Office for National Statistics

Statistical bulletin

Healthcare expenditure, UK Health Accounts: 2017

Healthcare expenditure statistics, produced to the international definitions of the System of Health Accounts 2011.

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1 . Main points

- Total current healthcare expenditure in 2017 was £197.3 billion, an increase in current prices of 3.3% on spending in 2016.
- Total current healthcare expenditure in the UK accounted for 9.6% of gross domestic product (GDP) in 2017, compared with 9.7% in 2016.
- In real terms, adjusted for inflation, total healthcare spending increased by 1.1% in 2017, while real healthcare expenditure per person grew by 0.5%; these represented the lowest rates of growth since the start of the series in 2013.
- Government-financed healthcare expenditure in 2017 accounted for 79% of total healthcare spending, at £155.6 billion.
- Government-financed healthcare expenditure, in real terms, grew by 0.3% in 2017, while non-government healthcare financing increased by 4.3%, the lowest and highest rates respectively since the series started in 2013.
- While curative and rehabilitative care made up 65% of government-financed healthcare expenditure, it only represented 29% of non-government expenditure, a similar amount to the share of long-term care (health) and medical goods spending.
- Spending on long-term care was £48.2 billion in 2017; the increase in real terms of 1.3% on 2016 was the lowest since 2014 and a result of lower growth in long-term care (health).

2 . Things you need to know about this release

This bulletin contains data from the UK Health Accounts, providing figures for 2013 to 2017. Health accounts are a set of statistics analysing healthcare expenditure by three core dimensions:

- financing scheme – the mechanism through which healthcare is financed
- function – the type of care and mode of provision
- provider organisation – the setting in which healthcare is delivered

The UK Health Accounts are produced according to the System of Health Accounts 2011: SHA 2011 framework. This provides internationally standardised definitions both for total current healthcare expenditure, and the analysis of this spending by financing scheme, function and provider organisation. Several supplementary dimensions also exist, including the revenues of financing schemes. All EU member states and most other Organisation for Economic Co-operation and Development (OECD) countries measure healthcare expenditure from 2014 onwards using SHA 2011 definitions. Some OECD member states also produce healthcare expenditure statistics to these definitions for years before 2014, but the length of the back series produced to these definitions varies by country. The time series for UK Health Accounts runs back to 2013.

The definition of healthcare used in health accounts is somewhat broader than that used in other UK healthcare expenditure analyses (including our earlier Expenditure on Healthcare in the UK publication), and includes a number of services that are typically considered social care in the UK. More information about the definitions of health accounts and the differences between health accounts and other healthcare expenditure analyses is available in the Introduction to health accounts.

The analyses of health spending by function, provider and financing scheme in this bulletin only measure current expenditure on healthcare. This means that spending on the formation and acquisition of capital items, such as buildings and vehicles, in any given year, is not included in these statistics. However, the cost of the consumption of fixed capital, a concept analogous to depreciation, is included. All figures contained in this bulletin are for current expenditure only, with the exception of Annex 1, which contains figures for current and capital expenditure produced using the definitions from our previous Expenditure on Healthcare in the UK analysis.

Past editions of this bulletin reported expenditure in current prices – that is, the price of goods or services at the time they were purchased, unadjusted for inflation. However, for the first time, this bulletin reports expenditure adjusted for inflation. The GDP deflator is used to account for general, whole economy price changes. It is important to note that using a general price deflator will not account for the variation in price inflation across different components of health spending. For example, the price increase in medical goods may be very different from the price increase in long-term care services, but this variation will not be observed using the GDP deflator.

Throughout this article, figures adjusted for inflation are termed as being in “real terms”, or in “2017 prices”, as 2017 is the chosen reference year. Note that growth rates in real terms are subject to revisions of the GDP deflator, which could influence growth in healthcare spending in future editions of this bulletin.

3 . Total current healthcare expenditure in the UK

In 2017, spending on healthcare in the UK totalled £197.3 billion. This equates to approximately £2,988 spent per person, or 9.6% of gross domestic product (GDP). This includes both government and non-government spending on healthcare.

Healthcare expenditure in 2016 was equal to 9.7% of GDP. This figure has been revised slightly since last year’s bulletin (9.8%), due partly to a small upward revision to GDP and a slight downward revision to total healthcare expenditure. For more information, see Section 8: Revisions.

Table 1 shows that while health spending grew by 3.3% between 2016 and 2017 in current prices, when these figures are adjusted for general price inflation, spending increased by only 1.1%. This is largely attributed to slower growth in government spending in real terms (see Section 4 for further details). Across the whole period from 2013 to 2017, health spending grew by 14.7% in current prices, compared with 7.7% in real terms. The lower growth in real terms expenditure demonstrates the effects of controlling for inflation.

Table 1: Healthcare expenditure has grown in current prices and 2017 prices, both in total and per person, each year between 2013 and 2017

Expenditure and growth rates in total current healthcare, UK, 2013 to 2017

		2013	2014	2015	2016	2017
Current Prices	Expenditure (£ billions)	172.0	179.9	183.6	191.0	197.3
	Growth rates (%)[1]		4.6%	2.1%	4.0%	3.3%
	Expenditure per person (£ per person)	2,683	2,786	2,821	2,910	2,988
2017 Prices	Expenditure (£ billions)	183.3	188.5	191.6	195.2	197.3
	Growth rates (%)[1]		2.9%	1.7%	1.9%	1.1%
	Expenditure per person (£ per person)	2,859	2,918	2,943	2,974	2,988
Expenditure as % of GDP		9.8%	9.8%	9.7%	9.7%	9.6%

Source: Office for National Statistics - UK Health Accounts

Notes

1. Growth rates for a single year are given as the growth between the stated year and previous year. Back to table

4 . How healthcare in the UK is financed

Healthcare expenditure in 2017 continued to be mostly financed through government expenditure

Government expenditure on healthcare, which includes spending by the NHS, local authorities and other public providers of healthcare, was £155.6 billion in 2017, accounting for 79% of total current healthcare expenditure. The share of total healthcare expenditure financed through government has been relatively consistent since 2013, the years for which comparable data are available.

The remaining healthcare expenditure was financed through four categories of non-government expenditure [1]. These categories are:

- voluntary health insurance – covering healthcare insurance such as private medical and dental insurance, employer self-insurance schemes, health cash plans, dental capitation plans (dental plans where monthly premiums are typically set by dentists based on patients' dental history) and the element of travel insurance relating to healthcare cover

- charitable financing, referred to as non-profit institutions serving households (NPISH) – covering charity expenditure funded through voluntary donations, grants and investment income, excluding charity expenditure funded through client contributions (classed as out-of-pocket expenditure) and purchases of care by public and NHS bodies (classed as government expenditure)

- enterprise financing – covering healthcare activity funded by organisations (primarily employers) outside of an insurance scheme, such as occupational healthcare

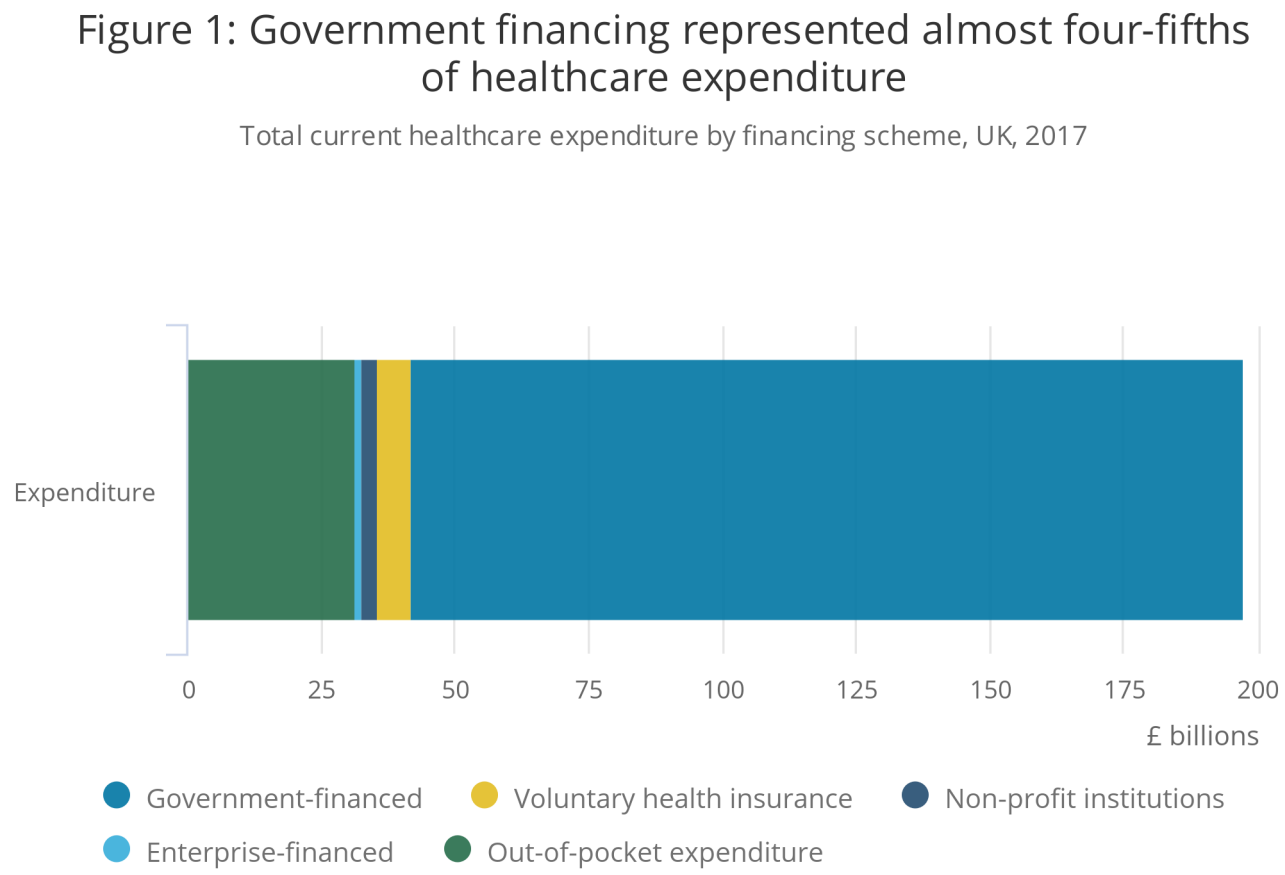
- out-of-pocket expenditure – covering household spending on healthcare goods and services, including client contributions for local authority and NHS-provided services and prescription charges but excluding healthcare costs claimed back through insurance

More information on these schemes can be found in An introduction to health accounts and UK Health Accounts: methodological guidance.

The largest of the non-government financing arrangements in 2017 was out-of-pocket expenditure, which accounted for 16% of overall spending or £31.5 billion. Voluntary health insurance accounted for 3% of overall spending on healthcare, or £6.0 billion, and NPISH and enterprise financing were the smallest financing schemes, accounting for 2% and less than 1% respectively.

