Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

# Annual National Report 2012

# Pensions, Health Care and Long-term Care

# United Kingdom

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On behalf of the
**European Commission**
**DG Employment, Social Affairs and Inclusion**

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# 1 Executive Summary

The public deficit of the United Kingdom maintains to be one of the highest within the European Union. The Conservative-Liberal coalition government is committed to continue its austerity programme, as outlined in 2010.

Public pension provision continues to be largely unaffected by the austerity programme, aside from the reforms in the occupational pension programmes for public sector employees that are currently implemented and have caused conflict with public sector unions leading to a national strike. In order to 'raise' revenue the government has significantly reduced the tax relief for private and occupational pensions, affecting high income tax payers.

Within the health care sector the government continues to push for its structural reform of the governance and commissioning system within the NHS against the opposition of a large proportion of stakeholders. At the same time the NHS is required to deliver significant efficiency savings to reduce the cost of health care. Whether the government will be successful with its efficiency drive and structural reform seems far from certain.

Despite the Dilnot Report (Dilnot Commission 2011) with its very critical findings and recommendations for the long overdue reform of the long-term care system in England, the government has delayed the publishing of a White Paper outlining its policy proposals.

Within the health and social care sectors serious limitations in the quality of care provided and the regulatory framework became apparent during the past year.

# 2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

## 2.1 Overarching developments

The public deficit of the United Kingdom maintains to be one of the highest within the European Union. The Conservative-Liberal coalition government is committed to its austerity programme, as outlined in 2010. Nevertheless, economic growth continues to be more or less flat and below expectations; labour market developments have been less than encouraging. The opposition Labour Party continues to argue that the policy approach taken by the government "isn't working", albeit without offering a clear alternative policy strategy.

Public pension provision continues to be largely unaffected by the austerity programme, aside from the reforms in the occupational pension programmes for public employees that are currently implemented and have caused conflict with public sector unions leading to a national strike. In order to 'raise' revenue the government has significantly reduced the tax relief for private and occupational pensions, affecting high income tax payers. Within the health care sector the government continues to push for its structural reform of the governance and commissioning system within the NHS against the opposition of a large proportion of stakeholders. At the same time the NHS is required to deliver significant efficiency savings to reduce the cost of health care. Whether the government will be successful with its efficiency drive and structural reform seems far from certain. Despite the Dilnot Report with its very critical findings and recommendations for the long overdue reform of the long-term care system in England, the government has delayed the publishing of a White Paper outlining its policy proposals. Within the health and social care sectors serious limitations in the quality of

care provided and the regulatory framework became apparent during the past year. Without major structural reforms of the NHS and the reform of the long-term care system in England, it is very likely that the quality of care will deteriorate due to constraint budgets.

## 2.2 Pensions

### 2.2.1 The system's characteristics and reforms

The UK has a very distinctive pension mix, combining "one of the least generous state systems in the developed world" with one of the "most developed" voluntary arrangements (Pension Commission 2004: X). The pension system is based on three 'pillars': an unfunded Basic State Pension, an additional State Pension and voluntary funded occupational and personal pension schemes. Pensioners with 30 qualifying years are entitled to a flat Basic State Pension of £102.15 per week. An additional State Pension is provided by the government for pensioners who have built up entitlements through employment (minimum annual earnings of £5,304) or qualifying periods of care (SERPS and the State Second Pension). In order to mitigate poverty in old age various means-tested programmes were introduced by the previous government. The Basic State Pension for pensioners on low income can be topped up through the receipt of the guarantee credit to a weakly income of £137.35 for a single pensioner and £209.70 for a coupled pensioner household. Nevertheless, a core element for an adequate income, sufficient to maintain the living standard after retirement, is the receipt of an occupational or personal pension. While in the past the majority of these pension schemes have been defined-benefit schemes, there has been a clear trend towards defined-contribution systems in the private sector (for an overview of the pension system in the UK see Blake 2003 and Pension Commission 2004).

An increasing percentage of pensioners are dependent on means-tested pension supplements and the percentage of the workforce in the private sector covered by an occupational pension is declining (cf. Seeleib-Kaiser et al. 2012). Hence, the UK for the last couple of years has been undergoing a process of reforming the state and occupational pension systems, with the aim of increasing adequacy as well as sustainability: a) access to the Basic State Pension has been improved and further reform seems to be likely to be enacted over the next couple of years; b) the state pension age will be increased and the default retirement age has been abolished, which should lead to a later de facto retirement age; c) starting 2012, every worker will be automatically enrolled in an occupational pension, with the option to opt out.

### 2.2.2 Debates and political discourse

The current government is committed to continue largely upon the trajectory laid down by the previous Labour government in its major pension reforms of 2007 and 2008. Although the Conservative-Liberal coalition government has changed the indexation mechanisms for all other benefits, leading to lower inflation adjustments, by switching from using the Retail Prices Index (RPI) to the Consumer Price Index (CPI), it has increased the Basic State Pension in April 2011 by using the RPI. The additional State Pension (SERPS/S2P) as well as public service pensions were increased in line with the CPI (House of Commons Library 2011), which has contributed to lower increases in pension benefits. For the future it has decided to uprate the Basic State Pension by a triple guarantee of earnings, prices (using the CPI) or 2.5%, whichever is highest.

To offset some of the costs associated with recent pension reforms and to cope with demographic change, the government will bring forward the phased increase in the state pension age from 65 to 66 to be fully implemented by 2020. The default retirement age was abolished in October 2011. Both of these measures should contribute to an increase of the de facto retirement age in the medium term.

Significant changes were made to the tax relief system for personal and occupational pensions. Effective in April 2011 the annual allowance for tax-privileged pension saving will be reduced from £255,000 to £50,000, and the lifetime allowance will be reduced from £1.8 million to £1.5 million. This measure will raise £4 billion per annum. It will be targeted at those who make the most significant pension savings. According to the government, an annual allowance of £50,000 will affect 100,000 pension savers – 80% of those will have incomes over £100,000 (HM Treasury 2010). However, it has to be highlighted that the annual allowance is still approximately twice the level of average income and thus continues to primarily benefit higher income groups. A further reduction of the tax relief is currently under discussion and will possibly be included in the Budget for 2012/13 to be announced in March (Stacey 2012).

As already mentioned the Conservative-Liberal government seems to be committed to further pension reforms. According to figures from the Department of Work and Pensions (DWP), about 45% of pensioners are eligible for Pension Credit to top up their state pension. Although the percentage is projected to fall to around a third by 2050, as more pensioners qualify for a full state pension in their own right and benefit from a more generous uprating of the Basic State Pension, the government is concerned, that it does not fall fast or far enough and that continued relatively high levels of means testing can deter people from saving. Furthermore, Pension Credit is not claimed by around a third of pensioners who are entitled to it, a proportion which has proved fairly resilient despite efforts by successive governments to encourage pensioners to take up their entitlement (DWP 2011: 21). Hence the government is currently consulting on two options, which are intended to increase pension savings as well as improve the adequacy of the public pension system: a) speeding up the transition to a flat-rate two-tiered pension; b) to combine the Basic State Pension and State Second Pension to create a single-tier state pension for future generations of pensioners set at a level above the Pension Credit standard minimum guarantee. According to the government's assessment a weekly state pension benefit of around £140 would be cost neutral and could be funded within the overall spending on state pensions. This would be achieved through the abolition of the Savings Credit, closure of the State Second Pension and the introduction of a seven year minimum qualifying rule for future pensioners (DWP 2011: 30).

Important cutbacks in the realm of pensions will most likely affect public sector workers, who are currently covered by various occupational pension schemes based on the principle of defined benefits relating to their final salary. Within the public political discourse the relatively 'generous' public sector pensions are often portrayed as 'unfair'. Hence, the government had asked the Labour peer Lord Hutton to present reform proposals. The Hutton Report was eventually published in mid-March 2011 and the main proposals included in the report were: a) a switch from final salary to career-average pensions; b) an increase in the normal pension age from 60 to 65 for many staff and c) increased employee contributions (Independent Public Service Pensions Commission 2011). The government has based its reform proposals mainly on the proposals made by the commission. After a national strike and subsequent minor concessions by the government the majority of unions have accepted the proposals; nevertheless, some organisations, such as the British Medical Association, have threatened industrial action (Groom/Neville 2012) and other unions such as the Fire Brigades Union, the

National Union of Teachers, the Public and Commercial Services Union and Unite planned to ballot their members, and warned of possible coordinated strikes on March 28 (Groom 2012).

Overall, private pension saving has been declining in the UK for years and participation in occupational pensions varies hugely by sector and earnings level. The following Table provides a brief overview of the differences between the private and public sector occupational pension coverage for the year 2010.

Table 1: Private and Public Sector Occupational Pension Coverage for the Year 2010

| | **All** | **Male** | **Female** |
|---|---|---|---|
| **Public Sector** | 84 | 87 | 82 |
| **Private Sector** | 34 | 39 | 28 |

*Source: Annual Survey of Hours and Earnings, Office for National Statistics*.

To counter the trend of declining coverage, employers will have to auto-enrol all workers as part of the 2008 pension reform starting in 2012, to be fully implemented by 2018. Alongside auto-enrolment, the Government has introduced a low cost, defined contribution, pension scheme that employers can enrol their employees into (or individuals can opt-in to) called NEST (National Employment Savings Trust).

