–17, while total service spending by LAs fell by 18% over the same period. Source: N. Amin-Smith, D. Phillips and P. Simpson, 'Adult social care funding: a local or national responsibility?', IFS Briefing Note BN227, 2018, <https://www.ifs.org.uk/publications/12857>.

wider policy on local government finance.⁸⁷ A shift towards a model where LAs depend on local tax revenues (such as council tax revenues and retained business rates) for the vast majority of their funding risks a situation where revenues from those taxes do not keep pace with rising pressures on adult social care services.⁸⁸ This would be particularly concerning in poorer areas with typically higher needs and less ability to raise revenues.⁸⁹ And this could make it difficult to achieve consistent national minimum standards.

An alternative would be to fully centralise the funding of adult social care and allocate spending across the country according to the assessed level of need. This would not be painless, however, and would raise a number of new challenges – not least for the government’s devolution agenda. By design, local authorities currently have discretion over not just spending levels, but also (to a degree) the generosity of the means test, the level of co-payments charged to care recipients and the quality of care provided to those who are eligible. This, coupled with variation in the care needs of the local population and in local authority revenues, means that there is considerable variation in social care spending across different areas.⁹⁰ Moving from this to a national funding arrangement with national standards would be complicated, with a whole host of other issues that are not discussed here but that would require careful consideration.

Unlike the NHS, social care is not universally free at the point of use

The NHS provides healthcare free at the point of use to everyone regardless of their income or wealth. In contrast, under the current social care system, public funding is targeted at the most vulnerable individuals with the greatest level of need and limited financial means. People of sufficient financial means are expected to contribute towards the costs of their social care, with no lifetime cap on the costs they can face.⁹¹ Because they have to pay for one but not the other, there is an incentive for people to (where possible) use more healthcare and less social care. Policymakers thinking about social care funding must consider not just the overall level of public spending, but also who qualifies for public support, how much those that do not qualify are expected to pay, and what impact this will have on the health service.

Issues in designing a social care funding system

Discussion so far in this section has focused on funding within the existing system. The relatively severe means test (in terms of both income and assets) in the current system

⁸⁷ N. Amin-Smith, D. Phillips and P. Simpson, ‘Adult social care funding: a local or national responsibility?’, IFS Briefing Note BN227, 2018, <https://www.ifs.org.uk/publications/12857>.

⁸⁸ For example, since 2010, the business rates tax base has grown by just 0.3% a year (ibid.), while the projections outlined in Chapter 3 suggest that spending on adult social care will need to grow by more than 3.7% per year up to 2033–34.

⁸⁹ In poorer regions, a greater proportion of care home residents qualify for local authority support: in 2017, 21.9% of care home residents in the North East were self-funders (with the remainder receiving LA support), compared with 61.9% in the South East. Source: Cited by T. Jarrett, ‘Social care: care home market – structure, issues, and cross-subsidisation (England)’, House of Commons Library, Briefing Paper CBP-8003, 2018, <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8003>.

⁹⁰ For instance, in 2015–16, 10% of LAs in England spent less than £325 per adult resident, while 10% spent more than £445 per adult resident (in 2016–17 prices). Source: D. Phillips and P. Simpson, *National Standards, Local Risks: The Geography of Local Authority Funded Social Care, 2009–10 to 2015–16*, IFS Report R128, 2017, <https://www.ifs.org.uk/publications/9122>.

⁹¹ The exception to this is if individuals are covered by NHS Continuing Healthcare, which provides both health and social care free at the point of use to individuals with long-term complex health needs and is not means tested.

keeps public costs down by shifting more of the burden from the state onto individuals who receive social care. If the government's priority is to minimise costs to the public purse over the coming years, it might wish to keep the existing system in place. The estimates of future public spending on social care set out in Chapter 3 assume this to be the case.

However, there is a case for reform and an important debate to be had on the design of the social care funding system. It is not just a case of finding more tax revenue, but also a question of how funding should be structured. Over the past 20 years, there have been numerous in-depth reviews of the issue of how people should pay for social care.⁹² A range of possible policy reforms have been floated, but none of the reviews has led to fundamental reform.⁹³ The government has committed to the publication of a Green Paper on the future of social care for older people in England, due to be published in the summer of 2018. The Welsh government is considering introducing a 'social care levy', which would involve additional tax contributions into a dedicated fund for social care.⁹⁴ In Scotland, the government is committed to the integration of health and social care.⁹⁵ Assessing the relative merits of different approaches to social care funding and making specific recommendations is beyond the scope of this report.⁹⁶ Here, we outline some of the key issues that must be addressed in the design of any social care funding system.

