Annual National Report 2009

Pensions, Health and Long-term Care

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1 Executive Summary

The UK economy faces difficult times as a result of the financial turmoil and global downturn. Due to the automatic expansion of public spending and a *sharp* decline in revenues the country is confronted with a crisis of public finances. As a consequence of the unfavourable economic climate and 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 at the rate witnessed in the previous years.

The UK Government has enacted a significant pension reform 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 poverty amongst pensioners has once again increased, after much progress during the previous years. Nevertheless, the Government seems to be committed to continue its efforts to reduce poverty amongst this group, as demonstrated in the recent budget. The financial and economic crisis had a significant negative impact on private/occupational pension funds. The implications of the negative impact for future pensioners are very uncertain and will depend to a large extent on the speed and level of a rebound in the equity markets.

Investment in healthcare continued at a very high level and included improvements in the infrastructure and an expansion of the workforce. In addition, the healthcare system in England underwent a major review, setting the priorities for the future. In January 2009, the Government published (following consultation) a constitution for the National Health Service in England, setting out patients' rights to care and their responsibilities. Tackling the challenges of health inequality was a major priority in all four countries of the UK.

The situation of the long-term care arrangements in England, Northern Ireland and Wales are consider by many observers as unsatisfactory. The Government began a consultation process on the future shape of care and support services in England. Similarly, consultation processes were started in Northern Ireland and Wales.

2 Current Status of Social Protection

2.1 Pensions

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.[1] A second reform (Pensions Act 2008), building on the Pensions Act 2007, was enacted in November 2008.[2] According to the legislation all workers with an income above a certain minimum threshold will be automatically 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.[3]

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.[4] 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.[5]

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 few decades and as coverage significantly differs by sector, we will witness cohort effects that will especially impact workers with low skills and earnings.

According to the latest government figures available, 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.[6] This is the first increase in poverty among pensioners in the past decade.

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

2 Pensions Act 2008 available at http://www.opsi.gov.uk/acts/acts2008/ukpga_20080030_en_1. For further details see http://www.opsi.gov.uk/acts/acts2008/pdf/ukpga_20080030_en.pdf.

3 Currently, coverage in these schemes is strongly influenced by class and gender; however, variations in coverage are also the product of chance; cf. Traute Meyer/Paul Bridgen (2008) "Politically Dominant by Socially Flawed: Projected Pension Levels for Citizens at Risk in Six European Multi-Pillar Pension Systems," in Martin Seeleib-Kaiser (ed.) *Welfare State Transformations. Comparative Perspectives*, Basingstoke: Palgrave, pp. 111-127.

4 Cf. http://www.dwp.gov.uk/docs/genderimpactassessment.pdf.

5 For an assessment of the gender impact see http://www.dwp.gov.uk/docs/genderimpactassessment.pdf.

6 See http://www.dwp.gov.uk/asd/hbai/hbai2007/first_release_0607.pdf and http://research.dwp.gov.uk/asd/hbai.asp respectively.

More people in work and working longer

The employment rate of older workers (55-64) has continuously increased over the past decade, leading to a comparatively high employment rate of 57.4% (EU25 43.7%).[7] 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.[8] Whether the UK will be able to maintain such high employment rates, during the more difficult economic times ahead, needs to be seen.

The effective labour market exit age is 63.2 years (2006). Overall, the effective labour market exit age is close to the statutory retirement of 65 years for men. For a long time Incapacity Benefits have been a pathway to early exit from the labour market in the UK, which contributed to a comparatively high recipiency rate.[9] However, the UK continues on its previous reform path towards activation and additional reforms have been introduced in October 2008. These are aimed at differentiating between those claimants potentially fit to be employed on a full or part-time basis and those more severely impaired. In other words, the new system will consider what an individual is capable of, and what help and support they may need to manage their condition and return to work.[10] Further reform proposals have been made by the Government in a Green Paper and are currently undergoing a consultation process. These proposals include a further streamlining of benefits as well as a pledge to increase funding to support disabled people finding work or staying in employment.[11]

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 (see Table 1) and earnings level. Whereas 72% of employees earning between GBP 25,000-GBP 39,999 were in an employer-sponsored scheme in 2003, only 43% of those in the GBP 9,500-GBP 17,499 earnings band participated.[12] Due to gendered labour markets, women have lower coverage rates as they are predominantly employed in sectors that do not offer work-related pension benefits.[13] Furthermore, there has been a shift from DB towards DC. According to a 2008 survey conducted by Watson Wyatt more than three-quarters of DB schemes have closed for new entrants and 6% have closed to further contributions from existing employees.

