

The funding pressures facing the NHS from 2010/11 to 2021/22

# A decade of austerity?

*Research summary*

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Spending on the UK NHS as a share of national income has more than doubled since its introduction in 1948, rising by an average of four per cent a year in real terms. This period of rapid growth has now come to a halt, but funding pressures on the NHS continue to rise. The NHS in England is targeting efficiency savings of £15 to £20 billion by 2014/15 to meet this challenge, and it is likely that austerity will be required beyond this period. But where are the pressures likely to come from and how can the shortfall in funding be met? A new Nuffield Trust research report, summarised in this paper, attempts to address these questions by quantifying the pressures facing the NHS in England over the decade to 2021/22. It forms part of a wider Nuffield Trust programme that is exploring the potential funding gap facing the NHS in England over the next decade and how it could be met.

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## Key Points

- After 2014/15, to avoid cuts to the service or a fall in the quality of care patients receive, the NHS in England must either achieve unprecedented sustained increases in productivity, or funding will need to increase in real terms.
- Cost pressures on the NHS are projected to grow at around four per cent a year up to 2021/22. These arise from growing demand for health care – to meet the needs of a population which is ageing, growing in size, and experiencing more chronic disease. They also result from increases in the cost of providing health care – of which the largest item is workforce pay.
- If NHS funding is held flat in real terms beyond this spending review period, the NHS in England could experience a funding gap worth between £44 and £54 billion in 2021/22, unless offsetting productivity gains can be delivered.
- The NHS is committed to improving productivity (the ‘QIPP challenge’ (Quality, Innovation, Productivity and Prevention)) by around four per cent a year to 2014/15. If this is achieved, the funding gap of £44 to £54 billion would be reduced to a potential shortfall of £28 to £34 billion by 2021/22. This would require continued efficiency savings of around four per cent a year if funding is kept flat in real terms (as it is now) beyond 2014/15.
- If NHS funding increased in line with the historic average (four per cent a year) after 2014/15, this would be sufficient to meet the projected demands on the service. However, the outlook for public finances makes this highly unlikely, as such a settlement for the NHS would have significant implications for other public services and welfare spending, or would require major increases in taxation.
- If spending grew more modestly, in line with the forecast growth in Gross Domestic Product (GDP) (2.4 per cent a year), the NHS would need to make efficiency savings of around two per cent a year if the current QIPP challenge is achieved. This represents a profound challenge for the NHS.

- Managing demand, particularly among people with long-term chronic conditions, will be critical – pressure on costs from this group is at least equal to, if not more than, that from the expanding and ageing population.
- Pay restraint is likely to contribute around 40 per cent of the required QIPP savings by 2014/15. The scale of the productivity challenge facing the NHS after 2015 is increased by the very different outlook for pay across the NHS workforce. If NHS earnings start to increase in line with the historic increase of two per cent a year above inflation, greater savings will need to be made in other areas.
- Our projections are based on analysis of recent trends in the use and cost of health care, but the past is not always a reliable guide to the future. Therefore, more can and should be done to understand the impact of a wide range of policy changes and service redesign initiatives on productivity. There should be more transparent analysis of research evidence and assumptions in future. Such analysis can only help to put the NHS on a more sustainable footing over the next decade.

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## About this work programme

The Nuffield Trust is examining how the NHS and social care system in England can meet the key challenge of improving patient care within a severely constrained budget. The programme brings together research and evidence on the efficiency and effectiveness of health and social care to answer these key questions:

- What is the scale of the financial challenge facing the NHS and social care system over the next ten years?
- Can the NHS in England meet the challenge by delivering more efficient and effective health and social care?

The programme is empirically based and consists of two phases:

- Phase 1 (2011 to 2012): Assessing the scale of the financial challenge
- Phase 2 (2013 to 2014): Rising to the challenge: the scope for productivity gains.



## Introduction

Spending on the UK NHS as a share of national income has more than doubled since its introduction in 1948. During this time NHS spending has risen by an average of four per cent a year in real terms, outpacing economic growth. Funding growth has been most rapid over recent years, with the period between 1996/97 and 2009/10 seeing average annual funding increases of over six per cent (Crawford and Emmerson, 2012). The government spent almost £450 billion on all public services in 2010/11, over a quarter of which (27 per cent) was spent on the English health system. With planned reductions in public spending of £81 billion, in real terms, between 2011/12 and 2014/15 (HM Treasury, 2010), the period of rapid funding growth for the NHS has come to a halt. NHS funding in England is set to increase by an average of 0.1 per cent a year in real terms over the four-year period 2011/12 to 2014/15. This is relatively generous, as other public services are having their funding reduced by an average of 2.9 per cent a year in real terms (Crawford and Emmerson, 2012), but is nonetheless unprecedented in the history of the NHS.