Insurance

For those who do not qualify for public support, there is no limit on the lifetime costs they can face.⁹⁷ The Dilnot Commission estimated in 2011 that around one in 10 people, at age 65, face future lifetime care costs of more than £100,000, with considerably higher costs for younger adults with care needs.⁹⁸ It is impossible to tell who will end up with a long-term care need in old age and the potential costs are extremely high. Many people would like to be able to insure themselves against that risk. However, the market for long-term care insurance (LTCI) is limited in nature. Providers worry that uptake of LTCI will be highest amongst those most at risk of developing a care need (for instance, someone with a family history of motor neurone disease) and respond by raising premiums. At those higher premiums, only high-risk individuals want to buy LTCI and, as a result, few people

⁹² For a more detailed chronological discussion, see T. Jarrett, 2017, 'Social care: government reviews and policy proposals for paying for care since 1997 (England)', House of Commons Library Briefing Paper CBP-8000, <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8000>.

⁹³ The exception is the introduction of free personal care in Scotland in 2002 following the recommendations of the Royal Commission chaired by Sir Stuart Sutherland, which published its report in March 1999. The Labour government rejected the proposals.

⁹⁴ <http://gov.wales/funding/fiscal-reform/welsh-taxes/developing-new-taxes/?lang=en>.

⁹⁵ <http://www.gov.scot/Topics/Health/Policy/2020-Vision>.

⁹⁶ For an excellent discussion, see L. Wenzel, L. Bennett, S. Bottery, R. Murray and B. Sahib, 'Approaches to social care funding', Health Foundation Working Paper 2, 2018, <https://www.health.org.uk/publication/approaches-social-care-funding>.

⁹⁷ There is a limit in the sense that once an individual's assets fall below the lower means test (currently £14,250 in England), they are entitled to full local authority support. However, they are still expected to contribute out of their income, and an individual in residential care with no dependants could have to sell their home before reaching this point.

⁹⁸ *Fairer Care Funding*, Report of the Commission on Funding of Care and Support, 2011, <http://webarchive.nationalarchives.gov.uk/20130221121529/www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>.

end up covered. This is a case of what economists refer to as ‘adverse selection’.⁹⁹ There is therefore a case for the state to step in to correct the market failure by pooling risks and insuring people against the catastrophic costs against which they are unable to insure themselves. The NHS provides insurance in the case of healthcare, but the state fails to fulfil this role under the existing social care system.

Potential for spillovers

Inadequate provision of social care is likely to have consequences for other public services. For instance, there may be negative spillovers to the health service if individuals with an unmet care need instead make greater use of public hospitals or primary care. Lack of availability of long-term care packages can make it more difficult for older people to be discharged from hospital back into the community, meaning they occupy hospital beds for longer.

In the absence of publicly funded formal care, informal carers will in many cases have to fill the gap. These carers may have to scale back their hours of work, or leave the labour force entirely, in order to care for their loved one. This can have a cost to the carer themselves, as well as to the wider economy through lost tax revenue and productive capacity.

The design of a social care funding system should take into account the potential for these spillover effects and in particular how the social care system interacts with the NHS.

Informational issues

Many people (understandably) experience difficulty in understanding and planning for low-probability events with extremely high potential costs – such as a severe social care requirement in old age. In addition, there may be widespread misunderstanding of the extent and generosity of publicly funded social care provision. For instance, people might wrongly assume that publicly funded social care functions much like publicly funded healthcare in the UK.¹⁰⁰ This leads to people not planning and preparing for their care needs.

The onset of a care and support need often comes as a shock and many people who require social care do so because of limitations arising from mental disabilities or illness. Important decisions with repercussions for both the recipient and their family often have to be made quickly at a time of distress and vulnerability. Issues arising from these informational problems could be mitigated through a clear, well-understood public social care system that provides support to help people make an informed choice.

Fairness

If the proposals in the Green Paper are to avoid being added to the ever-growing pile of abandoned social care reforms, it is essential that the new system is perceived by the public as being ‘fair’. Of course, there are many facets to fairness. Many people believe that it is unjust for the poor to be denied healthcare because they are unable to afford it;

⁹⁹ For discussion of the issues facing a market for long-term care insurance, see J. Brown and A. Finkelstein, ‘Why is the market for long-term care insurance so small?’, *Journal of Public Economics*, 2007, 91, 1967–91 (http://users.nber.org/~afinkels/papers/Brown_Finkelstein_Small_Feb07.pdf).

¹⁰⁰ The Dilnot Commission noted that ‘many believe they will receive free care in later life and are often shocked when they discover the scale of their financial liabilities at the point that they, or a family member, need care’.

this argument could just as easily apply to social care. Social care could be provided free at the point of use to all. Or some might regard it as fairer if people are expected to contribute towards the cost of their care if they can afford to do so. But this creates inequalities between those who have saved for old age and those who have spent all their income earlier in life, who could have had exactly the same resources over their lifetimes. If care is to be means-tested, should individuals be expected to sell their homes to cover the costs of their care or should housing wealth be exempt from the capital means test? What if the house is lying empty? Decisions must be made on how much financial responsibility lies with the individual and the state, and to what extent people's assets should be protected from the cost of care.

