Annual National Report 2010

Pensions, Health and Long-term Care

United Kingdom

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On behalf of the
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1 Executive Summary

The UK economy faces difficult times as a result of the financial turmoil and global downturn. Mainly due to a sharp decline in revenues, the country is confronted with a crisis of public finances. As a consequence of the dire public finances it is unclear, whether the Government will be able to continue its investments towards achieving a higher level of social inclusion and improving health care services at the rate witnessed in the previous decade, independently of which party wins the upcoming election.

The UK Government has enacted a significant pension reform in 2007/08 that will improve the access to and benefit levels of the private as well as public schemes and thereby contribute to an increased overall adequacy of the pension system. Recent data has shown that the Government was less successful in further reducing poverty amongst pensioners during the past three years, after significant reductions during the previous decade. Nevertheless, the Government seems committed to continue its efforts to reduce poverty amongst this group, as demonstrated in the recent budgets. The financial and economic crisis of 2008/09 had a significant negative impact on private/occupational pension funds. However, the last year has seen some improvements in the asset value of pension schemes.

Investment in health care continued at a very high level and included improvements in the infrastructure and an expansion of the workforce. Although tackling health inequality has been a policy priority, relative health inequalities remain quite stark. Overall, the quality of and access to health care has improved; differences between the four countries remain significant. In some instances, such as the Staffordshire Health Trust, the quality assurance system seems to have failed, which subsequently led to excess deaths.

The situation of the long-term care arrangements in England, Northern Ireland and Wales are considered by many observers as unsatisfactory and unsustainable. The Government in England has published a White Paper in 2010 and started to implement reform elements. Similarly, consultation processes to reform long-term care were started in Northern Ireland and Wales. However, differences between the parties in the upcoming parliamentary election have led to the postponement of a comprehensive reform, as they could not agree on the funding mechanism.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the Previous Year

The previous year has been dominated by the upcoming election and a political debate on the impact of the economic crisis on domestic policies and public finances. Due to the upcoming election on May 6, political parties have been rather reluctant to specify any detailed budget cuts. Both major parties, the Conservatives as well as Labour, have promised to protect spending for the NHS. The main political debate has centred on the question, when to start cutting public expenditure. Whilst the Conservative Party has emphasised that cutting public expenditure should be made an immediate priority, the Labour Party as well as the Liberal Democrats have argued that it is too early to withdraw public money from the economy and that such an approach would lead to double-dip recession. They propose to start cutting the budget deficit in 2011. It seems likely that after the election, political parties will be more forthcoming with reforms of the social protection system and tax increases, a combination of which is deemed inevitable due to the crisis in public finances. One of the likely measures will be an increase in the statutory retirement age and cutbacks in pension entitlements for public sector workers. The Institute for Fiscal Studies, an independent think tank, concludes in a recent study: "None [of the political parties] has announced plans for significant cuts to social security spending and, without them, their plans would require deep cuts to spending on public services. Over the four years starting in April 2011, both Labour and the Liberal Democrats would need to deliver the deepest sustained cut to spending on public services since the four years from April 1976 to March 1980. Starting this year, the Conservative plans imply cuts to spending on public services that have not been delivered over any five-year period since the Second World War."[1]

2.1 Pensions

In 2007/08, the UK has embarked on a significant pension reform trajectory that will impact the public as well as the private pillars. In general, these changes will improve the access to and benefit levels of the private as well as public schemes and thereby contribute to an increased overall adequacy of the pension system. The Pensions Act 2007 will benefit especially those future pensioners with shorter contributory periods, as the years it takes to build a full Basic State Pension will be reduced from 44 years for men and 39 years for women to 30 years for everyone retiring on or after 6 April 2010. In the medium-term, the Government will reintroduce earnings uprating, subject to affordability and the fiscal position in 2012, but in any event at the latest of the next Parliament. The state pension age will be raised over time from currently 65 (60 for women) to age 68 in 2046.[2] A second reform (Pensions Act 2008), building on the Pensions Act 2007, was enacted in November 2008.[3] According to the legislation all workers with an income above a certain minimum threshold will be automatically

[1] Institute for Fiscal Studies (2010a) Filling the Hole: How the three main UK parties plan to repair the public finances. London: Institute of Fiscal Studies [available at http://www.ifs.org.uk/bns/bn99.pdf].

[2] Pensions Act 2007 available at http://www.opsi.gov.uk/acts/acts2007/ukpga_20070022_en_1.

[3] Pensions Act 2008 available at http://www.opsi.gov.uk/acts/acts2008/ukpga_20080030_en_1. For further details see http://www.dwp.gov.uk/pensionsreform/pensions_act_2008.asp.

enrolled into a qualifying workplace pension, with an option to opt out. Auto-enrolment will most likely lead to higher participation rates in workplace pensions.[4]

The overall direction of pension reform is supported by both major parties and the social partners. Both reforms will contribute to increased gender equality among pensioners. As women tend to have shorter work histories a majority of them currently does not qualify for the full Basic State Pension.[5] Furthermore, women are more likely to be lower earners and to work for small firms, two groups that are not currently served well by the pensions market.[6]

As the various reform elements are phased in over longer time periods, these reforms do not sufficiently address the issue of benefit adequacy for current pensioners. Especially, the auto-enrolment into qualifying workplace pensions will have a significant impact only after years of savings. As occupational pension coverage has declined over the last decade and as coverage significantly differs by sector, we will witness cohort effects that will especially impact workers with low skills and earnings.

According to government figures, the number of pensioners at risk of poverty (below 60% of median income) has increased from 2.2 million in 2005/06 to 2.5 million in 2006/07, and since then has stayed more or less constant.[7] The reasons for the increase in pensioners poverty are still not well understood; nevertheless, one of the reasons for government policies not having been more successful is the low take-up rate of the various means-tested programmes available to poor pensioners. A report by a parliamentary committee highlighted the complexity of the benefit system as a key cause of poverty, with some 1.7 million older people failing to claim money to which they were entitled.[8]

The Government has included a number of provisions for pensioners in the 2009 and 2010 Budgets as part of its policy to combat the recession (see chapter 3).
To assess the adequacy of pensions in the UK it is important to include occupational pensions, as they can significantly supplement public pensions. The following table provides an overview of prospective replacement rates for various multiples of average income from public and private pension schemes for selected countries:

4 For an assessment of the reforms see Daniela Silcock, Sean James and John Adams (2010) *Retirement income and assets: outlook for the future.* London: PPI.

5 Cf. http://www.dwp.gov.uk/pensionsreform/pdfs/GenderImpactAssessment.pdf.

6 For an assessment of the gender impact see http://www.dwp.gov.uk/pensionsreform/pdfs/GenderImpactAssessment-5-Dec2007.pdf.

7 See DWP (2009) *Households Below Average Income: An analysis of the income distribution 1994/95 – 2007/08.* London [available at http://research.dwp.gov.uk/asd/hbai/hbai2008/pdf_files/full_hbai09.pdf].

8 House of Commons, Work and Pensions Committee (2009) *Tackling Pensioner Poverty. Fifth Report of Session 2008–09*. Volume I, Report, together with formal minutes. Ordered by the House of Commons to be printed 15 July 2009. London: TSO.

