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

Annual National Report 2011

Pensions, Health Care and Long-term Care

United Kingdom

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1 Executive Summary

The UK faces one of the largest budget deficits in the western world. The new Coalition Government of Conservatives and Liberal Democrats has embarked on a major austerity programme with aim to significantly reduce the budget deficit during the current parliament. It is very likely that the austerity measures will have a negative impact on health and long-term care provision as well as the occupational pensions for public sector workers.

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). 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 programmes have been introduced to reduce poverty among pensioners. The current government seems to be committed to continue on the trajectory to improve the adequacy and sustainability of the pension system. Overall, the current structure of the pension system leads to undersaving by a substantial proportion of the population. 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.

The English National Health Service (NHS) is facing the challenge of major organisational reforms and an era of tight budget allocations. The proposed organisational reforms of the NHS to overhaul its commissioning face clear opposition from a number of stakeholders. Although the proposed organisational reforms might yield efficiency savings in the medium to long-term, it would seem to be a big gamble should the government decide to enact them without revisions and against opposition from core stakeholders. As the NHS has to cope with significant efficiency savings, it seems likely that waiting times will increase, after years of decline due to large investments into health care; furthermore, as is suggested by some observers, service provision might also decline as local NHS entities have to live within the constraints of tight budget allocations.

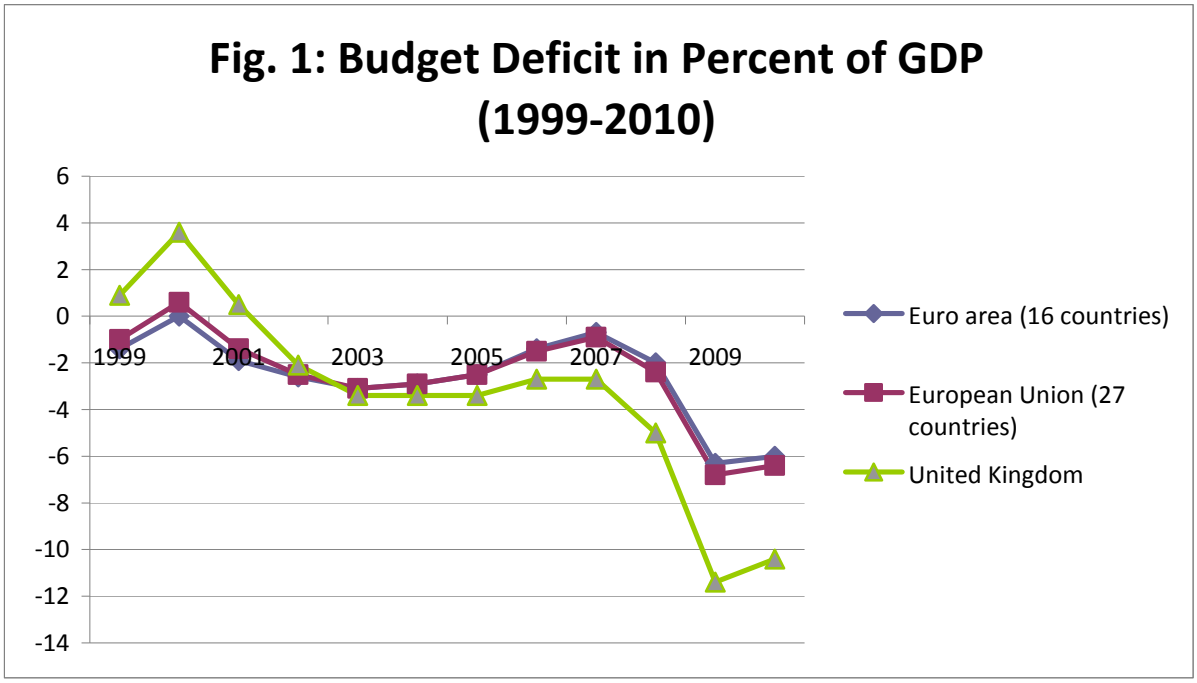
It is widely accepted that long-term care provision and financing is in need of comprehensive reforms in England and Wales. For years governments have discussed and proposed reforms for long-term care provision and financing, especially for England and Wales, without any major effect on the disjointed and unequal provision within an overall public system characterised by means testing. As is highlighted by the current Chair of the *Commission on Funding of Care and Support*, Andrew Dilnot, as well as by the recent report of the *Law Commission* 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 the reductions in funding for local authorities.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

After the general election in May 2010, the Conservatives and Liberal-Democrats formed a coalition government, ending 'New Labour's' 13 years in power. Despite the fact that they have campaigned on different economic and social policy platforms (Seeleib-Kaiser 2010) – the Conservatives calling for significant budget cutbacks and the Liberal-Democrats for a much less ambitious programme to cut the fiscal deficit – budget consolidation has become the top priority of the new UK government, as it is committed to reduce government spending by £95bn by 2015/16 (HM Treasury 2011: 10). As a result the government assumes that public sector net borrowing will decline from its peak of 11.1% of GDP in 2009/10 to 1.5% of GDP in 2015/16 (HM Treasury 2011: 2). According to some estimates, these cutbacks may lead to UK public expenditure dropping below the projections for the US by 2014. Peter Taylor-Gooby and Gerry Stoker (2011: 3) conclude: "This is simply unprecedented and, if fully implemented, indicates a radical new departure in UK policy directions." It is argued by the current government that these drastic steps are necessary to reduce the deficit of more than 10% of GDP in 2010, one of the largest public deficits in the EU (see Fig. 1; HM Treasury 2011). Despite one of the largest demonstrations in recent history, organised by the Trades Union Congress on March 26, 2011 and involving more than 250.000 people coming to London to protest against the government cuts, the government continues to be committed to implement its fiscal austerity programme (BBCa 2011). The effects of the austerity programme start to bite as the government implements its Budget 2011/12 starting in April 2011.

Figure 1



Source: Eurostat; last update: 29.04.2011; date of extraction: 02 May 2011 17:06:41 MEST; Hyperlink: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=teina200.

But not only does the current government intend to scale back the size of the state, it also aims to decentralise its structure, allowing for more local government decision making and private involvement. Normatively the Conservative-Liberal coalition government justifies its policies as providing the underpinning for the creation of a *Big Society*. In the words of David Cameron (2010): "The Big Society is about a huge culture change … where people, in their everyday lives, in their homes, in their neighbourhoods, in their workplace … don't always turn to officials, local authorities or central government for answers to the problems they face but instead feel both free and powerful enough to help themselves and their own communities."

Comparatively speaking, the UK has been characterised as the proto-type of a liberal welfare state in Europe. Nevertheless, compared to other European welfare states, welfare provision has historically been quite state-centric and centralised (Powell 2008). Some of the proposed changes might bring the provision and funding mechanisms of social protection in Britain closer to the more decentralised structures found in many conservative welfare states of Continental Europe. However, due to the approach of fiscal austerity chosen by the current government, and without rapidly increasing economic growth or major productivity increases, which are very hard, if not impossible, to achieve in the health and social care sector, access to health and social care is very likely to be restricted in the short and medium term. A number of unions have threatened strike action in relation to pay freezes and pension reforms likely to affect public sector workers (BBC 2011b; Wright 2011a).
Recent economic data seems to suggest a rather lacklustre economic climate: unemployment, although having slightly declined since December 2010, continues to be at 7.8% (ONS 2011a); Gross Domestic Product (GDP) increased by 0.5% in the first quarter of 2011, following a decrease of 0.5% in the fourth quarter of 2010. The *'effect of the snow'* in December 2010 is estimated to have subtracted 0.5% from growth in the fourth quarter. GDP is estimated now to have returned to the level in the third quarter of 2010 (ONS 2011b). Inflation is running at an annual rate of 5.3% in March 2011, down from 5.5% in February, using the Retail Price Index (RPI) and 4.0%, down from 4.4% in February, using the Consumer Price Index (CPI) (ONS 2011c).

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 Commssion 2004: X). An increasing percentage of pensioners is 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 2010). 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 abolished, which should lead to a later de facto retirement age; c) starting next year, every worker will be automatically enrolled in an occupational pension, with the option to opt out.