Figure 1: Government financing represented almost four-fifths of healthcare expenditure

Total current healthcare expenditure by financing scheme, UK, 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures are given in current prices, unadjusted for inflation.

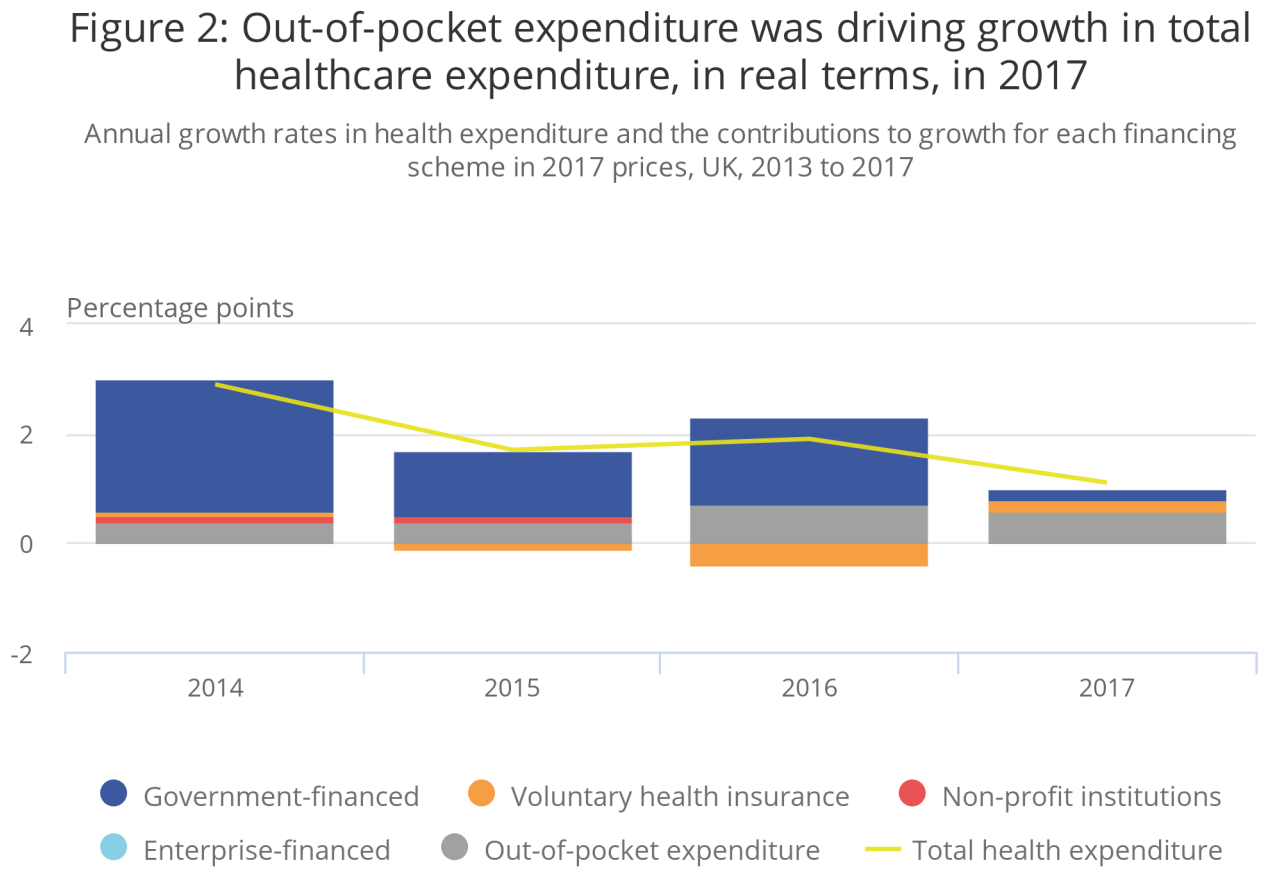
Low growth in total healthcare expenditure in 2017 attributable to government-financed healthcare

Adjusting for inflation, expenditure in all financing schemes grew in 2017. Changes in overall growth in healthcare expenditure are generally driven by increases or decreases in government expenditure, due to its size. Between 2013 and 2016, an increase in government expenditure was the factor largely driving the increase in healthcare expenditure, but between 2016 and 2017, the growth in government-financed expenditure slowed, resulting in lower growth in overall healthcare expenditure.

The substantial fall in healthcare financed through voluntary health insurance in 2016 is largely a result of the introduction of the Solvency II directive rather than a fall in premiums purchased. This European Commission directive was designed to ensure that insurers have the capital needed to continue to fund claims during periods of slow economic growth. While the additions to the capital requirements are not included in the health accounts figures, the resulting fall in net premium income to insurers results in a fall in voluntary health insurance in 2016, which appears in the administration of health financing function.

Figure 2: Out-of-pocket expenditure was driving growth in total healthcare expenditure, in real terms, in 2017

Annual growth rates in health expenditure and the contributions to growth for each financing scheme in 2017 prices, UK, 2013 to 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures are based on expenditure in 2017 prices, adjusted for inflation.
2. Contributions to growth may not sum to overall growth due to rounding.

Further information on government financing can be found in Section 5 and further information on the other financing schemes is available in Section 6.

Around four-fifths of healthcare expenditure was funded from public revenues

Financing schemes, as shown in Figures 1 and 2, represent the way in which healthcare is accessed, for example, through the NHS or voluntary health insurers. However, health spending can also be analysed from the perspective of the sources of revenue of these financing schemes. This can be important to understanding the financial sustainability of healthcare financing in a country.

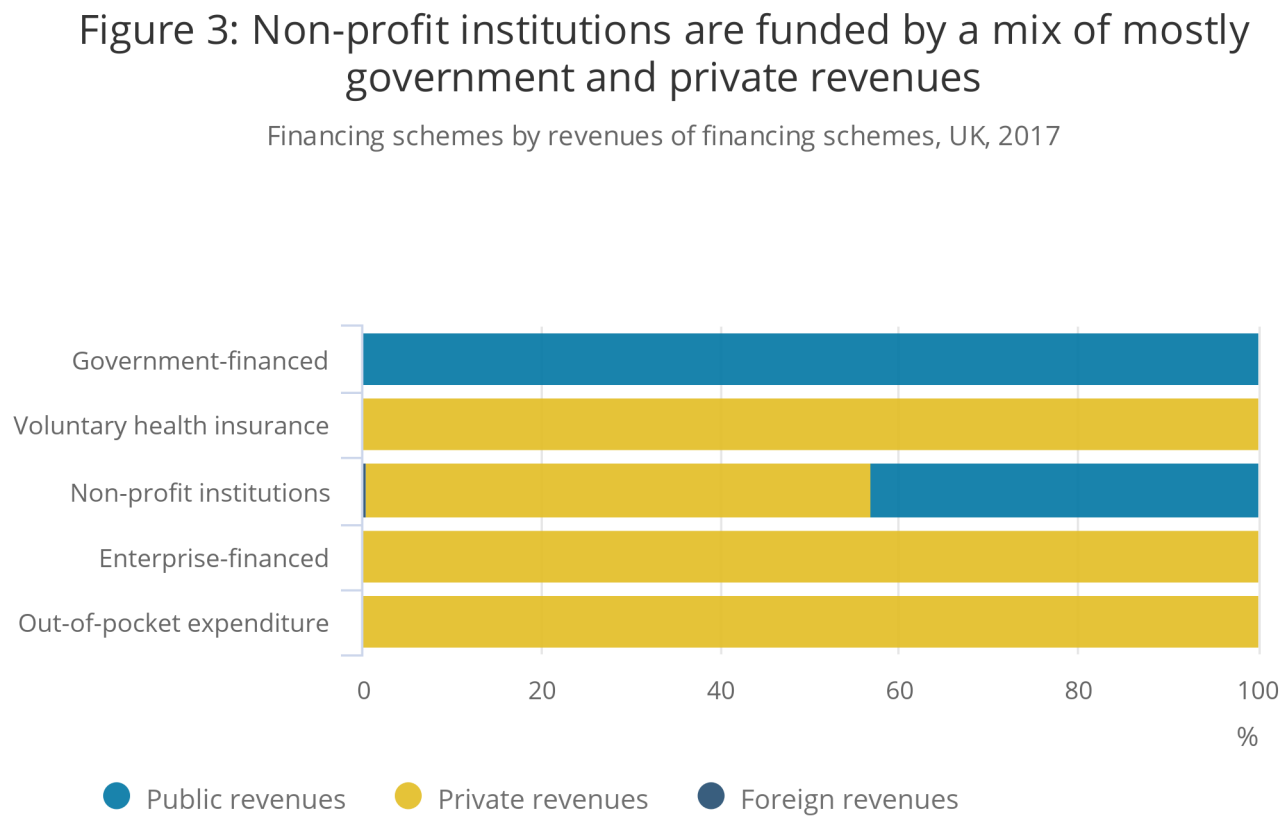
Public revenues amounted to 79% of the funding for healthcare expenditure in 2017. Public revenues funded government schemes, and also a portion of charity (NPISH) revenues, through government grants. However, because NPISH expenditure only accounts for 2% of total healthcare expenditure, this does not increase the share of total healthcare expenditure funded through public revenues beyond 79%.

Government healthcare expenditure in the UK is almost entirely funded from public revenues (99.9%), mainly from tax revenues and National Insurance contributions. A small amount of revenue is also raised from private insurance and enterprise that reimburse the NHS collected by the Compensation Recovery Unit (0.1%).

NPISH, which captures charity spending on healthcare, is funded through a mixture of government grants (43%), private revenues (56%), such as household donations and charity investment income, and a small amount of revenues from abroad (1%). The other non-government financing schemes are funded privately; enterprise-financed healthcare by the organisation's revenues, out-of-pocket expenditure through household funds and voluntary health insurance through insurance premiums.

Figure 3: Non-profit institutions are funded by a mix of mostly government and private revenues

Financing schemes by revenues of financing schemes, UK, 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures may not sum due to rounding.
2. Private revenues include voluntary prepayments and other domestic revenues.

Notes for: How healthcare in the UK is financed

1. Compulsory insurance was reported as a financing scheme in previous editions of UK Health Accounts, however, this is now classified as a component of government-financed expenditure. This reallocation results in a 0.1% increase to government expenditure for 2017. For full details, please see the Revisions section.