Against such a challenging economic and fiscal outlook, resuming the historical growth rate in NHS funding within the next decade therefore looks unrealistic. However, funding pressures on the NHS continue to rise due to a growing and ageing population, increasing prevalence of chronic conditions and the rising costs of providing health care. The NHS in England is aiming to achieve efficiency savings of £15 to £20 billion by 2014/15 to meet these rising pressures, but it is likely that austerity will extend beyond this period.

But where are the main pressures on funding likely to come from and what is the scale of the financial challenge facing the NHS up to, and beyond, the current spending review period?

This research attempts to answer these questions by quantifying the funding pressures facing the NHS in England over the decade to 2021/22. It is based on new modelling by researchers at the Nuffield Trust. It draws on research that the Nuffield Trust commissioned from the Institute for Fiscal Studies (IFS) (Crawford and Emmerson, 2012) to examine the amount of funding which might be available to the NHS in England beyond 2014/15. This also follows research undertaken by the IFS for The King's Fund (Appleby and others, 2009).

In the report that this paper summarises: *A Decade of Austerity? The funding pressures facing the NHS in England 2011/12 to 2021/22* (Roberts and others, 2012), Nuffield Trust researchers explore the funding pressures in two distinct periods. Firstly, the pressures faced during the current spending review period (2010/11 to 2014/15) and, secondly, for the period 2015/16 to 2021/22. As discussed above, NHS funding until March 2015 has already been set by the government. We examine the contribution of different approaches within the QIPP programme to bridge the funding gap.

The funding outlook beyond 2015 is not fixed and will be determined by subsequent spending reviews. As a result, we estimate the size of the potential funding gap between 2015/16 and 2021/22 under three funding scenarios that the government might consider:

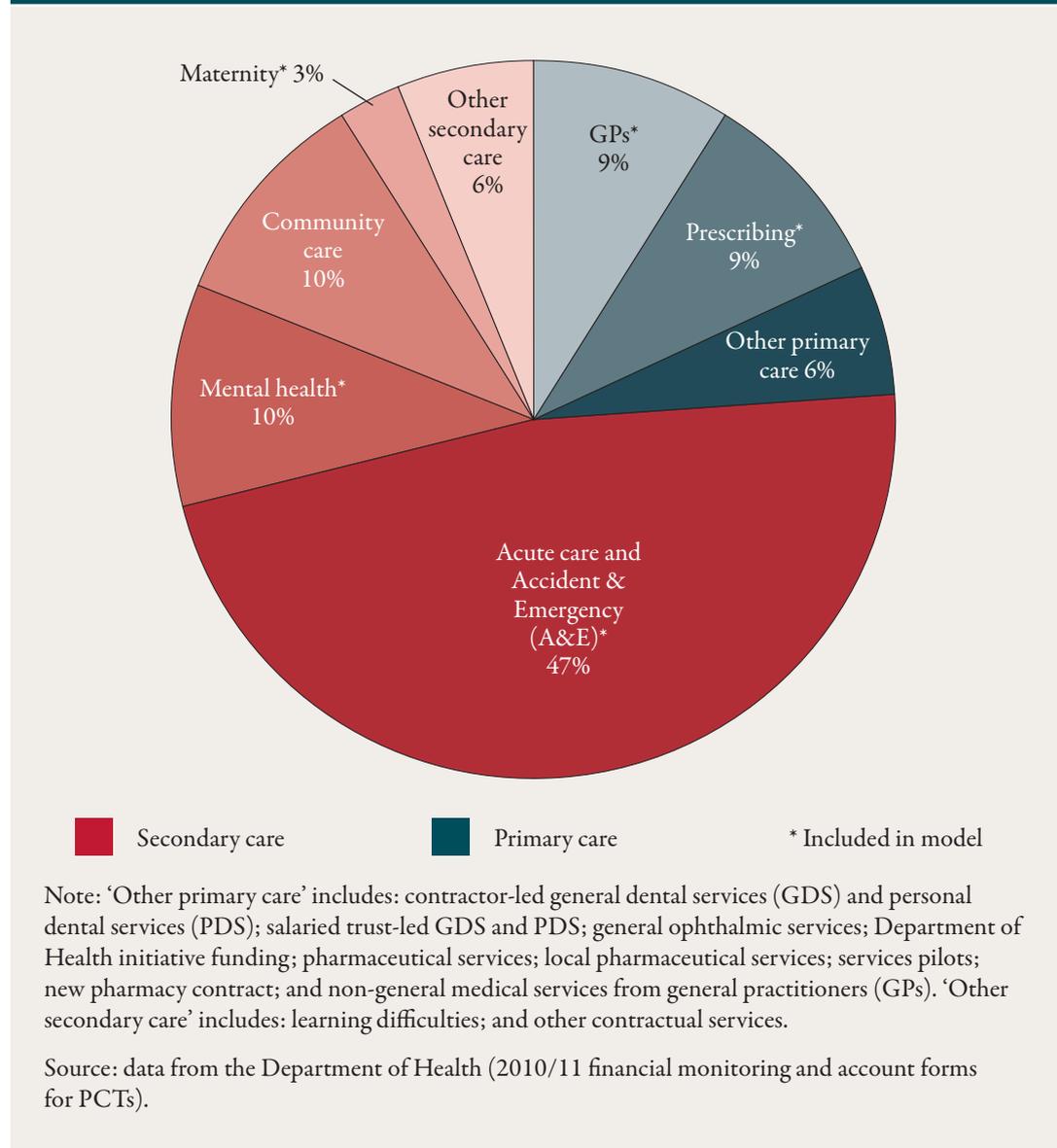
- a continued real-terms freeze in NHS funding
- growth in line with the economy
- a return to the historical rate of increase of four per cent a year.