The current government is committed to largely continue 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 will increase the Basic State Pension in April 2011 by at least the equivalent of RPI. 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. The additional State Pension (SERPS/S2P) as well as public service pensions are scheduled to increase in line with the CPI (House of Commons Library 2011), which will lead to lower increases in pension benefits. 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 (for details see Table 1). The default retirement age will be abolished in October 2011. Both of these measures should contribute to an increase of the de facto retirement age in the medium term.

Table 1: Increase in State Pension age from 65 to 66 (men and women)

Period within which birthday falls	**Date new State Pension age reached**	**New State Pension age (years.months)**
6 December 1953–5 January 1954	6 March 2019	65.2 – 65.3
6 January 1954–5 February 1954	6 July 2019	65.5 – 65.6
6 February 1954–5 March 1954	6 November 2019	65.8 – 65.9
6 March 1954–5 April 1954	6 March 2020	65.11 – 66.0
From 6 April 1954	66th birthday	66

Source: DWP 2010a: 32.

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.

2.2.2 Debates and political discourse

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), currently 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 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. Within the public political discourse the more 'generous' public sector pensions are often portrayed as 'unfair'. Hence, the government has asked the Labour peer Lord Hutton to present reform proposals. The Hutton Report was published in mid-March 2011 and the main proposals are: a) a switch from final salary to career-average pensions and b) an increase in the normal pension age from 60 to 65 for many staff (Independent Public Service Pensions Commission 2011). The unions have voiced their strong opposition against these proposals (Barber 2011). Subsequently, a number of unions have started to ballot their members for strike action (BBC 2011b) or have already taken strike action (Shephard 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 and the discussion of the EU Pension Green Paper is largely restricted to 'insider' debates among pension professionals (cf. Pensions World 2010; NAPF 2010).

The UK government is committed to increase the retirement age and possibly link it with changes in life expectancy, whether this is a direct impact of EU social policy remains unclear. The default retirement age will be abolished in October 2011. Furthermore, the UK government has brought forward the date to phase-in the increase in state pension age from 65 to 66 to 2018, to be fully implemented by 2020. Both of these measures should contribute to an increase of the de facto retirement age in the medium term, which is also highlighted by the government in its 2011 National Reform Programme (HM Government 2011: 36). In 2009–10, age-related public spending (health, education, pensions and social care) accounted for 22.5% of Gross Domestic Product (GDP). With unchanged policies, this total is projected by the Office for Budget Responsibility to rise to 25.1% of GDP in 2029/30 and 26.6% of GDP by 2039–40, purely as a consequence of demographic change (Office for Budget Responsibility 2010: 145). Against this backdrop and to ensure sustainability, the government is currently consulting on a further proposal that will link the retirement age with increases in life expectancy (DWP 2011: 46).

Historically the pension system in the UK has heavily relied on complementary private and occupational pensions. However, the UK is faced with declining occupational pension coverage (only about 37% of the private sector workforce is enrolled in an occupational pension plan) and insufficient private pension savings (see Table 6). To address the challenge of undersaving, the previous Labour government enacted the 2008 pension reform. Accordingly, workers will be automatically enrolled into workplace pensions from 2012 unless they decide to opt out. Furthermore, the government is currently consulting on a proposal to introduce a single state pension of £140 per week, which should increase the incentives of low-income earners to save for their pension (DWP 2011). Nevertheless, as has

been pointed out above, changes in the tax code will negatively affect employees with higher incomes saving in private or occupational pension schemes.

2.2.4 Impact assessment

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 2 below:

Table 2: 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 18-04-2011; extracted on 04-05-2011 14:12:25; http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.

Based on Eurostat data older people in the United Kingdom seem to have been significantly less affected by the risk of poverty in 2009 than in previous years. Furthermore, the gender gap has slightly narrowed in recent years. Also with respect to severe material deprivation progress seems to have been made, although the data for the most recent year is still 'uncertain' (see Tables 3+4 below). The decline in pensioners' poverty is also reflected in national data published by the Department of Work and Pensions (DWP 2010b: 169). 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 in 2009, jumping from 0.74 in 2008 to 0.80 in 2009.[1] The aggregate replacement ratio (excluding other social benefits) was 0.44 in 2009, slightly below 2006 (0.45) and above 2007 and 2008 (0.43).[2] Whether the success in the recent reduction of poverty rates among older people was the result of declining incomes among the working age population during to the current recession, the special measures for pensioners included in the last budget of the previous Labour government, other circumstances, or a combination of all factors, remains unclear at the moment. The impact of career breaks on the level of the Basic State Pension has been limited recently, due to the reforms of the Basic State Pension implemented in 2010, i.e. only requiring 30 years of employment to receive a full pension.

[1] Eurostat, last update 15-04-2011, extracted on 04-05-2011 14:45:01; http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.

[2] Ibid.

Table 3: At-risk-of-poverty Rate of Older People (65+) by Sex

	2005	2006	2007	2008	2009
EU 27 total	26	25	24.6	23.2	21.7
United Kingdom total	25.9	27.4	28.8	28.5	23.1
EU 27 male	22	21	20.7	19.6	18.3
United Kingdom male	23.0	23.2	25.0	25.4	20.9
EU 27 female	21.1	21.1	21.8	21.2	20.1
United Kingdom female	27.1	29.1	30.6	29.7	24.1

Source: Eurostat; last update 15-04-2011, extracted on 04-05-2011 14:45:01; http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.

Table 4: Severe Material Deprivation of Older People (65+) by Sex

	2005	2006	2007	2008	2009
EU 27 total	10	9	8.6	7.4	6.7
United Kingdom total	1.8	2.1	1.9	1.4	1.2
EU 27 male	8	7	6.9	6.0	5.5
United Kingdom male	1.8	1.8	1.8	1.3	1.2
EU 27 female	11	10	9.8	8.5	7.6
United Kingdom female	1.8	2.3	2.0	1.6	1.2

Source: Eurostat; last update 15-04-2011, extracted on 04-05-2011 14:45:01; http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.

Tables 5 and 6 provide a longitudinal overview of the development of occupational and private pension income, showing a clear decline in the proportion of pensioners receiving occupational pensions among the recently retired.

Table 5: The proportion of pensioner units with occupational pension income and the average amount for those in receipt, 1994-95-2008-09

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Proportion in receipt of occupational pension income (%)															
All pensioner units															
Total	57%	58%	59%	59%	59%	59%	59%	59%	59%	60%	60%	59%	59%	59%	59%
Pensioner couples	69%	70%	71%	71%	70%	68%	68%	68%	67%	68%	68%	66%	67%	65%	65%
Single pensioners	48%	48%	51%	51%	51%	52%	52%	52%	53%	54%	53%	53%	52%	54%	55%
Recently retired pensioner units															
Total	65%	63%	66%	66%	65%	63%	60%	59%	60%	60%	60%	56%	59%	60%	60%
Pensioner couples	74%	73%	76%	77%	74%	72%	70%	67%	68%	68%	69%	65%	65%	62%	62%
Single pensioners	52%	50%	53%	51%	52%	52%	45%	45%	49%	48%	48%	43%	44%	43%	47%
Average amount of occupational pension income for those in receipt (£pw)															
Median amounts															
All pensioner units															
Total	68	66	72	77	76	80	85	91	91	95	103	99	105	103	104
Pensioner couples	103	95	105	111	117	119	129	136	133	144	150	142	155	158	158
Single pensioners	47	46	50	53	54	55	58	59	63	62	69	69	72	70	70
Recently retired pensioner units															
Total	95	92	101	107	107	118	117	140	127	137	143	139	136	135	136
Pensioner couples	111	108	121	134	130	146	144	163	144	157	160	159	168	163	184
Single pensioners	69	71	76	77	74	78	70	87	99	100	104	103	88	84	83

Note: Incomes in £ per week 2008-2009 prices.
Source: DWP Pensioners' Income Series retrieved from http://research.dwp.gov.uk/asd/index.php?page=pensioners_income_arc#PI_Latest.