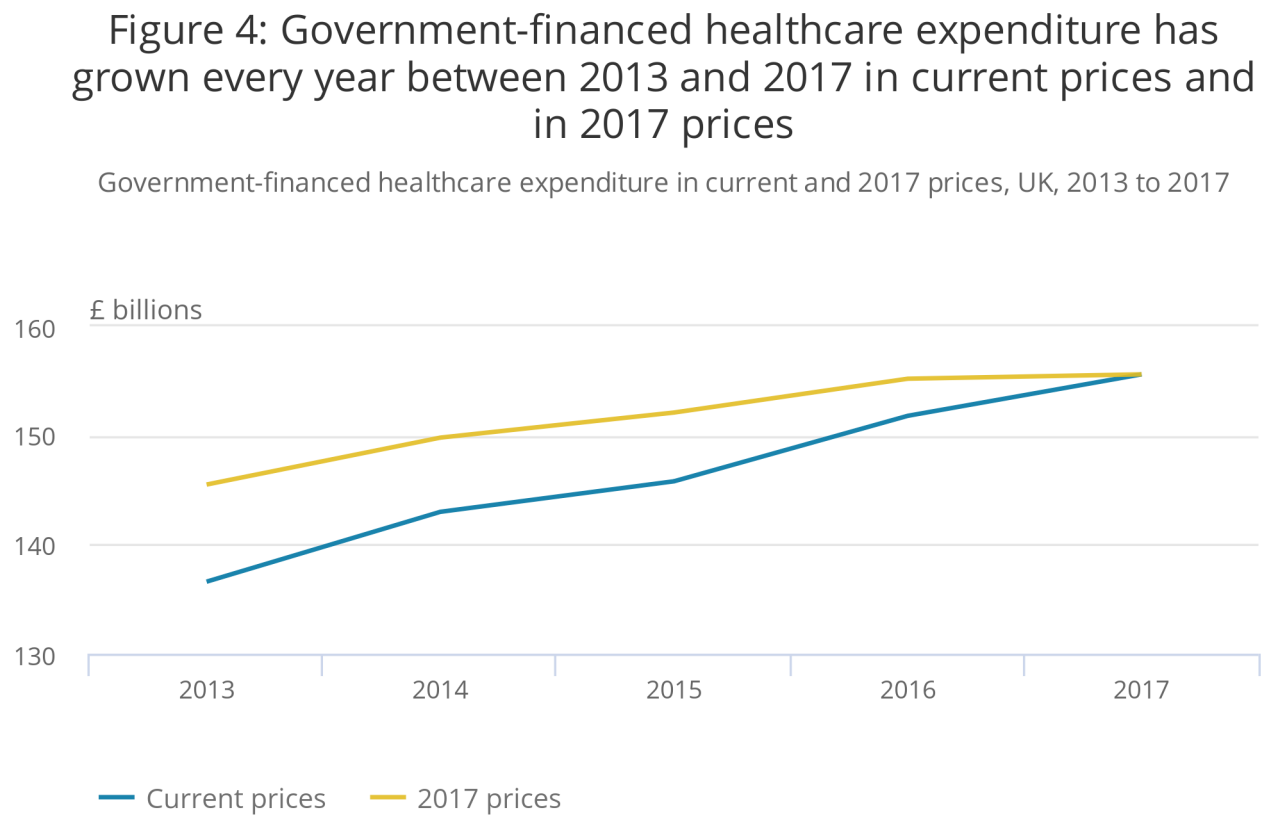
5 . Government healthcare expenditure

Government expenditure in 2017 was £155.6 billion. In current prices (the price of goods at the time they were purchased), government expenditure grew each year between 2013 and 2017. However, removing the inflationary increase in the general price of goods and services over time, shows that government expenditure grew only slightly between 2016 and 2017, by 0.3%.

Using definitions from the System of Health Accounts 2011: SHA 2011, the coverage of government healthcare expenditure is broader than just NHS spending and includes elements of local authority-funded social care and preventive healthcare provided by other government departments.

Figure 4: Government-financed healthcare expenditure has grown every year between 2013 and 2017 in current prices and in 2017 prices

Government-financed healthcare expenditure in current and 2017 prices, UK, 2013 to 2017

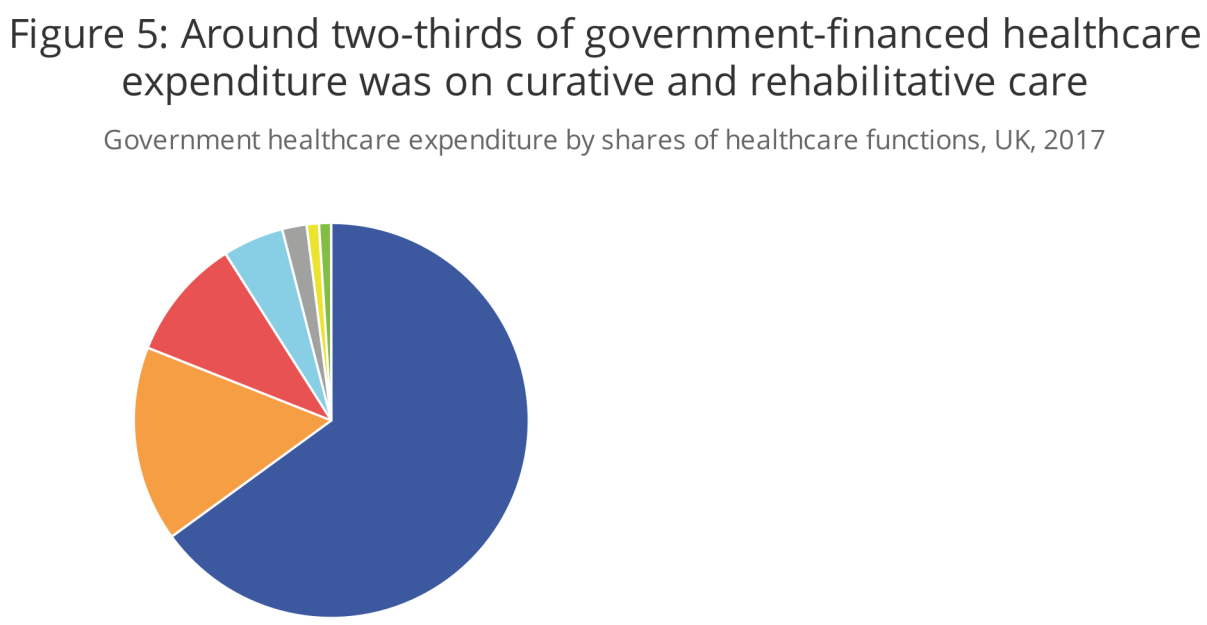


Source: Office for National Statistics - UK Health Accounts

Most government spending on healthcare relates to services providing curative or rehabilitative care, health-related long-term care, the provision of medical goods and preventive care. Combined, these categories account for nearly 96% of government healthcare spending. The remaining 4% comprises ancillary services; healthcare governance, which covers spending on central functions providing strategic governance and setting and monitoring standards of care; and a small proportion of spending on care not classified elsewhere.

Figure 5: Around two-thirds of government-financed healthcare expenditure was on curative and rehabilitative care

Government healthcare expenditure by shares of healthcare functions, UK, 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures may not sum due to rounding.

2. Medical goods excludes pharmaceuticals and other products used as part of a wider course of treatment, which are included in the costs of that treatment. For example, drugs consumed by a patient as part of an inpatient hospital episode will be included in the expenditure on hospital inpatients.

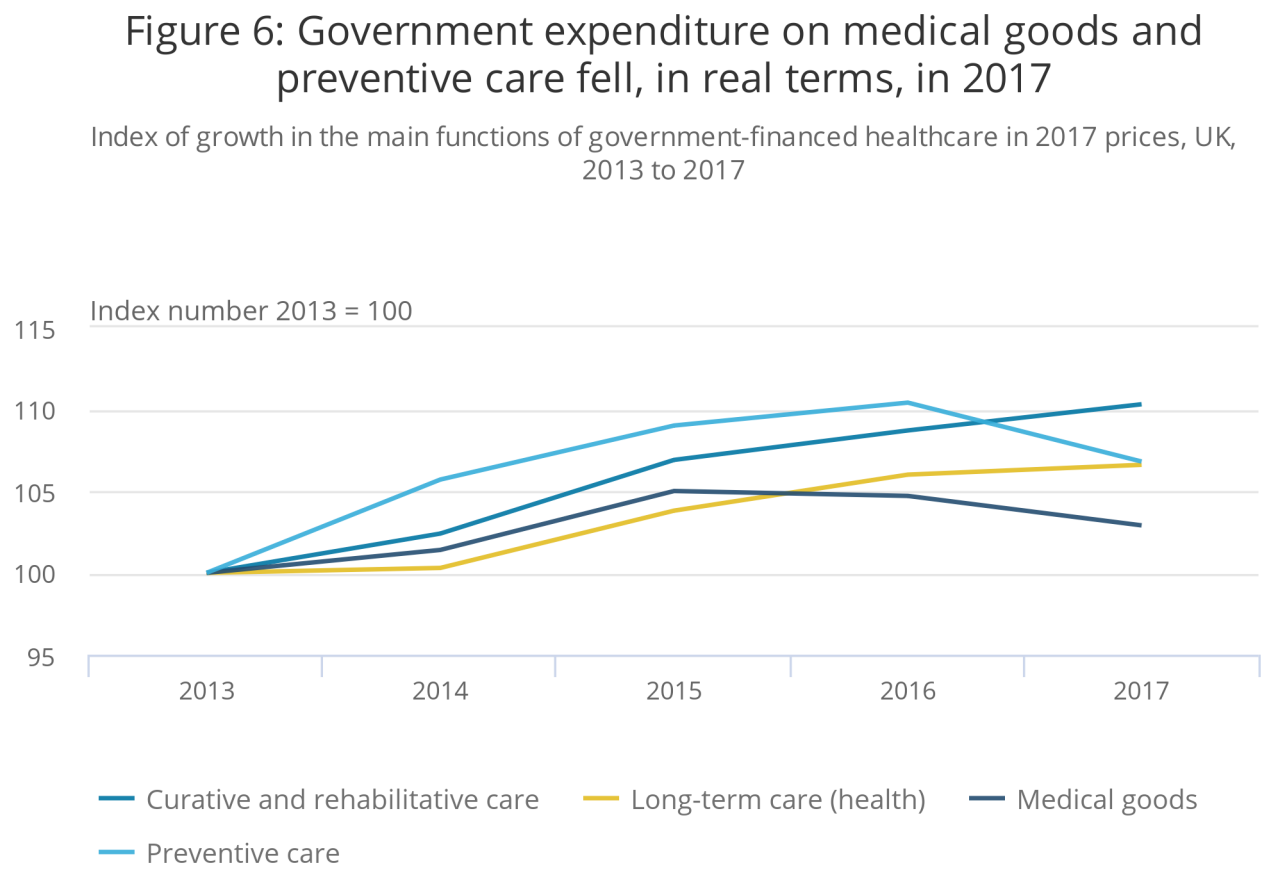
Figure 6 shows the growth in the four main functions of healthcare, financed by government expenditure, between 2013 and 2017 in real terms, adjusted for inflation. In this bulletin, all components of health expenditure are deflated using the gross domestic product (GDP) deflator, which assumes the same price inflation for all components. While this helps express the increase in expenditure relative to overall price inflation in the economy, it does not distinguish between the actual price inflation in different components of healthcare expenditure, which will vary.