The research is focused on the NHS in England, not the total UK NHS budget (the English NHS accounted for over 80 per cent of this figure in 2010/11). Within this, the analysis focuses on the portion of the total NHS budget in England that is spent by primary care trusts (PCTs) on commissioning services for the population of England, which amounted to £87 billion in 2010/11. The total budget for the English NHS in 2010/11 (what is referred to as the Resource Departmental Expenditure Limit (DEL) for health) was £107 billion (HM Treasury, 2012). Therefore, the analysis focuses on around 80 per cent of public health expenditure in England in 2010/11.

Finally, this research also examines funding pressures on social care services. To inform this analysis, the Nuffield Trust commissioned a new research report from the London School of Economics (Wittenberg and others, 2012).

These reports form part of a Nuffield Trust research programme exploring the potential funding gap facing the NHS and social care system in England over the next decade and how this challenge can be met.

**Figure 1: Breakdown of spending on NHS services in 2010/11**



## Key findings

This research sets out to quantify the funding pressures facing the NHS in England over the next decade, and estimates the impact of three key factors in reducing this pressure: pay restraint; improving care for people with long-term chronic conditions; and increasing acute sector productivity. The key findings are outlined below.

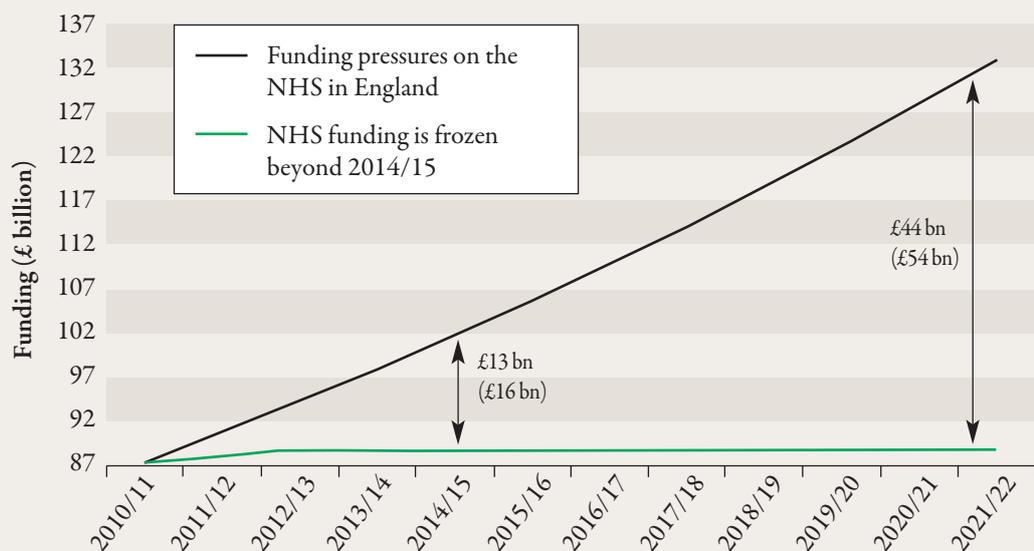
### The overall scale of the potential funding gap facing the NHS

If future governments decide to extend the real-terms funding freeze of this spending review period to 2021/22, as part of the programme to reduce both the cyclical and structural fiscal deficit, the NHS would need to increase productivity by four per cent a year in real terms for a decade, thus extending the QIPP challenge by a further seven years. By 2021/22 this would be equivalent to a shortfall of between £44 and £54 billion. Part of the funding gap arises from the well-known impact of population change. The population of England is expected to grow by four million people between 2010 and 2021. The population is also ageing and health care use increases in old age. Our research also examines the potential impact of recent trends in two other factors:

- rising rates of hospital utilisation for people with chronic conditions
- the rising cost of providing health care – as health care workers’ pay has previously risen by around two per cent a year in real terms.