Table 6: The proportion of pensioner units with private pension income and the average amount for those in receipt, 1994-95-2008-09

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Proportion in receipt of private pension income (%)															
All pensioner units															
Total	59%	60%	62%	62%	62%	63%	64%	64%	65%	67%	66%	66%	66%	67%	68%
Pensioner couples	73%	74%	74%	76%	75%	74%	76%	75%	75%	77%	78%	77%	77%	76%	77%
Single pensioners	49%	50%	52%	52%	53%	54%	55%	55%	56%	58%	57%	57%	56%	58%	60%
Recently retired pensioner units															
Total	69%	67%	70%	70%	71%	70%	67%	67%	68%	69%	70%	67%	67%	65%	66%
Pensioner couples	79%	77%	80%	81%	81%	80%	79%	77%	78%	80%	81%	77%	79%	76%	75%
Single pensioners	54%	53%	55%	55%	56%	56%	49%	50%	55%	55%	54%	51%	51%	49%	54%
Average amount of private pension income for those in receipt (£pw)															
Median amounts															
All pensioner units															
Total	68	65	72	76	75	79	85	90	90	93	100	98	102	102	102
Pensioner couples	103	93	104	109	116	117	126	130	127	136	144	138	149	149	148
Single pensioners	47	45	50	53	53	54	58	59	63	61	68	69	71	68	69
Recently retired pensioner units															
Total	93	90	102	108	107	113	112	130	121	130	138	129	128	127	130
Pensioner couples	110	110	121	133	132	142	136	156	141	147	156	153	161	152	167
Single pensioners	67	68	76	76	71	76	68	81	97	92	103	98	79	85	79

Note + Source see Table 5.

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 percentage of pensioners receiving occupational or other private pensions and 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). It seems very likely that public sector unions will stage industrial action should the government pursue its unilateral pension reforms announced for public sector workers.

2.3 Health Care

2.3.1 The system's characteristics and reforms[3]

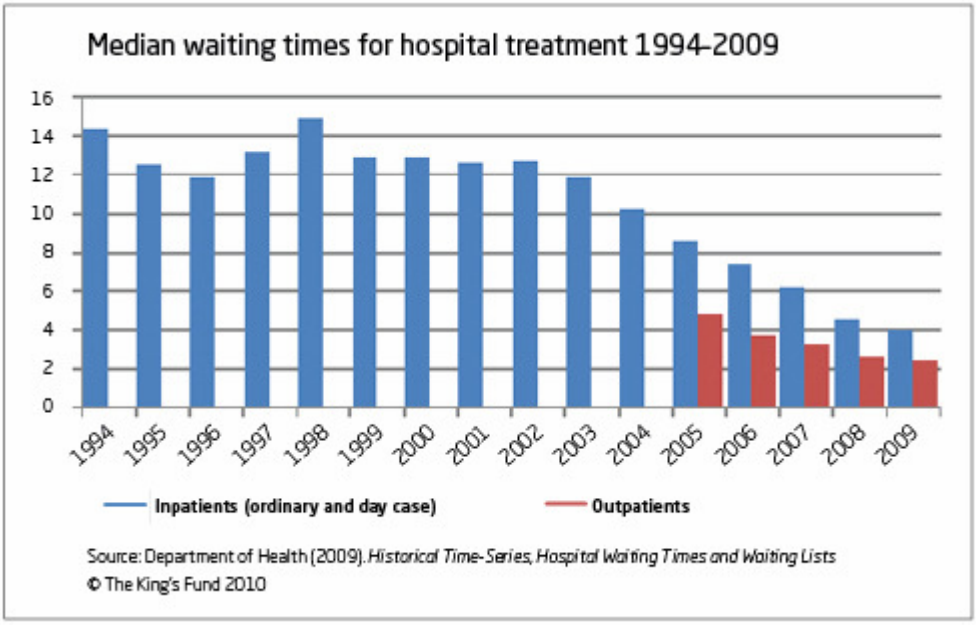
The NHS provides the bulk of health care in the United Kingdom. Although the private health care sector is gaining in importance, private spending is rather small in international comparison. Only about 11% of the UK population is covered by private health insurance. Private insurance has been stimulated mainly by the desire to avoid long NHS waiting times. There is little reliance on out-of-pocket expenditure to finance health care. A major issue continues to be health inequalities that persist and in some cases have even increased at a time when overall health conditions among the population have improved (Department of Health 2009).

Health care expenditure as a percentage of GDP has significantly increased during the last decade. Nevertheless, according to the latest data available from the Office of National Statistics, the UK still spends less than the EU average: expenditure on health care in the UK was estimated at 8.7% of national income in 2008 and the weighted average for European Union member states was 9.6% in 2006 (last year available) (Haynes 2010). The spending had increased by nearly 7% per year in real terms in the previous decade – the largest ever sustained increase in the history of the National Health Service. Clinical performance and patient satisfaction had increased substantially, and waiting times had dropped significantly, since Labour had been in power. But the NHS still lagged behind other European countries on several quality indicators and in particular on cancer mortality (Cooper/McGuire 2010).

"Since devolution in 1999, the four health systems of the UK, always historically different and now enabled by devolution, have drifted further apart" (Greer/Trench 2008). The state in all four nations continues to be the dominant supplier of health care to the population and de jure access is universal. The financing of health care basically relies on general tax revenues. The tremendous increase in health care spending over the past decade has contributed to a significant decline of waiting times, especially in England (see Figure 2).

[3] This section draws heavily on Seeleib-Kaiser (2010) and will mainly focus on the English NHS as it covers 84% of the total population of the United Kingdom and faces significant organisational reforms.

Figure 2



Note: Waiting times in weeks.
Source: King's Fund, retrieved May 4, 2011,
http://www.kingsfund.org.uk/current_projects/general_election_2010/key_election_questions/how_much_have.html.

Although access to health care in all four countries is 'universal', access to specific treatments differs between and within countries. Co-payments for drugs are one example. Whilst patients in England, that are not exempt due to old age, pregnancy, disability etc., have to pay co-payments for drugs, drugs are free of charge in Scotland and Wales. But independently of co-payments certain drugs are available in one region and not in another. A recent study analysing the devolved health services concluded: "In general, the regional analysis showed that the devolved countries tend to be outliers (i.e. outside the distribution of performance across the English regions), with poorer performance than any comparable English region (in some cases excluding London) for hospital waiting times and crude productivity of medical, dental and nursing staff members. Comparing Scotland with English regions (except London) showed that Scotland had the highest standardised mortality ratios, lowest life expectancy, highest levels of expenditure and staffing, and the lowest levels of crude productivity of hospital medical and dental staff, and nursing staff. Comparing Wales and Northern Ireland with the North East showed that Wales and Northern Ireland had per capita expenditure similar to that of the North East, but poorer performance in terms of hospital waiting times, and crude productivity of hospital medical and dental staff (crude productivity of nursing staff in Northern Ireland was marginally higher than in the North East, but in Wales was much lower than in the North East). The North East also had a lower per capita level of non-clinical staff" (Connolly et al. 2010: XIII-XIV).

In its *Spending Review* the government agreed to the equivalent of a 0.1% a year hike in real terms for the NHS in England over the next four years. This includes a 1.3% increase in the resource budget, and a 17% decrease in capital spending. The administration budget will be reduced by 33% (Department of Health 2010). However, historically health spending has gone up by over 4% annually in real terms (cf. BBC 2010) and in the past decade even by nearly 7%, as highlighted above. In its election manifesto of 2010 the Conservative Party had pledged to ring-fence NHS spending, but already at that time critical observers voiced their

scepticism about the claim that frontline services would not be impacted (cf. Seeleib-Kaiser 2010).

In Scotland, a Parliamentary Committee has raised questions about the ways in which budgets have been managed in the past, with staff seemingly employed in jobs that had no productive value. It concludes "The biggest question that emerges is: how did we get here in the first place? What criteria are being used to approve new spending, what standard of evidence is expected to support a spending plan, and how are changes monitored to ensure they have the desired effect? The Committee is concerned that these are fundamental weaknesses in NHS management" (Scottish Parliament 2010). More recently the Scottish Parliament approved a Bill designed to improve patients' experience of the National Health Service. It included a 12-week treatment time guarantee, and a charter of patient rights and responsibilities (Scottish Parliament 2011).

The Welsh Assembly Government agreed the action plan *Fairer Health Outcomes For All: Moving the Agenda Forward* to tackle avoidable and unfair differences in health. The plan has been developed by the Welsh Assembly Government with the support of Public Health Wales. It sets out a vision to improve health and wellbeing for everyone with the pace of improvement increasing fastest in the most disadvantaged communities. Specifically it focuses on seven action areas:

- building health into all policies and all policies into health;
- giving every child a healthy start;
- developing health assets in communities;
- improving health literacy;
- making health and social services more equitable;
- developing a healthy working Wales;
- strengthening the evidence base.