Within the private sector many final-salary schemes have closed for new employees, and some even for current workers; the majority of those private sector employees with occupational pension coverage rely on schemes based on the principle of defined contributions. According to latest estimates nine out of 10 private sector defined benefit schemes are now closed to new entrants and four out of 10 prevent existing staff from accruing further benefit entitlements. The two latest large companies to announce major changes in their occupational pension schemes were Shell and Unilever (Lucas/Groom 2012), to be followed most recently by the Church of England (Pickard/Cohen 2012). Not only will the decline in occupational pension coverage and the change in type of occupational pension scheme (switch from DB to DC) have a detrimental impact on future pensions (cf. Mundy/Masters 2012), but companies have also significantly reduced their contributions to DC schemes, leading to further retrenchment. Finally, employer contributions differ significantly by sector similar to coverage, with the highest contributions paid in financial services (10.3% of salary) and the lowest contributions in the retail sector (5.2%) (Alcover 2012). The changeover to indexing deferred benefits to consumer price index rather than the retail price index has significantly contributed to the halving of the aggregate pension deficit among the UK's largest companies (Cohen 2011).

### 2.2.3 Impact of EU social policies on the national level

To assess the direct impact of EU social policy is very difficult, if not impossible. Overall, EU social policy initiatives are not widely discussed in the UK. The most important issue with regard to EU policy is the potential impact associated with the implementation of the *Solvency II* proposal on UK pension funds, which are already struggling to plug deficits. The UK respondents to the consultation are 'vociferous in their rejection of the Solvency II concept for pensions' (Grene 2012). New estimates suggest that UK companies would have to pump as much as £600bn into their pension schemes under the proposed regulation. Joanne Segars, NAPF chief executive, said: "The UK already has one of the best protected pensions systems in the world. Perversely, these new laws would make pensions for UK workers less generous and less secure" (cited by Davies 2012).

### 2.2.4 Impact assessment

Based on Eurostat data (see Tables 2-5) older people in the United Kingdom continue to have a relatively high risk of poverty, despite the fact that the overall proportion of elderly affected by the risk of poverty has significantly declined since 2008. The gender gap, after slightly declining in previous years, has once again significantly increased in 2010. The decline in pensioners' poverty is also reflected in national data published by the Department of Work and Pensions (DWP 2010b: 169). However, the rate of severe poverty (40% of median) for women 75+ has stayed stubbornly high and is almost twice as high as the European average.

Table 2: Percentage of Population 65 years + at Risk of Poverty Rate (cut-off point: 60% of median equivalised income after social transfers)

| GEO/TIME | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| European Union (27 countries) | 18.9 | 19.0 | 19.3 | 18.9 | 17.8 | 15.9 |
| European Union (15 countries) | 19.9 | 19.7 | 20.0 | 19.1 | 17.8 | 16.2 |
| United Kingdom | 24.8 | 26.1 | 26.5 | 27.3 | 22.3 | 21.4 |

*Source: EU-SILC*

Table 3: Percentage of Male Population 65 years + at Risk of Poverty Rate (cut-off point: 60% of median equivalised income after social transfers)

| GEO/TIME | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| European Union (27 countries) | 15.9 | 16.1 | 16.2 | 15.9 | 14.9 | 12.9 |
| European Union (15 countries) | 17.0 | 16.9 | 17.1 | 16.3 | 15.3 | 13.5 |
| United Kingdom | 21.9 | 22.4 | 23.4 | 24.4 | 20.0 | 17.6 |

*Source: EU-SILC*

Table 4: Percentage of Female Population 65 years + at Risk of Poverty Rate (cut-off point: 60% of median equivalised income after social transfers)

| GEO/TIME | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| European Union (27 countries) | 21.1 | 21.1 | 21.6 | 21.2 | 20.1 | 18.2 |
| European Union (15 countries) | 22.1 | 21.9 | 22.2 | 21.3 | 19.8 | 18.4 |
| United Kingdom | 27.1 | 29.0 | 29.0 | 29.7 | 24.1 | 24.5 |

*Source: EU-SILC*

Table 5: Percentage of Female Population 75 years + at Risk of Poverty Rate (cut-off point: 40% of median equivalised income after social transfers)

| GEO/TIME | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| European Union (27 countries) | 4.9 | 5.7 | 5.7 | 4.8 | 4.1 | 4.0 |
| European Union (15 countries) | 4.8 | 5.8 | 5.7 | 4.8 | 3.9 | 4.1 |
| United Kingdom | 7.2 | 8.1 | 8.7 | 8.8 | 6.4 | 7.8 |

*Source: EU-SILC*

Whereas poverty rates are still clearly above the EU27-average, the UK is well below the EU average regarding the severe material deprivation indicator. The relative median income ratio of older people (65+) has also significantly improved, jumping from 0.74 in 2008 to 0.81 in 2010. The aggregate replacement ratio (excluding other social benefits) was 0.48 in 2010, an improvement compared to previous years. Whether the recent 'success' in the reduction of poverty rates among older people was largely the result of declining incomes among the working age population during to the current economic crisis, the special measures for pensioners included in the last two budgets of the previous Labour government, other circumstances, or a combination of all factors, remains unclear at the moment.

According to the projections the theoretical replacement rate for low income workers will improve in future years, whereas the replacement rate for high-income earners will decline. The simulations also indicate that the incomes for employees with career breaks due to childcare are likely to improve. The income from occupational and other supplementary pensions is projected to increase for average and high earners. More than 40% of pension income will come from occupational and other supplementary pensions for both the average and high income earner. However, the assumptions build into this model seem to be very optimistic, as currently only approximately 34% of all employees in the private sector are enrolled in occupational pension programmes.

Despite the decline in the proportion of pensioners living at the risk of poverty, the poverty rates for pensioners in Britain continued to be above EU average. Some groups, especially female pensioners above the age of 75, have not benefited from the recent improvements. Hence, a key challenge for the British public pension system continues to be the difficulty to provide pension income to residents sufficiently high to prevent poverty. Part of the challenge continues to be the low take up of means-tested programmes. The theoretical replacement rates suggest the average share of occupational and supplementary pensions to be about 38% of income for pensioners with an average career. However, what is not taken into account in these calculations is that the distribution is quite unequal and that about 40% of recent pensioners do not receive any occupational pension (Seeleib-Kaiser 2011).

Moreover, as occupational pension coverage among current workers has significantly declined over the past decade, we will very likely witness reduced adequacy of pension incomes for certain cohorts. Currently, only core insiders in the private sector and public sector workers, with some exceptions, are provided with the opportunity to build up occupational pension entitlements, a process that can be characterised as dualisation (Seeleib-Kaiser et al. 2012). In the long-term, it is hoped by the government that the decline in occupational pension coverage will be reversed due to auto-enrolment, which will be rolled out starting this year. Nevertheless, much will depend on the assumption that low and middle income employees will not opt out. Furthermore, with the shift from DB to DC schemes pension adequacy will depend on the development of financial markets and as Burtless (2009) has shown we are very likely to be witnesses of cohort effects. Furthermore, if the current trend of declining employer contributions continues, it is very likely that income from occupational or supplemental pensions will decline and not increase as assumed in the model.

The labour market participation of older workers, although slightly declining since the onset of the economic crisis in 2008, is still fairly high and clearly above the EU average as shown in the Table 6 below:

Table 6: Employment Rate of Older Workers (55-64)

| | EU | United Kingdom |
|---|---|---|
| 2010 | 46.3 | 57.1 |
| 2009 | 46.0 | 57.5 |
| 2008 | 45.6 | 58.0 |
| 2007 | 44.6 | 57.4 |
| 2006 | 43.6 | 57.3 |
| 2005 | 42.6 | 56.8 |
| 2004 | 42.6 | 56.2 |
| 2003 | 41.7 | 55.4 |
| 2002 | 40.2 | 53.4 |
| 2001 | 38.8 | 52.2 |
| 2000 | 37.8 | 50.7 |

*Source: Eurostat; last update 08-02-2012; extracted on 22-02-2012; http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.*

### 2.2.5 Critical assessment of reforms, discussions and research carried out

Pension reforms over the last couple of years have focused on increasing the adequacy as well as the sustainability of the pension system. The access to the Basic State Pension has been significantly improved and various means-tested programmes have been introduced to reduce poverty among pensioners. However, take-up of some of these programmes is quite low, e.g. about a third of entitled pensioners do not claim Pension Credit. Irrespective of the low take-up rate a comparatively large proportion of pensioners has to rely on means-tested benefits. Overall, the current structure of the pension system leads to undersaving by a substantial proportion of the population, as is demonstrated by the declining pension coverage among the workforce in the private sector. The automatic enrolment into occupational pension schemes, to be rolled out starting 2012, in combination with the possible introduction of a new flat-rate state pension should provide an improved pension system that allows lower-earning employees to save, without facing the prospect of losing access to means-tested retirement benefits (Harrison 2011). However, it has to be highlighted that the general public/workers are not very confident that pensions are the best way to save for retirement. According to a survey conducted by NAPF only 35% of the respondents stated pensions were the best way to save for retirement, down 9 percentage points from the previous year, whereas the popularity of property as the best way to save for retirement is now at its highest level since the survey began, with 25% favouring that route (NAPF 2011; also Ipsos Mori 2011).