Table 1: Gross prospective pension replacement rates from public and voluntary private pension schemes (percentage of individual earnings)

	Public			Voluntary DC			Voluntary DB			Total with voluntary		
	0.5	1	1.5	0.5	1	1.5	0.5	1	1.5	0.5	1	1.5
France	61.7	53.3	48.5									
Germany	43	43	42.6	18.3	18.3	18.1				61.3	61.3	60.8
United Kingdom	51	30.8	21.3	39.2	39.2	39.2	38.4	38.4	38.4	89.3	70	60.6
United States	50.3	38.7	34.1	40.1	40.1	40.1	30.6	30.6	30.6	90.4	78.8	74.2

Notes: Pension entitlements are calculated using the OECD pension models, based on national parameters and rules applying in 2006. They relate to a worker entering the labour market in that year.
DB = Defined Benefit: DC = Defined Contribution
Source: OECD pension models

2.1.1 More people in work and working longer

The employment rate of older workers (55-64) has continuously increased over the past decade until 2008, leading to a comparatively high employment rate of 58% (EU25 46.2%). In addition to the various policies implemented by the Government to facilitate employment by older workers, this positive development is likely to have been influenced by the overall very positive labour market developments during the past decade. Whether the UK will be able to sustain such high employment rates, during the more difficult economic times ahead, needs to be seen. There has been a slight drop-off in the employment rate to 57.5% during 2009, which has been triggered by a one percentage point decline among men and a 0.2 percentage point increase in employment among older women.[9]

The effective labour market exit age for men is 64.1 years (2008). Overall, the effective labour market exit age is close to the statutory retirement of 65 years for men. The effective labour market exit age for women is 62 years.[10]

The current Government has called for a review of the default retirement age to be conducted in 2010. The Conservative Party has proposed bringing the increase in pension age, agreed as part of the 2007/08 pensions reforms, forward, i.e. raising the age at which men are eligible for a state pension to 66 in 2016 and for women in 2020. Furthermore, all parties seem to suggest changes to the pension schemes for public employees, including increasing the retirement age. A study by Price Waterhouse Coopers suggests that the pension age will have to be raised to 70 by the middle of this century in order to cope with the impact of ageing and the condition of public finances.[11]

[9] Eurostat; data available at http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do?tab=table&pcode=tsiem020&language=en.

[10] Ibid.

[11] John Hawksworth, Chris Dobson and Nick Jones, Working Longer (2010) *Living Better: A Fiscal and Social Imperative*, London: PricewaterhouseCoopers.

2.1.2 Privately managed pension provision

As is well known, the British pension system depends to a large degree on private and occupational pensions. Private pension saving has been declining in the UK for years and participation in private pensions varies hugely by sector and earnings level, as has been highlighted in last year's report. To counter this trend, employers will have to auto-enroll all workers as part of the 2008 pension reform starting in 2012. The Pension Regulator has recently published detailed information on the staging process, whereby the employer duties will be staged over four years from October 2012 to 2016, starting with the largest to medium-sized employers, followed by small and micro employers. Subject to certain conditions, employers will be able to automatically enrol their employees in advance of their staging date but not before October 2012. The duties will be introduced by the size of employer with the new duties applying to the largest to medium-sized employers up to July 2014, followed by small and micro employers from August 2014 to February 2016.[12]

Alongside auto-enrolment, the Government plans to launch in 2012 a low cost, defined contribution, pension scheme that employers can enrol their employees into (or individuals can opt-in to) called NEST (National Employment Savings Trust). The Conservatives and the Liberal Democrats have both highlighted concerns about the potential for NEST to prompt employers to level down contributions into private pension provision and the Conservatives would conduct a review of NEST if they win the election.[13]

The major change in this year with regards to privately managed pension has been a cut in tax relief to the basic rate for high income earners (gross incomes of £130.000 and over).[14] The Conservatives have promised to reverse this policy, whilst the Liberal Democrats propose to allow only basic-rate tax relief on pension contributions – meaning that higher-rate tax relief will be scrapped all altogether and not only for the highest earners.[15] The National Association of Pension Funds fears that the tax changes will undermine the EET principle[16] and create uncertainty as the changes are said to also affect people with lower earnings.[17]

The Conservatives and the Liberal Democrats have both pledged to get rid of the requirement to annuitise all private pension pots before the age of 75. According to the Institute for Fiscal Studies such a reform risks worsening the operation of the annuities market and higher prices for some.[18]

Due to the financial crisis, the value of pension assets has dropped significantly between 2007 and 2008. However, the pension assets once again grew substantially during 2009, according to Towers Watson. The following table provides an overview of pension assets growth rates in the UK and a number of other rich OECD countries.

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12 Cf. http://www.thepensionsregulator.gov.uk/pensions-reform/staging-and-phasing.aspx.

13 PPI (2010) "What are the main parties policies' on pensions?" *PPI Briefing Note Number 55*.

14 PPI (2010) op.cit.

15 PPI (2010) op.cit.

16 A form of taxation of pension plans, whereby contributions are exempt, investment income and capital gains of the pension fund are also exempt and benefits are taxed from personal income taxation.

17 National Association of Pension Funds (2010) *A Budget for pensions. An NAPF submission to HM Treasury on the 2010 Budget.* London: NAPF.

18 For a discussion of the proposals see Institute for Fiscal Studies (2010b).

Table 2: Global Pension Assets Growth Rates (selected countries)

Market	1-year (31/12/07 – 31/12/08) (Actual)	Growth Rates (2009 Estimates; Local Currency)		
		1-year (31/12/08 – 31/12/09)	5-year (31/12/04 – 31/12/09) CAGR[1]	10-year (31/12/99 – 31/12/09) CAGR
Canada	1.5%	12.7%	8.0%	3.1%
Netherlands	-16.0%	14.2%	4.9%	5.6%
UK[2]	-26.5%	13.6%	4.3%	2.8%
US[3]	-23.3%	12.2%	2.5%	2.6%

Notes: [1)] Compound Annual Growth Rate; [2)] excludes Personal and Stakeholder DC assets; [3)] includes (Individual Retirement Accounts).
Source: Towers Watson (2010) 2010 Global Pension Asset Study, p. 13.

The recession significantly affected the financial position of private sector defined benefit pension schemes in 2008-2009. The aggregate funding position has deteriorated from a surplus of £12.3 billion (a funding level of 101.5%) at 31 March 2008 to a deficit of £200.6 billion (a funding level of 79.5%) at 31 March 2009.[19] Figures from the 2009 National Association of Pension Funds' Annual Survey show that the average allocation to equities has fallen from 51% in 2008 to 44% in 2009. Furthermore the survey reveals that 23% of schemes remain open to new members, compared to 28% in 2008. However, change is very likely to affect existing members in the future, since 18% of schemes plan to switch to DC provision for future accrual.[20]

2.1.3 Minimum income provision for older people

The minimum income provisions for pensioners have been improved in recent years. However, poverty among pensioners is still comparatively high and has been increasing in the years 2005-2007, before staying constant. This was the first increase in poverty among pensioners during the past decade. Overall, the UK had made significant progress towards poverty reduction since the late 1990s. The reasons for the increase in pensioners poverty are still not well understood.[21] Nevertheless, one of the reasons for government policies not having been more successful is the low take-up rate of the various means-tested programmes, such as Pension Credit, available to poor pensioners. A report by a parliamentary committee highlighted the complexity of the benefit system as a key cause of poverty, with some 1.7 million older people failing to claim money to which they were entitled.[22]

19 Pensions Regulator (2010) *Purple Book 2009.* London.
20 NAPF (2009) *National Association of Pension Funds' Annual Survey 2009*. London.
21 See Maria Evandrou and Jane Falkingham (2009) "Pensions and income security in later life," in John Hills, Tom Sefton and Kitty Stewart (eds.) *Towards a more Equal Society. Poverty, inequality and policy since 1997.* Bristol: Policy Press, pp. 171 f.
22 House of Commons, Work and Pensions Committee (2009) *Tackling Pensioner Poverty. Fifth Report of Session 2008–09*. Volume I, Report, together with formal minutes. London: TSO.

Poverty among pensioners differs based on demographic and socio-economic group. Due to lower labour market participation and lower wages of women and ethnic minorities, pensions among these groups tend to be significant lower and poverty significantly higher than among white male pensioners.[23] The following table provides an overview of the risk of poverty by gender and ethnicity:

Table 3: Percentage of Pensioners in Poverty (income below median) before Housing Costs (2007/08)

	50%	**60%**	**70%**
Gender			
Male	10	20	31
Female	14	24	35
Ethnic group (3-year average)			
White	12	22	34
Indian	24	33	36
Pakistani and Bangladeshi	32	46	61
Black or Black British	15	25	40
Chinese or other ethnic group	21	30	43
All pensioners	13	23	34

Source: DWP (2009) *Households Below Average Income: An analysis of the income distribution 1994/95 – 2007/08.* London, p. 140 available at http://research.dwp.gov.uk/asd/hbai/hbai2008/pdf_files/full_hbai09.pdf.