While spending on the two largest categories, curative and rehabilitative care and long-term care (health), rose in every year of the series, real terms spending on preventive care and medical goods (excluding pharmaceuticals and other products used as part of a wider course of treatment) fell in 2017. The 3.2% real-terms fall in prevention was due mainly to a reduction in real-terms spending on information, education and counselling programmes, such as promoting smoking cessation, health visiting and school nursing. The real-terms fall of 1.7% in medical goods expenditure was due to a combination of prescribed medicines (its largest subcategory), and therapeutic appliances and durable medical goods.

Real-terms expenditure on health system governance and care not classified elsewhere [1] also fell between 2013 and 2017. However, curative and rehabilitative care drives the direction of growth in government-financed healthcare more than other functions due to its large size.

Figure 6: Government expenditure on medical goods and preventive care fell, in real terms, in 2017

Index of growth in the main functions of government-financed healthcare in 2017 prices, UK, 2013 to 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures are based on expenditure in 2017 prices, adjusted for inflation.

Spending on curative and rehabilitative care accounted for around two-thirds of government healthcare expenditure

Spending on curative and rehabilitative care accounted for 65% of government healthcare spending, or £100.9 billion. This category covers care for treatable illnesses or injuries and includes most healthcare services typically carried out in hospitals, as well as ambulatory settings such as in General Practitioner (GP) surgeries or by dentists.

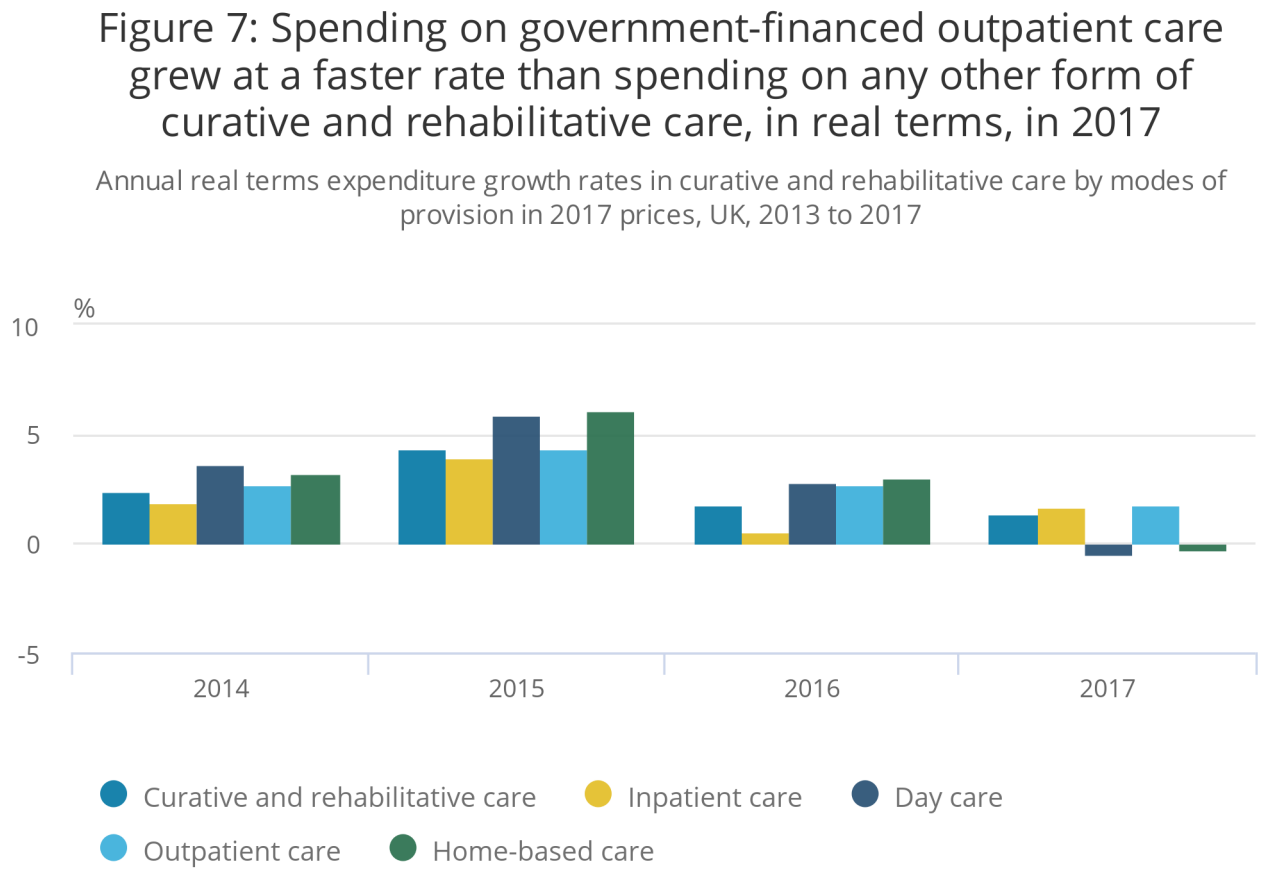
Curative and rehabilitative healthcare can be disaggregated by the organisational arrangement in which care is carried out, known as the mode of provision. The four modes of provision are:

- inpatient care
- day care
- outpatient care
- home-based care

Adjusting for inflation, spending on curative and rehabilitative care increased each year between 2013 and 2017. By mode of provision, between 2013 and 2017 the annual growth in spending on day care, outpatient care and home-based care tended to be greater than spending on inpatient care, although spending on day care and home-based care fell in 2017.

Figure 7: Spending on government-financed outpatient care grew at a faster rate than spending on any other form of curative and rehabilitative care, in real terms, in 2017

Annual real terms expenditure growth rates in curative and rehabilitative care by modes of provision in 2017 prices, UK, 2013 to 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures are based on expenditure in 2017 prices, adjusted for inflation.

When analysing trends in the mode of provision used for delivering care, looking at activity data can also be informative.

The Organisation for Economic Co-operation and Development (OECD) and the EU cite patients receiving elective treatment released on the same day (rather than kept as an inpatient) as an example of how hospital resources can be used more efficiently. Internationally, the number of surgical procedures carried out as day case treatments has been increasing, in part due to innovations in less intrusive surgery techniques and better anaesthetics.

Table 2 shows how the number of elective procedures carried out in NHS hospitals as day cases has grown between 2013 and 2017, while the number of elective procedures carried out with an overnight stay has fallen. However, inpatient admission growth was increased by non-elective admissions, particularly in 2016, when growth in non-elective admissions also exceeded that of day cases.

While these data are not a complete picture of activity by mode of provision, they show the shift in activity away from treatment requiring overnight admission to procedures that allow patients to leave on the same day as arrival.

Table 2: While the number of elective inpatient admissions fell every year between 2013 and 2017, other hospital admissions and the number of hospital outpatients increased

Growth in NHS hospital activity by type of admission, England, 2013 to 2017

Growth rate (%)

	2014[2]	**2015**	**2016**	**2017**
Elective inpatient	-0.5%	-3.0%	-1.3%	-3.7%
Elective day case	4.5%	4.7%	2.6%	0.7%
Non-elective	3.5%	1.2%	4.2%	2.0%
Outpatient	3.5%	2.9%	3.2%	0.9%
Total admissions[1]	3.5%	2.4%	2.8%	0.8%

Source: Office for National Statistics, NHS England

Notes

1. Total admissions is the sum of elective inpatient elective day case and non-elective inpatient activity. Back to table

2. Growth rates for a single year are given as the growth between the stated year and previous year. Back to table

We also produce estimates for the quantity of healthcare outputs delivered across the health service for the UK, including activity outside of hospitals, such as community services, primary care services and prescribing. These statistics weight the growth rates of thousands of different types of activity across the health service by their cost, to give an estimate for the change in the quantity of healthcare provided. Therefore, the quantity output figures account for the fact that, unlike simple admission numbers, not all care is of equal cost. These figures estimate growth in cost-weighted output across UK public service healthcare of 3.5% in 2016, the latest year available, slower than output growth in 2015.

In terms of the human resources available in the NHS, workforce statistics for England show NHS full-time equivalent staff numbers increased by an average of 1.9% per year between 2013 and 2017, from approximately 974,000 to 1,050,000. These numbers include both professionally qualified clinical staff and other staff employed in the English NHS, with much of the increase in staff numbers over this period coming from support staff, although nursing and medical staff numbers also grew.

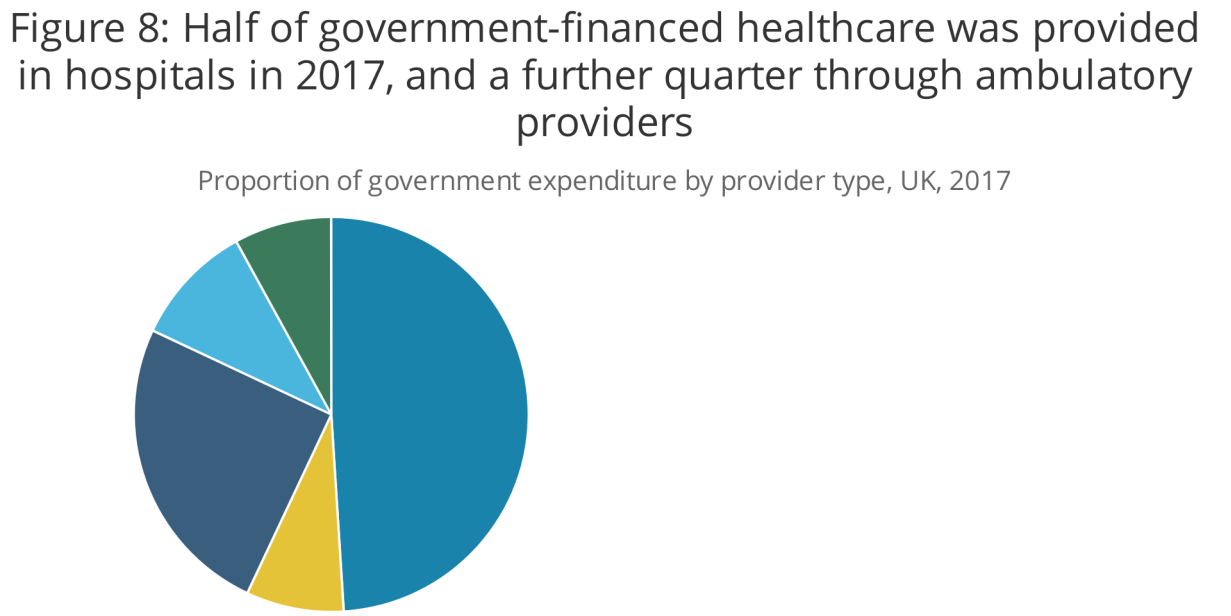
By combining the cost-weighted output measure with the quantity of staff and other inputs used in the NHS, our public service productivity statistics provide insight into changes in the productivity of the health service. More information can be found in Public service productivity estimates: healthcare.