The government theoretically would have the resources to further improve the adequacy of pension provision with immediate effect without impacting other government priorities, through a restructuring of government expenditures within the domain of old-age income and pension policies. Such an approach could include the following elements to raise the financial resources for a significant improvement of the basic state pension:

a) the abolishment of the universal ‘winter fuel allowance’, free bus pass for pensioners and other special programmes for pensioners; and

b) a further substantial reduction of the tax relief for private/occupational pensions from the current annual allowance of £50,000 to about £13,000, i.e. to a level of about 50% of the average wage income.

In effect, politicians of all parties have pledged to keep the winter fuel allowance and free bus pass for pensioners and it was only the current Conservative-Lib/Dem government that significantly reduced the tax reliefs for personal/occupational pensions. With regard to option b), the current discussions tend to focus on using the savings of any reductions in pension tax relief for an increase in the personal tax allowance. Only if the British government would be willing to improve the level of the Basic State Pension, would it seem plausible to *significantly* improve the adequacy of income in old-age, especially for female pensioners above the age of 75, in the short term.

## 2.3 Health Care

### 2.3.1 The system's characteristics and reforms

The share of GDP allocated to health has increased strongly in the United Kingdom over the past decade, particularly during the 2008-09 recession. It went up from 8.4% in 2007 to 9.8% in 2009 (compared to an OECD average of 9.6%). Per capita health spending over 2000-2009 grew in real terms by 4.8%, more than the OECD average of 4.0%. The UK's spending on health per person is also now slightly above the OECD average, with spending of USD 3,487 in 2009 (OECD average USD 3,233). The NHS provides the bulk of health care in the United Kingdom. Although the private health care sector is gaining in importance, private spending is rather small in international comparison and has stayed more or less constant at 1.5/1.6% of GDP since 2000 (Office of National Statistics 2011). Only about 11% of the UK population is covered by private health insurance. Private insurance has been stimulated mainly by the desire to avoid long NHS waiting times. There is little reliance on out-of-pocket expenditure to finance health care. In the United Kingdom, 84% of health spending was funded by public sources in 2009, well above the average of 72%, and among the highest share in OECD countries (cf. OECD 2011).

Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations. Per head Northern Ireland spends the most on health services (£2,213 per head in 2009/10) and England spends the least (£1,875 per head). The following Table provides an overview of spending in the four nations (Harker 2011).

Table 7: NHS net expenditure, £m and per head, UK countries, 2005/06 to 2009/10

| Year | Total expenditure, £m | | | | Expenditure per head, £ | | | |
|---|---|---|---|---|---|---|---|---|
| | England | Wales | Scotland | N. Ireland | England | Wales | Scotland | N. Ireland |
| 2005/06 | 73,203 | 4,649 | 8,562 | 2,630 | 1,451 | 1,574 | 1,681 | 1,525 |
| 2009/10 | 97,130 | 5,922 | 10,616 | 3,959 | 1,875 | 1,975 | 2,044 | 2,213 |

*Source: Haker 2011: Tab. 3.*

As has been pointed out in Seeleib-Kaiser (2011), the NHS has to make significant efficiency savings of 4% for the next four years, equating to up to £20 billion by 2014-15. These savings are intended to be delivered through the NHS quality and efficiency improvement work, known as the Quality, Innovation, Productivity and Prevention (QIPP) challenge. However, it is feared that the savings required by the government will potentially have a negative impact on the quality of care provided. Jo Webber, Deputy Policy Director of the NHS Confederation, told a parliamentary committee in 2011: "This year it feels like you can keep quality up and it would not be compromised by the savings. The vast majority of our members feel confident that they are going to make the savings this year. When you start projecting this two or three years out,

then that balance between quality and savings becomes more finely balanced" (cited in House of Commons, Health Committee 2012: 14). The Health Select Committee concluded: "The Government remains confident that savings are on track. Nevertheless, we have heard strong concerns from the NHS Confederation, the Foundation Trust Network and the King's Fund, among others, about the ability of NHS organisations firstly to meet their saving plans and second, to do so in a manner that is sustainable and releases further savings in future years. We are concerned that there appears to be evidence that NHS organisations are according the highest priority to achieving short-term savings which allow them to meet their financial objectives in the current year, apparently at the expense of planning service changes which would allow them to meet their financial and quality objectives in later years" (ibid.: 15). The government beliefs it is crucial to reform the NHS structures in order to make the necessary financial savings.

### 2.3.2 Debates and political discourse

As part of its major restructuring of the public sector, the Department of Health (2010) has proposed in its NHS White Paper to transfer a large part of budgetary responsibility from NHS Primary Care Trusts to GP consortia with the responsibility to commission services from a wide range of competing providers, including for-profit and not-for-profit private organisations.[1] Currently, around 80% of NHS funding in England is allocated to 152 Primary Care Trusts, according to a population and needs-based formula. From this money, PCTs are free to commission health services to meet local needs. Though most commissioning still takes place within the NHS, PCTs are increasingly purchasing services from the independent and voluntary sectors, and from local authorities. The structural reorganisation proposed in the Department of Health White Paper *Equity and Excellence* means that the funding system looks set to change. PCTs are to be abolished, with responsibility for local commissioning, and hence the bulk of the NHS budget, passed to groups of GPs (Harker 2011).

Many stakeholders of the health care system have voiced stark opposition during the past year, leading the government to 'pause and listen' to concern. Despite a number of amendments of the draft legislation,[2] many stakeholders continue to oppose the reforms. Only very recently has even the Deputy Prime Minister Nick Clegg from the Liberal Democrats publicly called for further amendments (BBC 2012). The following organisations continue to oppose core elements of the organisational shakeup: the Royal College of GPs, the British Medical Association, Royal College of Radiologists, the Royal College of Nursing, and the Royal College of Midwives (Jowitt et al. 2012). The British Medical Association (BMA 2012) argues that the reforms would be "irreversibly damaging to the NHS" and irreparably damage the relationship between family doctors and patients.

### 2.3.3 Impact of EU social policies on the national level

Similarly to the domain of pension policies, EU social policies seem to have little or no effect on the national health care debate or reform.

[1] For a succinct review of the planned changes see National Audit Office (2011).
[2] For an up-to-date overview of the changes see http://healthandcare.dh.gov.uk/factsheets/.

### 2.3.4 Impact assessment

Despite increases in spending, the UK continues to score below average with regards to certain health indicators. Although survival rates for different cancers are improving in the UK, most other OECD countries achieve higher rates. The UK does well in avoiding hospital admissions for people with uncontrolled diabetes, but could improve the treatment of people with asthma and chronic obstructive pulmonary disease. The 5-year relative survival rate for breast cancer during 2004-2009 was 81%, up from 75% during 1997-2002, but still lower than the OECD average of 84%. For cervical cancer, it was 59%, also lower than the OECD average of 66%. And for colorectal cancer, the 5-year relative survival rate in the UK during 2004-2009 was 54% for females and 53% for males, compared with an OECD average of 62% for females and 60% for males. Avoidable hospital admissions for asthma complications and chronic obstructive pulmonary disease (COPD) are higher in the UK than the OECD average. For asthma admissions, the rate was 74 per 100 000 adults in 2009, compared to an OECD average of 52. For COPD it was 213 (OECD average 198). On the other hand, admissions for uncontrolled diabetes in the United Kingdom are less than half the OECD average (24 vs. 50 admissions per 100 000 population) (OECD 2011). As highlighted in previous annual reports, health care provision and quality differs within the UK. A recent report highlighted that amputation rates for diabetes patients are 10 times higher in some parts of England than in others. Researchers say the figures highlight the importance of ensuring the right specialist care (Holman et al. 2012). As highlighted in the section on long-term care below, the quality of health and social care was not always at a satisfactory level and included some scandals. The *Care Quality Commission* (2011) found that almost one-half of England's National Health Service hospitals and care homes failed to meet required standards of nursing because they did not give patients safe and effective treatment. Despite these shortcomings, satisfaction with the NHS overall is at its highest ever level. Seven out of ten people (70%) are satisfied with the NHS overall, the highest level ever recorded by the survey; the figure is up from 34% in 1997, when it was at its lowest point (Clery 2011: 141). The Conservative-Liberal government has announced a series of measures designed to improve nursing care in hospitals in England. Nurses would be freed from 'non-essential paperwork and excessive bureaucracy' so that they could spend more time with patients. A new Nursing Quality Forum would look at how the best nursing practice could be spread throughout the National Health Service, and how nursing leadership on hospital wards could be strengthened. A new patient-led inspection regime would also be established, covering food, privacy, cleanliness, and dignity (DH 2012).

Although fighting health inequalities is a proclaimed priority in the four nations of the UK, health inequalities in the United Kingdom remain stubbornly high, as highlighted in previous Annual Reports (Seeleib-Kaiser 2010; 2011). Without further significant reductions in inequality and poverty it does not seem likely that health inequalities will narrow substantially. A recent study on health inequalities in Scotland indicated further increases, it states: "Recent Scottish evidence demonstrates that inequalities in mortality are increasing between social classes and between more and less deprived areas, partly due to increases in diseases relating to alcohol and drug use in deprived areas and, at the same time, reductions in ischemic heart disease in affluent areas" (Craig 2011: 3; for a recent analysis of health inequalities in England see Mackenbach 2011).