If the recent trends in pay and use of health services to treat chronic conditions continue, these factors would put greater pressure on the NHS than population change.

**Figure 2: The funding gap by 2021/22, assuming English NHS funding rises as set out in the 2010 Spending Review to 2014/15 and is frozen in real terms after, and without the effect of QIPP savings**



Note: The funding gap for PCT-commissioned NHS services in England is displayed together with the estimate for the departmental expenditure limit, in brackets.

### The financial challenge to 2014/15

In 2009 the NHS Chief Executive Sir David Nicholson alerted the NHS to the potential scale of the funding gap, and therefore the productivity challenge facing the NHS during the current spending review period. This was estimated at between £15 and £20 billion by 2014/15. This Nuffield Trust research estimates that the potential funding gap for PCT-commissioned NHS services in England, which make up 80 per cent of the total budget for the English NHS, would be £13 billion in 2014/15. This equates to £16 billion over the whole English health revenue budget. Closing this gap will require efficiency savings of four per cent a year – the QIPP challenge.

This research suggests that around 40 per cent of the potential funding gap in 2014/15 could be met through pay restraint, in line with the pay policy in place in England. Stemming the rising trend in hospital use for people with chronic conditions could close a further quarter of the total gap. An additional quarter could be realised through acute sector productivity savings. This would leave a deficit of half a billion pounds in real terms (less than half of one per cent) in 2014/15, thus effectively meeting the financial challenge posed by the NHS allocation over this period.

- **The impact of pay restraint**

A major contributor to funding pressures is staff pay. Pay for hospital and community health service staff (including doctors, nurses, support staff and managers) rose by an average of around two per cent a year in real terms over the 35 years to 2009/10.<sup>1</sup>

Pay rises continuing at this level beyond 2010/11 would have been a major contributor to the funding gap. However, the government's public sector pay policy is making a significant contribution to delivering the QIPP challenge: closing around 40 per cent of the potential funding gap by 2014/15.

With the pay policy in place for 2011/12 and 2012/13, and the assumption of a one per cent cap on pay awards for 2013/14 and 2014/15, on top of incremental progression, the potential funding gap in 2014/15 would be reduced by £5 billion in real terms (42 per cent of the total gap). The remaining funding gap equates to a QIPP challenge of around two per cent a year.

- **Management of long-term chronic conditions**

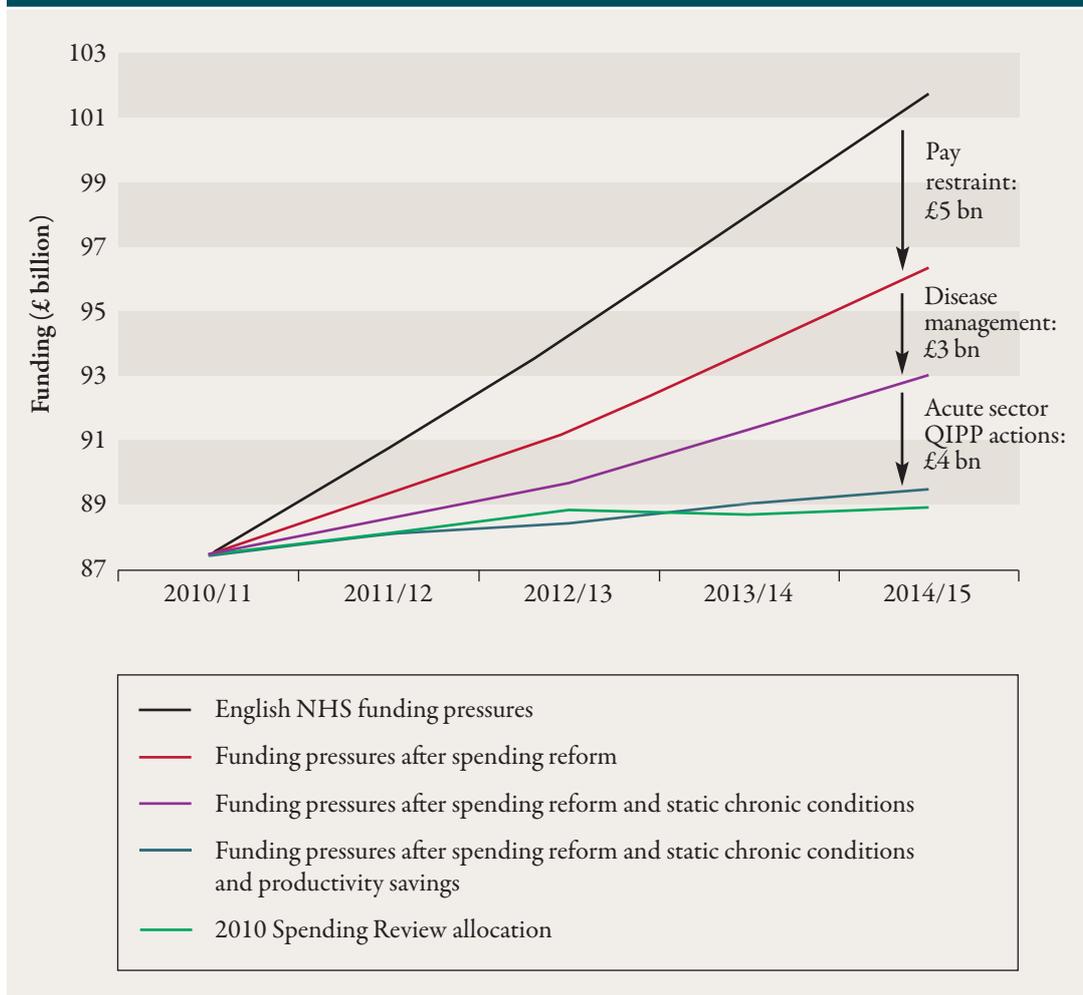
Growth and ageing of the population, alongside rising trends in hospital admissions for patients with chronic conditions, are creating pressure on NHS services in England. The combined effect of a rising number of people with chronic conditions being admitted to hospital, plus the growth and ageing of the population, will increase total pressure on hospitals and other acute services in England by three per cent a year in real terms. While the growing and ageing population is often cited as driving the rise in demand for health care, the increase in age- and sex-specific hospital activity for chronic conditions presents an equal or greater pressure.

