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National standards, local risks: the geography of local authority funded social care, 2009–10 to 2015–16

David Phillips
Polly Simpson

The Health Foundation

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

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David Phillips
Polly Simpson
Copy-edited by Rachel Lumpkin

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7 Ridgmount Street
London WC1E 7AE

Tel: +44 (0) 20-7291 4800
Fax: +44 (0) 20-7323 4780
Email: mailbox@ifs.org.uk
Website: http://www.ifs.org.uk

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Preface

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Executive Summary

A significant number of adults with mental or physical ill-health or disability require support with the routine activities of daily living – such as cooking, cleaning and dressing themselves – or to ensure their safety and welfare (and the safety and welfare of others). That is, they require some form of 'social care'.

This report considers variations in the amount different local authorities (LAs) spend on social care for such adults, and how changes in spending, since recent cuts to LA budgets began in 2009–10, differ across England.

LA-organised care and the local government finance system

LAs organise and (partially) fund a range of adult social care services for their local populations, including short- and long-term residential, community and day care, and support for carers

Use of this funding is rationed using both care-needs assessments and eligibility criteria, and a financial means-test. Since April 2014, the needs assessment process has been set nationally, and all LAs must use eligibility criteria that are at least as generous as a national minimum standard. By excluding the value of the primary residence of the care-receiver, the means-test for home-based and day care is more generous than that for residential care.

Conditional upon meeting national minimum assessment standards, and eligibility criteria, LAs decide how much of their overall revenues to allocate to adult social care services

A number of factors will affect how much different LAs allocate to social care. Most obvious are the local population's need for social care, and the costs different LAs face in providing care. However, spending will also be affected by whether the LA goes beyond the minimum national eligibility standards, the quality of care it provides and the level of co-payment fees it charges. Different LAs will make different trade-offs between social care, other services and council tax rates.

LA revenues include council tax, business rates, grants from central government and financial transfers from the NHS to LAs to support social care services via the Better Care Fund

Historically, central government grants to LAs were based, at least notionally, on an assessment of local spending needs (including for adult social care) and the amount each LA could raise via council tax. Recent years have seen moves away from this system: the annual updating of needs assessments was ended and, more generally, recent cuts to LA budgets have fallen much heavier on those relatively poorer, more needy areas that depend more on central government grants. These changes will have affected funding available for social care.

that high-spending grant-reliant councils have faced in recent years (Amin Smith et al., 2016). It helps to explain why cuts have been larger in London and metropolitan districts, and, outside these areas, larger in the north than the south of England.

It also means that those LAs ranking higher on our (imperfect) indicators of social care spending need in 2009–10 subsequently made larger cuts to adult social care spending, on average. The apparent exception to this – the proportion of the population aged over 65 in 2009–10, which on its own is correlated with smaller subsequent cuts to adult social care spending – is explained by the typical relative affluence of the LAs that have larger shares of their population over 65. The elderly are therefore clustered in areas less dependent on grants in 2009–10, which have subsequently seen smaller cuts to their overall budgets, and therefore have been able to make smaller cuts to their social services, than typically more deprived areas with relatively few older residents.

This emphasises the role that the overall budgets of LAs are likely to play in the amount available for social care in the coming years. Even additional ring-fenced money for social care may not find its way fully to social care if LAs are facing broader budget cuts, and struggling to fund other service areas such as children's social services. With moves to the full devolution of business-rate revenues to LAs (so-called '100% business rates retention'), the government will also need to think carefully about the balance between providing councils with incentives to grow their own revenues, and redistributing revenues to support spending in areas that are seeing increasing demand for services such as adult social care. Future IFS research will examine these trade-offs and will look in more detail at the interactions between social care and the health service.

Appendix A: Calculating adult social care spend

LAs are required to submit annual returns to the DCLG setting out their expenditures and incomes by service area, including for adult social care.[22] The basis for the figures used in this report is the net expenditure on adult social care as reported in these returns.

However, the period between 2009–10 and 2015–16 saw shifts in responsibilities between LAs and the NHS, and new pooling arrangements via the Better Care Fund. The net expenditure figures reported in these returns would therefore not provide a consistent measure of LA spending on social care over time. We therefore make several adjustments to obtain a more consistent measure.