Hospitals accounts for around half of government healthcare expenditure

In terms of healthcare providers, about half (49%) of government-financed healthcare related to care provided in hospitals in 2017. One-quarter (25%) was spent on care delivered in ambulatory settings, which includes £13.5 billion on services provided in GP surgeries, £2.9 billion in dental practices, and £22.3 billion in other ambulatory providers. Providers of medical goods, which include pharmacies, accounted for the third-largest share of government healthcare expenditure (10%), and residential long-term care facilities accounted for the fourth-largest share, at 8%. In total, these four provider types accounted for 92% of all government spending on healthcare in the UK.

Figure 8: Half of government-financed healthcare was provided in hospitals in 2017, and a further quarter through ambulatory providers

Proportion of government expenditure by provider type, UK, 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures may not sum due to rounding.

2. The category "other providers" includes providers of ancillary services, providers of preventative care, providers of healthcare system administration and financing, providers in the rest of the economy, providers in the rest of the world and providers not elsewhere classified.

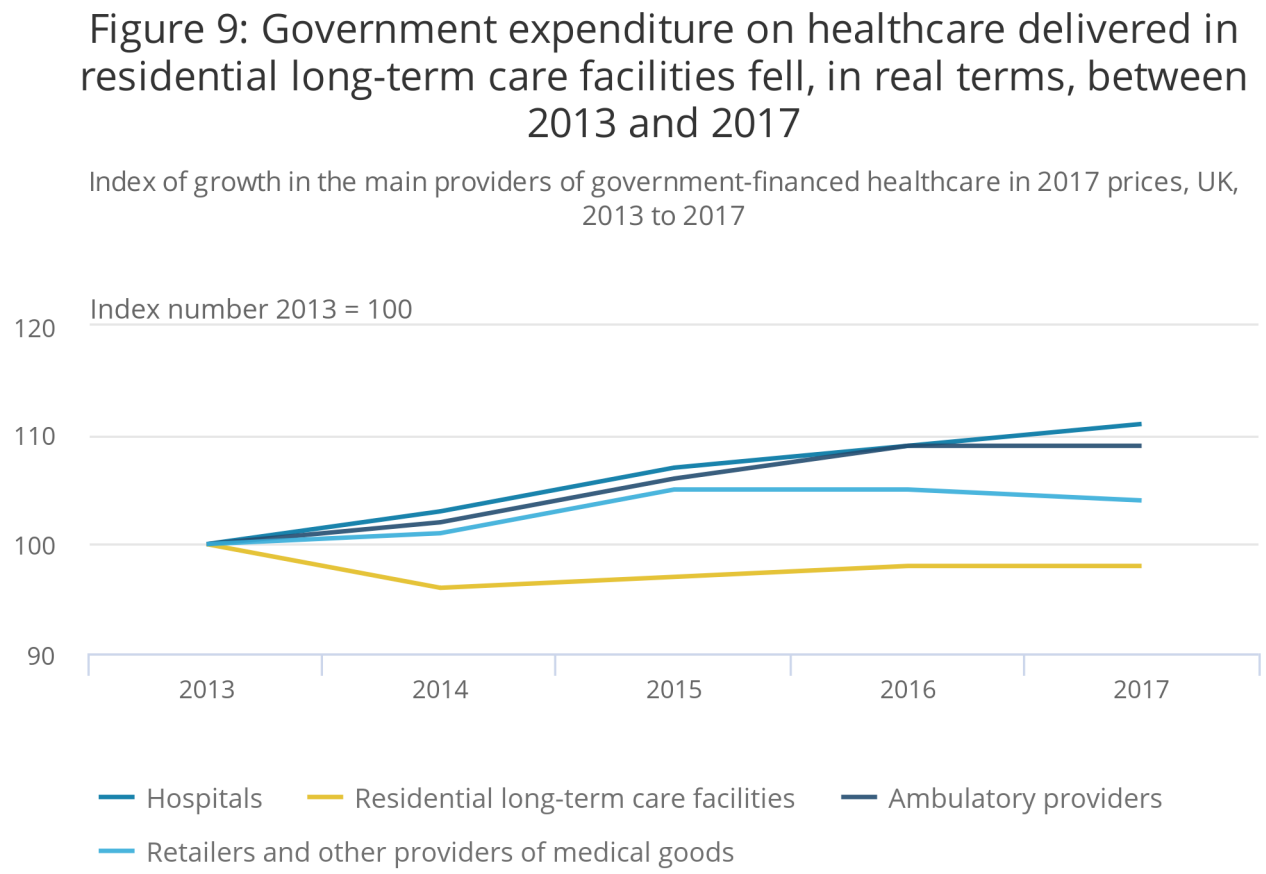
3. Expenditure on mental health services falls across a range of healthcare providers

Spending on three of the four largest providers of government-financed healthcare, in real terms, was higher in 2017 than in 2013. The exception to this was spending on care delivered in residential long-term care settings. The slight fall in real spending on services provided in residential care settings reflects the aim of healthcare bodies such as NHS England to consider alternatives to institutional care where possible (see the NHS England report for more information). The OECD report that this is part of an international trend, and that many of their member states have placed greater emphasis on providing community-based care programmes in recent years, to accommodate users' preference for living at home (for more information, see Health at a glance: 2017). In the UK, whereas government funding for residential long-term care fell in real terms between 2013 and 2017, funding for long-term home care, including Carer's Allowance, increased by 15.6% in real terms, more than offsetting this fall.

While spending in 2017 on healthcare provided by retailers of medical goods, such as pharmacies, is above the level of spending in 2013, it fell in real terms in 2017.

Figure 9: Government expenditure on healthcare delivered in residential long-term care facilities fell, in real terms, between 2013 and 2017

Index of growth in the main providers of government-financed healthcare in 2017 prices, UK, 2013 to 2017



Source: Office for National Statistics - UK Health Accounts

Notes for: Government healthcare expenditure

1. Expenditure on care not classified elsewhere is partly a residual of the different data sources used to estimate total government healthcare expenditure and the apportionment of this expenditure by function, and as a result can experience volatility in year-on-year changes. More information on these methods can be found in the UK Health Accounts methodological guidance.

6 . Non-government healthcare expenditure

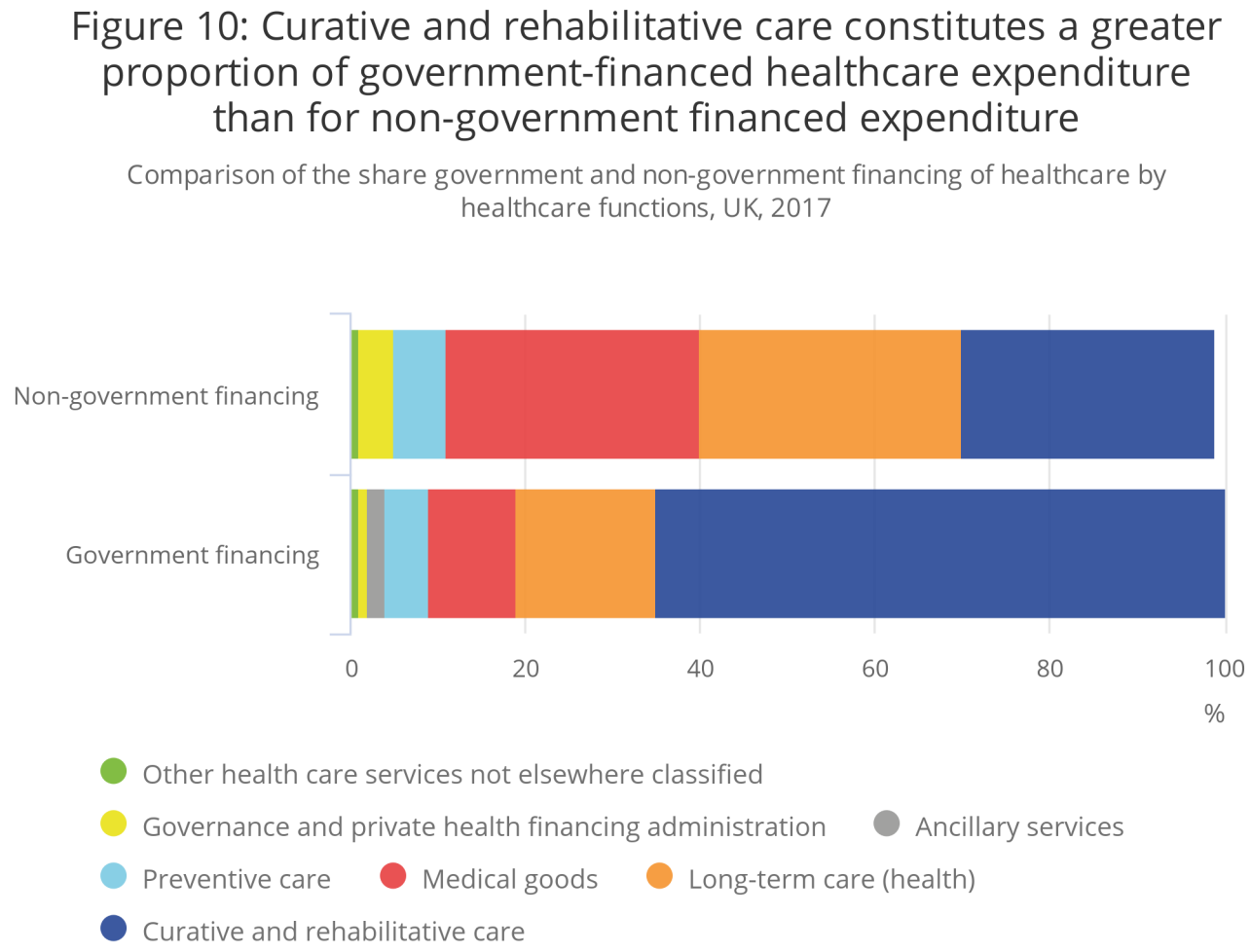
In 2017, expenditure on healthcare financed through non-government schemes totalled £41.8 billion. These schemes relate to out-of-pocket expenditure, voluntary health insurance, non-profit institutions serving households (NPISH) and enterprise-financed healthcare.

Curative and rehabilitative care was a smaller element of non-government financing schemes than for government-financed healthcare

Curative and rehabilitative care, long-term care (health) and spending on medical goods accounted for most non-government financed healthcare in 2017; as they did for government-financed healthcare. However, the allocation of expenditure across these three types of healthcare differed between government and non-government financing schemes. While curative and rehabilitative care comprises 65% of government-financed healthcare, it accounted for a much smaller proportion of overall non-government spending (29%). Instead, long-term care and medical goods spending made up much larger shares of expenditure at 30% and 29%, respectively.