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7 Eurostat, Labour Force Survey 2007.

8 For a more comprehensive analysis of factors influencing the employment rate see Ulrike Hotopp (2005) **"**The employment rate of older workers," *Labour Market Trends*, February, pp. 73-88, available at http://www.statistics.gov.uk/articles/Labour_market_trends/employment_rate_old_workers.pdf.

9 For a comparative perspective see Peter Kemp (2008) "The Transformation of Incapacity Benefits," in Martin Seeleib-Kaiser (ed) op. cit., pp. 164-181.

10 Cf. http://www.opsi.gov.uk/acts/acts2007/pdf/ukpga_20070005_en.pdf.

11 Cf. http://www.dwp.gov.uk/docs/noonewrittenoff-complete.pdf; Andrew Taylor (2008) "Unemployed will have to work in benefits shake-up," in *Financial Times*, 22 July 2008, p. 4.

12 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.

13 Ibid., p. 262.

Table 1: Occupational pension plans by major industry group: 1997–2008

Industry	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Construction	44%	37%	33%	31%	33%	42%	41%	39%	35%	36%	33%	34%
Financial Intermediation	76%	77%	77%	82%	81%	80%	80%	80%	79%	81%	81%	77%
Health & Social Services	56%	58%	60%	61%	61%	63%	62%	63%	62%	62%	61%	60%
Hospitality & Food Services	19%	16%	15%	13%	12%	12%	12%	13%	10%	9%	8%	8%
Manufacturing	56%	57%	57%	57%	58%	61%	59%	58%	57%	57%	54%	53%
Mining, Quarrying & Energy	84%	85%	84%	83%	81%	82%	83%	78%	81%	83%	77%	79%
Real Estate, Renting & Business Services	41%	39%	38%	38%	39%	45%	44%	40%	39%	38%	38%	36%
Wholesale/Retail Trade & Repair	40%	40%	42%	42%	42%	41%	39%	34%	32%	32%	31%	29%
Total Private Sector Coverage	46%	45%	45%	45%	46%	47%	46%	43%	41%	41%	39%	37%

Source: Martin Seeleib-Kaiser, Adam M. Saunders and Marek Naczyk (2009) Shifting the Public-Private Mix: A New Dualisation of Welfare? Draft paper prepared for presentation at 'The Dualisation of European Societies?' Conference, Green Templeton College, Oxford, 23-24 April, 2009.

Note: Calculations based on data derived from the Annual Survey of Hours and Earnings (ASHE) Pensions Analysis Tables (1997 – 2008), Office for National Statistics.

In the schemes surveyed, joint employer and employee contributions averaged 14.7%.[14] According to the OECD the mean contribution rate to voluntary occupational pension programs is 9%.[15] Currently, the main incentives to participate in private and occupational plans are tax relief. However, these tax incentives primarily benefit the better off and thereby increase inequality among pensioners.[16] According to Adrian Sinfield, "[t]he very unequal opportunities to contribute to a non-state pension are a major cause of being 'under-pensioned'."[17]

In 2006-07 around two-thirds of pensioner households had private pension income. The average private pension income was GBP 11,059 for pensioner couples, while for single male pensioners it was GBP 6,812, and for single female pensioners it was GBP 5,519. 39% of pensioner couples, 58% of single male pensioners, and 64% of single female pensioners who received private pension income received less than GBP 5,000.[18]

To achieve a higher level of participation the Government will introduce auto-enrolment into qualifying workplace pensions from 2012. This strategy to improve access to workplace pensions will increase the adequacy of the overall retirement income for many 'lower'

[14] The Watson Wyatt Pension Plan Design Survey 2008 focused on larger private sector pension schemes with total assets of over GBP 230 billion. Some 75% of the 134 organisations in the survey had more than 1,000 employees in the UK and 30 of the FTSE 100 were represented. Cf. http://www.watsonwyatt.com/news/press.asp?ID=19401. Nicholas Timmins and Kate Burgess (2008) "Defined benefit pensions fall further," in *Financial Times*, 26 August 2008, p. 19.