The latest 18-week referral-to-treatment waiting times data for November 2011 show slight increases in the percentage of patients waiting longer than 18 weeks for inpatient and outpatient treatment. Currently, about 10% of patients wait for longer than the 18 weeks target (King's Fund 2012).

Health and social care services across the UK face one of the most severe funding situations since the Second World War. The latest budget for Northern Ireland suggests health and social care will receive a real cut in its budget by 2014/15 of around 2.7%. This compares to a real cut of around 0.25% (more if social care is included) in England, a real cut of around 7.9% in Wales (by 2013/14) and, for next year at least, a real cut of 2.9% in Scotland (not including social care). However, applying England's unit HRG costs to Northern Ireland activity reveals large 'excess' costs of production. Provisional data for 2009/10 shows: Elective inpatients, 16% excess costs; non-elective inpatients, 29%; day cases, 5%. Overall, costs were around 22% higher (cf Appelby 2011).

### 2.3.5 Critical assessment of reforms, discussions and research carried out

The organisational reforms proposed by the current government face clear opposition from a number of stakeholders. Although the proposed organisational reforms might yield efficiency savings in the medium to long-term, it seems a big gamble should the government decide to enact them without further revisions. As the NHS has to cope with significant efficiency savings, it seems likely that waiting times will continue to increase and, as is suggested by some observers, service provision is likely to decline.

## 2.4 Long-term Care

### 2.4.1 The system's characteristics and reforms

Unlike health care in England and Wales, social care is strictly means-tested by the majority of local authorities. Care support is provided only for those with the highest needs and the lowest means. In terms of financial eligibility for residential care, for example, currently an individual must have assets less than £23,250 in England to qualify for local authority placement into a care home. Hence, much of the needed care is provided informally. There are approximately six million unpaid carers in the UK with important variations among this dedicated group of people. 1.5 million are themselves over 60, 60% are women, and there are particularly high instances of caring in some black, minority and ethnic communities (twice as many Pakistani women, for example, are carers compared to the national average) (Centre for Social Justice 2010). In Scotland care is provided free to everyone in need, while Northern Ireland is considering the introduction of free care. Access to care is usually determined by councils, based on very broad national frameworks, leading to rather varied provision.

### 2.4.2 Debates and political discourse

During the past year the three most important developments were: A) the report of the Dilnot commission; B) various reports highlighting issues associated with the quality of care and care inspection in England; and C) the collapse of Southern Cross, the UK's largest care provider, with a 9% share of the national market and about 30% in the north-east of England.

A) Dilnot Report

There is now general consensus that the current system of long-term care is unsustainable. For over 15 years politicians and interested stakeholders have advocated the need to reform the way long-term care of older people is financed, and a number of reports have set out potential solutions to the problem, but no agreement has yet been reached. The Dilnot commission clearly states: "The adult social care funding system conceived in 1948 is not fit for purpose in the 21st century and is in urgent need of reform. Having to cope with a care and support need – both emotionally and financially – often comes as a major shock" (Dilnot Commission 2011a: 11). In contrast to many other risks, individuals cannot protect themselves against the risk of very high care

costs by pooling their risk. In areas such as motoring and housing, people buy private insurance to pool their risk and cover themselves against exposure to high costs. For health care, the NHS pools risks by providing social insurance to everyone; for care costs, however, the state does not provide universal support and people are unable to take out private protection. In effect, there are currently 152 different adult social care systems – one for each local authority in England. Entitlement to services differs across the country and people complain of a 'postcode lottery' of care. Different people, with similar care needs, can receive very different levels of support from their local authorities. Each local authority carries out a financial assessment of what the person can afford to pay. Due to the insufficient arrangement the Dilnot commission estimates that demand outstripped expenditure by 9%, leading to unmet needs. To deal with the insufficient system the commission recommends:

> a) capping the lifetime contribution to adult social care costs that any individual needs to make at between £25,000 and £50,000. The Commission suggests that £35,000 is an appropriate and fair figure. Where an individual's care costs exceed the cap, they would be eligible for full support from the state. This change should bring greater peace of mind and reduce anxiety, for both individuals and carers.
>
> b) means-tested support should continue for those of lower means, and the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000.
>
> c) people born with a care and support need or who develop one in early life cannot be expected to have planned in the same way as older people. Those who enter adulthood already having a care and support need should immediately be eligible for free state support to meet their care needs, rather than being subjected to a means test.
>
> d) people should contribute a standard amount to cover their general living costs, such as food and accommodation, in residential care. The Commission believes a figure in the range of £7,000 to £10,000 a year is appropriate.
>
> e) eligibility criteria for service entitlement should be set on a standardised national basis to improve consistency and fairness across England, and that there should be portability of assessments (Dilnot Commission 2011).

The annual costs of the recommended changes to the funding system are estimated to be between £1.3 billion, for a cap of £50,000, and £2.2 billion for a cap of £25,000.

Although a White Paper outlining the long overdue reform of long-term care was expected in 2011, the publication has been postponed until April 2012, as there are some concerns within government regarding the overall price tag of the suggested reform. The Health Secretary Andrew Lansley is to have privately characterised the proposals as 'regressive', as those within the top quintile will benefit the most (Neville 2012).

B) As highlighted in the Annual Report 2010 (Seeleib-Kaiser 2010) the quality of care within the NHS and social care is not always of the highest standard. Moreover, the provision of care was plagued by a series of scandals, among them those at a private care home operated by Castlebeck, which were revealed by a BBC documentary (BBC 2011). However, the noncompliance with quality standards is not limited to institutional care home. As an investigation by the Equality and Human Rights Commission concluded the poor quality of home care for many older people was breaching their human rights (Equality and Human Rights Commission 2011). After a number of investigations into the work of the *Care Quality Commission*, which was only established in 2009 to oversee the quality of care within the NHS and social care, its Chief Executive, Cynthia Bower, resigned in February 2012 (for an overview see Campbell 2012). A report by the National Audit Office (2011) concluded that the

Care Quality Commission had had a difficult task in establishing itself, and had not so far achieved value for money in regulating the quality and safety of health and adult social care in England. The Commission had missed deadlines for registering health and social care providers, other than National Health Service trusts, at the same time as levels of compliance and inspection activity had been falling significantly. In its interim report the Commission on Dignity made the following ten key recommendations for care homes:

> 1. The Government should establish a Care Quality Forum (in parallel with the Nursing Quality Forum) to look at all aspects of care home staffing, including issues of status and pay, qualifications, recruitment, retention, development, monitoring and regulation. In the longer term the profession should consider working towards establishing a College of Care to lead on these issues.
>
> 2. The care sector should work with professionals, residents, relatives' organisations, local authorities and government to develop a clear rating scheme for care homes based on nationally agreed standards and benchmarks.
>
> 3. Care homes need to work with residents to create an environment that make their lives happy, varied, stimulating, fulfilling and dignified. This means involving older people as full and active participants in shaping their daily lives, rather than seeing them as passive recipients of care.
>
> 4. Building links with the wider community is an important part of creating a caring environment and developing a culture of openness. Volunteers can greatly enhance the quality of life in care homes.
>
> 5. Care homes should invest in greater use of technology to improve the quality of care and support residents in enjoying active and independent lives.
>
> 6. All care home staff must take personal responsibility for putting the person receiving care first, and staff should be urged to challenge practices they believe are not in the best interests of residents.
>
> 7. Care home providers should invest in support and regular training for their managers. Local authorities have an important role to play in facilitating this as commissioners of care.
>
> 8. Boards and managers have a duty to ensure buildings are fit for use for older people, particularly those with dementia.
>
> 9. Ensuring access to medical care is an important responsibility of care homes. Residents in a private care home have just the same rights to NHS care as everyone else.
>
> 10. Providing end-of-life care tailored to the wishes and needs of each individual is central to dignified care in all care homes. Residents should be allowed to die in their own care home if that is their wish (Commission on Dignity in Care 2012: 6).

It remains to be seen whether and to what extent these recommendations will be implemented.

C) The largest private provider of social care, Southern Cross, came under severe financial pressure in May 2011 and eventually collapsed. The company was providing care for 31,000 people in 750 homes, all of which had to be transferred to other care providers. Obviously, this caused some concern among those dependent on the provision of care. Only through the collaboration between the industry, local authority care leaders and the Department of Health could a crisis situation be averted (Humphries 2011).

### 2.4.3 Impact of EU social policies on the national level

Similarly to the domains of pension and health care policies, EU social policies seem to have little or no effect on the long-term care debate or reform.

### 2.4.4 Impact assessment

The available funds in delivering frontline services in England for elderly people with care needs have indeed been cut by 4.5% in the current budget year, compared to 2010-11. Age UK estimates that, in order to maintain the care system at the same level as in 2010 (before current spending cuts), expenditure on older people's social care should be £7.8 billion in 2011-12. But this year total spending it is only £7.3 billion. Even making allowances for efficiency gains, this has left a total shortfall of £500 million. Based on the further cuts in the coming years, AgeUK estimates that the situation will worsen (AgeUK 2012). Furthermore, out of 2 million older people in England with care-related needs, 800,000 received no formal support from public or private sector agencies before the cuts came into force. With spending cuts under way, the figure was likely to pass 1 million between 2012 and 2014 (AgeUK 2011). Even the Conservative-led House of Commons, Health Select Committee (2012) concludes "The weight of evidence that we have received suggests that social care funding pressures are causing reductions in service levels which are leading to diminished quality of life for elderly people, and increased demand for NHS services. Although the transfer of £2 billion from health to social care is welcome, it is not sufficient to maintain adequate levels of service quality and efficiency. As it reported in its recent report on Public Expenditure, the Committee believes that the levels of efficiency gain which have been planned by the Government will not be achieved unless there are fundamental changes in the way care is delivered. In particular the Committee believes that successful delivery of the Government's plans requires a dramatic strengthening of its commitment to deliver more integrated services."