- In 2009–10, we add on local expenditure associated with the 'Valuing People Now' initiative. This is spending on long-term support for those with learning disabilities, which prior to 2011–12 was the responsibility of the NHS but has shifted to LAs since that year. Our source for these data lists expenditure on this programme in 2010–11;[23] we assume that real-terms expenditures were the same in each LA area in 2009–10 as in 2010–11.

- In 2015–16, we add on an estimate of transfers from the NHS for social care via the Better Care Fund. Total Better Care Fund allocations are taken from the Supporting Information to the 2015–16 local government finance settlement.[24] The share of this total allocation going to social care is based on national-level analysis by the NHS, which implies that just over half (£1.81 billion in cash-terms) of the NHS's compulsory contributions to the Better Care Fund (£3.46 billion) supported social care activities.[25]

This approach is the same taken in NHS Digital (2016). We have tested the sensitivity of the findings of this report to these assumptions and they are robust. However, the assumptions may not hold for individual LAs. For instance, if spending on 'Valuing People Now' changed significantly between 2009–10 and 2010–11 at a local level, or if local allocations of Better Care Fund monies to social care vary significantly from the national level, then spending on social care may differ by a few percentage points from the amount calculated via this method. Unfortunately, there is no comprehensive published source of spending on the Valuing People Now monies or Better Care Fund social care monies at an LA level. It is hoped that better data on the latter will be available in NHS Digital's analysis of social care spending in 2016–17.

[22] These Local Authority Revenue Expenditure and Financing data are available at: https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing.
[23] See government response to consultation on this funding shift, available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122563.pdf.
[24] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400630/Spending_Power_2015-16_Supporting_Information_FINAL.xlsx.
[25] Available at: https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-meta-analysis-summary-feb-update.pdf. £1.81 billion is £1.84 billion in 2016–17 prices.

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Appendix B: NHS continuing healthcare

NHS continuing healthcare refers to a package of health and social care services that is organised and fully funded by the NHS, at a cost of around £3.1 billion in 2015–16.[26] For those who remain in their own home, NHS funding will fully cover the cost of support with both 'health' needs (such as services from a nurse) and social care needs (such as assistance with shopping, cooking and personal hygiene). For those in a residential care home, the NHS will pay the full costs of support with health and social care needs, and board and accommodation charges. Because, unlike LA-funded care, there are neither means-tests nor co-payments, eligibility for continuing healthcare is very valuable.

Eligibility for continuing healthcare is assessed by an individual's local NHS clinical commissioning group (CCG) using a two-stage process: an initial assessment using the so-called 'Checklist Tool', followed by a more in-depth assessment using the 'Decision Support Tool'. The aim is to target continuing healthcare funding at those with long-term, significant and complex medical and care needs, who are deemed to have a 'primary health need' for care. There is no legal definition of what constitutes a 'primary health need', but guidance issued states that 'an individual has a primary health need if, having taken account of all their needs [...], it can be said that the main aspects of majority part of the care they require is focused on addressing or preventing health needs.'[27]

Nonetheless, there is significant variation in the relative number of people in receipt of continuing care in different CCG-areas, and related major differences in the cost of continuing care per adult resident of these areas (much greater than the variation in LA-funded social care spending described in this report). Figure B.1 shows, for instance, that reported spending per adult resident varied from £0 in several authorities to as high as £180 in 2015–16, compared with an average of around £72 per resident across England as a whole. Around 10% of CCGs incurred expenditure of less than £39 per adult resident, while another 10% incurred expenditure of more than £117 per adult resident. In addition to genuine variation in needs across the country, such wide variation may reflect differences in the stringency with which different CCGs assess eligibility.

The proportion of adults eligible for continuing healthcare was broadly stable between 2013–14 and 2015–16, although The King's Fund reports that previous increases mean that the number of recipients of continuing care increased by 38% between 2009–10 and 2015–16, in stark contrast to the substantial declines in the number of people in receipt of LA-funded care (Robertson, 2016). It is not clear whether the increase in the number of people receiving continuing healthcare is linked to the decline in the number receiving LA-funded care.

Finally, it is worth noting that those deemed ineligible for continuing healthcare may still be eligible for NHS-funded nursing and medical care (at home or in a residential nursing home) – again, this support is not means-tested.