[15] OECD (2007) *Pensions at a Glance.* Paris: OECD.

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

[17] Ibid.

[18] Office for National Statistics, Press release 14 July 2008, http://www.statistics.gov.uk/pdfdir/pentrd0708.pdf.

middle-class employees. To what extent low-wage earners will also benefit from these changes, remains to be seen. Table 2 provides replacements rates for various hypothetical incomes. The data provided by the Government indicate that workers with higher incomes and longer work histories are the main 'winners' of this reform. The effects for low earners with interrupted work histories will be marginal. Furthermore, the improvement in access does not address the huge inequalities with regard to tax incentives.[19]

Recent debates have focused on the inequalities between workers employed in the public sector vis-à-vis those in the private sector, as the overwhelming majority of workers in the public sector is entitled to pensions based on final salary schemes (defined benefits). It is very likely that occupational pensions in the public sector will be reformed in the foreseeable future.[20]

[19] Sinfield, op. cit. The Government has announced changes for very high-income earners in its Budget for 2009/10, see Chapter 3.

[20] Cf. Jean Eaglesham and Chris Giles "Tories take risk over pay and pensions," in *Financial Times*, 7 April 2009, p. 1.

Table 2: Replacement rates for workers with different incomes

Annual Earnings		(a) Full BSP and full S2P, 40 years of pension saving	(b) Full BSP and full S2P, 30 years of pension saving	(c) Full BSP and 30 years S2P, 20 years pension saving	(d) Full BSP and 20 years S2P, 10 years of pension saving
GBP 10,000	Final net weekly income with saving (GBP)	175	173	149	140
	Replacement rate with saving (%)	92	91	78	73
	Improvement in replacement rate from saving (%)	8	6	1	1
GBP 15,000	Final net weekly income with saving (GBP)	189	184	152	143
	Replacement rate with saving (%)	67	65	51	50
	Improvement in replacement rate from saving (%)	12	10	2	1
GBP 20,000	Final net weekly income with saving (GBP)	209	196	162	147

	Replacement rate with saving (%)	48	45	34	31
	Improvement in replacement rate from saving (%)	13	11	3	1

Source: The Parliamentary Under-Secretary of State, Department for Work and Pensions, Lord McKenzie of Luton, Hansard, 3 July 2008: Column WA53, available at:

http://www.publications.parliament.uk/pa/ld200708/ldhansrd/text/80703w0002.htm

Note: Rates in the table are rounded to the nearest whole number. In all cases, the results are based on a male who starts work aged 22 in 2012, with savings at the default level, phased in over a three-year period. The figures may therefore represent only a few years of saving at the 4% individual contribution level. For example (d), this means that the hypothetical individual will have saved at the full level only for eight years.

Despite the huge inequalities outlined above, it has to be emphasised that based on simulations conducted by the OECD the 'Average Worker' *enrolled* in an occupational pension plan in the UK will have an adequate pension income in the future. The net replacement rate of the public system, often used in international comparisons, does underestimate the overall pension 'entitlement' for a substantial percentage of workers in the UK (see Table 3).

Table 3: Prospective pension minima and replacement rates for 'average workers' (2004 Baseline)

Country	Minimum Income for Pensioners as % of Average Earnings	Gross Replacement Rate of Public System (AW)	Net Replacement Rate of Public System (AW)	Gross Replacement Rate of Public and Voluntary Occupational Pensions (AW)
France	24.0	64.7	78.1	N/A
Germany	19.3	39.9	58.0	56.0
United Kingdom	20.0	30.8	41.1	67.0
United States	22.0	41.2	52.4	81.2

Source: OECD (2007) Pensions at a Glance. Paris: OECD.

Note: Minimum income provisions are based on means-tested programmes available to pensioners. All replacement rates are based on the assumption of a full career. Gross replacement rates of public and voluntary occupational/private pensions are based on assumed contribution rates of 9% (currently the mean) in the United Kingdom and the United States. For Germany the assumed contribution rate is 4%, currently the maximum contribution to receive the full tax incentive.