Figure 10: Curative and rehabilitative care constitutes a greater proportion of government-financed healthcare expenditure than for non-government financed expenditure

Comparison of the share government and non-government financing of healthcare by healthcare functions, UK, 2017



Source: Office for National Statistics, LaingBuisson, Association of British Insurers

Notes:

1. Figures may not sum due to rounding.

Spending on non-government financed healthcare varies across schemes

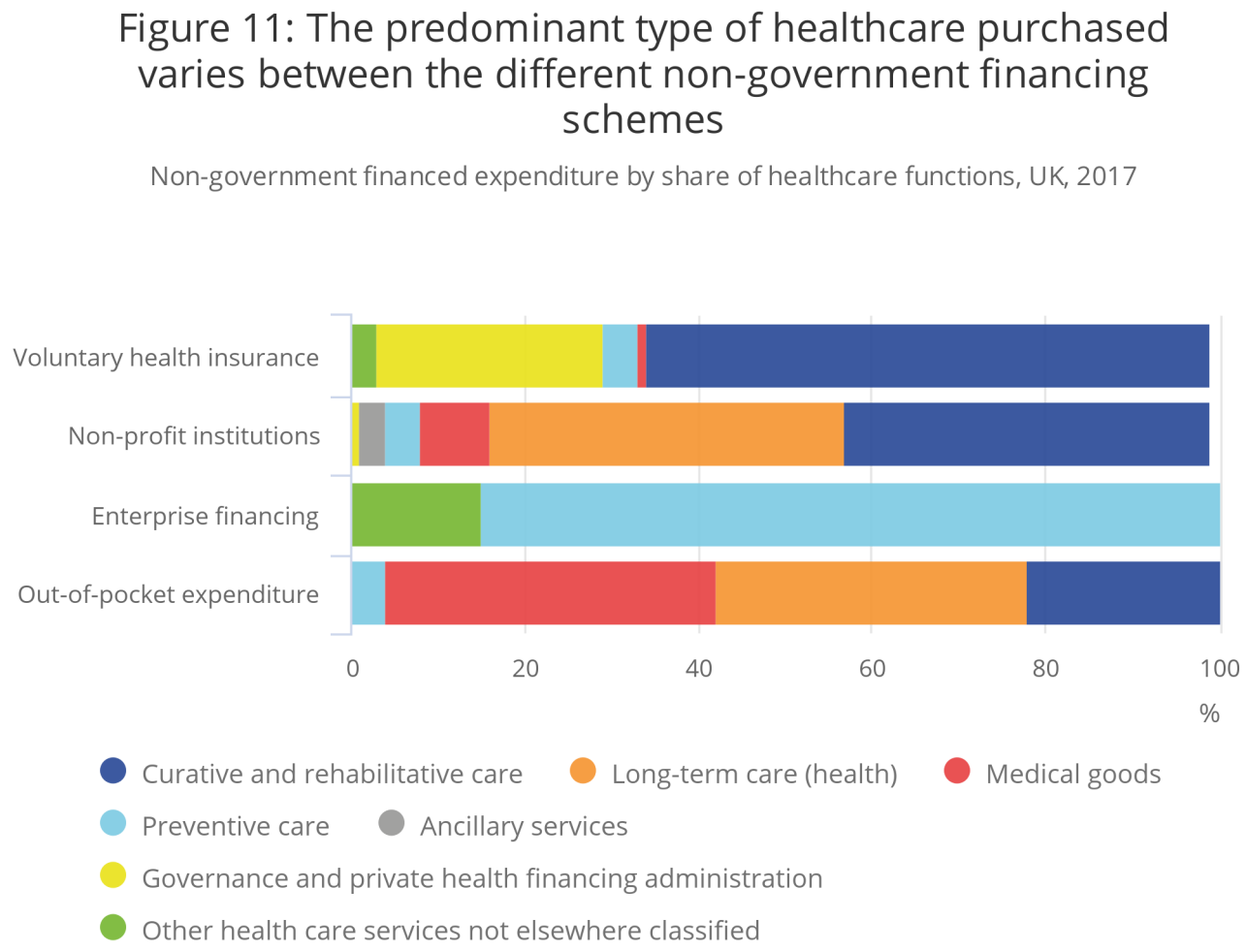
Figure 11 shows the variation in the type of healthcare financed through different non-government schemes. The largest of these schemes, out-of-pocket expenditure, principally comprises curative and rehabilitative care, health-related long-term care and spending on medical goods. Out-of-pocket expenditure covers care that is privately organised, as well as user charges for NHS dental services, NHS prescription fees and client contributions to local authority-organised adult social care.

By comparison, curative and rehabilitative care makes up the majority of health spending (65%) by voluntary health insurance. Around one-quarter (26%) of expenditure by voluntary health insurance relates to the administration of health financing. This accounts for the administrative costs of providing insurance, as well as profits earned by insurers on policies.

Of the two remaining financing schemes, NPISH mostly consists of charities financing either curative and rehabilitative care or long-term care. Enterprise financing consists mainly of preventive care, which covers occupational healthcare services provided by organisations for their employees.

Figure 11: The predominant type of healthcare purchased varies between the different non-government financing schemes

Non-government financed expenditure by share of healthcare functions, UK, 2017



Source: Office for National Statistics,LaingBuisson, Association of British Insurers

Notes:

1. Figures may not sum due to rounding.

Non-government expenditure grew strongly in 2017, increasing by 4.3% in real terms, driving growth in total current healthcare expenditure. The rise in non-government expenditure was driven by the two largest non-government financing schemes, out-of-pocket and voluntary healthcare insurance, which grew at 4.1% and 6.3% respectively.

There were a range of factors behind the increase in out-of-pocket spending in 2017, with over-the-counter drugs providing the largest contribution, along with residential and nursing care fees and outpatient curative and rehabilitative care, such as private dental treatment. Strong growth in voluntary health insurance is due partly to the relatively low figure for this category in 2016, when significant one-off transfers of risk were required due to the introduction of the Solvency II regulations. These transfers are unlikely to be required in 2017 or subsequent years and this is a factor in the strong growth between 2016 and 2017.

7 . Long-term care expenditure

Long-term care expenditure accounts for services aimed at managing chronic health conditions related to long-term care dependency (including old-age and disability-related conditions) and reducing suffering where an improvement in health is not expected. Under System of Health Accounts 2011: SHA 2011 definitions, long-term care is split into:

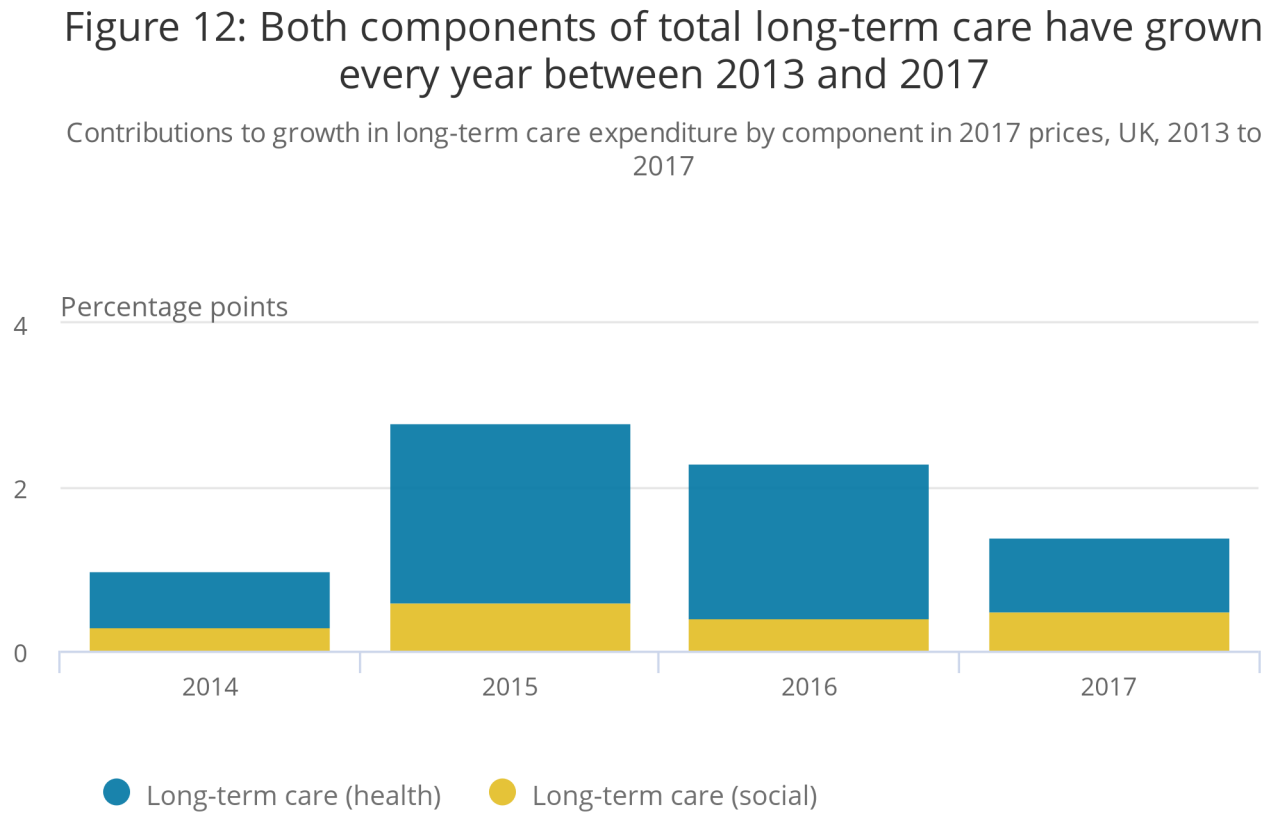
- long-term care (health), a health-related element that is included in the measure of total current health expenditure
- long-term care (social), an element relating to assistance-based services, which sits outside the health accounts and so is not included in the measure of total current healthcare expenditure

Services included in the long-term care (health) category cover care where a substantial proportion of the service involves support with basic activities of daily living (ADLs), which include activities such as bathing, dressing and walking. Long-term care (social), which is not included in the definition of total current healthcare expenditure, covers services where care predominantly consists of support with instrumental activities of daily life (IADLs), such as shopping, cooking and managing finances. In terms of care in residential settings, while long-term care (health) covers services provided in residential and nursing homes, long-term care (social) includes spending on supported housing and supported accommodation, which are services providing support for people to live independently and primarily relates to help with IADL activities.

Total long-term care expenditure in 2017 was £48.2 billion. This was an increase of 3.6% in current prices, which equates to a real-terms increase of 1.3%. Looking at the health-related and social-related components of long-term care, growth has tended to be driven by the larger long-term care (health) component, although both components have grown each year in real terms since 2013.

Figure 12: Both components of total long-term care have grown every year between 2013 and 2017

Contributions to growth in long-term care expenditure by component in 2017 prices, UK, 2013 to 2017



Source: Office for National Statistics, LaingBuisson

Notes:

1. Figures are based on expenditure in 2017 prices, adjusted for inflation.

These figures do not include the care of people with long-term care needs provided informally by friends or relatives free of charge[1]. Our household satellite accounts provide estimates for the value of unpaid production in the economy. The most recent analysis suggests that the value of informal adult care, in current prices, was approximately £60 billion in 2016.