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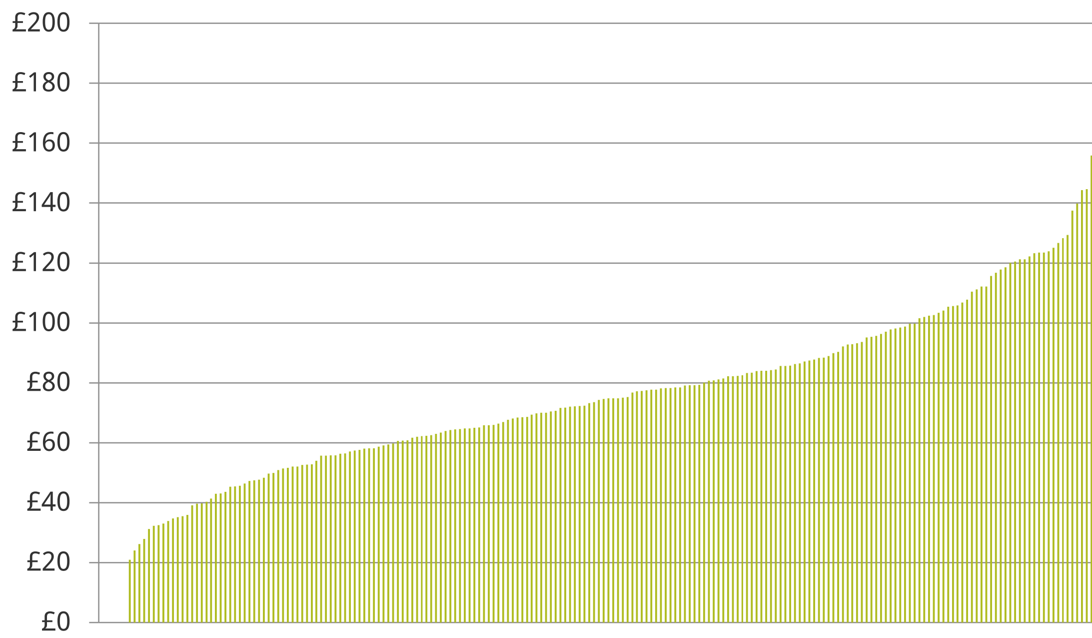
[26] In this appendix, we draw on information on the continuing healthcare programme, available on the NHS website: http://www.nhs.uk/chq/Pages/2392.aspx?CategoryID=68. Spending figures are taken from:
https://www.whatdotheyknow.com/request/continuing_healthcare_spend_and#incoming-878831.
[27] See Department of Health (2012).

Figure B.1. Spending on continuing healthcare per adult resident by CCG, 2015–16



Source: Authors' calculations using population figures and expenditure figures discussed in footnote 26.

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Appendix C: Recent changes to the local government finance system

Historically, the allocation of grants to LAs was based, at least notionally, on an assessment of local relative spending needs (including for adult social care) and the amount each LA could raise itself via council tax.[28] In particular, there were needs assessment formulae for different service areas, with each formula including variables understood to be drivers of local needs or costs for the service in question, and with the weight placed on each variable based on the historic relationship between that variable and spending on the service area in question by LAs. Each year, these needs assessments were updated.

This system was notional in the sense that layered on top of it was a system of 'damping' arrangements to guarantee minimum increases in funding or grants, and cap reductions in grants. Together with differences in funding that arise from LAs' decisions to set council tax above or below the average level for England as a whole, this 'damping' meant that the system never led to a full needs-based equalisation of funding for local services across England. However, recent years have seen big changes that have further weakened the link between each LA's relative level of spending need and their relative level of funding.

- First, the way the 'Four Block Model' of grant allocation, in use between 2007–08 and 2013–14, was used to allocate cuts to grants from 2010–11 onwards does not appear to have properly taken into account differences in the ability of different LAs to raise their own revenues via council tax.[29] This meant that between 2010–11 and 2013–14, LAs with relatively small council tax bases (and hence high dependence on grant funding) saw substantially larger cuts to their overall budgets than those with relatively large council tax bases (low dependence on grant funding).

- Second, since 2013–14, part of the grant funding LAs receive has been replaced by a locally retained portion of business rates. While there continues to be redistribution of these business-rate revenues from LAs with high revenues to low revenues, this redistribution was fixed in real terms in 2013–14 and has been increased in line with inflation since then. This provides an incentive for LAs to grow their business-rate revenues – as they gain or lose depending on whether their revenues grow by more or less than inflation. However, it also means that the allocation of this portion of funding is not updated to account for changes in relative needs or relative revenues.