As an increasing proportion of occupational plans are based on the principle of defined contributions, we are very likely to witness cohort effects with regards to the actual replacement rates, as Gary Burtless has shown in his research relating to the US occupational pension system. Based on the experiences of past developments in equity markets replacement rates can vary significantly depending on the time first contributions were made and the time a worker retires.[21]

The governance and regulatory structures of private work-based pension schemes have improved within the last couple of years. In this context, I want to highlight the Pension Protection Fund and the Financial Assistance Scheme, which have significantly improved the security for those entitled to DB pensions. Information on the governance of DC schemes is still very sketchy (and some research indicates a need for improvement).[22]

The information on financial literacy is still quite limited. However, a recent report has identified 7.5 million adults as 'vulnerable' with regards to their financial capabilities; people in this group tend to belong to those with lower income and lower education levels; they are younger than average, slightly more female than male and more likely to live in Wales, Scotland, Northern Ireland and the North of England.[23] In the summer of 2008 the Government has launched a Financial Capability Action Plan to improve financial literacy.[24]

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 recently. According to the latest government figures available, 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, constituting 23% of pensioners before housing costs and 19% after housing costs. Independently of which poverty indicator is chosen, i.e. 50%, 60% or 70% of median income and before or after housing costs, the poverty rate has increased by two percentage points (also see Table 3).[25]

This is the first increase in poverty among pensioners during the past decade, during which the UK had made significant progress towards poverty reduction. The reasons for the recent increase in poverty thus far remain unclear. However, one contributing factor might have been a decline in the take-up rate of the Pension Credit,[26] aimed at supporting low-income pensioners. Thus, further efforts to increase the take-up of the benefit might be an effective measure to reduce poverty among pensioners.

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21 Burtless, Gary (2009) 'The Impact of Financial Market Turbulence on Retirement Security: Comparing Social Security and Individual Retirement Accounts,' in Mitchell Orenstein (ed.) Pensions, Social Security, and the Privatisation of Risk. New York: Columbia University Press.

22 Cf. Pensions Regulator (2008) DC research Data on the occupational DC landscape plus results of independent research, available at http://www.thepensionsregulator.gov.uk/pdf/DCResearch.pdf.

23 Jackie Wells (2007) *Target Market Analysis for Generic Financial Advice*, available at http://www.hm-treasury.gov.uk/media/C/1/thoresenreview_annex1.pdf.

24 Cf. http://www.hm-treasury.gov.uk/press_73_08.htm.

25 See http://www.dwp.gov.uk/asd/hbai/hbai2007/first_release_0607.pdf. DWP (2008) *Households Below Average Income. An analysis of the income distribution 1994/95 – 2006/07,* available at http://www.dwp.gov.uk/asd/hbai/hbai2007/pdf_files/full_hbai08.pdf, and http://research.dwp.gov.uk/asd/hbai.asp respectively.

26 Cf.http://research.dwp.gov.uk/asd/income_analysis/jun_2009/0708_PensionCredit.pdf.

Table 4: Percentage of pensioners in poverty (before housing costs)

	Percentage of Pensioners Below Median		
	50%	**60%**	**70%**
1998/99	14	27	41
1999/00	14	25	40
2000/01	13	25	39
2001/02	14	25	39
2002/03	13	24	39
2003/04	12	23	36
2004/05	11	21	34
2005/06	11	21	33
2006/07	13	23	35
Change			
1998/99-2006/07	-1	-4	-6
2005/06-2006/07	2	2	2

Source: See FN 24.

However, it has to be emphasised that current projections taking into account the various provisions of the Pension Act 2007 show a decline in the proportion of pensioner households reliant on means-tested support in the future (see Table 5).

Table 5: Proportion of pensioner households entitled to Pension Credit in selected years, under the reformed state pension system

	Guarantee Credit only	**Guarantee and Savings Credit**	**Savings Credit only**	**Pension Credit***
2005	10%	20%	15%	45%
2010	10%	15%	15%	45%
2020	5%	15%	20%	40%
2030	5%	10%	15%	35%
2040	5%	10%	15%	30%
2050	5%	10%	15%	30%

*Total number entitled to any element of Pension Credit.