2.1.4 Critical Assessment

The UK currently has a very distinctive pension mix, combining "one of the least generous state systems in the developed world" with one of "most developed" voluntary arrangements.[24] The last couple of years have seen major legislative changes that will have a significant impact on pensioners in the future. The main aim of the Government has been to improve the income of pensioners with low income. However, as the most recent national data show, poverty among pensioners has not continued to decline in recent years. Enacted changes in the Basic State Pension will

[23] John Hills et al. (2010) *An anatomy of economic inequality in the UK: Report of the National Equality Panel*. London: Government Equalities Office, pp. 373 ff.

[24] Cf. Pension Commission (2004) *Pensions: Challenges and Choices. The First Report of the Pensions Commission* (London: TSO), p. 62 – available at http://www.webarchive.org.uk/pan/16806/20070802/www.pensionscommission.org.uk/publications/2004/annrep/fullreport.pdf, p. X.

improve the situation for many workers, especially female employees, with shorter contributory periods retiring in 2010 or later. However, a further increase in *public* pension spending might be warranted, to achieve the goal of lower poverty rates among pensioners.[25] Such an increase in *public* spending can be achieved in a cost-neutral way by *further* reducing the tax incentives for private pensions of high-income earners.[26] Further changes to be implemented starting 2012 will improve the accessibility to workplace pension schemes.

2.2 Health

The NHS provides the bulk of health care in the United Kingdom. Although the private health care sector is gaining in importance[27], 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.[28] 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.[29]

"Since devolution in 1999, the four health systems of the UK, always historically different and now enabled by devolution, have drifted further apart."[30] The report will mainly focus on the English NHS as it covers 84% of the total population of the United Kingdom. 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 last decade has seen a tremendous increase in health-care spending. These increased investments have contributed to a significant decline of waiting times, especially in England.[31] 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

25 Currently, the UK spends 5.7% of GDP for public pensions, 1.5 percentage points less than the OECD average; cf. OECD (2009) *Pensions at a Glance 2009.* Paris: OECD.

26 Cf. Adrian Sinfield (2007) "Tax Welfare," in: Martin Powell (ed.) *Understanding the Mixed Economy of Welfare*. Bristol: Policy Press, pp. 129-146.

27 The number of people covered by private medical insurance rose from 5,879,000 in 2006 to 6,004,000 in 2007, an increase of 2.1%; cf. Association of British Insurers, Press release 23 April 2008 [available at http://www.abi.org.uk/Media/Releases/2008/04/Private_Medical_Insurance_coverage_rises_again.aspx].

28 Peter Smith and Maria Goddard (2009) *The English Health Service: An Economic Health Check.* OECD Economics Working Paper 717, p. 5.

29 Cf. DH (2009): *Tackling Health Inequalities 10 Years on*. London: Department of Health.

30 Scott L. Greer and Alan Trench (2008) *Health and Intergovernmental Relations in the Devolved United Kingdom.* The Nuffield Trust for Research and Policy Studies in Health Services. London [available at http://www.nuffieldtrust.org.uk/ecomm/files/Health_and_Intergovernmental_Relations.pdf].

31 King's Fund (2007) "18-week Waiting Times Target – An Update," Briefing August 2007 [available at http://www.kingsfund.org.uk/publications/briefings/18week_waiting.html].

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."[32]

2.2.1 Key trends and priorities

Within England core policy foci are to provide patients with more 'choice', improve the quality of care, and allocate financial resources based on results.[33] The Government continues to be committed to address health inequalities, increasingly focusing on combating the challenges of health inequalities and poor lifestyles. Furthermore, it is aiming at improving access to preventive measures as recently outlined in the document *Putting Prevention First*.[34]

The Conservative Party has pledged to provide health care free at the point of use and available to everyone based on need should they win the election. Furthermore they have ring-fenced the NHS from any budget cuts and promise real spending increases; to some extent similar to Labour they intend to provide more choice for patients.[35] In a plan published in 2008, the Conservatives proposed to abolish central performance targets, which have been a core element of the current Government 's strategy, and introduce measures to increase the power of patients. According to the plan patients would be allowed to choose their family doctor and people with long-term conditions would be enabled to control their care through a personal budget.[36] Late in 2009, the Conservatives proposed to rename the Department of Health as the 'Department of Public Health' – because improving public health would be one of the department's key priorities. The overall health budget would be ring-fenced: but the £4.5 billion annual bill for administering the NHS would be cut by one-third over the following four years.[37] The Liberal Democrats emphasise more local control leading to greater transparency and accountability.[38]

In 2008, the Government published the final report of a review (conducted by the Health Minister, Lord Darzi) into the future of the National Health Service. The report proposed a shift of emphasis away from increasing the quantity of health care to improving its clinical quality. The income of hospitals and family doctors would depend on how much they improved their patients' health. National Health Service trusts would be paid according to the outcome of treatment, using a new set of indicators ranging from surgeons' death rates to surveys of how well patients felt after

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32 Sheelah Connolly, Gwyn Bevan and Nicholas Mays (2010) *Funding and performance of health care systems in the four countries of the UK before and after devolution*. London: The Nuffield Trust, pp. XIII-XIV.

33 Department of Health (2008) *High Quality Care For All: NHS Next Stage Review Final Report*. London: Department of Health.

34 Department of Health (2008) *Putting prevention first*. London: Department of Health.

35 Cf. http://www.conservatives.com/Policy/Where_we_stand/Health.aspx.

36 Conservatives (2008) *NHS Improvement Plan*. London: Conservative Party.

37 Cf. Andrew Sparrow (2009) "David Cameron: Tories would rename Department of Health," Guardian, 2 November 2009 [available at http://www.guardian.co.uk/politics/2009/nov/02/cameron-rename-department-of-health].

38 Cf. Norman Lamb (2010) *The NHS: A Liberal Blueprint*, CentreForum [available at http://www.centreforum.org/assets/pubs/nhs-a-liberal-blueprint.pdf].

treatment and patients' views about the quality of service and the compassion of staff. In order to establish greater competition within the NHS, patients would be given enough information to enable them to choose the nearest hospital that could demonstrate superior medical results.[39]

Early in 2009, the Government published (following consultation) a constitution for the National Health Service, setting out patients' rights to care and their responsibilities. Patients have the right to access services predominantly free of charge, free of discrimination, and delivered in a professional manner. In return patients are expected to treat staff with respect, register with a family doctor, keep appointments, take part in vaccination programmes, and make a contribution to their own, and their family's, good health.[40] The Health Bill sets out proposals designed to give patients more choice and control over the care they received, and to improve the quality of health services. It placed a legal duty on the National Health Service and its providers to have regard to the NHS Constitution, which would safeguard the principles and values of the NHS, and set out the rights and responsibilities of patients and staff. The Bill includes proposals to pilot direct payments to give patients greater choice and control over their health care. The Health Act 2009 was given Royal assent on 12 November, 2009.

In December 2009, the Government published a 5-year strategy for the National Health Service in England. It said that there was a need to accelerate the pace of reform and make the system more productive. Hospital income would increasingly be linked to patient satisfaction. There would be more choice for patients – through abolishing family doctor practice boundaries, and improving access to a family doctor. There would be more freedom for the best hospitals to expand their services out into the community across a wider area including family doctor centres. Personal health budgets would give patients more control over their care.[42]

In March 2010, the Government announced a freeze in National Health Service prescription charges for 2010-11.[43]

2.2.2 Access to health care

As stated above, the health systems of all four countries provide universal access to health care. However, access to specific treatments might differ 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.

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39 Department of Health (2008) *High Quality Care For All: NHS Next Stage Review Final Report* [Darzi Review], Department of Health, London: TSO.

40 Department of Health (2009) *The NHS Constitution for England*. London: Department of Health. ssent in November.[4141] Department of Health (2009) *Health Bill*. London: Department of Health [available at http://www.publications.parliament.uk/pa/ld200809/ldbills/018/2009018.pdf]. Cf. http://www.opsi.gov.uk/acts/acts2009/pdf/ukpga_20090021_en.pdf.

42 Department of Health (2009) *NHS 2010–2015: from good to great. preventative, people-centred, productive*. London: Department of Health [available at http://www.official-documents.gov.uk/document/cm77/7775/7775.pdf].