Health and social care services are co-operating to manage the delivery of long-term care

Demographic changes in the UK, such as an ageing and expanding population, has led to an increase in the number of people with complex social care and healthcare needs. Efforts have been made to integrate health and social care services to manage the delivery of services to people. In England, legislation such as the Health and Social Care Act 2012 and the Care Act 2014 set out obligations for the health system to make it easier for health and social care services to work together. This has resulted in the establishment of programmes such as the Better Care Fund, which encourages greater collaboration between NHS and local authorities through pooled budget arrangements and integrated spending plans.

Furthering this trend to greater integration of health and social care, Sustainability and Transformation Partnerships were started in 2016 with the aim of promoting co-operation between NHS and local authorities for 44 geographical “footprints”. In 2018, 14 of the Sustainability and Transformation Partnerships evolved into the first Integrated Care Systems (ICS), where NHS and local authorities take collective responsibility for managing budgets and delivering services. The NHS long-term plan envisions ICSs covering the whole of England by April 2021, reflecting its broader ambition to strengthen the co-ordination of care. Health and social care integration has also developed in the devolved administrations of Scotland, Wales and Northern Ireland.

Two-thirds of long-term care spending was financed through government schemes

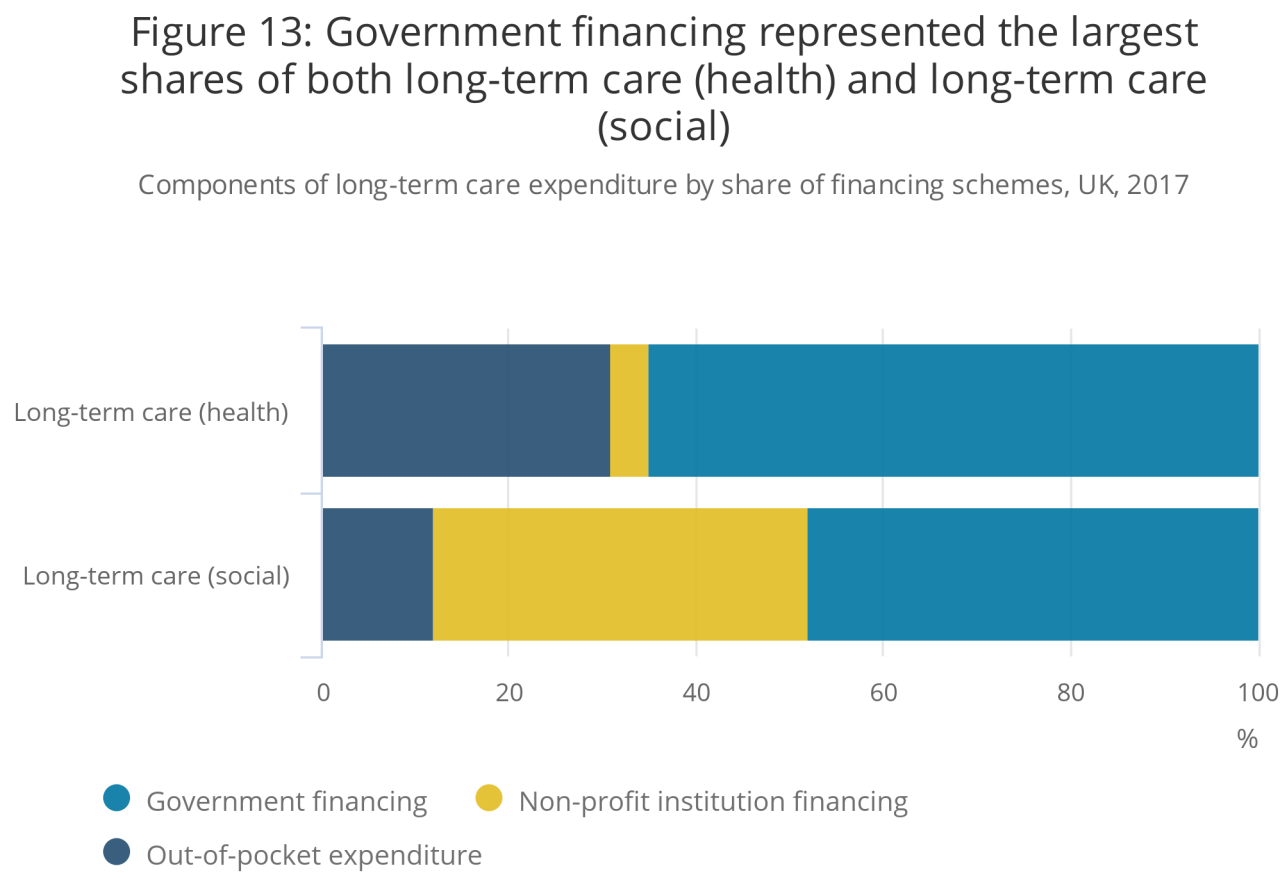
Long-term care was mostly financed through government schemes in 2017. Around two-thirds (66%) of health-related long-term care was financed through government, with 31% financed through out-of-pocket funds and the remaining expenditure financed through charities. Out-of-pocket financing consists of privately purchased services, as well as contributions to local authority-organised care.

The financing of long-term care (social) was more varied, with government still the largest contributor (48%), but with a greater proportion being financed through other means. This was partly a reflection of the level of care needs of clients receiving these services. The services provided under long-term care (social) mostly relate to helping people with long-term care conditions to live independently, rather than related to providing essential personal care.

The distribution of financing of long-term care (health) and long-term care (social) was very similar in 2017 to the pattern of financing in preceding years.

Figure 13: Government financing represented the largest shares of both long-term care (health) and long-term care (social)

Components of long-term care expenditure by share of financing schemes, UK, 2017



Source: Office for National Statistics,LaingBuisson

Notes:

1. Figures may not sum due to rounding.

Our latest adult social care public service productivity estimates analyse the growth in adult social care inputs, output and productivity for publicly funded, local authority-organised services in England. Public service productivity in adult social care fell by 0.6% in the financial year ending 2018, due to increasing inputs and decreasing output.

Notes for: Long-term care expenditure

1. Health accounts do not include free informal care, but do include payments of the Carer's Allowance; a cash benefit available to people with full-time caring responsibilities.

8 . Revisions

Overall, revisions to the UK Health Accounts series between 2013 and 2016 have resulted in changes in total current healthcare expenditure of no more than 1% for any one year. The largest revision to 2016 data was a reduction in voluntary health insurance spending. This relates primarily to restatements of gross and net insurance premiums following the introduction of the Insolvency II directive in 2016.

Other revisions to 2016 data include supply-use balancing revisions to national accounts data and the implementation of an improved methodology for determining self-funded residential and nursing care, based on LaingBuisson estimates. The revisions to 2014 and 2015 data were mostly from changes to government expenditure, for which an improved methodology to measure local government final consumption expenditure on health was introduced.

Compulsory private health insurance schemes

Previous editions of the UK Health Accounts have measured compulsory insurance as an additional financing scheme, last year accounting for 0.1% of health care expenditure in 2016. This financing scheme measured the health element to insurance claims, for example health expenses claimed on motor insurance or employer liability insurance, as well as an estimate for the proportion of insurers administration costs that were attributable to these claims. New international guidelines (to be published by OECD) clarify that healthcare is not accessed through these types of insurance; instead they are a revenue of financing, primarily of government-financed healthcare. For example, those injured in a motor accident are often treated in NHS hospitals, which are subsequently reimbursed by motor insurers. Consequently, NHS reimbursement from motor and employer liability insurance claims has now been added to government-financed healthcare, while in terms of the revenues of healthcare financing they are considered to be non-government domestic revenues. This can be seen in Figure 3. The administrative costs associated with providing this cover have been removed entirely from the UK health accounts.

9 . Quality and methodology

The UK Health Accounts Quality and Methodology Information report contains important information on:

- the strengths and limitations of the data and how it compares with related data
- uses and users of the data
- how the output was created
- the quality of the output, including the accuracy of the data

More detailed information on methods is available in the Introduction to health accounts, and UK health accounts: methodological guidance.

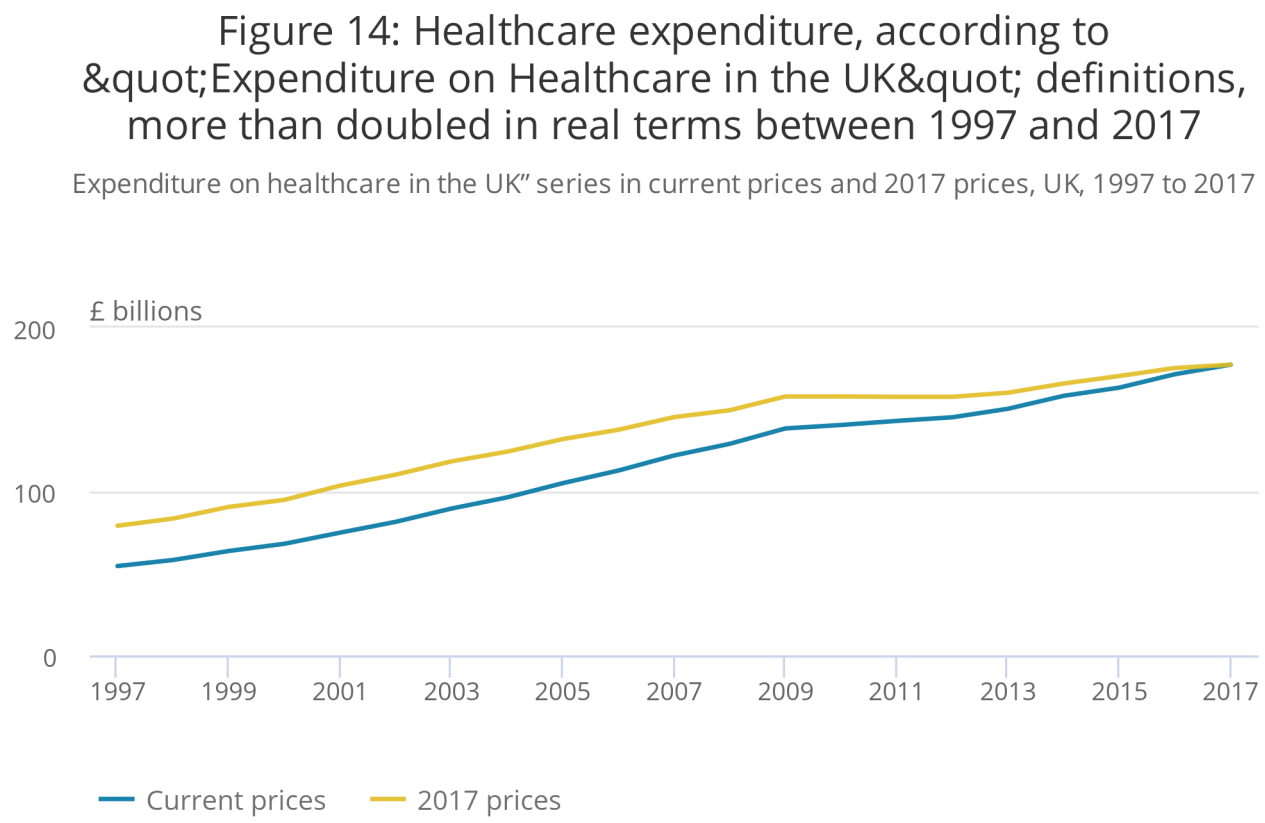
10 . Annex 1: Data from the series: Expenditure on healthcare in the UK (1997 to 2017)

Figure 14 shows the growth of healthcare expenditure between 1997 and 2017. It uses a longer-running data series that Office for National Statistics (ONS) produces: Expenditure on Healthcare in the UK. These figures differ from health accounts excluding, for example, long-term care, and including capital spending on healthcare. Information on how the data in Figure 14 differ from the health accounts can be found in the Introduction to health accounts article.