### 2.4.5 Critical assessment of reforms, discussions and research carried out

For years governments have discussed and proposed reforms for long-term care provision and financing, especially for England and Wales. As is highlighted by the *Commission on Funding of Care and Support* (Dilnot Commission 2011), as well as by the recent report of the *Law Commission* (2011) long-term care provision and financing are in urgent need of reform. Whether this will be achieved remains to be seen. In the short-term it is very likely that provision will be scaled back due to reductions in funding for local authorities. Although this annual report has primarily focused on England, various reports have indicated further demand for reform in Scotland as well as Northern Ireland (Scottish Parliament, Health and Sport Committee 2011; AgeNI 2011).

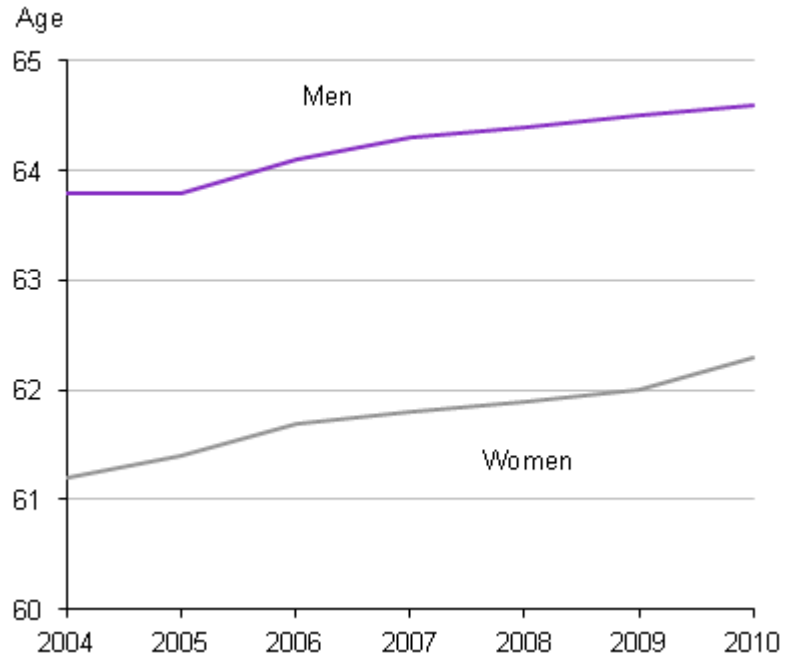
## 2.5 The role of social protection in promoting active ageing

### 2.5.1 Employment

People are working longer than they used to. The average age at which people leave the labour market – a proxy for average age of retirement – rose from 63.8 years to 64.6 years for men and

from 61.2 years to 62.3 years for women between 2004 and 2010 (ONS 2012: Chapter 4). Partly this increase in the de facto retirement age might be related to the fact that it is no longer possible to draw a pension before the age of 55 (cf. Cohen 2012).

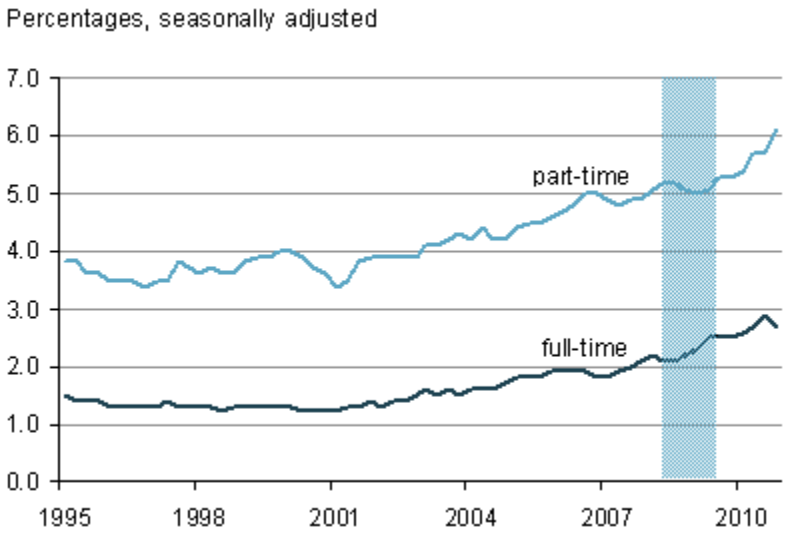
Figure 1: Average age of withdrawal from the labour market, UK




*Source: Office for National Statistics (2012: 4-9).*

However, not only has the de facto retirement age increased, but the employment of senior citizens above age 65 has continued to increase, even during the recent recession and the current economic slump.

Figure 2: People aged 65 and over in full-time and part-time employment, 1995-2010, United Kingdom




*Source: Labour Force Survey - Office for National Statistics (2011) Older workers in the labour market – 2011, available at [http://www.ons.gov.uk/ons/dcp171776_234491.pdf](http://www.ons.gov.uk/ons/dcp171776_234491.pdf), accessed February 29, 2012.*

### 2.5.2 Participation in society

The public social protection system does not explicitly promote volunteer work. However, individual employers might consider periods of unpaid/volunteer work as qualifying periods for pension purposes. E.g. NHS employees can preserve their membership of the NHS Pensions Scheme while they volunteer oversees.[3]

### 2.5.3 Healthy and autonomous living

Data compiled by the Office of National Statistics shows that between 1981 and 1999, healthy life expectancy rose overall (by 1.6 years for men and 1.2 years for women, old basis) but there were years where it remained static or fell in comparison to the previous year. The upward trend continued between 2001 and 2008 (rising by 0.5 years for men and 0.8 years for women, new basis). However, if healthy life expectancy increases more slowly than life expectancy in coming decades, people will spend a greater part of their retirement in poor health. How these trends develop will determine the proportion of retirement that people have to enjoy life in a good or relatively good state of health (ONS 2012: Chapter 3). To what extent this development has been influenced by the social protection system is not clear. Obviously improved health care and medical progress are very likely to have contributed to this overall trend. As highlighted above, the long-term care system is somewhat underdeveloped in the United Kingdom, especially in England. Nevertheless, public support increasingly prioritises support for home care as opposed to institutional care. Furthermore, healthy life expectancy is higher in England than in the other countries, indicating that life styles might matter more than free social/long-term care.

[3] Cf. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5044914.

Table 8: Period life expectancy, healthy life expectancy and disability-free life expectancy at 65: by country and sex, 2008

| | Men | | | Women | | |
|---|---|---|---|---|---|---|
| | Life expectancy | Healthy life expectancy | Disability-free life expectancy | Life expectancy | Healthy life expectancy | Disability-free life expectancy |
| UK | 17.6 | 9.9 | 10.2 | 20.2 | 11.5 | 11.2 |
| England | 17.8 | 10.0 | 10.5 | 20.4 | 11.7 | 11.4 |
| Wales | 17.2 | 10.7 | 10.3 | 20.0 | 10.1 | 11.6 |
| Scotland | 16.4 | 8.8 | 8.9 | 19.0 | 10.7 | 10.9 |
| Northern Ireland | 17.1 | 9.6 | 9.0 | 19.9 | 10.7 | 9.2 |

*Notes: Estimates calculated using life table data from the Office for National Statistics, and health related data from the GLF, CHS and the Census.*
*Estimates are based on a three year moving average plotted on the central year. Therefore the 2008 figures use data from 2007 to 2009 (population data are mid-year estimates).*
*Healthy life expectancy is based on new definition (a person being in 'good' or 'very good' general health on a 5-point scale).*
*Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency, ONS 2012: Chapter 3*

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# 3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

## [R] Pensions

**[R3; R4]** BERRY, Craig (2011), *Gradual Retirement and Pensions Policy*, International Longevity Centre – UK. Retrieved from http://www.ilcuk.org.uk/files/pdf_pdf_200.pdf (February 29, 2012).

The report shows that there is strong public support for gradual retirement, but little evidence that it happened in practice on a large scale. It recommended that the government should make the positive case for extending working lives much more strongly, and should consider the introduction of a graduated state pension.

**[R5]** CARRERA, Leandro et al. (2011), *The Implications of Government Policy for Future Levels of Pensioner Poverty*, Pensions Policy Institute. Retrieved from https://www.pensionspolicyinstitute.org.uk/uploadeddocuments/2011/20110711_PPI_The_implications_of_Government_policy_for_future_levels_of_pensioner_poverty.pdf (February 29, 2012).

The Pensions Policy Institute's report provided new projections of the percentage of pensioners living in relative income poverty under a continuation of existing government policy on pensions, and under alternative policy scenarios.

**[R5]** HOLLAND, James et al. (2011), *Early Findings from the Evaluation of the Pension Credit Payment Study*, Department for Work and Pensions. Retrieved from http://research.dwp.gov.uk/asd/asd5/summ2011-2012/PC_Trial_Interim_Findings.pdf (February 29, 2012).