43 Cf. http://www.parliament.the-stationery-office.co.uk/pa/cm200910/cmhansrd/cm100325/wmstext/100325m0003.htm.

England

Access to treatment has improved through the significant decline in waiting times (currently 18 weeks). Although access to health care is legally universal, there have been regional differences with regards to access to drugs that have not yet received approval by the National Institute for Health and Clinical Excellence (NICE). This practise (coined postcode lottery by the media) results from the fact that some Primary Care Trusts (PCT) offer treatment on a local basis, independently of NICE's approval.[44] Furthermore, a recent study by the King's Fund shows that the amount spent per patient with cancer, mental illness or circulatory diseases such as heart disease varies greatly from one PCT to the next, even after controlling for age and the health of the population. These differences in spending so far cannot be explained, but may be the result from differences in access to or quality of treatment. The researchers of the report conclude: "Tackling unjustified variations in spending will first require much more effort in understanding why variations occur – and persist – and second, determined efforts to change spending patterns to produce a more efficient and fairer NHS."[45]

Scotland

Within the UK Scotland faces particular problems, which, however, are acknowledged by the Scottish Government. In the 2008 report *Equally Well* the Scottish Government states: "In terms of health and mortality, Scotland generally compares unfavourably with the rest of the United Kingdom, the European average, other small countries in Europe and is frequently more on a par with Eastern European countries than with its more affluent neighbours."[46] Patients in Scotland will be given hospital treatment within 18 weeks of being referred by their GP under a new three-year plan to deliver swift and quality care for all by 2011 (the current target in England).[47] An audit report, published in early 2010, concluded that changes in how the NHS in Scotland managed waiting lists since 2008 had made the system fairer for patients.[48]

Wales

While England has set a target of 18 weeks from GP referral to start of treatment and has focused substantial amounts of financial resources to achieve the target of significantly reduced waiting times, the reduction of waiting times (although declining) has not been at the centre of Welsh policy. The Welsh Assembly Government's target for patients is 26 weeks from GP referral to the start of treatment.[49]

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[44] According to the support network Rarer Cancers Forum access to certain treatments vary widely. Rarer Cancers Forum (2008) *Taking Exception: An audit of the policies and processes used by PCTs to determine exceptional funding requests* [available at http://www.rarercancers.org.uk/news/archive/winter_2008_12_03/new_rcf_report_reveals_striking_postcode_lottery_in_the_chances_of_having_an__exceptional_request_approved/rcf_taking_exception.pdf].

[45] John Appleby and Sarah Gregory (2008) *NHS spending. Local variations in priorities: an update.* London: King's Fund [available at http://www.kingsfund.org.uk/publications/nhs_spending.html].

[46] The Scottish Government (2007) *Equally Well: Report of the Ministerial Task Force on Health Inequalities - Volume 2*. 3. KEY STATISTICS ON HEALTH INEQUALITIES - SUMMARY PAPER [available at http://www.scotland.gov.uk/Publications/2008/06/09160103/3].

[47] Cf. http://www.scotland.gov.uk/News/Releases/2008/02/06093923.

[48] Audit Scotland (2010) *Managing NHS Waiting Lists: A review of new arrangements.* [available at http://www.audit-scotland.gov.uk/docs/health/2010/nr_100304_nhs_waiting%20_lists.pdf].

[49] House of Commons, Welsh Affairs Committee (2008) *The provision of cross–border health services for Wales: Interim Report*. London: The Stationery Office [available at

Northern Ireland

In Northern Ireland waiting times have also been reduced, the target being 13 weeks.[50] The Northern Ireland Executive has abolished prescription charges, effective April 2010.[51]

2.2.3 Quality of health care

All four countries give high priority to improving the quality of health care. The significant increase in health-care spending is indicative for this policy approach. All four countries are increasingly focusing on preventive care. All four countries have mechanisms in place to systematically monitor quality. The Health and Social Care Act 2008 provides for the creation of an integrated regulator, the Care Quality Commission, which would be responsible for providing assurance about patient safety and the quality of care in the health and social services. The Act included measures to enhance professional regulation in the National Health Service; and it also extended the provisions of the Human Rights Act to any independent sector care home that provided accommodation together with nursing or personal care on behalf of a local authority.[52]

Although quality in the NHS in England had improved significantly since 1997 – increased funding and a dynamic reform programme had enhanced both the resources available and the impetus for quality improvement – it was less clear whether the gains made were commensurate with the effort and investment made.[53] A recent performance report for England has highlighted that despite sustained improvements in meeting the Government 's standards and targets, with dramatic improvement in waiting times, there "remains unacceptable variation, and a small number of services or organisations do not meet minimum standards of safety and quality."[54]

One example of poor standards has been the Mid-Staffordshire NHS Foundation Trust, which has raised many questions about quality assurance within the overall health care system. According to an independent inquiry, appalling standards of care may have contributed to the deaths of at least 400 patients at the hospital. The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care. Robert Francis QC has made 18 recommendations for both the Trust and Government. His final report is based on evidence from over 900 patients and families. The evidence gathered by the Inquiry shows clearly that for many patients the most basic elements of care were neglected. Calls for help to use the bathroom were ignored and patients were left lying

http://www.publications.parliament.uk/pa/cm200708/cmselect/cmwelaf/870/870.pdf]. Cf. the letter from the Minister for Health and Social Services to Chairs for NHS Trusts dated 9 March 2009 available at http://wales.gov.uk/docs/dhss/publications/090311letter00409en.pdf.

50 Cf. http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-july-2007/news-dhssps-090707-mcgimpsey-sets-new.htm. For the latest figures see http://www.northernireland.gov.uk/news-dhssps-05032009-publication-of-the.

51 Northern Ireland Executive, Press release 29 September 2008, available at http://www.northernireland.gov.uk/news/news-dhssps-290908-historic-day-for.

52 Health and Social Care Act 2008, available at http://www.opsi.gov.uk/acts/acts2008/pdf/ukpga_20080014_en.pdf.

53 Sheila Leatherman and Kim Sutherland (2008) *The Quest for Quality: Refining the NHS reforms*. London: Nuffield Trust.

54 Care Quality Commission (2010) *The state of health care and adult social care in England.* London: TSO, p. 7.

in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid. Patients were left unwashed, at times for up to a month. Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding. Staff failed to make basic observations and pain relief was provided late or in some cases not at all. Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.[55]

Furthermore, health inequalities continue to constitute a major problem. A recent report analysing health inequalities within England during the past decade concluded, "much achieved; more to do".[56] A few macro indicators provide a crude picture of the development during the last decade:

Table 4: Changes in Health Inequalities since the 1990s

	1995–97	2005–07	Difference
Life expectancy: males (years)			
England	74.6	77.7	+3.1
Spearhead areas	72.7	75.6	+2.9
Absolute gap	1.9	2.1	
Life expectancy: females (years)			
England	79.7	81.8	+2.1
Spearhead areas	78.3	80.2	+1.9
Absolute gap	1.4	1.6	
Infant mortality (per 1,000 live births)			
England	5.8	4.7	–1.1
Routine and manual groups	6.6	5.4	–1.2
Absolute gap	0.8	0.7	

Note: Spearhead areas = 70 local authority areas with the worst health and deprivation indicators.
Source: DH (2009): Tackling Health Inequalities 10 Years on. London: DH.

[55] Cf. Independent Inquiry (2010) *Final Report of the Independent InquiryiInto Care Provided by Mid Staffordshire NHS Foundation Trust*. 2 Volumes. London: TSO [available at http://www.midstaffsinquiry.com/news.php?id=30].

[56] DH (2009): *Tackling Health Inequalities 10 Years on*. London: DH.

Table 5: Chronic sickness: prevalence of reported longstanding illness (percentage who reported longstanding illness)

Socio-economic classification of household reference person	Males Age					Females Age				
	0-15	16-44	45-64	65 and over	Total	0-15	16-44	45-64	65 and over	Total
Large employers and higher managerial	12	17	32	62	25	8	18	27	57	23
Higher professional	9	16	38	61	26	11	23	33	59	27
Lower managerial and professional	18	17	41	58	29	14	19	39	60	29
Intermediate	15	14	42	66	28	17	25	37	57	35
Small employers and own account	10	19	40	60	31	11	15	41	54	28
Lower supervisory and technical	17	24	48	64	37	16	22	45	58	33
Semi-routine	14	25	48	64	34	14	24	49	62	37
Routine	14	21	55	68	38	17	26	53	69	41
Never worked and long-term unemployed	...	...	...	...	37	...	...	...	...	38

Source: General Household Survey 2007, cited in DH (2009): Tackling Health Inequalities 10 Years on. London: DH.