Between 1997 and 2017, total healthcare expenditure increased from £54.5 billion to £177.4 billion in current prices, growing by an average annual rate of 6.1%[1]. However, adjusting the series to constant 2017 prices, healthcare spending was £79.1 billion in 1997, growing at a lower average annual rate of 4.1%.

Figure 14: Healthcare expenditure, according to "Expenditure on Healthcare in the UK" definitions, more than doubled in real terms between 1997 and 2017

Expenditure on healthcare in the UK" series in current prices and 2017 prices, UK, 1997 to 2017

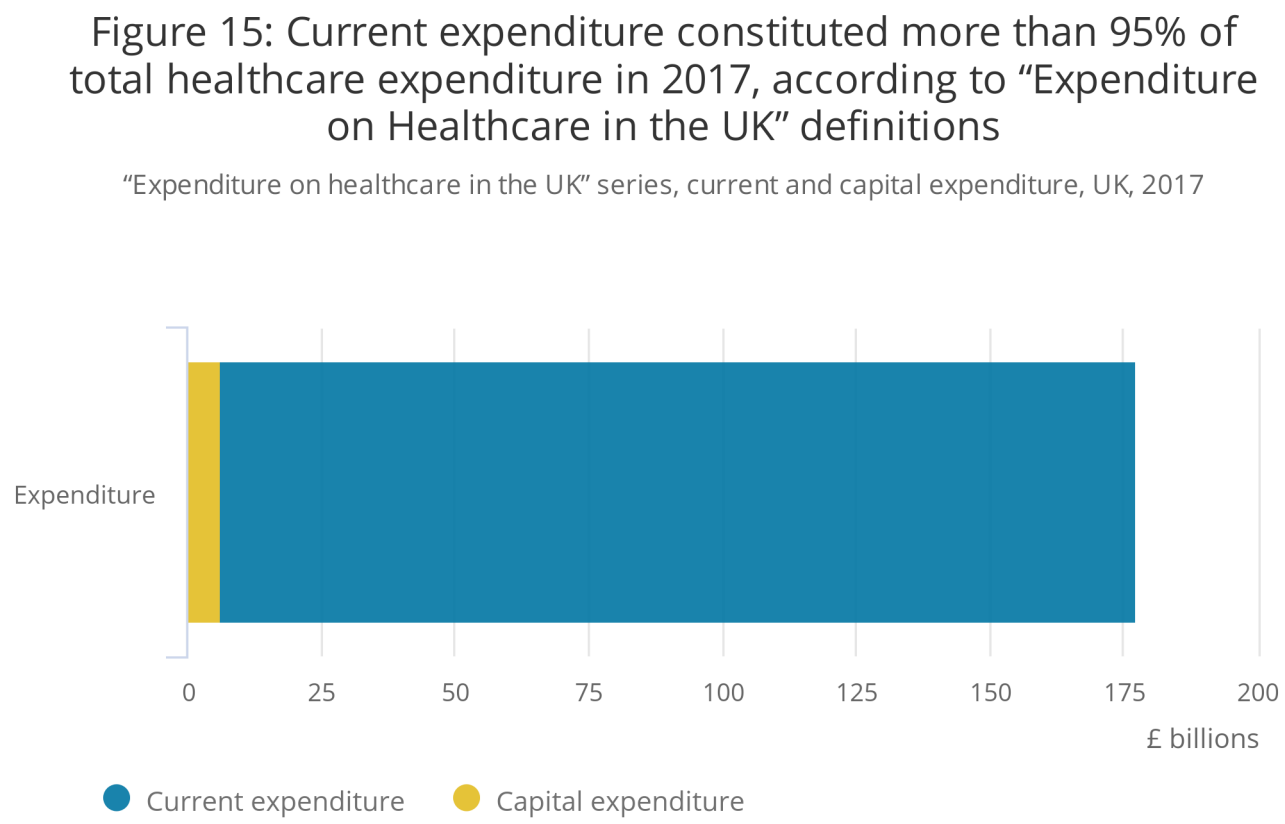


Source: Office for National Statistics - UK Health Accounts

Of total healthcare expenditure in 2017, £171.1 billion was spent on current expenditure and the remaining £6.3 billion was an estimate of capital expenditure.

Figure 15: Current expenditure constituted more than 95% of total healthcare expenditure in 2017, according to "Expenditure on Healthcare in the UK" definitions

"Expenditure on healthcare in the UK" series, current and capital expenditure, UK, 2017



Source: Office for National Statistics - UK Health Accounts

Notes:

1. Figures are based on expenditure in current prices, unadjusted for inflation.

Each year the data from the Expenditure on Healthcare in the UK series are revised, primarily for capital expenditure, due to revisions made to the national accounts. Changes to the measurement of capital stock is an ongoing development area, and these data may be revised further in future editions of this publication.

Overall, the revisions to the series published in this bulletin compared with last year's bulletin have resulted in changes to total healthcare expenditure of less than 1% for any given year. These revisions are available in the datasets accompanying this release.

Reconciliation between UK Health Accounts and Expenditure on Healthcare in the UK

Table 3 presents the differences between healthcare expenditure from the UK Health Accounts series and Expenditure on Healthcare in the UK for 2017.

Table 3: The treatment of spending on long-term care represents the largest difference between the UK Health Accounts and "Expenditure on healthcare in the UK" definitions of healthcare
Reconciliation between UK Health Accounts and "Expenditure on healthcare in the UK", UK, 2016 and 2017

	2016		2017	
	£ billions	% of GDP	£ billions	% of GDP
Expenditure on healthcare in the UK[1]	171.6	8.7%	177.4	8.7%
Capital expenditure[2]	-6.0	-0.3%	-6.3	-0.3%
Changes to government expenditure				
Addition of healthcare services provided by government bodies other than health departments[3]	0.4	0.0%	0.4	0.0%
Addition of health-related social care	13.4	0.7%	13.6	0.7%
Addition of Carer's Allowance	2.8	0.1%	2.9	0.1%
Addition of compensation recovery scheme income from private revenues	0.2	0.0%	0.2	0.0%
Other changes to government expenditure	-0.6	0.0%	-0.2	0.0%
Changes to out-of-pocket expenditure				
Transfer of health insurance claims from out-of-pocket expenditure to insurance expenditure	-2.8	-0.1%	-2.8	-0.1%
Addition of long-term care (health)	10.9	0.6%	11.4	0.6%
Other change to out-of-pocket expenditure	-0.6	0.0%	-1.9	-0.1%
Changes to voluntary health insurance expenditure				
Transfer of health insurance claims from out-of-pocket expenditure to insurance expenditure	2.8	0.1%	2.8	0.1%
Other changes to insurance expenditure	0.5	0.0%	1.3	0.1%
Changes to other financing schemes				
Changes to expenditure by NPISH	-2.6	-0.1%	-2.6	-0.1%
Addition of Enterprise financing[1]	1.0	0.0%	1.1	0.1%
UK Health Accounts	191.0	9.7%	197.3	9.6%

Source: Office for National Statistics - UK Health Accounts

Notes

1. The pre-existing healthcare expenditure series published by ONS. Back to table

2. Capital spending is not included in the health accounts, which is a measure of current healthcare expenditure Back to table

3. Net addition of providers of preventive care and services provided by government bodies whose purpose is not primarily to provide healthcare (e.g. Health and Safety Executive, police healthcare spending, etc). Back to table

4. Health-related elements of social care spending are included in health accounts but not part of the 'Expenditure on Healthcare in the UK series'. Back to table

5. State welfare payments to carers looking after someone with significant personal care needs are included in long-term care in the SHA 2011 definitions, but not in 'Expenditure on Healthcare in the UK'. Back to table

6. Includes revisions to the measurement of education and training, and research and development expenditure deducted from health accounts. Back to table

7. Includes data source changes. Back to table

8. Includes the addition of employer self-insurance schemes (where the employer assumes the risks associated with cover), dental capitation plans, the healthcare element of travel insurance and Insurance Premium Tax on eligible products, and the removal of accident insurance. Back to table

9. Whereas the third sector in the 'Expenditure on Healthcare in the UK' series included all charity healthcare spending, health accounts include only spending funded through NPISH sources- voluntary donations, grants and investment income, excluding charity expenditure funded through client contributions and purchases of care. Back to table

10. Enterprise financing schemes were not part of 'Expenditure on Healthcare in the UK. Back to table

The main item excluded from health accounts but included within Expenditure on healthcare in the UK is capital expenditure. This was £6.3 billion in 2017. While the health accounts capture the consumption of fixed capital, a concept similar to depreciation, the Expenditure on healthcare in the UK series also includes a measure of capital formation.

The main items included within health accounts but excluded from Expenditure on healthcare in the UK relate to health-related long-term care. This includes local authority-funded social care, spending on the carer's allowance and long-term care financed through households. In total, these items equate to an additional £27.1 billion measured as healthcare spending in the health accounts.

Other changes relate to the definitions of certain financing schemes within health accounts. Under the System of Health Accounts 2011, non-profit institutions serving households (NPISH) only covers expenditure funded through donations, grants and investment income and not expenditure financed by sales and charges. As a result of this, the health accounts NPISH expenditure is £2.6 billion less than the Expenditure on Healthcare in the UK figure. Enterprise financing schemes do not form part of the Expenditure on Healthcare in the UK series.

While both the health accounts and Expenditure on Healthcare in the UK reconcile closely to national accounts definitions of final consumption expenditure on health and HM Treasury's PESA statistics on health expenditure, there are slight variations in how spending is allocated. For calendar year 2017 and financial year ending 2018, interest payable to private sector organisations as part of NHS Private Finance Initiative schemes has been separately identified and is reported with other government debt payments instead of being under healthcare expenditure in the UK National Accounts and PESA respectively. This means that growth in healthcare spending over the most recent period will differ slightly between the UK Health Accounts and the UK National Accounts.

Notes for: Annex 1: Data from the series: Expenditure on healthcare in the UK (1997 to 2017)

1. Averages in the “Expenditure on Healthcare in the UK” section are calculated as compound averages.

11 . Authors and acknowledgments

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