It also addresses the annual cost to the economy of dealing with the consequences of health inequities in Wales which could be as much as £4 billion per year. This is caused by the cost of additional illness, productivity losses, lost taxes and higher welfare payments (Welsh Assembly Government 2011).

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. The concomitant bill is currently under parliamentary consideration (cf. http://services.parliament.uk/bills/2010-11/healthandsocialcare.html).[4] The British Medical Association (BMA) is quite sceptical about the proposed changes. For one the BMA argues that "This is a very difficult climate in which to make substantial service changes and reconfigurations." Secondly, the association reaffirms its opposition to "the commercialisation and active promotion of a market approach in the NHS" (BMA 2010). The NHS confederation in its assessment highlighted a series of risks associated with the proposals and argued that significant cultural and behavioural changes would be required for the reform to be successful (NHS Confederation 2011). Most recently, the government came under pressure also from the Liberal Democrats and the House of Lords. Subsequently it

[4] For a succinct review of the planned changes see National Audit Office (2011).

agreed to "pause, listen and engage" with its critics and promised to bring forward "amendments to improve the plans further" (Parker/Timmins 2011). At their annual meeting the Royal College of Nurses has passed the first vote of no confidence in a health secretary in history (Timmins 2011a).

Furthermore, as the efficiency savings legislated by the previous government and the further efficiency savings demanded by the current government start to bite, considerable controversy has arisen regarding the (potential) increase in waiting times (Timmins 2011b). Many NHS Finance Directors are uncertain whether they will be able to meet their 4% efficiency target this year (Timmins 2011b); a recent report suggested that efficiency savings of 4% this year would not be enough for hospitals to balance their books, arguing that they would have to look for 50% more savings (Gainsbury/Timmins 2011a). Nigel Edwards, acting Chief Executive of the NHS Confederation, summarised the situation: "Very few hospitals are having to make only 4% efficiency savings. Many are facing six, 7 or 8% and one or two 10%. And not necessarily for one year, but year on year for two or three years. Whether that is achievable without fundamental changes in the way services are delivered must be in doubt" (cited in Gainsbury/Timmins 2011b).

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. The consideration of health policies within the UK National Reform Programme 2011 can at best be characterised as marginal and is mostly limited to the section on social exclusion (HM Government 2011: 48 ff.).

2.3.4 Impact assessment

The current environment of cutbacks and 'efficiency' savings is very likely to negatively impact access to health and social care services. The drive to make 'efficiency savings' worth of £20bn by 2015 in the English NHS is said to have already led to the postponement of routine surgery, especially affecting hip and knee replacements, in a number of areas in England. According to Peter Kay, the president of the British Orthopaedic Association, "GPs were told not to send as many patients to hospital, maybe to delay referrals until the end of the financial year while perhaps introducing thresholds for surgery." Seemingly, two different approaches to delay surgery are used: (1) GPs simply stop referring their patients for surgery, which will result in longer de facto waiting, although these are not recorded in the official waiting statistics. (2) The introduction of stricter new criteria which have the effect of delaying the point when a patient can be referred for treatment.[5] Nevertheless, waiting times have also increased significantly since last summer, as hospital waits have hit a three-year high. This seems to be at least partially the result of abolishing waiting time targets, implemented by Health Secretary Andrew Lansley last summer, as well as the pressure on the system to make efficiency savings (Timmins 2011b).

As highlighted in the previous Annual Report (Seeleib-Kaiser 2010) health inequalities in the United Kingdom remain stubbornly high. Without further significant reductions in inequality and poverty it does not seem likely that health inequalities will narrow substantially. A recent study by Hacking et al. (2011) found that inequalities in all-cause mortality between the north and south of England were 'severe and persistent' over the period 1965-2008. The increase in inequalities from 2000 to 2008 was notable, and occurred despite the public policy emphasis in England on reducing inequalities in health. Nevertheless, a very high percentage of the UK population perceived their health as very good (see Table 7).

[5] http://www.bbc.co.uk/news/health-12964360.

Table 7: Self Perceived Health (% of UK population perceiving their health as very good)					
	2005	2006	2007	2008	2009
European Union	20.7	20.3	20.6	21.4	22.3
United Kingdom	33.1	33.0	34.1	39.4	41.2

Source: Eurostat; last update 22-02-2011; extracted on 04-05-2011 18:20:50; http://appsso.eurostat.ec.europa.eu/nui/setupDownloads.do.

A study by Stuckler et al. (2010) argues that public spending cuts announced in the 2010 Budget could cause up to 38,000 extra deaths over the following decade. Reductions in welfare payments, and the 25% cut in spending across many government departments, could lead to an increase in heart attacks and alcohol-related illnesses.[6]

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 revisions. As opposition among members of the Liberal Democrats has also increased recently, however, it seems likely that the proposals will be amended. 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.

In Scotland a report by an independent review came to the conclusion that despite some practical difficulties in its formative years, the free personal and nursing care policy remained popular and had worked well on the whole, delivering better outcomes for Scotland's older people (Seeleib-Kaiser 2010). The improvement of care quality remained an important issue (cf. e.g. Northern Ireland Audit Office 2010)

2.4.2 Debates and political discourse

Based on the unsatisfactory conditions of long-term care a significant debate has been ongoing for years to reform the system in England and Wales. The previous government consulted and eventually drafted a reform programme, proposing the creation of a new

[6] See also http://www.guardian.co.uk/uk/2010/jun/25/budget-mortality-rate-warning.

National Care Service. The comprehensive reform outlined in the White Paper was to be phased in over a period of time. As a first step the Government introduced the Personal Care at Home Bill, to provide free personal care to people in their own homes, for those with the highest needs starting in 2011. The Government estimated that the Bill would help around 400,000 people with care needs and guarantee free personal care for the 280,000 people with the greatest need. The legislation intended to establish a new National Care Service. From 2014 care entitlements were proposed to be extended to anyone staying in residential care for more than two years; people on low incomes would have continued to have free access. After 2015 full free care should have been provided for all. However, during the 2010 election campaign a heated debate developed over funding the system, as the Labour Government suggested introducing a compulsory contribution paid from peoples' estates. The Conservatives dubbed this option as a "death tax" and proposed an alternative partial insurance-based model. Subsequently the Labour Government proposed that funding the comprehensive reform will be decided after a commission reports on funding methods during the forthcoming parliament (Seeleib-Kaiser 2010).

The new government has once again appointed a Commission on Funding of Care and Support (Dilnot Commission) to come up with a long-term reform. The commission will present its report in July 2011 and is likely to recommend a system that neither fully relies on taxation nor on private provision, but some combination of both. The government intends to legislate for a new way of funding care for the elderly in 2012. The commission's chairman, Andrew Dilnot, in a recent newspaper interview said: "Social care is the last vestige we've got of the poor laws ... My own feeling is that the system we have at the moment is not one that we can be very proud of. It is inefficient and ineffective. It is complex and there is a lack of integration across bits of the public sector" (cited by Wright 2011: 2).

The Law Commission (2011) on Adult Social Care recently issued a report relating to adult social care in England and Wales. It concluded: "The legal framework for adult social care consists of an often incoherent patchwork of legislation, which makes interpretation and application of the law complex and time consuming. In our view, consolidation and simplification would be best achieved by establishing a unified adult social care statute." Furthermore, it called for statutes in England and Wales setting out "core duties and powers of local social services authorities, which would not be subject to further directions or approvals. ... Under our scheme, an assessment of need and the application of eligibility criteria would be the sole means by which a person's eligibility for community care services (including residential care) is determined. Following an assessment, local authorities would be required to determine whether a person's social care needs are eligible needs, using eligibility criteria, and to provide or arrange community care services to meet all eligible needs. The duty to meet eligible needs would be an individual duty, enforceable through judicial review."

Whether the commission reports will trigger legislative changes and improvements of care provision in future remains to be seen. However, it is very likely that the cuts in local government spending, expected to decline by 27% over the next four years, will have a negative impact in the short-term on social care provision, as large amounts of local spending (40-60%) are allocated to adult social care and children services. However, as Whitehall does not prescribe where the axe within local government spending should fall, much depends on the priorities set by local councils and their financial resources. Nevertheless, recent analysis by the prestigious King's Fund suggests that there could be a funding gap of more than £1 billion by 2014 unless councils can achieve unprecedented efficiency savings. This would have a knock-on effect on the NHS, with cuts to frontline social care services leading to fewer

people getting the help they need, causing more emergency admissions, delayed discharges and longer waiting times (Humphries 2011).