It is therefore critical for the NHS to improve the care of people with long-term conditions to reduce the reliance on hospital-based care. If the age- and sex-specific likelihood of receiving inpatient care for chronic conditions remains at the level observed in 2009/10, rather than rising with recent trends, the estimated funding gap in 2014/15 will be reduced by a further £3 billion, leaving a remaining gap of £4 billion.

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1. Authors' calculations, based on Department of Health, 2011.

**Figure 3: Additive reduction in the funding gap per year between 2010/11 and 2014/15, due to pay restraint in the NHS, reduction in hospital activity through management of chronic conditions, and acute sector productivity savings**



- **Increasing acute sector productivity**

After implementing pay restraint and significant changes to the management of chronic conditions, a funding gap of £4 billion in real terms remains in 2014/15; closing this would require additional savings of one per cent a year. Increases in NHS productivity are needed if this challenge is to be met. These productivity gains are intended to be achieved through delivery of local QIPP plans to improve performance and increase the quality and productivity of services.

We have explored the potential savings achievable from reducing the variation in acute sector productivity using the national Better Care, Better Value (BCBV) indicators (NHS Institute, 2012).<sup>1</sup> Reductions in hospital activity are a key focus of local plans as the acute sector accounts for almost half of the spending on NHS

1. The data provided by BCBV indicators use specific subsets of data in their calculations. We adapted these to create our own estimates based on whole hospital episode statistics activity. We accept full responsibility for these calculations, and any mistakes are our own.

services. The research examined the scope for savings from those BCBV indicators that reflect the major cost areas in the acute sector, and estimated the potential savings that would result if all hospitals in England converged at the performance of the top 50 per cent (or at the level of the top 25 per cent for length of stay). If this were to happen, further savings of almost £4 billion in real terms could be achieved in 2014/15.

### The financial challenge between 2015/16 and 2021/22

After examining how the gap in NHS funding in 2014/15 could be met, this research focuses on the potential funding gap to 2021/22, assuming that the NHS meets the QIPP challenge, and that the potential funding gap has been closed (to within half a billion pounds) by end of the 2014/15 financial year.

The funding allocation for the NHS in England thereafter is uncertain. Economic forecasts, including those from the Office for Budget Responsibility (OBR), anticipate that there will be an outstanding structural budget deficit after additional planned cuts of around 1.9 per cent of GDP (Office for Budget Responsibility, 2012). This research projects that funding pressures on the English NHS will continue to rise at a rate of four per cent a year between 2015/16 and 2021/22. If the NHS achieves the QIPP savings in this spending review period, we estimate that the additional funding pressures on the NHS will amount to a further £28 billion in 2021/22 for PCT-commissioned health services. This would be equivalent to £34 billion across the total English health resource budget. This estimate is based on further pressures on the NHS resulting from population changes after 2015, rising demand on acute services from chronic disease, and the re-emergence of pay pressures after the end of the current pay policy.