Early findings were published from a trial that tested the effect of making automatic pension credit payments (without a claim) on the basis of personal data already held by the government. 9% of participants were claiming pension credit at the end of the trial, compared with just over 3% of the eligible non-recipient population.

**[R3, R5]** LAIN, David (2011), "Helping the poorest help themselves? Encouraging employment past 65 in England and the USA", *Journal of Social Policy*, Volume 40, Issue 3, pp 493-512.

The article examined whether an American-style 'self-reliance' policy approach would increase employment among the poorest people over 65, and enhance or diminish their financial position. The poorest people over 65 were more likely to work in the United States of America than in England in 2002: but employment rates were still relatively low. An American policy approach would therefore probably damage the financial position of the poorest people in the United Kingdom, as increased employment would not sufficiently compensate for lost benefits.

**[R2]** LEGRAND, Kevin (2012), "Reinvigoration of private occupational pensions in the United Kingdom: What are the chances?" *Pensions, 17*, 8–19.

The article considers the promise made by the coalition government when it came into power, to 'reinvigorate occupational pensions'. It considers the current situation of pension provision in the United Kingdom, identifying the main problems and suggesting focus for possible solutions. Although the article is focused on the government's pledge to reinvigorate occupational (that is, employment based) provision, it also considers briefly the present State pension provision, which forms the base upon which occupational provision is built. The reinvigoration project is 'work in progress' for the coalition government, and the article considers what has been done to date. The on-going nature of the subject means that new policies are likely to be announced at any time; however, the article focuses on suggested principles behind provisions, rather than on detailed policies resulting from those. Readers will then be able to compare detailed policies with the suggested principles.

**[R3]** MALTBY, Tony (2011), "Extending working lives? Employability, work ability and better quality working lives", *Social Policy and Society,* Volume 10, Issue 3, pp 299-308.

Faced with a changing economic and demographic outlook, this article suggests the adoption of a proactive and preventative approach to the quality of work and 'work life' for the UK's 'older workers'. Ultimately, it seeks to explore the possibilities for the implementation of the Finnish concept of Work Ability in the context of the UK policy agenda. It will be suggest that this approach provides a policy framework that addresses recessionary pressures whilst maximising quality of life and the active ageing of individuals.

**[R1; R2; R3; R4; R5]** OFFICE OF NATIONAL STATISTICS (2012), *Pension Trends—2012 edition.* Retrieved from http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-21627 (February 29, 2012).

Pension Trends draws together statistics from ONS, a number of government departments and other organisations to highlight the complex issues that shape trends in pension provision in the UK.

## [H] Health

**[H1]** HARKER, Rachel (2011), *NHS Funding and Expenditure*, Standard Note SN/SG/724. London: House of Commons Library.

This briefing paper examined National Health Service expenditure since 1948; summarised the structure of the NHS and how it was financed; and described how primary care trusts were allocated funding.

**[H1]** HOUSE OF COMMONS, HEALTH COMMITTEE (2012), *Public Expenditure*, Thirteenth Report (Session 2010-12), HC 1499, London: TSO. Retrieved from http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499.pdf (March 9, 2012).

The committee report highlighted that both the National Health Service and local authorities were struggling to meet cost-saving targets in a sustainable, long-term manner that would maintain high quality, efficient care in the future. There was a 'marked disconnect' between the concerns expressed by those responsible for delivering services and the relative optimism of the coalition government over achieving cuts. The coalition's simultaneous plans for reorganising the NHS 'continued to complicate' the push for cost-cutting measures.

**[H1]** QAISER, Uma (2011), *Expenditure on Health care in the UK*, London: Office for National Statistics.

The ONS report presents estimates of expenditure on health care in the United Kingdom that were consistent with international definitions. Health care expenditure as a share of national income reached 9.8% in 2009, compared with 6.6% in 1997.

**[H3]** CRAIG, Pauline (2011), *Focus on Inequalities: A Framework for Action*, Briefing Paper 30, Glasgow: Glasgow Centre for Population Health. Retrieved from http://www.gcph.co.uk/assets/0000/2626/GCPH_Briefing_Paper_30web.pdf (March 9, 2011).

The briefing paper examines health inequalities in Scotland and provides evidence that health inequalities across the Scottish population were increasing, despite efforts to tackle the problem.

**[H4; H5]** BOYLE, Sean (2011), *United Kingdom (England): Health System Review 2011*, Health Systems in Transition, Vol. 13, No. 1, European Observatory on Health Systems and Policies. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/135148/e94836.pdf (March 9, 2012).

The report provides a comprehensive overview of the health care system in England, its governance structure and recent policy developments.

**[H3]** APPLEBY, John et *al*. (2011), *Variations in Health Care: The good, the bad and the inexplicable*, London: King's Fund.

The study found 'persistent and widespread' variations across England in patients' chances of undergoing surgery for common medical conditions. This suggested that many patients were

not being given surgery that they needed, and that some might be undergoing operations that they did not benefit from.

**[H2]** DEPARTMENT OF HEALTH (2011), *Healthy Lives, Healthy People: Update and way forward*, Cm 8134, London: TSO. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf (March 9, 2012).

The coalition government published a policy statement setting out its vision for a new public health system, and the progress made towards achieving it. It highlighted the new leadership role for local authorities and their directors of public health. Plans to abolish the Health Protection Agency were postponed for a year, to 2013.

**[H1]** MALLEY, Juliette et al. (2011), "The effect of lengthening life expectancy on future pension and long-term care expenditure in England, 2007 to 2032", *Health Statistics Quarterly* 52, Winter 2011, pp. 33-61.

The article examines the effect of different assumptions about future trends in life expectancy on the sustainability of the pensions and long-term care systems.

**[H1]** AUDIT COMMISSION (2011), *NHS Financial Year 2010/11: A summary of auditors' work*, London: Audit Commission, retrieved from http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/20110808_NHSPerformance.pdf (March 9, 2012).

The audit report found that the overall financial performance of the National Health Service had been 'good' in 2010-11. Most trusts had made progress in reducing costs: on average, primary care trusts had saved nearly 2% of their gross operating costs, and other trusts had saved over 4%. Most of the savings had been found through improving clinical productivity and reducing workforce costs.

**[L] Long-term Care**

**[L]** AgeNI (2011), *Would You Have Sandwiches for Your Tea Every Night? Older people's views of social care in Northern Ireland*. Retrieved from http://www.ageuk.org.uk/Global/age-ni/documents/policy/Age-NI-Sandwiches-every-night-Older-peoples-views-of-social-care-July-2011.pdf (February 29, 2012).

The report examined the experiences of older people in Northern Ireland in relation to the social care system. Although a number of participants reported positive experiences, most believed that the care system did not meet the needs of the people it was meant to support.

**[L]** AgeUK (2012), *Care in Crisis 2012.* Retrieved from http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/care_in_crisis_2012_report.pdf?dtrk=true (February 29, 2012).

The report argues that spending on older people's social care in England in 2011-12 would fall £500 million short of even maintaining the 'inadequate' levels of provision in place when the coalition government had come to power in 2010. Funding for frontline services had not been protected, and additional money from the National Health Service had not filled the gap.

**[L]** AgeUK (2011), *Care in Crisis: Causes and solutions.* Retrieved from http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/Care%20in%20Crisis%20-%20FINAL.pdf?dtrk=true (February 29, 2012).

The report argued that out of 2 million older people in England with care-related needs, 800,000 received no formal support from public or private sector agencies. With spending cuts under way, the figure was likely to pass 1 million between 2012 and 2014.

**[L]** DILNOT COMMISSION (2011), *Fairer Care Funding*. Retrieved from https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf (February 29, 2012).

The report highlighted that the current funding system is in urgent need of reform: it is hard to understand, often unfair and unsustainable. People are left exposed to potentially catastrophic care costs with no way to protect themselves. Two further volumes provide additional background information (all reports/volumes available at http://www.dilnotcommission.dh.gov.uk/our-report/.

**[L]** EQUALITY AND HUMAN RIGHTS COMMISSION (2011). *Close to home. An inquiry into older people and human rights in home care*. Retrieved from http://www.equalityhumanrights.com/uploaded_files/homecareFI/home_care_report.pdf (February 29, 2012).

The Equality and Human Rights Commission found that 'disturbing evidence' that the poor quality of home care for many older people was breaching their human rights. Too many older people were struggling to voice their concerns about their care, or be listened to about what kind of support they wanted.

**[L]** SCOTTISH PARLIAMENT, HEALTH AND SPORT COMMITTEE (2011), *Report on Inquiry into the Regulation of Care for Older People*, 3rd Report 2011, SP Paper 40. Retrieved from http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/heR11-03.pdf (February 29, 2012).

The report said that a review of national care standards for older people was 'overdue'. The review should address changes such as the move towards a greater integration of health and social care, the rise in the number of older people with dementia, and the issue of widespread prescription of psycho-active medications to care home residents.

**[L]** SINCLAIR, Alan (2011), *A Life Worth Living*, Scottish Council for Voluntary Organisations. Retrieved from http://www.scvo.org.uk/wp-content/uploads/2011/11/A_Life_Worth_Living_Oct11.pdf (February 29, 2012).