The Scottish Government recently outlined a proposal to integrate health and social care for adults. The plan is designed to give quicker access to care and reduce delayed discharges. Local councils and health boards would be expected to work more closely together under a 'lead commissioning' model (Scottish Government 2011).

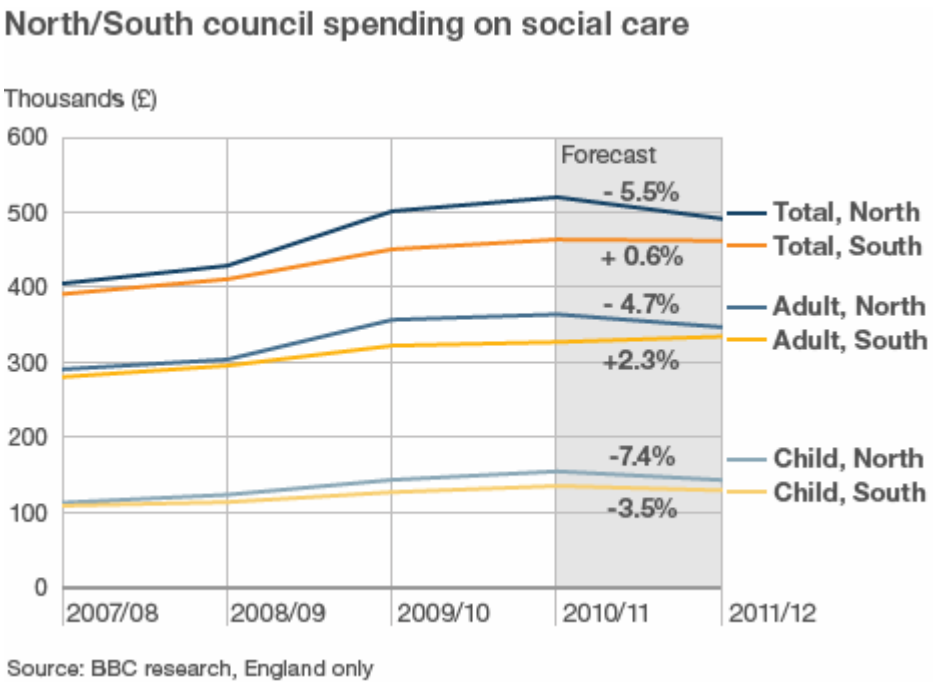
2.4.3 Impact of EU social policies on the national level

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

According to analysis by the Financial Times and the Local Government Association of local budget allocations for social care services there will be severe cutbacks in the magnitude of 23%, or £1.4bn worth nationally. Although the NHS has been instructed to shift £800m of spending previously allocated for capital investment to mediate the shortfall in local council funding, this would still result in a substantial net loss of funding (Gainsbury/O'Murchu 2011). A survey commissioned by the BBC (2011c) found that there will be significant regional disparities: Overall, social care budgets of the councils surveyed are set to be cut by about 2.6%, from £9.79bn to £9.54bn in the current financial year, compared to 2010/11. Durham County Council is among those seeing the biggest cuts to social care, with a planned 18.1% reduction in 2011/12. Adult social care spending will fall by an estimated 4.7% to £3.4bn in the North in 2011/12 and rise by 2.3% to £3.33bn in the South (see Figure 3).

Figure 3:



Hence, it seems very likely that access to long-term care will be restricted in many areas in the near future. According to a recent study the reduction in public support would prompt more people to pay privately for care and/or seek more informal care. However, the substitution of public with private expenditure is likely to be limited because of the limited financial resources available to individuals with needs, who cannot always afford the high costs of private care. As a result, overall (state plus private) expenditure is likely to decline as

the level of public funding is reduced. As a consequence serious equity consequences might arise – with more private funding required, richer people would do better and the poorest people would be the biggest losers (Forder/Fernandez 2010).

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 current Chair of the *Commission on Funding of Care and Support*, Andrew Dilnot, as well as by the recent report of the *Law Commission* 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.

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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

[R5] BOZIO, ANTOINE et al., *How Much Do Lifetime Earnings Explain Retirement Resources?*, Working Paper 11/02, Institute for Fiscal Studies, 2011, available at

http://www.ifs.org.uk/publications/5470.

The working paper by the Institute for Fiscal Studies used a unique dataset, containing individual survey data from the English Longitudinal Study of Ageing linked to administrative data on earnings histories from administrative records, to construct measures of lifetime earnings and examine how these relate to financial resources in retirement. Retirement income and wealth at retirement is, as expected, positively correlated with lifetime earnings but there is also substantial dispersion in retirement income and retirement wealth among people with similar lifetime earnings. For example, the authors find that those with greater numerical ability and higher education tend to have greater retirement resources even after controlling for differences in lifetime earnings. The retirement resources of single women are far less well explained by their own lifetime earnings than those of couples or single men.

[R4] DINI, ERCILIA "Older workers" withdrawal from the labour market 1991 to 2007: impact of socio-demographic characteristics, health and household circumstances', *Population Trends* 142, Winter 2010, Office for National Statistics, available at

http://www.statistics.gov.uk/populationtrends/downloads/poptrends142web.pdf.

The article examines the withdrawal from the labour market of older workers in England and Wales between 1991 and 1995, and in England between 2002-03 and 2006-07. It looked at the relationship between withdrawal from the labour market and demographic and socio-economic characteristics of older workers, their labour market status, health status, housing, household circumstances, and caring commitments at the start of each period being considered.

[R5] DISNEY, RICHARD et al., *Booms, Busts and Retirement Timing*, Working Paper 10/233, Centre for Market and Public Organisation (University of Bristol), Bristol, 2010, available at

http://www.bristol.ac.uk/cmpo/publications/papers/2010/wp233.pdf.

The research analyses the effect on people's retirement timing of asset prices and labour market conditions over the economic cycle. There was little evidence that 'wealth' effects influenced retirement timing: but there were significant effects of labour market conditions, with higher unemployment rates leading to earlier retirement.

[R1] HIGGS, PAUL; GILLEARD, CHRIS "Generational conflict, consumption and the ageing welfare state in the United Kingdom", *Ageing and Society*, Volume 30 Issue 8, 2010, available at

http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=7909168.

The study critically examined the argument that the levels of income and wealth enjoyed by older cohorts (the 'welfare generation' born in the post-war period) could only be sustained by cutbacks in entitlements for younger cohorts. The very success of the 'welfare generation' is perceived as undermining the future viability of the welfare state, and some argue that the current levels of income and wealth enjoyed by older cohorts can only be sustained by cutbacks in entitlements for younger cohorts. This will lead to a growing 'generational fracture' over welfare policy. This paper challenges this position, arguing that both younger and older groups find themselves working out their circumstances in conditions determined more by the contingencies of the market than by social policy.

[R3] KETER, VINCENT *Retirement Age*, Standard Note SN/BT/961, House of Commons Library, London, 2011, available at

http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/snbt-00961.pdf.

The briefing paper examined policy and legal developments in relation to a mandatory retirement age.

[R5] MACLEOD, ALISON et al., *Managing an Ageing Workforce: How employers are adapting to an older labour market*, Chartered Institute of Management /Chartered Institute of Personnel and Development, London, 2010, available at

http://www.managers.org.uk/sites/default/files/CMI_CIPD_Managing_an_Ageing_Workforce_Sept_2010.pdf.

Only 14% of managers and HR managers consider their organisation very well prepared to cope with the issues caused by an ageing workforce. Only a third of managers reported that there is board-level recognition of the need for an effective strategy on employing older workers.

[R5] MAWHINNEY, PHIL *Ready for Retirement? Pensions and Bangladeshi self-employment*, Runnymede Trust, London, 2010, available at

http://www.runnymedetrust.org/publications/154/32.html.

The report examined pensioner poverty and access to pensions among black and minority-ethnic communities. Minority-ethnic groups were up to three times as likely as white people to experience poverty in retirement. The report highlighted the ways in which self-

employment – common among Bangladeshi people – posed particular barriers to having a good pension.