We have compared our estimate of funding pressure with three potential government funding scenarios for the NHS in England. These scenarios were previously developed by the IFS as part of this Nuffield Trust research programme (Crawford and Emmerson, 2012).<sup>1</sup> Alongside assumptions for population growth and health care activity (fully detailed in the main report) we assume that pre-2010/11 trends in inflation of pay (of around two per cent per year in real terms), prices and activity resume following the savings of the period 2010/11 to 2014/15.

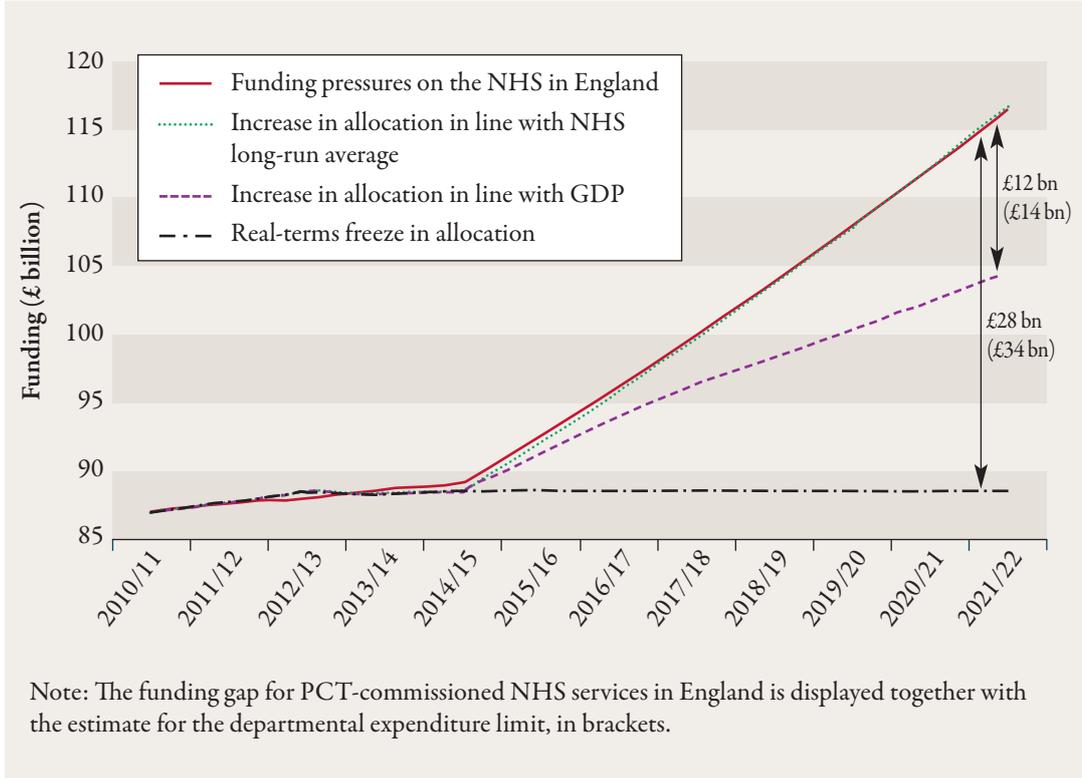
- **Scenario 1: Spending is frozen in real terms**  
If austerity continues at the current level, and spending on the NHS remains broadly flat in real terms, the funding gap in England will equate to the rise in funding pressures of around £28 to £34 billion in 2021/22.
- **Scenario 2: Spending grows in line with national income**  
If the government increases funding for the NHS in England in line with economic growth (GDP),<sup>2</sup> the funding gap would be around £12 to £14 billion in 2021/22. This would require savings of around two per cent a year.
- **Scenario 3: Spending grows in line with historic average**  
If funding for the NHS in England grows in line with the historic average for the NHS of four per cent a year, funding would match our estimate of pressure, leaving no

1. The figures we use here are lower than those used by the IFS (Crawford and Emmerson, 2012) as we take only the portion of the health budget that is spent on PCT-commissioned services, which account for around £8 in every £10 spent on the NHS in England.

2. Based on OBR forecasts for economic growth used by the IFS.

shortfall in funding. However, this is highly unlikely to be a realistic scenario, with further cuts to total public spending already announced for the period to 2016/17. This scenario would also preclude other public services, which have already experienced cuts in their funding, from receiving any funding increases in real terms without additional taxation or government borrowing.

**Figure 4: Funding pressure in relation to three possible funding scenarios for the NHS in England**



### What is the outlook for social care up to 2021/22?

For social care, the challenge is potentially even greater, particularly given recent cuts in funding. Similarly to health care, social care services in England are also experiencing rising pressure from the ageing population and increases in the prevalence of chronic conditions. There have been real-terms cuts to social care funding, with a recent survey of directors of adult social services indicating that almost £1 billion had been cut from budgets in 2012/13 (equivalent to 6.8 per cent), following a 7.7 per cent cut in the previous year (Smulian, 2012). This has resulted in services being restricted and a rising level of unmet need for care (Age UK, 2011). Shortfalls in social care funding are impacting on NHS services through: increased demand for NHS community services; increased emergency and unplanned care admissions to hospital; and delayed transfers of care (Blunt and others, 2012; NHS Confederation, 2012).