- Third, the annual updating of needs assessments for remaining grant funding was also ended. In 2014–15 and 2015–16, in effect, each LA saw the same proportional cut to its grant funding, further increasing the tendency for LAs with relatively small council tax

[28] This appendix draws heavily on the analysis in Chapter 2 of Amin Smith et al. (2016).
[29] The Four Block Model was so called because it had four elements: a 'relative needs' block based on spending needs assessments for different service areas; a 'relative resources' block based on the ability of LAs to raise revenues themselves via council tax; a 'central block' allocating a fixed per-person amount to LAs that depends only on the type of LA in question; and a 'damping block' to guarantee minimum increases or maximum cuts to LAs.

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bases (and hence high dependence on grant funding) to see larger cuts to their overall budgets than other LAs.[30]

Amin et al. (2016) have shown that these various factors led to significant differences in the cuts to overall budgets faced by different LAs (see Figure 2.1 of the current report, which shows the variation by the grant dependence of an LA).

[30] This system was further reformed in 2016–17 so that grants are now set in such a way as to deliver an equal proportional change to overall spending power (not the grant itself).

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Appendix D: Adult social care unit costs

LAs provide and commission a range of adult social care services, and they are responsible for negotiating their own prices for these services. The prices they pay will reflect a combination of the local costs of inputs to these services (e.g. wages), the quality of service provision, the severity of needs of the users of services and the efficiency with which they are delivered.

Table D.1 shows for each region the implied hourly rate paid for home care services, and the weekly rate paid for residential and nursing care services for adults under and over 65. These are calculated by NHS Digital as part of their Personal Social Services: Expenditure and Unit Costs statistics. It is worth noting that they are based on a broader measure of expenditure than used in the rest of this report (including fee income and some other income from the NHS).

Table D.1. Unit costs for adult social care services by region and service type 2015–16 (2016–17 prices)

Region	Hourly rate for home care		Cost per week for residential and nursing care	
	Internal provision	External provision	Users age 18–64	Users age 65+
East	16.9	14.9	1,320	604
East Midlands	37.7	14.2	1,085	514
London	37.7	14.5	1,262	683
North East	31.6	13.0	1,000	519
North West	21.8	12.7	941	480
South East	33.6	16.3	1,242	611
South West	40.8	16.6	1,293	629
West Midlands	25.6	14.0	1,202	520
Yorkshire and The Humber	32.1	13.9	1,004	506

Note: Externally provided home care rate is the average hourly rate of all domiciliary care that is out-sourced to other providers. The internally provided home care rate is the average standard hourly rate of home care provided by the LA itself. Differences in these rates may reflect a number of factors including differences in severity of the needs of individuals receiving home care delivered by different organisations. Weekly/hourly costs are calculated as follows: total cost of an activity (including income from NHS and fees and charges) minus the portion that covers grants to voluntary organisations, divided by total activity (in weeks/hours).

Source: Authors' calculations using NHS Digital (2016) Reference Tables T14 and T16.

Appendix E: Further analysis of factors correlating with social care spending

Table E.1. Summary statistics for local needs-related characteristics

% of population in 2015–16, unless otherwise stated	Median	10th percentile	90th percentile
LA net adult social care spending per adult in 2015–16 (£, 2016–17 prices)	383.50	324.60	445.10
Population age 65 or over	22.2%	14.0%	28.4%
Claiming disability benefits	9.7%	6.8%	14.0%
Claiming carers' allowance	1.5%	1.0%	2.4%
Claimant PCGC	2.2%	1.4%	3.3%
Claiming ESA (income-related)	2.9%	1.6%	4.3%
Median gross weekly earnings (£)	420.00	374.40	547.20
Share of households renting (as of 2011 census)	32.8%	26.1%	53.4%
Share of 65+ population not in a couple (as of 2011 census)	42.2%	37.1%	53.6%
LA average IMD score (as of 2015)	23.2	12.2	33.4

Source: Authors calculations using sources listed in Chapter 3.