[H] Health

[H1] APPLEBY, JOHN, *Rapid Review of Northern Ireland Health and Social Care Funding Needs and the Productivity Challenge: 2011/12-2014/15*, Belfast: Northern Ireland Executive, 2011, retrieved from

http://www.dhsspsni.gov.uk/final_appleby_report_25_march_2011.pdf.

The report highlighted that Northern Ireland health and social care services were facing a funding gap of £1 billion. There was a 9% greater need for health and social care services in Northern Ireland than in England.

[H1] AUDIT COMMISSION**,** *More for Less 2009/10: Are efficiency and productivity improving in the NHS?*, London: Audit Commission, 2010, retrieved from

http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20101216moreforless200910.pdf.

An audit report said that National Health Service trusts could make savings through doing more day surgery by moving to the best quartile performance on each relevant procedure and changes in staffing.

[H7] BUTTERS, ANDREW; WEBSTER, MIKE; HILL, MATT Literature Review: Understanding the Needs of People with Mental Health Conditions and/or Learning Disabilities and the Implications for the Pension, Disability and Carers Service, Research Report 654, Department for Work and Pensions**,** London, 2010, available at

http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep654.pdf.

A literature review examined the needs, preferences, and experiences of people with mental health conditions and/or learning disabilities when accessing benefits, specifically disability living allowance and attendance allowance.

[H1] CALEY, MICHAEL; SIDHU, KHESH "Estimating the future healthcare costs of an ageing population in the UK: expansion of morbidity and the need for preventative care", *Journal of Public Health,* Volume 33 Number 1, 2011, available at

http://jpubhealth.oxfordjournals.org/content/33/1/117.short.

The health care costs of an ageing population have major consequences for health care organisations and have major implication for strategic planning of services. The authors present a methodology of estimating the future health care costs to an organisation due to an ageing population that takes account of the excess costs in the years before death and the effect of morbidity compression or expansion. The performance of three different models is evaluated. The three models all give markedly different estimated costs. Models failing to take into account both the cost burden towards the end of life and compression or expansion of morbidity can vastly under- or overestimate the most accurate estimates of health care expenditure due to an ageing population with annual increases in costs varying from 0.48 to

1.12%. The importance of being able to accurately predict demand and costs of health care within the NHS cannot be underestimated. Making over simplistic assumptions and not using well-established principles in these models leads to greatly different outcomes that have the potential to have massive organisational consequences in terms of short-to-medium term strategic planning.

[H7] CARE QUALITY COMMISSION *The Operation of the Deprivation of Liberty Safeguards in England, 2009/10*, Care Quality Commission, London, 2011, available at

http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=37200&FAArea1=customWidgets.content_view_1&usecache=false.

The inspectorate for health care and social care published its first monitoring report on the implementation of the deprivation of liberty safeguards, designed to protect the rights of people in care homes and hospitals in England who lacked the mental capacity to consent to their care or treatment.

[H3] COLLIS, ALEX; STOTT, NEIL; ROSS, DANIELLE, *Workers on the Move 3: European Migrant Workers and Health in the UK – The evidence*, Keystone Development Trust, Norfolk, 2011, available at

http://www.keystonetrust.org.uk/documents/122.pdf.

The study examined access to, and uptake of, health services by European migrant workers in the United Kingdom; and their experiences and perceptions of local health services. It also considered migrant workers' uptake of, and attitudes towards, health promotion activities – both in their country of origin and in the UK.

[H1] COOPER, ZACK; MCGUIRE, ALISTAIR *Health: Higher Spending Has Improved Quality, But Productivity Must Increase*, Centre for Economic Performance/London School of Economics, London, 2010, available at

http://cep.lse.ac.uk/pubs/download/ea009.pdf.

The LSE working paper presents clear data showing that health care spending had increased by nearly 7% per year in real terms in the previous decade – the largest ever sustained increase in the history of the National Health Service. Clinical performance and patient satisfaction had increased substantially, and waiting times had dropped significantly, since Labour had been in power. But the NHS still lagged behind other European countries on several quality indicators and in particular on cancer mortality.

[H4, H5] DIXON, ANNA *et al.*, *Patient Choice: How patients choose and how providers respond*, King's Fund, London, 2010 available at

http://www.kingsfund.org.uk/press/press_releases/support_for_patient.html.

The report published by The King's Fund shows that having a choice of hospitals is valued by the majority of patients. However, it is not yet operating as intended and has not so far acted as a lever to improve quality and increase competition.

[H4] GREER, SCOTT; TRENCH, ALAN "Intergovernmental relations and health in Great Britain after devolution", *Policy & Politics,* Volume 38 Number 4, 2010, available at

http://www.ingentaconnect.com/content/tpp/pap/2010/00000038/00000004/art00002.

This article analyses the impact of devolution on health policy options. It is based on extensive elite interviewing, identifies 'bottom-up' issues in which health policy divergence creates intergovernmental friction and 'top-down' issues in which broader conflicts affect health. The rest of the article identifies and explains the mechanisms of coordination and dispute resolution, finding them probably inadequate to managing conflict.

[H1] GOLDMAN, CHARLOTTE; CARRIER, JANE, "Joint financing in the new NHS: thinking to the future", *Journal of Integrated Care,* Volume 18, Number 6, 2011, retrieved from

http://pierprofessional.metapress.com/content/351122t536355272.

This article follows an earlier study by Goldman and examines the emerging government policy on integration and considers some of the implications for joint financing. Most primary care trusts (PCTs) and councils with adult social care responsibilities are engaged in joint financing and wider health and social care partnership arrangements. But, with the demise of PCTs and the growth in GP commissioning, there are issues and questions about the future of such arrangements.

[H3] HACKING, JOHN; MULLER, SARA; BUCHAN, IAN 'Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study', *British Medical Journal,* 15 February 2011, available at

http://www.bmj.com/content/342/bmj.d508.short?rss=1&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+bmj%2Frecent+%28Latest+from+BMJ%29.

The study found that inequalities in all-cause mortality between the north and south of England were "severe and persistent" over the period 1965-2008. The increase in inequalities from 2000 to 2008 was notable, and occurred despite the public policy emphasis in England on reducing inequalities in health.

[H4,H5] HEINS, ELKE *et al*., "A review of the evidence of third sector performance and its relevance for a universal comprehensive health system", *Social Policy and Society,* Volume 9 Issue 4, 2010, available at

http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=7887941&fulltextType=RA&fileId=S1474746410000230.

UK policy promotes third sector organisations as providers of NHS funded health and social care. The authors examine the evidence for this policy through a systematic literature review. The results highlight several problems of studies comparing non-profits with other provider forms, questioning their usefulness for drawing lessons outside the place of study. Most studies deem contextual factors and the regulatory framework in which providers operate as much more important than ownership form. The authors conclude that the literature does not support the policy of a larger role for the third sector in health care, let alone a switch to a market-based system.

[H1] HOUSE OF COMMON, HEALTH COMMITTEE*, Public Expenditure*, Second Report (Session 2010-11), HC 512, House of Commons Health Select Committee/TSO, London, 2010, retrieved from

http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/512.pdf.

The report emphasised that health and social care services would need to make efficiency gains on an 'unprecedented scale' if levels of service were to be maintained and improved. Local councils had not been provided with the necessary resources to sustain existing eligibility levels for social care, and would need to sustain further efficiency savings of up to 3.5% per annum in order to do so: but the government had not provided a 'clear enough narrative' on its vision of how these savings were to be made.

[H5] HUMPHRIES, RICHARD; CURRY, NATASHA *Integrating Health and Social Care: Where Next?*, King's Fund, London, 2011, available at

http://www.kingsfund.org.uk/press/press_releases/rethink_needed_on.html.

A think-tank report called for a single performance framework to ensure that National Health Service and social care services worked together to improve outcomes for patients and service users. Government plans for separate outcomes frameworks for the NHS, social care, and public health could threaten effective joint working at a local level, reducing benefits for patients and service users.

[H4, H5] NATIONAL AUDIT OFFICE, *National Health Service Landscape Review*, HC 708 (Session 2010-11), National Audit Office, London: TSO, available at

http://www.official-documents.gov.uk/document/hc1011/hc07/0708/0708.pdf.

The report reviews the proposed organisational reforms and accesses the risks associated with their implementation.