The next decade could see funding pressures rise between three and four per cent a year in real terms. According to Nuffield Trust calculations building on findings from the Personal Social Services Research Unit (PSSRU), there would be a funding gap of between £7 and £9 billion by 2021/22 if funding were held constant in real terms. These funding pressures would rise to between five and six per cent a year if the

recommendations of the Commission on Funding of Care and Support were implemented, resulting in a total funding gap of £10 to £12 billion by 2021/22.

Both increased funding of social care, and greater integration of health and social care services, are needed to ensure an efficient and sustainable system (NHS Confederation, 2012). Reducing unmet need for social care may contribute to reduced demand on the NHS, and better integration of services should help to maximise efficiency and productivity savings, although further evaluation of these inter-relationships is needed.

### Closing the NHS funding gap: 2015/16 to 2021/22

Given that funding is more likely either to be flat in real terms or, at best, perhaps rising in line with GDP, the NHS is facing further austerity measures beyond the end of the current spending review period. Our research assesses the prospects for closing the potential funding gap through productivity savings, managing chronic conditions and holding down pay:

- **Translating productivity gains into cash savings**

This research assumes that the NHS would find it difficult to rapidly turn productivity gains from the QIPP programme fully into ‘cashable’ efficiency savings. This is because hospitals have substantial fixed and semi-fixed costs. The research assumed that around one-third of the semi-fixed (staff) costs associated with the productivity gains achieved between 2010/11 and 2014/15 could be translated into cash savings during this period. If the remaining two thirds of these semi-fixed costs can be released by 2021/22, further savings of around £6 billion could be made reducing the financial challenge (by 2021/22) to £22 billion under scenario one (spending freeze in real terms) and to £6 billion under scenario two (spending increases in line with national income).

- **Managing pressure from chronic conditions**

If acute sector activity for chronic conditions is managed and the probability of receiving inpatient care for these conditions remains at the level observed in 2009/10, the funding pressures would be reduced by a further £6 billion by 2021/22. If health spending increases in line with national income, this combined with realising the cash savings from productivity gains, could be sufficient to close the potential funding gap. Taken together, however, releasing savings and managing demand related to chronic conditions will still not be sufficient to close the funding gap if funding is frozen in real terms after 2014/15. A gap of between £16 and £19 billion would remain in 2021/22, and further efficiency savings of two per cent a year would be required to meet this challenge.

- **Further pay restraint**

Our research assumes that pay in the NHS will return to its historical average growth of two per cent above inflation after 2014/15. This is in line with OBR projections for whole-economy earnings growth after this time. It would mean that NHS workers would have seen a reduction in their real pay during the current spending review period. However, if the salaries of health care professionals were to only grow in line with inflation – meaning no pay growth in real terms between 2014/15 and 2021/22 – the pressures on NHS funding would be reduced by a further £8 billion by 2021/22. This would put a sizeable dent in the funding shortfall but could risk loss of staff and low morale as it would follow four years of low pay awards. Our research has not modelled the impact on recruitment and retention of a sustained real-terms squeeze in health service pay.

- **Further productivity gains**

If pay is frozen in real terms beyond 2014/15, the NHS would still need to find additional productivity gains to close the funding gap if health spending is frozen in real terms through to 2021/22. This would require further productivity gains of around one per cent a year. It may be difficult to achieve further increases in hospital productivity following the savings already made in the period up to 2014/15, although reconfiguration of services may bring further savings. Additional savings may be possible in other health services. For example, this research assumes that the number of GP consultations per person rises each year, but if this was held at the 2010/11 rate the funding gap could be reduced by an additional £3 billion. However, it is likely that increases in primary and community care activity would be required to support the reductions in hospital activity, through increased management of conditions out of hospital where appropriate. A reduction of this magnitude may prove detrimental under these circumstances.

If productivity does not improve, pressures on health care will grow at rates that are not fiscally sustainable under current tax policy. If NHS productivity could grow by at least one per cent a year, the impact on the share of GDP and tax would be considerable.

### Can the challenge be met?

If funding rises in line with economic growth from 2015/16, the financial challenge in 2021/22 could be met through a combination of fully translating productivity gains into cash savings over this period, and preventing the probability of inpatient care for chronic conditions from rising above the 2010/11 level.