Despite recent improvements, the UK still trails other 'advanced' industrial economies with regard to availability of certain treatments as well as on a number of outcome indicators. For instance, while there has been some increase in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in the UK, the number of MRIs in 2006 was 5.6 per million population, below the OECD average of 10.2. Furthermore, the number of CT scanners stood at 7.6 per million population in 2006, less than half the OECD average of 19.2.[57] Similarly, infant mortality rates were significantly higher in the UK with 5.1 per 1000 births, compared to other European countries, such as Iceland with 2.3, France with 3.6 and Germany with 3.9.[58] A recent OECD working paper concludes: "The Eurocare project has examined trends in cancer mortality in selected countries, indicating improving trends everywhere, but continued higher rates in the UK. It found for all malignancies a survival rate of 44.8% for men and 52.7% for women, compared with averages of 66.3% and 62.9% across all European registries. There may be reasons other than quality of care for such results, such as variations in the incidence and type of cancers. However, data for a range of individual cancers tend to corroborate evidence that UK cancer outcomes have lagged behind those found in many European counterparts, notably in Scandinavia and central Europe. This could be due to the late stage of diagnosis in the United Kingdom, implying a health system weakness."[59]

2.2.4 Sustainability of the health care system

As has been emphasised in this report, the UK has made significant efforts to provide better health-care services over the past decade. One instrument to achieve this has been an unprecedented expansion of health-care spending. As it is very unlikely that government funding will continue to increase at rates experienced over the past decade, much will depend on efficiency gains and increases in productivity to continue on the trajectory of improvement. Reports suggest that the financial situation of some health care trusts is critical, as more than a third of NHS primary health care trusts, which fund hospitals in England, are running deficits that have led to cutbacks in some treatments. The Department of Health has warned the trusts that they have to pay back the deficit from the funds allocated for the current budget year.[60]

2.2.5 Critical Assessment

The four countries are committed to reduce health inequalities as well as improve access to and the quality of health care. However, for many of the recently introduced measures it is much too early to judge their effectiveness. Although there were some improvements, significant health inequalities continue to persist. Furthermore, some independent reports indicate the improvements in quality health care provision were not commensurate to the increased spending. Overall, the UK still trails many of its

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57 OECD (2008) *OECD Health Data 2008*. Paris: OECD.

58 Cf. Nick Bosanquet et al. (2008) *NHS Reform: National mantra, not local reality.* London: Reform.

59 Peter Smith and Maria Goddard (2009) *The English Health Service: An Economic Health Check.* OECD Economics Working Paper 717, p. 10.

60 Randeep Ramesh (2010) "Patients hit as NHS cash crisis forces big cutbacks," guardian.co.uk, retrieved at http://www.guardian.co.uk/society/2010/mar/02/nhs-primary-healthcare-trusts-cuts March 20, 2010.

European neighbours on a number of health (policy) dimensions. Finally, it is unclear to what extent the experiences in the various four countries are used in the others to learn from best practices. The constituent countries of the UK could easily work as 'laboratories of democracies' in health policy innovation and effectiveness. Whether or not health care provision will continue to improve is very hard to assess, as the financial resources necessary in the next couple of years are very likely to be limited (see chapter 3).

2.3 Long-term Care

Similar to the health-care system, the responsibility for long-term care was devolved to the four constituent countries of the UK. In *England* and *Wales* eligibility for long-term care is based on a means-test. A survey conducted by *The Coalition on Charging*, a coalition of various advocacy groups, shows, fees are very much of concern to those receiving care. An overwhelming majority of those who no longer use care services said that, charges played a part in the decision to end using services. Subsequently, there is considerable reliance on informal care.[61] Although funding for social care has increased in real terms by 11% since 2003-04, and by 53% since 1998-99,[62] overall social care seems to be underfunded.

Furthermore, problems exist with regards to determining eligibility for care in England, according to the Commission for Social Care Inspection. People looking for support frequently failed to have an opportunity to have their needs properly taken into account, and to receive advice about the choices open to them. The Commission recommended a clearer, simpler, framework for deciding who was a priority for publicly-funded support. It called for the development of a single, national formula for determining individual budgets, in order to increase transparency and make it easier for people to take their assessment from one local authority to another.[63]

Based on the unsatisfactory conditions of long-term care a significant debate on its future has begun in England. Subsequently, the Government began a consultation on the future shape of care and support services in England. The Government stated that finding a solution to these issues will require a radical rethink of how we pay for and deliver care and support services. The long-term challenge is to create a new settlement between individuals, families and the Government that will be sustainable in the future, that offers us all protection and dignity, and that is fair. A rapidly ageing population meant that within 20 years one-quarter of the entire adult population would be over 65, and the number of people over 85 would have doubled: the growth in the number of people with care and support needs would put tremendous pressure both on services and on the financial support that they received through benefits and other funding streams. The Government sought views on how to create a new system that promoted independence, choice, and control for everyone who used the care and support system; ensured that everyone could receive the high-quality care and

[61] Coalition on Charging (2008) Charging into Poverty? London [available at http://www.guardian.co.uk/society/2008/jun/04/disability.socialexclusion]. Also see Resolution Foundation (2008) Mapping Long-term Care Markets [available at http://www.resolutionfoundation.org/pdf/publication_reports/A-Z_Report.pdf].

[62] NHS Information Centre (2008) *Personal Social Services Expenditure and Unit Costs England, 2007-08*. Leeds: NHS Information Centre.

[63] Commission for Social Care Inspection (2008) *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care*. London.

support they needed, and that government support should be targeted at those most in need.[64]

In 2009, the Government published a Green Paper and conducted a wide ranging consultation, leading to a White Paper published in 2010. In the White Paper the Government proposed the creation of a new 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 estimates 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 is intended to be the first step towards establishing a new National Care Service.[65] The second stage of the planned reform, during the next Parliament, is to put in place the building blocks of a national care system, in particular the establishment of clear, national standards and entitlements. From 2014 care entitlements are proposed to be extended to anyone staying in residential care for more than two years; people on low incomes will continue to have free access. After 2015 full free care should be provided for all.[66]

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.[67]

Recently, the *Welsh Assembly Government* also began a consultation on new ways of paying for social care services. It said that there could be no doubt that reform of the existing system for funding care was needed. Wales already had a higher proportion of older people than the rest of the United Kingdom, and over the next 20 years many more people would live longer and in better health. It predicted that a large funding gap would open up between the cost of care services and the money that was available to pay for them. These factors would present real challenges that needed to be addressed if the care system were to be both affordable and sustainable. In late 2009, the Welsh Government has published a Green Paper and started a consultation process. The Government will establish a Commission to consider how the challenges facing social services are met over the next decade. Whilst the Welsh Assembly Government is responsible for the social care system in Wales, the levers to change the system for paying for care are largely the responsibility of the Westminster Government, and the existing legal framework covers England as well as Wales.[68] In other words, it remains unclear how the social care system in Wales will be funded, as this decision has been postponed by Westminster.

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64 Department of Health (2008) *The Case for Change: Why England needs a new care and support system*. London: Department of Health.

65 Cf. Personal Care at Home Act 2010 [available at http://services.parliament.uk/bills/2009-10/personalcareathome/documents.html].

66 HM Government (2010) *Care Support Independence. Building the National Care Service*. London: TSO.

67 Cf. Alex Barker and Nicholas Timmins (2010) "Burnham unveils social care plans," FT.com, March 30, 2010.

68 Welsh Assembly Government (2009) Paying for Care in Wales: creating a fair and sustainable System. Cardiff [available at http://wales.gov.uk/docs/dhss/consultation/091116payingforcareinwalesen.pdf].