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Table E.2. Regression results – relationship between social care spending and local area characteristics in 2015–16

	LA net adult social care spending per adult		
	(1)	(2)	(3)
Share of adult population age 65 plus	92.8 (0.60)	335.2 (1.79)	325.7 (1.74)
Share of adult population claiming disability benefits	447.4 (0.81)	578.2 (1.05)	480.5 (0.87)
Share of adult population claiming carers' allowance	−4794.0* (−2.23)	−2808.6 (−1.16)	−1118.5 (−0.41)
Share of adult population claiming PCGC	1359.7 (1.39)	1046.9 (0.97)	1185.0 (1.10)
Share of adult population claiming ESA	2085.2 (1.95)	2100.9 (1.67)	3063.9* (2.12)
Median gross weekly earnings		0.32*** (3.38)	0.25* (2.22)
Share of households renting		90.1 (0.83)	127.6 (1.15)
Share of 65+ population not in a couple		−104.6 (−0.44)	−53.8 (−0.22)
LA average IMD score			−3.06 (−1.34)
Constant	304.6*** (10.60)	83.8 (0.96)	106.3 (1.20)
Observations	150	150	150
R^2	0.15	0.24	0.25
Adjusted R^2	0.12	0.19	0.20

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table E.3. Regression results – relationship between proportion of adult population receiving long-term care and local area characteristics in 2015–16

	Share of adults receiving LA funded long-term care	
	(1)	(2)
Share of adult population age 65 plus	0.047** (3.06)	0.045** (3.03)
Share of adult population claiming disability benefits	−0.028 (−0.62)	−0.045 (−1.02)
Share of adult population claiming carers' allowance	0.26 (1.33)	0.55* (2.58)
Share of adult population claiming PCGC	0.070 (0.80)	0.094 (1.10)
Share of adult population claiming ESA	0.15 (1.43)	0.31** (2.74)
Median gross weekly earnings	−0.000 (−1.01)	−0.000* (−2.40)
Share of households renting	−0.022* (−2.47)	−0.015 (−1.71)
Share of 65+ population not in a couple	0.043* (2.20)	0.052** (2.69)
LA average IMD score		−0.001** (−2.95)
Constant	−0.007 (−0.96)	−0.003 (−0.42)
Observations	150	150
R^2	0.48	0.51
Adjusted R^2	0.45	0.48

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

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Table E.4. Regression results – relationship between percentage change in adult social care spending per adult (2009–10 to 2015–16) and local area characteristics in 2009–10

	Change in adult social care spend per adult (%)			
	(1)	(2)	(3)	(4)
Share of adult population age 65 plus	1.00*** (5.10)	0.23 (1.04)	0.21 (0.51)	0.49 (1.08)
LA adult social care spend per adult		−0.001*** (−6.04)	−0.001*** (−6.36)	−0.001*** (−6.27)
Share of LA revenues from grants		−0.15 (−1.76)	−0.27 (−1.94)	−0.34* (−2.11)
Share of adult population claiming disability benefits			0.33 (0.39)	0.82 (0.94)
Share of adult population claiming carers' allowance			−5.37 (−1.00)	1.31 (0.19)
Share of adult population claiming PCGC			1.63 (0.78)	1.23 (0.51)
Share of adult population claiming ESA			12.8 (1.09)	22.6 (1.66)
Median gross weekly earnings				0.00029 (1.61)
Share of households renting				0.33 (1.46)
Share of 65+ population not in a couple				−0.19 (−0.37)
LA average IMD score				−0.0041 (−1.04)
Constant	−0.30*** (−7.72)	0.29** (3.28)	0.35** (3.10)	0.17 (0.97)
Observations	150	150	150	146
R^2	0.15	0.40	0.42	0.45
Adjusted R^2	0.14	0.39	0.39	0.41

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

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Table E.5. Regression results – relationship between percentage change in adult social care spending per adult and percentage point change in local area characteristics (2009–10 to 2015–16)

	Percentage change in adult social care spend per adult	
	(1)	(2)
Δ share of adult population age 65 plus	2.27** (3.04)	0.97 (1.23)
Δ share of adult population claiming disability benefits	−1.12 (−0.45)	2.21 (0.96)
Δ share of adult population claiming carers' allowance	−3.67 (−0.49)	−13.6 (−1.97)
Δ share of adult population claiming PCGC	19.3*** (3.77)	10.6* (2.18)
Δ share of adult population claiming ESA	0.43 (0.24)	4.89** (2.71)
LA adult social care spend per adult in 2009		−0.001*** (−5.86)
Share of LA revenues from grants in 2009		−0.16 (−1.55)
Constant	−0.084* (−2.58)	0.31*** (3.99)
Observations	150	150
R^2	0.31	0.45
Adjusted R^2	0.28	0.43

Note: *t* statistics in parentheses. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

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