The report called for urgent reform of the care system for older people in Scotland. Service providers needed to consult and engage with Scotland's people in order to design cost-effective personalised services. Costly overlaps in service needed to be 'engineered out'. There was a need to improve measures of well-being in older age, so that the quality and impact of social and health care provision could be monitored better.

# 4 List of Important Institutions

**Age UK**

*England*

| | |
|---|---|
| Address: | York House, 207-221 Pentonville Road, London N1 9UZ |
| Phone: | +44(0)800 169 87 87 |
| Webpage: | http://www.ageuk.org.uk/ |
| Address | Astral House 1268 London Road, London SW16 4ER |
| Phone: | +44(0)20 8765 7200 |
| Email: | contact@ageuk.org.uk |

*Scotland*

| | |
|---|---|
| Address: | Causewayside House 160 Causewayside, Edinburgh EH9 1PR |
| Phone: | +44(0)845 833 0200 |
| Webpage: | http://www.ageuk.org.uk/scotland/ |
| Email: | enquiries@ageconcernandhelptheagedscotland.org.uk |

*Wales*

| | |
|---|---|
| Address: | Tŷ John Pathy 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ |
| | Webpage: http://www.ageuk.org.uk/cymru/ |
| Phone: | +44(0)29 2043 1555 |
| Email: | enquiries@agecymru.org.uk |

*Northern Ireland*

| | |
|---|---|
| Address: | 3 Lower Crescent, Belfast BT7 1NR |
| Phone: | +44(0)28 9024 5729 |
| Webpage: | http://www.ageuk.org.uk/northern-ireland/ |
| Email: | info@ageni.org |

*Age UK was created on 1 April 2009 by the merger of Age Concern England and Help the Aged. These well-known national charities had decided to combine forces in order to improve later life for more people in the UK and around the world. The organisation has over 2,500 staff, 45 offices. Main objectives are policy advocacy and providing services for the aged. 2008 the organisations reached over 5 million older people with their services, information and products. One of its key publications is Older People in the United Kingdom - key facts and statistics 2008 (updated annually). Furthermore, the organisations publish a large number of policy documents and research addressing all issues relevant for older people. They are key advocacy groups for older people.*

**Carers UK**

*Carers UK*

| | |
|---|---|
| Address: | 20 Great Dover Street, London, SE1 4LX |
| Phone: | 0044 (0) 20 7378 4999 |
| Fax: | 0044 (0) 20 7378 9781 |
| Email: | info@carersuk.org |
| Webpage: | http://www.carersuk.org |

*Carers Scotland*

| | |
|---|---|
| Address: | The Cottage, 21 Pearce Street, Glasgow, G51 3UT |
| Phone: | 0044 (0) 141 445 3070 |

Email: info@carerscotland.org
Webpage: http://www.carerscotland.org

*Carers Wales*
Address: River House, Ynysbridge Court, Gwaelod-y-Garth, Cardiff, CF15 9SS
Phone: 0044 (0) 29 2081 1370
Fax: 0044 (0) 29 2081 1575
Email: info@carerswales.org
Webpage: http://www.carerswales.org

*Carers Northern Ireland*
Address: 58 Howard Street, Belfast, BT1 6PJ
Phone: 0044 (0) 28 9043 9843
Fax: 0044 (0) 28 9032 9299
Email: info@carersni.org
Webpage: http://www.carersni.org

*Carers UK seeks to improve recognition and support for carers, through informing and creating dialogue with policy makers and professionals working with carers. It provides a wide variety of policy papers and research on topics affecting carers. The most important publications are Policy Briefings on various topics (http://www.carersuk.org/professionals/resources/briefings). Carers UK is the key advocacy group for carers.*

**Centre for Social Justice**

Contact Person: Mark Florman (Chairman Board of Directors)
Address: The Centre for Social Justice
1 Westminster Palace Gardens, Artillery Row, London, SW1P 1RL
Webpage: http://www.centreforsocialjustice.org.uk/default.asp
Phone: 020 7340 9650
Email: admin@centreforsocialjustice.org.uk

*The Centre for Social Justice (CSJ) is an independent think tank established by Rt Hon Iain Duncan Smith MP in 2004 to seek effective solutions to the poverty that blight parts of Britain. Its mission is to put social justice at the heart of British politics and to build an alliance of poverty fighting organisations in order to see a reversal of social breakdown in the UK. The CSJ highlights the work of profoundly differing and unique small voluntary organisations and charities. In addition, the centre conducts policy research that combines data, anecdotal evidence and polling. Through this we seek to gain an accurate picture of poverty in Britain, its causes and consequences, and to define the role the state and other players can and can't play in its reduction.*

**Department of Health**

*England*
Address: Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS.

*The Department of Health (DH) is the key Department responsible for health care and social care policies in England. The Department is led by Secretary of State for Health - Rt Hon Andrew Lansley MP. He is responsible for the NHS and social care delivery and system reforms, finance and resources and strategic communications. The DH commissions and publishes countless reports (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/index.htm).*

*Northern Ireland*

| | |
|---|---|
| Contact person: | Edwin Poots |
| Address: | Minister for Health, Social Services and Public Safety, Castle Buildings, Stormont Estate, Belfast, BT4 3SQ |
| Phone: | 0044 (0) 28 9052 0643 |

*The Department's publications can be found at http://www.dhsspsni.gov.uk/index/publications.*

*Scotland*

| | |
|---|---|
| Contact person: | Kevin Woods (Director General Health) |
| Address: | Health Directorate, St Andrews House, Regent Road, Edinburgh EH1 3DG |
| Phone: | 0044 (0) 131 556 8400 |

*Nicola Sturgeon is Deputy First Minister and Cabinet Secretary for Health & Wellbeing. Her responsibilities include: NHS, health service reform, allied health care services, acute and primary services, performance, quality and improvement framework, health promotion, sport, public health, health improvement, pharmaceutical services, food safety and dentistry, community care, older people, mental health, learning disability, substance misuse, social inclusion, equalities, anti-poverty measures, housing and regeneration. Publications by the Scottish Government on health are available at:*
*http://www.scotland.gov.uk/Publications/Search/Q/Subject/474.*

*Wales*

| | |
|---|---|
| Contact person: | Minister Lesley Griffiths |
| Address: | Department for Health & Social Services<br>Welsh Assembly Government, Cathays Park, Cardiff, CF10 3NQ |
| Phone: | 0044 (0) 8450 103300 |
| Webpage: | http://www.wales.nhs.uk/orgdets.cfm?orgid=246&srce=CO |

**Department of Work and Pensions**

| | |
|---|---|
| Address: | Department for Work and Pensions, Caxton House, Tothill Street, London, SW1H 9DA |

*The DWP is the key government department for the development of pension policies. The Department is headed by Rt. Hon Iain Duncan Smith, Secretary of State for Work and Pensions. Rt. Hon Steve Webbis Minister of State for Pensions. The DWP commissions and publishes a wide range of research and reports (http://www.dwp.gov.uk/asd/asd5/rrs-index.asp.*

**Non-Departmental Public Bodies (NDPB)** with relevance to pension policies are:

**The Pension Protection Fund**

| | |
|---|---|
| Address: | Knollys House, 17 Addiscombe Road, Croydon, Surrey, CR0 6SR |
| Phone: | 0044(0)845 600 2541 |
| Fax: | 0044 (0) 20 8633 4910 |
| Email: | information@ppf.gsi.gov.uk |
| Webpage: | www.pensionprotectionfund.org.uk |

*The Pension Protection Fund was established to pay compensation to members of eligible defined benefit pension schemes, when there is a qualifying insolvency event in relation to the employer and where there are insufficient assets in the pension scheme to cover Pension Protection Fund levels of compensation. The most important publication is the Purple Book, a joint annual publication by the Pension Protection Fund (the PPF) and the Pensions Regulator (the regulator) which focuses on the risks faced by defined benefit (DB) pension schemes, predominantly in the private sector.*

**The Pensions Regulator**

Address: Napier House, Trafalgar Place, Brighton, BN1 4DW;
Webpage: http://www.thepensionsregulator.gov.uk/

*The Pensions Regulator is the UK regulator of work-based pension schemes. The Pensions Act 2004 gives the Pensions Regulator a set of specific objectives:*

- *to protect the benefits of members of work-based pension schemes;*
- *to promote good administration of work-based pension schemes; and*
- *to reduce the risk of situations arising that may lead to claims for compensation from the Pension Protection Fund.*

*The Pensions Regulator also aims to promote high standards of scheme administration, and work to ensure that those involved in running pension schemes have the necessary skills and knowledge. The Pensions Act 2008 introduces new duties on employers and gives the Pensions Regulator a new objective to maximise compliance with the duties, and ensure safeguards that protect employees are adhered to. The approach to achieve this new objective is briefly described on the Pension Regulator's website at http://www.thepensionsregulator.gov.uk/aboutUs/pensionsReform.aspx.*
*The Pensions Regulator publishes various consultation documents and discussion papers on its website http://www.thepensionsregulator.gov.uk/onlinePublications/policy.aspx.*

**Joseph Rowntree Foundation (JRF)**

Address: The Homestead, 40 Water End, York, YO30 6WP
Phone: 0044 (0)1904 629241
Fax: 0044 (0)1904 620072
Email: info@jrf.org.uk