In *Scotland* care is provided free to everyone in need, while *Northern Ireland* is currently considering the introduction of free care. Access to care is usually determined by councils, based on broad national frameworks. 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 in Scotland remained popular and had worked well on the whole, delivering better outcomes for Scotland's older people. However, it predicted that the costs would increase from 2.6% of GDP in 2006 to 4.6% in 2031.[69] Echoing some of the findings, a report by Audit Scotland also found that local councils set different priorities that impact access. The report recommends that "[t]he Scottish Government and councils should work together to agree a national eligibility framework which defines risks and priority levels to ensure transparency in access to care for older people."[70]

All four countries have mechanisms in place to monitor the quality of care. Although there have been improvements, according to a latest report some services provided in *England* still do not meet government targets.[71]

2.3.1 Critical Assessment

The current situation of long-term care provision does not seem to be socially sustainable, especially in England, Northern Ireland and Wales. In England around 85 of disabled older people living in their own homes receive informal care. An overwhelming majority of this care is provided by family members, such as the spouse or an adult child. Recent research concludes: "Demand for informal care by disabled older people is projected to exceed supply by 2017, with the 'care gap' widening over the ensuing years. By 2041, the gap between the numbers of people projected to provide informal care and the numbers needed to provide care if projected demand is to be met amounts to nearly 250 thousand care-providers."[72] Although all four countries have allocated additional funding for long-term care over the short and medium term, the funding arrangements in the long-term seem to be unsustainable and reform inevitable.

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69 Lord Sutherland (2008) *Independent Review of Free Personal and Nursing Care in Scotland.* Edinburgh [available at http://www.scotland.gov.uk/Resource/Doc/221214/0059486.pdf].

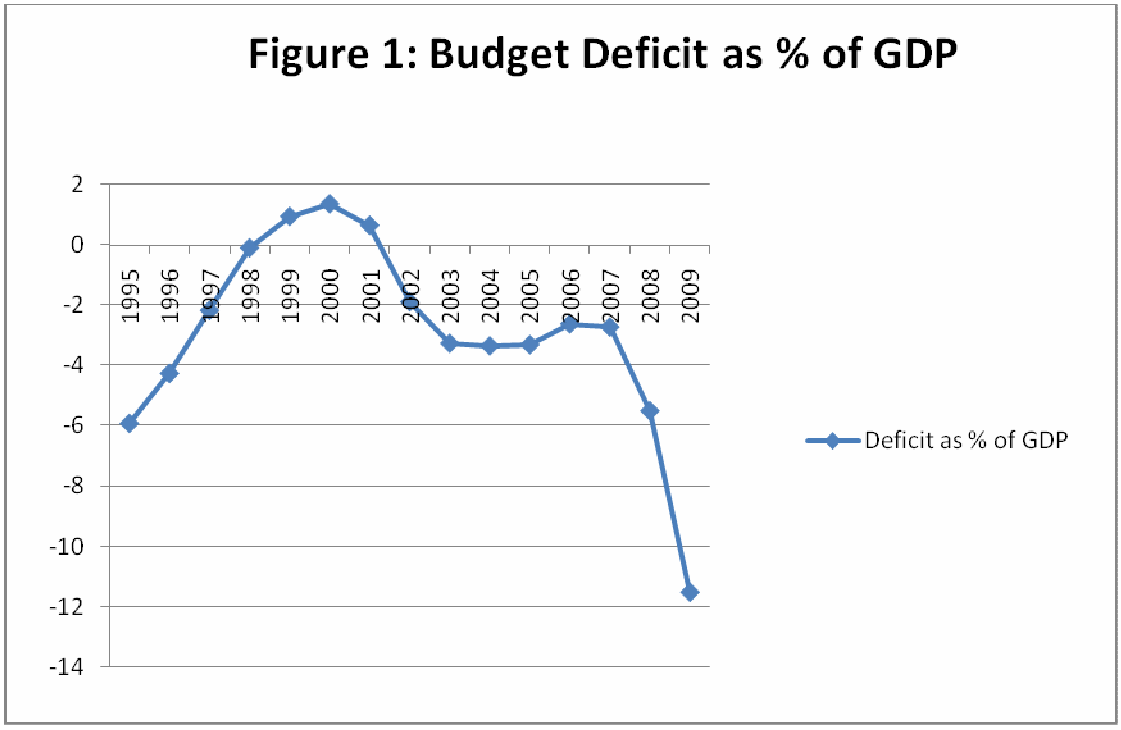
70 Audit Scotland (2008) *A review of free personal and nursing care.* p. 53, [available at http://www.audit-scotland.gov.uk/docs/health/2007/nr_080201_free_personal_care.pdf].

71 Care Quality Commission (2010) *The State of Health Care and Adult Social Care in England*. London: TSO, pp. 64 ff.

72 Linda Pickard (2008) *Informal Care for Older People Provided by Their Adult Children: Projections of Supply and Demand to 2041 in England*. PSSRU Discussion Paper 2515, p. 15.

3 Impact of the Financial and Economic Crisis on Social Protection

Since 2002, the Government has run an annual budget deficit to finance, among other priorities, many of the investments needed for improvements in health care. Hence, it entered the current crisis with a substantial annual deficit of more than 3% of Gross Domestic Product (GDP). The UK recorded a government deficit of 5.4% of GDP in 2008 and it is estimated to reach 11.2% in 2010. Public sector debt, expressed as a percentage of GDP, was 55.5% in 2008/09 and is predicted to increase to 89.2% in 2013/14.[73] The deterioration of public finances is not primarily the effect of massive deficit spending, but the result of a significant decline in corporation and property taxes.[74]



Source: Eurostat.
http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do;jsessionid=9ea7974b30dd4dc7ac02097647e79e55f16b1655a634.e34SbxiPb3uSb40Lb34LaxqRb30Ne0?tab=table&plugin=1&pcode=teina200&language=en.

Despite the critical situation of public finances the Government has not introduced any major cuts in social protection programmes; moreover it has provided extra benefits for pensioners and continued to expand the health care sector.

As part of the fiscal stimulus the Government has decided on a number of benefit increases for pensioners. The Basic State Pension was increased by 5% effective April 2009, ensuring that someone on a full pension will receive a weekly benefit of £95.25 instead of £90.70. The Pension Credit, a means-tested programme supporting poor

[73] HM (2010) *Budget 2010, Annex C: The public finances*, p. 186 [available at http://www.hm-treasury.gov.uk/budget2010_documents.htm].
[74] HM (2010) *Budget 2010,* p. 193.

pensioners, will increase from £124.05 to £130 per week. In addition, the Government has provided each pensioner with a special Christmas bonus of £60, equivalent to bringing forward uprating of the basic State Pension from April to January.[75] Furthermore, the Government has substantially increased the Winter Fuel Payments. Pensioners receive an additional payment between £50 (over 60) and £100 (over 80). The Conservative Party has pledged to protect these benefits for the elderly.[76] In 2009 the Government increased Pension Credits to those with savings of £10,000, rather than only those with less than £6,000. It is estimated that this will entitle an additional half million pensioners. Furthermore, the Basic State Pension was increased by 2.5% in 2010.[77]

Building on record levels of investment in public services since 1997, the Government has decided to bring forward £3bn of capital spending from 2010-11 into 2009-10 and 2008-09 in a number of sectors including health.[78] The NHS budget in England for 2010/11 will increase by approximately £4bn over the previous year.[79] The Government believes that savings can largely be achieved through 'efficiency savings'; for instance £500 million per annum will be saved through reductions in average length of stay in hospital, reducing waste in valuable hospital bed space and costs that occur when patients are kept in hospital longer than necessary, while improving patient experience and clinical outcomes.[80]

Employment in the NHS (England) has risen between 2008 and 2009 by 63,303. The following table provides a breakdown of the NHS staff development in England.

75 DWP (2009) "£4 billion boost for pensioners," Press Release, 11 December 2008.

76 Nicholas Timmins and Jean Eaglesham (2010) "Cameron to protect benefits for elderly," *Financial Times*, March 26, 2010 [available at: http://www.ft.com].

77 HM Treasury (2010) *Budget 2010 – Securing the Recovery.* London: Stationary Office.

78 HM Treasury (2008) *Pre-Budget Report.* London: Stationary Office [available at: http://www.hm-treasury.gov.uk/prebud_pbr08_repindex.htm].

79 HM Treasury (2010) *Budget 2010 – Securing the Recovery.* London: Stationary Office, p. 209.

80 Cf. Nicholas Timmins (2009) "Health care plans bear brunt," in: *Financial Times,* 23 April 2009, p. 17; HM Treasury (2009) *Budget 2009.* London: TSO, p. 135.