Perceived unfairness can also exist across people with similar levels of income and wealth. The Barker Commission noted that in the UK, with free universal health care, 'people with conditions that can involve very similar burdens, both for themselves and their families – cancer and dementia, for example – end up making very different contributions to the cost of their care'.¹⁰¹ Any proposal is unlikely to last long if a majority of the public – or MPs – deem it to be inequitable.

The cost of reform

The current system leaves many individuals responsible for meeting the costs of their social care. Reforms to the system that move from the individual to the state as funder are likely to increase the costs to the public purse. Recent Health Foundation analysis estimated that introducing a 'Cap and Floor' framework which limits lifetime social care costs and adjusts the means test (similar to the Conservative Party proposal at the 2017 general election) would cost an additional £6.7 billion per year by 2033–34. Introducing Free Personal Care (i.e. extending the Scottish model to the rest of the UK) would increase spending by an estimated £9.1 billion in the same year.¹⁰² There may be a strong case for the state to take the role of insurer, both for economic reasons and in response to political pressure and a widespread sense of unfairness. But the extra money will need to come from somewhere and will require more difficult choices to be made going forward.

4.8 Conclusion

There is vigorous debate about the current state of the NHS and social care systems, and how much more money will be needed going forward. Chapter 3 of this report provides estimates of how much it would cost to meet funding pressures over the next 15 years. These costs are substantial. Under the modernised NHS scenario, meeting the rise in estimated costs would amount to an additional 3.0% of GDP by 2033–34, or £64 billion in today's terms. Simply maintaining the status quo would also require significantly more funding for the NHS, of an additional 2.0% of GDP by 2033–34, or the equivalent of £42 billion today. Neither of these scenarios incorporates any increase in the generosity of the social care offer.

¹⁰¹ *A New Settlement for Health and Social Care*, Interim Report of the Commission on the Future of Health and Social Care in England, 2014, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/commission-interim-new-settlement-health-social-care-apr2014.pdf.

¹⁰² Data from T. Watt, M. Varrow, A. Roberts and A. Charlesworth, *Social Care Funding Options: How Much and Where From?* Health Foundation and King's Fund, 2018, <https://www.health.org.uk/sites/health/files/Social-care-funding-options-May-2018.pdf>.

The scale of the funding gap, on the back of almost a decade of austerity, means that finding a large share of the required additional money through cuts to other areas of public spending would pose considerable challenges. A significant share of the welfare budget is accounted for by the state pension, which is subject to similar pressures to health and social care. It would be hard to achieve cuts from other government departments without experiencing deteriorations in the quality of or access to other public services, such as education and law and order.

Recent surveys of public opinion suggest that the public are now prepared to pay more tax to fund NHS spending. Whether they would tolerate the level of increases required to meet the funding gap, particularly under the 'modernised' scenario, is less clear. Meeting the pressures under this scenario over the next five years alone would require an additional 6.5p in the pound on income tax or an additional 5p in the pound on VAT, for example. Reversing some of the tax cuts made since 2010, such as the reduction in corporation tax and the increase in the personal allowance, could raise significant sums.

It is important to note that although the implied tax rises are large, the resulting increase in tax levels would still leave the UK with a relatively low tax burden relative to comparable European countries. Even if taxes were increased to fund health and social care under the modernised scenario, tax as a share of GDP would still be lower than it is today in France, Germany, the Netherlands and Scandinavia. However, the UK does spend a higher share of tax revenue on health and social care than these countries. Devoting additional tax revenue to health and social care would increase this share still further.

The UK has low out-of-pocket charges for healthcare. This is a public and political decision about how healthcare should be accessed and paid for, which sees no signs of changing. Low out-of-pocket cost has advantages in terms of fewer individuals choosing not to seek or receive treatment on grounds of cost and in terms of lower administration costs. However, it also means that, for a given level of health spending, more needs to be raised in taxes, which also carries costs. While large-scale change to charges in the NHS seems unlikely, there are good reasons to review and rationalise current exemptions criteria. For example, it seems hard to justify exempting those aged 60–64 from NHS charges when no other state benefits are paid until 65.

The government is already raising or seeking to raise small sums of money from recouping charges from non-residents and selling certain pieces of NHS estate. These reforms and proposals could play a part in raising more funding for the NHS, but that role will be small.

The scale of the funding pressures on the NHS and social care over the next 15 years means that this and future governments have hard choices to make about the services the NHS and social care should offer and how these should be paid for. Choosing not to meet the funding pressures is likely to lead to further deteriorations in the quality of services available. By contrast, meeting the pressures means finding substantially more public money. Achieving this by cutting spending on other public services looks difficult and is likely to be very unpopular. This means that tax rises are likely to play an important role.