[H4] NHS CONFEDERATION, *Where Next for NHS Reform?*, NHS Confederation, London, 2011, available at

http://www.nhsconfed.org/Publications/Documents/NHS_reform_discussion_paper_0411.pdf.

The paper raises a number of issues of the planned NHS reform relating to competition, GP commission consortia, accountability and the risks in the transition.

[H4, H5] NHS CONFEDERATION, *Liberating the NHS. What Might Happen?*, NHS Confederation, London, 2011, available at

http://www.nhsconfed.org/Publications/Documents/liberating_NHS_leedsJan2011.pdf.

The report argued that there were real potential benefits in the new government's plans to move decision-making closer to family doctors, and in extending the range of health care providers. But it highlighted a series of risks associated with the proposals. Significant cultural and behavioural changes would be required, and low involvement by family doctors was among the biggest threats to success.

[H3] PHILLIMORE, JENNEY 'Approaches to health provision in the age of super-diversity: accessing the NHS in Britain's most diverse city', *Critical Social Policy*, Volume 31 Issue 1, 2011, available at

http://csp.sagepub.com/content/31/1/5.abstract.

Using data from research undertaken from studies of health service provision in the West Midlands the paper explores the challenges of meeting the needs of new migrants under existing provision, the costs of failing to adapt to super-diversity and the reasons why provision has failed to adapt. The paper concludes by arguing the need for different approaches to provision, and suggesting some new ways forward.

[H7] PRIESTLEY, MARK *et al.*, "Cultures of welfare at the front line: implementing direct payments for disabled people in the UK", *Policy & Politics,* Volume 38 Number 2, 2010, available at

http://www.ingentaconnect.com/content/tpp/pap/2010/00000038/00000002/art00008.

Direct payments are central to UK independent living and welfare modernisation agendas, however, little is known about the local cultures of welfare within which they are implemented. This article uses eight case studies of devolved governance within local authorities and trusts to explore the dynamics of implementation cultures at the front line. While national and local policies are clearly important, so too are political cultures, commissioning practices and interrelationships between key stakeholders. While local authorities have enjoyed considerable discretion and autonomy in this area, the article concludes that greater harmonisation may be required in the interests of social justice.

[H1, H5] SCOTTISH PARLIAMENT, *NHS Board Revenue Allocations*, 8th Report 2010, SP Paper 477, Scottish Parliament Health and Sport Committee, 2010, available at

http://www.scottish.parliament.uk/s3/committees/hs/reports-10/her10-08.htm#7.

The parliamentary committee highlighted "fundamental weaknesses" in National Health Service management relating to spending, budgeting, and staff resources.

[H1] SECRETARY OF STATE FOR HEALTH, *Government Response to the House of Commons Health Select Committee Report on Public Expenditure*, Cm 8007, London: Department of Health, TSO, 2011, retrieved from

http://www.official-documents.gov.uk/document/cm80/8007/8007.pdf.

The government response highlighted that the central government had made available sufficient amounts of money for local authorities to meet demographic pressures and continue to maintain access to services, if they implemented modernisation and efficiency with vigour.

[H3] SMITH, MICHAEL; OLATUNDE, OLUGBENGA; WHITE, CHRIS "Inequalities in disability-free life expectancy by area deprivation: England, 2001-04 and 2005-08", *Health Statistics Quarterly 48*, Winter 2010, Office for National Statistics, available at:

http://www.statistics.gov.uk/hsq/downloads/hsq48.pdf.

Life expectancy (LE) and disability-free life expectancy (DFLE) for males and females at birth and at age 65 were estimated using a combination of survey, mortality and population

data; survey data provided an estimate of the prevalence of limiting long-standing illness or disability (LLSI) used in the DFLE metric. An estimate of the inequality in DFLE between area-based quintiles of relative deprivation (using the Index of Multiple Deprivation 2007) in the periods 2001-04 and 2005-08 enabled the measurement of change in equality over time between advantaged and disadvantaged areas. The prevalence of LLSI among males and females rose incrementally with increasing levels of deprivation in both periods. Males and females in the most deprived areas were more than 1.5 times more likely to report LLSI compared to those in the least deprived areas. There were also large inequalities in LE and DFLE in a similar pattern to LLSI. The extent of inequality in DFLE between the most and least deprived quintiles was approximately twice that of LE. Although LE and DFLE generally increased over time, this improvement varied across quintiles, causing the gap between the most and least deprived quintiles to increase. In comparison with more advantaged areas, people experiencing the greatest deprivation spent the greatest proportion of their lives with a limiting illness or disability, and this proportion increased over time.

[H3] THOMAS, BETHAN; DORLING, DANNY; SMITH, GEORGE D. "Inequalities in premature mortality in Britain: observational study from 1921 to 2007", *British Medical Journal,* 22 July 2010, available at

http://www.bmj.com/content/341/bmj.c3639.short?rss=1&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+bmj/recent+%28Latest+from+BMJ%29.

The objective of this study is to report on the extent of inequality in premature mortality as measured between geographical areas in Britain. The study is based on routinely collected mortality data and public records (population subdivided by age, sex, and geographical area (parliamentary constituencies from 1991 to2007, pre-1974 local authorities over a longer time span). When measured by the relative index of inequality, geographical inequalities in age-sex standardised rates of mortality below age 75 have increased every two years from 1990-1 to 2006-7 without exception. Over this period the relative index of inequality increased from 1.61 (95% confidence interval 1.52 to 1.69) in 1990-1 to 2.14 (2.02 to 2.27) in 2006-7. Simple ratios indicated a brief period around 2001 when a small reduction in inequality was recorded, but this was quickly reversed and inequalities up to the age of 75 have now reached the highest levels reported since at least 1990. Similarly, inequalities in mortality ratios under the age of 65 improved slightly in the early years of this century but the latest figures surpass the most extreme previously reported. Comparison of crudely age-sex standardised rates for those below age 65 from historical records showed that geographical inequalities in mortality are higher in the most recent decade than in any similar time period for which records are available since at least 1921. Inequalities in premature mortality between areas of Britain continued to rise steadily during the first decade of the 21st century. The last time in the long economic record that inequalities were almost as high was in the lead up to the economic crash of 1929 and the economic depression of the 1930s. The economic crash of 2008 might precede even greater inequalities in mortality between areas in Britain.

[H2] TUC, *The Case for Health and Safety*, Trades Union Congress, London, 2010, available at

http://www.tuc.org.uk/workplace/tuc-18416-f0.cfm.

The TUC report reveals that more than 20,000 people in the UK are killed prematurely by their work every year – the equivalent of the entire population of the Orkney Islands. The report finds that many workers are also injured during the course of their work. The Health

and Safety Executive (HSE) estimates that 246,000 workplace injuries should have been reported last year but many accidents go unreported or are not reported correctly.

[H2] WELSH ASSEMBLY GOVERNMENT, *Fairer Health Outcomes For All: Moving the agenda forward*, Welsh Assembly Government, Cardiff, 2011, available at

http://wales.gov.uk/docs/phhs/publications/110329working2en.pdf.

The Welsh Assembly Government published an action plan designed to promote its public health objectives, including: giving every child a healthy start; developing health assets in communities; improving health literacy; and making health and social services more equitable.

[L] LONG-TERM CARE

[L] CHALLIS, DAVID et al. "Comprehensive assessment of older people with complex care needs: the multi-disciplinarity of the single assessment process in England", *Ageing and Society*, Volume 30 Issue 7, 2010, available at

http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=7894630.

The quality of assessment of older people with health and social care needs has for some time been a concern of policy makers, practitioners, older people and carers in the United Kingdom and internationally. This article seeks to address a key aspect of these concerns, namely whether sufficient expertise is deployed when, as a basis for a care plan and service allocation, an older person's eligibility for local authority adult social-care services requires a comprehensive needs assessment of their usually complex and multiple problems. Is an adequate range of professionals engaged, and is a multi-disciplinary approach applied? The Single Assessment Process (SAP) was introduced in England in 2004 to promote a multi-disciplinary model of service delivery. After its introduction, a survey in 2005-06 was conducted to establish the prevalence and patterns of comprehensive assessment practice across England. The reported arrangements for multi-disciplinary working among local authority areas in England were categorised and reviewed. The findings suggest, first, that the provision of comprehensive assessments of older people that require the expertise of multiple professionals is limited, except where the possibility arose of placement in a care-home-with-nursing, and second that by and large a systematic multi-disciplinary approach was absent. Policy initiatives to address the difficulties in assessment need to be more prescriptive if they are to produce the intended outcomes.