Table 6: NHS Hospital & Community Health Service (HCHS) and General Practice workforce as at 30 September each specified year

	1999	2002	2004	2006	2007	2008	2009	Change 1999-2009	Average Annual change	Change 2008-2009	Change 2008-2009
Total	1,098,348	1,224,934	1,331,857	1,338,779	1,331,109	1,368,693	1,431,996	333,648	2.7%	63,303	4.6%
Doctors	94,953	104,460	117,806	126,251	128,210	133,662	140,897	45,944	4.0%	7,235	5.4%
Total qualified nursing staff	329,637	367,520	397,515	398,335	399,597	408,160	417,164	87,527	2.4%	9,004	2.2%
Support to clinical staff	296,619	344,524	368,285	357,877	346,596	355,010	377,617	80,998	2.4%	22,607	6.4%
NHS infra-structure support	171,205	189,274	211,489	209,387	207,778	219,064	236,103	64,898	3.3%	17,039	7.8%

Source: NHS; available at http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1999--2009-overview.

Simulations for the time period 2011/12 to 2016/17 by The King's Fund and the Institute for Fiscal Studies reveal, that average real funding increases will be necessary to cope with demographic pressures. Only in their optimistic funding scenario, which assumes annual real increases of 2% for the first three years, increasing to 3% in the following three years, can quality standards be maintained. However, this scenario requires real average annual spending cuts in the other government departments of 4.5%, which politically seems very unlikely. Compared with past recommendations of required future spending the shortfall would obviously be even much greater. Between the years 1994/95 to 2010/11 the real average annual increase has been 5.1%!

Theoretically, the funding shortfall could partially be offset by productivity increases within the NHS; nevertheless, according to the authors of the simulations these would by far not be sufficient to deal with the funding shortfall. For the three-year period 2011/12–2013/14 the average annual productivity gains needed would be 8.0% for the worst case funding scenario, 6.0% for the intermediate scenario, and 4.0% for the most optimistic scenario. For the subsequent spending review period up to 2016/17, productivity improvements would need to average 6.8%, 5.8% and 2.8%, respectively. Figures from the Office of National Statistics show that between 1997 and 2007, UK NHS productivity fell by 4.3%, with an annual average of –0.4%.[81]

They further note that even under their most optimistic scenario the percentage of GDP devoted to health care spending will 'flatten off' from 2011 and caution that the 'gap between other European countries could widen.' Under their pessimistic scenario, which assumes annual real reductions of 2% for the first three years and reductions of 1% in the subsequent three years, total health care expenditure as a percentage of GDP will decline from an estimated 9.7% in 2010/11 to around 7.9% in 2016/17.[82]

In order to reduce the budget deficit and debt in future years, cutbacks in various programmes or significant tax increases seem inevitable. However, none of the major political actors/parties has identified specific cuts or proposed significant tax hikes. Although the majority of the population acknowledges that cuts are inevitable, 76% of voters want the NHS to be protected.[83] Both major parties so far have pledged not to cut health care and various programmes for pensioners.

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81 ONS (2009). *Total Public Service Output and Productivity* [online]. Newport, Wales: Office for National Statistics, UK Centre for the Measurement of Government Activity. www.statistics.gov.uk/articles/nojournal/TotalPublicServiceFinalv5.pdf, accessed 15 September 2009.

82 John Appleby, Rowena Crawford and Carl Emmerson (2009) *How cold will it be? Prospects for NHS funding: 2011-17.* London: The King's Fund/Institute for Fiscal Studies.

83 Peter Ridell (2009) 'The war on spending cuts is all about image for Labour and Tories,' *The Times*, 15 September 2009. Timesonline.

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HM TREASURY (2009),'Budget 2009', London: TSO.

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4 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

[R1] NATIONAL ASSOCIATION OF PENSION FUNDS, *National Association of Pension Funds'Annual Survey 2009.* London, 2009.

Overview of development in private pension market, based on a survey among members. The 2009 Survey is based on responses from 300 NAPF fund members - including both smaller employers and multi-national organisations. It covers members with defined benefit schemes, defined contribution schemes and local authorities.

[R1] PENSIONS REGULATOR, *Purple Book 2009*. London, 2010.

The Purple Book is published annually by the Pension Protection Fund and the Pensions Regulator. It provides comprehensive data and analysis on the defined benefit pensions' landscape.

[R1] SILCOCK, Daniela; JAMES, Sean; ADAMS, John *Retirement income and assets: outlook for the future*. London: PPI, 2010.

Changes in the private pensions market which are leading to more pensioners receiving income from DC pensions mean that many of the risks associated with pension saving are being passed from the employer to the employee. The amount that pensioners are likely to receive from their private pension income will depend heavily on employer and individual responses to the Government's private pension reforms and subsequent contribution levels.

[R2] WAINE, Barbara "New Labour and Pensions Reform: Security in Retirement?" *Social Policy and Administration,* 2009, Volume 43 Issue 7, 754 – 771.

New Labour has defined the problem of security in retirement as one of undersaving and has sought to resolve it both by measures which encourage saving and by improving financial literacy. The article discusses both of these approaches, arguing that each is flawed and that, in addition, New Labour's pension policy exhibits several tensions which threaten to undermine the objective of providing a secure income in retirement.

[R2] PPI "What are the main parties' policies on pensions?" PPI Briefing Note Number 55.

Provides a detailed policy analysis and synopsis of political parties' proposal with the realm of pensions.

[R3] DEPARTMENT OF WORK AND PENSIONS, *Building A Society For All Ages*, Cm 7655, London: TSO, 2009.

The Government published a strategy designed to help Britain prepare for an ageing society. It said that a review of the default retirement age would be brought forward from 2011 to 2010. More needed to be done to respond to changing families as a result of the ageing society – with grandparents playing a stronger role, and more people caring for elderly relatives.

[R3] HAWKSWORTH, John; DOBSON, Chris; JONES, Nick *Working Longer, Living Better: A Fiscal and Social Imperative*, PricewaterhouseCoopers, 2010.

The report argues that the state pension age should be raised sooner and further than already planned, in order to fund higher state pensions, reduce public debt, and reflect the population trend of longer, healthier lives.

[R5] BERTHOUD, Richard; BLEKESAUNE, Morten and HANCOCK, Ruth **"**Ageing, income and living standards: evidence from the British Household Panel Survey**,"** *Ageing and Society* (2009), 29:1105-1122**.**

In Britain, older people have lower average incomes and a higher risk of income poverty than the general population. Older pensioners are more likely to be in poverty than younger ones. Yet certain indicators of their living standards suggest that older people experience less hardship than expected, given their incomes. A possible explanation is that older people convert income into basic living standards at a higher rate than younger people, implying that as people age they need less income to achieve a given standard of living. Much existing evidence has been based on cross-sectional data and therefore may not be a good guide to the consequences of ageing. The authors use longitudinal data on people aged at least 50 years from the British Household Panel Survey to investigate the effects of ageing on the relationship between standard of living, as measured by various deprivation indices, and income. They find that for most indices, ageing increases deprivation when controlling for income and other factors. The exception is a subjective index of 'financial strain', which appears to fall as people age. The authors also find evidence of cohort effects. At any given age and income, more-recently-born older people in general experience more deprivation than those born longer ago. To some extent these ageing and cohort effects balance out, which suggests that pensions do not need to change with age.

[R5] BRINKLEY, Andrew; LESS, Simon *Cold Comfort: Fuel poverty and the winter fuel payment*, Policy Exchange, 2010.

A think-tank report called for a more honest approach from the Government to tackling fuel poverty. If the Government wanted to use the winter fuel payment to boost the incomes of older people, it should do so transparently through the pensions or benefits system. If, on the other hand, it was serious about helping people who struggled to heat their homes, the Government should focus on improving domestic energy efficiency.

[R5] HOUSE OF COMMONS WORK AND PENSIONS SELECT COMMITTEE *Tackling Pensioner Poverty*, Fifth Report (Session 2008-09), HC 411, London: TSO, 2009.

The report by a committee of MPs said that the number of pensioners living in poverty was one-third lower than it had been in 1997. But it called on the Government to

commit itself to ending pensioner poverty altogether. The complexity of the benefits system was highlighted as a key cause of poverty, with some 1.7 million older people failing to claim money to which they were entitled. It also called for the default retirement age to be abolished, and for protection from discrimination for older workers to be strengthened, to ensure that every pensioner who wished to could continue working.