However, if funding is frozen in real terms until 2021/22, the financial challenge facing NHS services in England will be to make a further £16 billion in efficiency savings – equivalent to two per cent a year – on top of the previous efficiency savings and the continued management of activity for chronic conditions. Delivering something on this scale would go beyond anything the NHS has ever had to achieve before.

These projections are based on analysis of recent trends in the use and cost of health care. But the past is not always a reliable guide to the future. In particular the last decade saw a very rapid growth in health service funding. Whilst over half of this growth went toward increasing the real pay of health care workers, the accessibility, range and quality of care improved. If patient demand and expectations moderate as funding is constrained, some of the pressures may be reduced. However, there are also factors which could work in the other direction. Over the recent past, the pressures on the prescribing budget have been relatively limited, as the rate of new drugs being launched has slowed and many drugs have reached the end of their patent life.

If the pressures on health spending do increase in line with the projections in this research, the government faces some very difficult decisions. It could devote an even greater share of public spending to the NHS. This could be managed by reducing the share of spending on other public services (education, transport, criminal justice and defence, for example); reducing spending on welfare, including payments to unemployed people, pensions and disability support; or through higher taxes.

However, the scope for this is increasingly limited. Spending on health accounted for more than a quarter of all spending on public services in 2010/11 (Institute for Fiscal Studies, 2012). This has grown substantially over the last 30 years. Modelling by the

IFS for the Nuffield Trust (Crawford and Emmerson, 2012) found that further health spending increases – such as moving back to the historic level of four per cent per year in real terms or in line with national income – would substantially limit increases to other public spending.

## Conclusion

This analysis suggests that without unprecedented, sustained increases in health service productivity, funding for the NHS in England will need to increase in real terms between 2015/16 and 2021/22 to avoid cuts to the service or a fall in the quality of care patients receive. This could be avoided if the government were to return the NHS in England to funding growth at the historic (pre-2010/11) average rate of four per cent a year in real terms. However this is highly unlikely, with further cuts to total public spending already planned until 2017.

If NHS funding remains flat in real terms, with a continuation of the real-terms freeze in funding currently experienced, the funding gap would amount to £44 to £54 billion in real terms in 2021/22. The NHS is striving to achieve savings of four per cent a year required under the QIPP programme between 2010/11 and 2014/15. If this challenge is met, then the shortfall would reduce to £28 to £34 billion by 2021/22. This would require continued savings beyond 2014/15 of around four per cent a year.

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## The NHS in England may face continued austerity measures into the early 2020s

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With no clear signs of economic recovery, it is conceivable that NHS funding may be frozen beyond March 2015. If this is the case, the NHS in England would face continued austerity measures into the early 2020s. This austerity comes at a time of rising pressures on the NHS. While it might appear that the health allocation has fared relatively well to date, increases in funding would have been required to keep pace with trends in demand for, and the costs of, health care. A decade of flat spending on health in real terms would be unprecedented in England, or indeed in other advanced Western economies. Indeed, this represents the tightest funding period for the NHS in the past 50 years (Crawford and Emmerson, 2012).

It is therefore clear that there are no easy options for health beyond the current spending review period. The pressures on the health budget from demography, rising chronic conditions and increasing input costs (principally pay) will remain. Productivity must increase and be sustained to maintain the availability and quality of services provided to local communities. Management and clinical leadership will need to focus beyond the current four-year plans, extending them for at least the decade. And particular attention should be placed on improving quality and performance, turning these improvements into cash-releasing efficiency savings. As productivity increases in health care are unlikely to match that of the whole economy, the government will need to balance the pressures on health against pressures on other public services, welfare payments (including for older people) and/or additional taxation.

All this will most likely require a major re-evaluation of how health services in England are funded, organised and provided. NHS Chief Executive Sir David Nicholson recently stated that fundamental changes to the functioning of care systems are needed if the NHS is to make further efficiency improvements and quality gains (Limb, 2012).

Turning to social care, while absolute increases in funding in this area are smaller, the rate of funding increase required to maintain service access and quality may be as large, if not greater. This is likely to be between three and six per cent a year, depending on trends in chronic conditions and whether recommendations by the Commission on Funding of Care and Support (Dilnot and others, 2011) are implemented.

#### Further research

This work is a beginning, and clearly there are many more factors that might help to reduce funding pressure. These could be modelled in line with emerging evidence from research findings, for example the impact of: major service reconfiguration; integrated care; changing the skill mix of the workforce; more or less publicly-funded social care; and greater use of assistive technologies such as telehealth and telecare.

It is clear that there is a role for much more comprehensive, independent and transparent analysis of research evidence and assumptions in future, given the present funding squeeze. This might help identify the policies and local initiatives that might make most impact on quality and costs if rolled out nationally. This can only help to put the NHS on a more sustainable footing over the next decade.

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