[L] CURRIE, COLIN "Health and social care of older people: could policy generalise good practice?", *Journal of Integrated Care,* Volume 18 Number 6, 2010, available at

http://pierprofessional.metapress.com/content/3326441653163q58.

Current provision of health and social care for older people reflects a dysfunctional historic legacy of separatism, one with increasingly unacceptable consequences for the quality and cost-effectiveness of the care provided. However, there is now detailed and encouraging comparative evidence to support the view that more integrated care – delivered jointly, promptly and flexibly to meet the changing clinical and dependency needs of frailer older people at home – can minimise unnecessary use of more costly and less preferable care elsewhere, and thus reduce the overall costs of late-life care while improving its quality. This paper considers the background to the widely prevailing culture of separatism, presents

quantitative evidence of the current postcode lottery in care, describes examples of current good practice, considers some options on functional and structural integration, and speculates on policy that might deliver better and more cost-effective care for an ageing population at a time of impending stringency in the funding of public services.

[L] DARTON, ROBIN *et al*., "Slicing up the pie: allocation of central government funding of care of older people", *Social Policy and Administration,* Volume 44 Number 5, 2010 available at

http://www.ingentaconnect.com/content/bpl/spol/2010/00000044/00000005/art00001.

The allocation of central government funds is a critical element in the equitable provision of local authority-commissioned and -provided services. A variety of approaches to allocating funding for social services for older people have been used over the years, most recently founded on `needs-based' formulae. In 2004, the Department of Health for England commissioned research to help inform the improvement and updating of the formula. The results of individual-level analyses were compared with the results obtained from analyses of small area (ward-level) data on service users. Both analyses were affected by problems of data availability, particularly the individual-level analysis, and the Department of Health and the (then) Office of the Deputy Prime Minister decided that the formula calculations should be based on the results of the small area analysis. However, despite the differences in approach, both methods produced very similar results. The correlation between the predicted relative needs weights for local authorities from the two models was 0.982. The article discusses the strengths and weaknesses of each approach and developments that could allow a normative approach that would incorporate future policy objectives into formulae that, to date, have inevitably been based on historical data and service patterns.

[L] FORDER, JULIEN; FERNANDEZ, JOSE-LUIS *The Impact of a Tightening Fiscal Situation on Social Care for Older People*, Discussion Paper 2723, Personal Social Services Research Unit, Canterbury, London, Manchester, 2010, available at

http://www.pssru.ac.uk/pdf/dp2723.pdf.

The study modelled the impact of a tightening fiscal situation on social care for older people. A reduction in public support would prompt more people to pay privately for care and/or seek more informal care. However, the substitution of public with private expenditure was limited because of the limited financial resources available to individuals with needs, who could not always afford the high costs of care. As a result, overall (state plus private) expenditure was lower when the level of public funding was reduced. There were also equity consequences – with more private funding required, richer people would do better and the poorest people would be the biggest losers.

[L] LOCAL GOVERNMENT ASSOCIATION *Discussion Paper – The Future of Adult Social Care*, Local Government Association, London, 2010, available at

http://www.lga.gov.uk/lga/core/page.do?pageId=14762210.

A discussion paper said that the social care system would collapse if elderly and disabled people continued to be 'pushed' into nursing homes and day centres. A change of approach was needed, under which local councils – building on relationships with health professionals

and community groups – provided care services for older people and those with physical and learning disabilities in their own homes and communities.

[L] MAYHEW, LES et al. "The role of private finance in paying for long-term care", *Economic Journal,* Volume 120 Issue 548, 2010, available at

http://www.res.org.uk/journals/abstracts.asp?ref=0013-0133&vid=120&iid=548&aid=7&doi=10.1111/j.1468-0297.2010.02388.x.

An ageing population and increased longevity means that long-term care will become progressively more expensive. In 2009 the Government published a Green Paper on future funding options and a White Paper in 2010. This article considers the role of private finance products under the 'Partnership' option. It finds that few households are able to pay for LTC based on income and savings but the number increases if housing assets are included. Mayhew et al. show that products can be devised for a range of circumstances, although state support would need to continue. The authors propose a simplified means testing system based on a combination of income and assets.

[L] NORTHERN IRELAND ASSEMBLY, *Report on Arrangements for Ensuring the Quality of Care in Homes for Older People*, Fourth Report (Session 2010-11), Northern Ireland Assembly Public Accounts Committee, TSO, Belfast, 2011, available at

http://www.niassembly.gov.uk/public/2007mandate/press/2010/pac071011.htm.

The report argued that much more needed to be done to shift the balance of provision for older people from institutional care to care in the home.

[L] SHAH, SUNIL et al., "Quality of chronic disease care for older people in care homes and the community in a primary care pay for performance system: retrospective study", *British Medical Journal,* 8 March 2011, available at

http://www.bmj.com/content/342/bmj.d912.

The aim of this study was to describe the quality of care for chronic diseases among older people in care homes (nursing and residential) compared with the community in a pay for performance system. Design: Retrospective analysis of The Health Improvement Network (THIN), a large primary care database. Participants: 10,387 residents of care homes and 403,259 residents in the community aged 65 to 104 and registered for 90 or more days with their general practitioner. Results: After adjustment for age, sex, dementia, and length of registration, attainment of quality indicators was significantly lower for residents of care homes than for those in the community for 14 of 16 indicators. Conclusion: There is scope for improving the management of chronic diseases in care homes. The Quality and Outcomes Framework, and other pay for performance systems, should monitor attainment and exception reporting in vulnerable populations such as residents of care homes and consider measures that deal with the specific needs of older people.

[L] STONE, EMMA; WOOD, CLAUDIA "A funding settlement that works for people, not services", *Quality in Ageing and Older Adults,* Volume 11 Number 4 | Dot Gibson, "Time for a tax-funded national care service", *Quality in Ageing and Older Adults,* Volume 11 Number 4 | Richard Humphries and Julien Forder, "Options for funding long-term care: the

partnership model compared", *Quality in Ageing and Older Adults,* Volume 11 Number 4 | James Lloyd, 'Navigating the long road to long-term care funding reform', *Quality in Ageing and Older Adults,* Volume 11 Number 4, 2010, available at

http://pierprofessional.metapress.com/content/g765675q7t350q31.

This series of articles examines options for the funding of long-term social care services.

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)845 125 9732
Email:	enquiries@ageconcernandhelptheagedscotland.org.uk

Wales

Address:	Tŷ John Pathy 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ
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
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:	91 Mitchell Street, Glasgow, G1 3LN
Phone:	0044 (0) 141 221 9141
Fax:	0044 (0) 141 221 9140
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/Policyandpractice/PolicyResources/Policybriefings). 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
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, we conduct 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: vacant

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: The Scottish Government, Victoria Quay, Edinburgh, EH6 6QQ
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: Edwina Hart (Minister for Health and Social Services)
Address: Department for Health & Social Services
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 Rosie Winterton is Minister of State for Pensions and the Ageing Society. 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
Email: c.heidbrink@lse.ac.uk
Fax: 0044 (0) 20 7955 6803

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 Management Committee. 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)

Address: LSE, CASE, Houghton Street, London WC2A 2AE
Phone: 0044(0)20 7955 6679

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 Ltd, NIOC House, 4 Victoria Street, London, SW1H0NX
Phone: 0044 (0) 20 7808 1300
Fax: 0044 (0) 20 7222 7585
Email: napf@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. The 2008 Survey is based on responses from over 300 NAPF fund members - including both smaller employers and multi-national organisations.

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

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

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

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. The PPI is also part of a consortium which has been awarded a grant by the ESRC under their New Dynamics of Ageing research programme. This is to conduct a study of Modelling Ageing populations to 2030 and beyond (MAP 2030) in collaboration with researchers at the University of Essex, University of Leicester, London School of Hygiene and Tropical Medicine, and the London School of Economics. The three year study began in January 2007. The MAP 2030 website can be found at http://www.lse.ac.uk/collections/MAP2030/.

Social Market Foundation

Address: 11 Tufton Street, Westminster, London, SW1P 3QB

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/publications.html.

Social Policy Research Unit (SPRU), University of York

Address: University of York, Heslington, York, YO10 5DD

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 Caroline Glendinning. 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.

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(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