[R5] LEE, Michelle *Just Ageing? Fairness, equality and the life course*, Equality and Human Rights Commission, Age Concern, and Help the Aged, 2009.

The report made recommendations for tackling disadvantage in later life. It said that inequality in old age was the result of disadvantages that had accumulated during people's lifetimes. These inequalities had an impact on people's health, income, social support, and employment throughout their lives. Inequalities added up to create 'huge gaps in life outcomes' in later life.

[H] Health

[H1] APPLEBY, John; CRAWFORD, Rowena; EMMERSON, Carl *How Cold Will it be? Prospects for NHS Funding: 2011-2017.* London: The King's Fund/Institute for Fiscal Studies, 2009.

Comprehensive assessment of simulations regarding the impact of the crisis in public finances on the NHS in coming years. Key finding: very difficult to maintain the quality of health care.

[H1] SMITH, Peter; GODDARD, Maria *The English Health Service: An Economic Health Check.* OECD Economics Working Paper 717. Paris: OECD 2009.

The Government 's health reform programme since 2000 has covered many aspects of the organisation of health care and was accompanied by a sizeable increase in spending on health care. Many of these reforms have the potential to improve the efficiency and responsiveness of the health care system and ultimately health outcomes, although it is too early to make definitive judgements on their effectiveness. This working paper provides an overview of the organisation and financing of the National Health Service, reviews its performance, assesses the reforms since the start of the decade and provides recommendations for further development.

[H3] CARE QUALITY COMMISSION *The State of Health Care and Adult Social Care in England.* London: TSO, 2010.

Comprehensive analysis of the quality of health care and social care based on various government compliance data. Key finding: Overall improvement, while some organisations and public services do not meet minimum requirements.

[H3] DEPARTMENT OF HEALTH, *Tackling Health Inequalities 10 Years On.* London: Department of Health, 2009.

Comprehensive analysis of health inequalities and their development during the past decade. Based on a variety of surveys and government data. Key finding: "much achieved; more to do", showing that overall absolute health outcomes have improved, but some relative inequalities persist.

[H4] JARMAN, Holly; GREER, Scott L. "In the Eye of the Storm: Civil Servants and Managers in the UK Department of Health," *Social Policy & Administration*, 2010, Volume 44 Issue 2, 172 – 192.

In this article, the authors examine the organisation and leadership of the UK Department of Health and weigh its suitability to meet challenges. They find an organisation that is culturally split between public servants and managers, highly reliant on the ability of its key personnel to bridge these divides, and extremely responsive to the political goals of government ministers. They explore the modern DH using three types of evidence. First, the history of the department shows clear political efforts to reduce civil service discretion and focus the DH on the management of the English NHS. Second, the recent organisational structures of the DH show a bifurcation between policy direction and NHS management tasks. Third, an analysis of the top ranks of the department since 2005 shows the implementation of political preferences that are consistent with managerialism but inconsistent with the perceived characteristics of traditional civil servants. The result is a department which has changed just as frequently as the health service it oversees – a department which has been moulded by successive ministers into one for the management of the NHS. The findings raise important questions about the value and purpose of long-term organisational knowledge in policy formulation.

[H4] CONOLLY, Sheelah; BEVAN, Gwyn; MAYS, Nicholas *Funding and performance of health care systems in the four countries of the UK before and after devolution.* London: Nuffield Trust, 2010.

Comprehensive regional analysis of performance in the four countries of the UK. 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.

[H5] ABOTT, Stephen; PROCTER, Susan; IACOVOU, Nicci "NHS Purchaser–Provider Relationships in England and Wales: The View from Primary Care," *Social Policy and Administration,* 2009, Volume 43 Issue 1, 1-14.

Primary care organisations (PCOs) in the National Health Service in England and Wales are required to purchase most hospital-based health care for their populations. This 'quasi-market' in health care can be seen as 'relational', characterised by an emphasis on cooperative long-term relationships rather than on true competition. The English Government has recently introduced new market mechanisms as a response to the perceived weakness of the relational market. This article draws on three qualitative case studies of PCOs to investigate whether PCO personnel interviewed in 2005/6 concurred with that perception of weakness. Overall, relationships between PCOs and hospital services providers were regarded as unbalanced in favour of the

latter, despite a shared framework of central government policy. Commissioners were seen as generally weak, and providers were judged to be generally unresponsive to PCOs' wishes. Top–down pressure by governments on PCOs and providers of hospital services was more important than commissioning power in shaping hospital services. It remains to be seen whether the remarketisation strategy succeeds in strengthening the commissioning function in primary care.

[L] Long-term care

[L] CARE QUALITY COMMISSION *The State of Health Care and Adult Social Care in England.* London: TSO, 2010.

Comprehensive analysis of the quality of health care and social care based on various government compliance data. Key finding: Overall improvement, while some organisations and public services do not meet minimum requirements.

[L] HUSSEIN, Shereen; MANTHORPE, Jill; STEVENS, Martin; RAPAPORT, Joan et al. "Articulating the Improvement of Care Standards: The Operation of a Barring and Vetting Scheme in Social Care," *Journal of Social Policy*, 2009, Vol. 38, 2, pp. 259-275.

The vetting and barring scheme known as the POVA (Protection of Vulnerable Adults) List established in England and Wales by the Care Standards Act (2000) was intended to provide greater assurance about the quality of social care for adults. This article discusses referrals to the POVA List in the period 21 May 2004 to 17 November 2006, details of which were made available to the researchers. These comprised 5,294 cases. Further data relating to the investigation process were provided through drawing on all material supplied in a purposively selected sample of 298 referrals. These have been analysed and findings are reported here in respect of referrals and prior disciplinary action, interactions with local and national agencies and the involvement of the police. What happened to the referrals and the length of time for decisions about Listing are also reported. The article concludes with some policy recommendations for the future of the scheme and sets this in the context of regulation.

5 List of Important Institutions

Age Concern *and* Help the Aged

Regional office addresses

England
York House, 207-221 Pentonville Road, London N1 9UZ
Phone: **020 7278 1114**
Fax: 020 7278 1116
Email: info@helptheaged.org.uk
Astral House,
1268 London Road, London SW16 4ER
Phone: **020 8765 7200**
Email: General enquiries
Scotland
Causewayside House, 160 Causewayside, Edinburgh EH9 1PR
Phone: **0845 833 0200**
Email: enquiries@ageconcernandhelptheagedscotland.org.uk
Wales
Tŷ John Pathy
Units 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ
Phone: **029 2043 1555**
Email: enquiries@agecymru.org.uk
Northern Ireland
3 Lower Crescent, Belfast BT7 1NR
Phone: **02890 230 666**
Email: info@ageconcernhelptheagedni.org

On 1 April 2009 the four national Age Concerns in England, Scotland, Wales and Northern Ireland joined with Help the Aged to create four new national charities dedicated to improving the lives of older people. 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 (cf. chapter 4) 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
Homepage:	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.

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 Alan Johnson 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 (cf. chapter 4; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/index.htm).

Northern Ireland

Contact person: Michael McGimpsey (Head of Department)
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: Richard Wakeford (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

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 James Purnell, 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 (cf. chapter 4, http://www.dwp.gov.uk/asd/asd5/rrs-index.asp).

N**on-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 (cf. chapter 4).

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: Chris Hitchen (Chairman)
Address: NAPF Ltd, NIOC House, 4 Victoria Street, London, SW1H 0NX
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)

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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

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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 (cf. chapter 4).

Pension Policy Institute

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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. Chair of the Board is Lord (David) Lipsey. The Policy Advisory Board includes amongst others: Nicolas Barr, Vincent Cable, Lord Ralf Dahrendorf, and George Osborne. 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 (cf. chapter 4). Research carried out by this team focuses on the individual and collective views and experiences of people coping with disability or chronic illness and their families across the life course – particularly their experiences and evaluations of publicly-funded services. A major area of interest across projects within the team is on how, through using services and other formal and informal support arrangements, people can exercise choice and control over their lives and maximise their independence and well-being. SPRU also has a significant focus on research related to health and health care.

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

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

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