*JRF is an endowed foundation that funds a large, UK-wide research and development programme. The purpose of the foundation is to influence policy and practice by searching for evidence and demonstrating solutions to improve: the circumstances of people experiencing poverty and disadvantage; the quality of their homes and communities; the nature of the services and support that foster their well-being and citizenship. JRF have no political affiliations and work in partnership with all sectors – private, public and voluntary. The foundation publishes a wide variety of reports that have been influential in shaping debates on social protection (see http://www.jrf.org.uk/publications).*

**The King's Fund**

Address: 11-13 Cavendish Square, London, W1G 0AN
Phone: 0044 (0) 20 7307 2400
Webpage: www.kingsfund.org.uk

*The King's Fund is incorporated by a Royal Charter that was granted by Her Majesty the Queen in 2008 and which came into being on 1 January 2009. Previously, the Fund was known officially as the King Edward's Hospital Fund for London, and was established in 1907 by an Act of Parliament. The work of the Fund focuses on health and social care in England. It provides leading research on these topics at the same time it aims to be a resource to*

*parliamentarians at Westminster and other institutions, by providing impartial analysis on health and social care developments in the United Kingdom. The King's Fund has acted as an agenda setter and significantly influenced the political debate through the publication of numerous reports.*

**London School of Economics and Political Science (LSE)**
**LSE Health and Social Care**

| | |
|---|---|
| Address: | Cowdray House, London School of Economics and Political Science, Houghton Street, London WC2A 2AE |
| Phone: | + 44 (0) 20 7955 6840 |
| Fax: | + 44 (0) 20 7955 6803 |
| Email: | lse_health@lse.ac.uk |
| Webpage: | http://www2.lse.ac.uk/LSEHealthAndSocialCare/home.aspx |

*LSE Health and Social Care (LSEHSC) - a research centre in the Department of Social Policy at the London School of Economics and Political Science - was established in 2000. The Centre's fundamental mission is the production and dissemination of high quality research in health and social care. The Centre's unique research base contributes to the LSE's established world presence and reputation in health policy, health economics, social care policy and mental health economics. The LSE Health & Social Care promotes and draws upon the multidisciplinary expertise of 71 staff members. A leading member of the group is Professor Julian Le Grand, who is the Chair of the LSE Health and Social Care. In 2003-5 he was seconded to No 10 Downing St as a senior policy adviser to the Prime Minister. Furthermore, he has acted as an adviser to the World Bank, the World Health Organisation, Her Majesty's Treasury and the UK Department of Health.*

**Centre for Analysis of Social Exclusion (CASE)**

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|---|---|
| Address: | LSE, CASE, Houghton Street, London WC2A 2AE |
| Phone: | 0044(0)20 7955 6679 |
| Webpage: | http://sticerd.lse.ac.uk/case/ |

*The Centre for Analysis of Social Exclusion (CASE) was established in October 1997 with funding from the Economic and Social Research Council (ESRC). CASE is a multi-disciplinary research centre located within the Suntory and Toyota International Centres for Economics and Related Disciplines (STICERD) at the London School of Economics and Political Science; CASE is also associated with the School's Department of Social Policy. Professor John Hills is its Director. He was a member of the Pensions Commission between 2003 and 2006.*

**National Association of Pension Funds (NAPF)**

| | |
|---|---|
| Contact person: | *Joanne Segars, Chief Executive* |
| Address: | NAPF, Cheapside House, 138 Cheapside, London EC2V 6AE |
| Phone: | +44(0)20 7601 1700 |
| Fax: | +44(0)20 7601 1799 |
| Email: | napf@napf.co.uk |
| Webpage: | http://www.napf.co.uk/ |

*The National Association of Pension Funds is the leading UK body providing representation and other services for those involved in designing, operating, advising and investing in all aspects of pensions and other retirement provision. NAPF's aim is to be the leading voice of retirement provision through the workplace. The organisation speaks for 1,200 pension schemes with some 15 million members and assets of around GBP 800 billion. NAPF members also include over 400 businesses providing essential services to the pensions sector. All scheme types are covered including defined benefit, defined contribution, group personal pensions and*

*statutory schemes such as those in local government. Membership of the NAPF is open to companies, firms, local authorities and other organisations which provide pensions for their employees, industry-wide pension schemes and/or the trustee bodies associated with such pension funds. NAPF is a leading provider of pensions conferences, seminars and events which help members keep up-to-date with the fast-moving world of pensions and promote the pensions debate. The NAPF is one of the most influential industry bodies in the policy domain of pensions. Each year NAPF carries out a detailed survey amongst its members. The Survey provides schemes and their advisers with an invaluable insight into the pensions market and is a unique benchmarking tool.*

**NHS Confederation**

| | |
|---|---|
| Address: | NHS Confederation, London Office, 29 Bressenden Place, London, SW1E 5DD |
| Phone: | 0044 (0) 20 7074 3200 |
| Fax: | 0044 (0) 870 487 1555 |
| Email: | enquiries@nhsconfed.org |
| Webpage: | http://www.nhsconfed.org/Pages/home.aspx |

*The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. It represents over 95% of NHS organisations as well as a growing number of independent health care providers. The stated aim of the organisation is a health system that delivers first-class services and improved health for all. The NHS Confederation works with members to ensure an independent driving force for positive change by: influencing policy, implementation and the public debate; supporting leaders through networking, sharing information and learning; and promoting excellence in employment. Its most important publication is The NHS Handbook. This guide to the NHS contains essential and up-to-date information, combining expert commentary with detailed analysis in an easy-to-read format.*

**National Institute for Health and Clinical Excellence (NICE)**

| | |
|---|---|
| Contact person: | Andrew Dillon (Chief Executive) |
| Address: | MidCity Place, 71 High Holborn, London, WC1V 6NA |
| Phone: | 0044 (0)845 003 7780 |
| Fax: | 0044 (0)845 003 7784 |
| Email: | nice@nice.org.uk |
| Webpage: | http://www.nice.org.uk/ |

*NICE is a special health authority of the NHS in England and Wales. It was set up as the National Institute for Clinical Excellence in 1999, and on 1 April 2005 joined with the Health Development Agency to become the new National Institute for Health and Clinical Excellence (still abbreviated as NICE). The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidance in three areas of health: public health (guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector); health technologies (guidance on the use of new and existing medicines, treatments and procedures within the NHS); clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS).*

**The Nuffield Trust**

| | |
|---|---|
| Contact person: | Dr Jennifer Dixon (Director) |
| Address: | 59 New Cavendish Street, London, W1G 7LP |

Phone: 0044 (0) 20 7631 8450
Fax: 0044 (0) 20 7631 8451
Email: info@nuffieldtrust.org.uk
Webpage: http://www.nuffieldtrust.org.uk/

*The Nuffield Trust is one of the leading independent health policy charitable trusts in the UK. The Trust's mission is to promote independent analysis and informed debate on UK health care policy. The Trust's purpose is to communicate evidence and encourage an exchange around developed or developing knowledge in order to illuminate recognised and emerging issues. Similar to The King's Fund, the Nuffield Trust has acted as an agenda setter and significantly influenced the political debate through the publication of numerous reports.*

**Pension Policy Institute**

Contact person: Niki Cleal (Director)
Address: King's College, 26 Drury Lane, London, WC2B 5RL
Phone: 0044 (0) 20 7848 3744
Email: niki@pensionspolicyinstitute.org.uk
Webpage: http://www.pensionspolicyinstitute.org.uk/

*The PPI is an educational charity which provides non-political, independent comment and analysis on pension policy in the UK. Findings of its research are used extensively by government decision-makers and advisers, pension and savings providers, employers and trades unions, academics, commentators and the wider public. The PPI has developed a suite of economic models (initially funded by the Nuffield Foundation) that enable the PPI to model the implications of alternative pension policies for hypothetical individuals, for the total aggregate costs of the pensions system and of the distributional implications of alternative policies.*

**Social Market Foundation**

Address: 11 Tufton Street, Westminster, London, SW1P 3QB
Phone: +44(0)207 222 7060
Email: enquiries@smf.co.uk
Webpage: http://www.smf.co.uk/

*The Social Market Foundation is a leading UK think tank, developing innovative ideas across a broad range of economic and social policy. It champions policy ideas which marry markets with social justice and takes a pro-market rather than free-market approach. Its work is characterised by the belief that governments have an important role to play in correcting market failures and setting the framework within which markets can operate in a way that benefits individuals and society as a whole. The Social Market Foundation is politically independent, and works with all of the UK's main political parties. Ian Mulheirn is Director. Chair of the Board is Mary Ann Sieghart. A list of recent publications can be found at http://www.smf.co.uk/research/.*

**Social Policy Research Unit (SPRU), University of York**

Address: University of York, Heslington, York, YO10 5DD
Phone: 01904 321231
Fax: 01904 321270
Webpage: http://www.york.ac.uk/inst/spru/research/aoc.html

*SPRU is one of the leading social policy research centres in the UK. It organises its research around various themes. The Adults, Older People and Carers Team is headed by Professor Gillian Parker. Research carried out by this team focuses on the individual and collective*

*views and experiences of people coping with disability or chronic illness and their families across the life course – particularly their experiences and evaluations of publicly-funded services. A major area of interest across projects within the team is on how, through using services and other formal and informal support arrangements, people can exercise choice and control over their lives and maximise their independence and well-being. SPRU also has a significant focus on research related to health and health care.*

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en