Source: Department of Work and Pensions (2008) Projections of Entitlement to Income Related Benefits to 2050, London: Department for Work and Pensions, available at http://www.dwp.gov.uk/docs/projections-of-entitlement-to-incomerelatedbenefitsjune2008.pdf.

Notes: Figures rounded to nearest five percentage points. Components may not sum to totals due to rounding. Projections from 2010.

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.[27] 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 is once again rising. Enacted changes in the Basic State Pension will improve the situation for many workers, especially female employees, with shorter contributory periods retiring in 2010 or later. However, as the UK spending on public pensions continues to be below the EU25 average, a further increase in *public* pension spending might be warranted, to achieve the goal of lower poverty rates among pensioners. Such an increase in *public* spending can be achieved in a cost-neutral way by reducing the tax incentives for private pensions of high-income earners.[28] Further changes to be implemented starting 2012 will improve the accessibility to workplace pension schemes.

2.2 Health

"Since devolution in 1999, the four health systems of the UK, always historically different and now enabled by devolution, have drifted further apart."[29] Nevertheless, the state continues to be the dominant supplier of health care to the population in all four countries and de jure access is universal.[30] The financing of healthcare basically relies on general tax revenues. The last decade has seen a tremendous increase in health-care spending, although as a percentage of GDP, spending in the UK is still slightly lower than average spending by EU Member States.[31] These increased investments have contributed to a significant decline of waiting times.[32] A key characteristic in the UK has been that health inequalities continue to persist and in some cases have even increased at a time when overall health conditions among the population have improved.[33] 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."[34] The WHO in its recent report on social determinants of health clearly highlighted that social factors are key determinants for the huge variations in ill

27 Pensions Commission, op. cit., p. X.

28 Sinfield op. cit.

29 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.

30 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.

31 See Annex 4.3 of the NSR.

32 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.

33 Cf. Department of Health (2008) Tackling Health Inequalities: 2007 Status Report on the Programme for Action. London: London; also see Department of Health (2008) Health Inequalities: Progress and Next Steps. London: Department of Health.

34 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.

health and life expectancy. For instance, within the city of Glasgow the male life expectancy at birth is 54 years in the poor neighbourhood of Calton and 82 years in affluent Lenzie.[35] Also parts of former mining and industrial areas in Wales have "some of the worst health indicators in Europe" (cf. NSR, p. 76). Without further significant reductions in inequality and poverty it does not seem likely that health inequalities will narrow substantially.

Key trends and priorities

England

Within England a core focus is on providing patients with more choice, improving the quality of care and allocating financial resources based on results.[36] 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*.[37]

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 healthcare 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 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.[38]

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.[39] 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 healthcare.[40]

The opposition Conservative Party is also committed to improve the NHS. In a plan published in 2008, the Conservatives propose to abolish central performance targets, which have been a core element of the current Government's strategy, and introduce measures to increase the

[35] WHO (2008) Closing the gap in a generation. Health equity through action on the social determinants of health.

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

[37] Department of Health (2008) Putting prevention first. London: Department of Health.

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

[39] Department of Health (2009) *The NHS Constitution for England*. London: Department of Health.

[40] Department of Health (2009) *Health Bill*. London: Department of Health, available at http://www.publications.parliament.uk/pa/ld200809/ldbills/018/2009018.pdf.

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.[41]

Scotland

The Scottish Government published an Action Plan in late 2007, setting out the main aims. The central themes of the Action Plan are patient participation, improved healthcare access, and a focus on the challenges of improving public health and tackling health inequalities.[42] Accordingly, in June 2008 the Scottish Government introduced the *Health Boards (Membership and Elections) (Scotland) Bill* to address the governance issues set out in the Action Plan.[43]

Wales

In spring 2008, the Welsh Assembly Government published a Consultation paper entitled *Proposals to Change the Structure of the NHS in Wales*.[44] The aim of the Government is to end the internal market and to make significant changes in the governance structure of health care delivery. Compared to England, Wales seems to be moving towards a more centralised health-care system. A recent report strongly criticised the governance of health care in Wales.[45] In early 2009, the Welsh Assembly Government began consultation on proposals for a unified public health system comprising a new National Health Service Trust, designated the Public Health Wales National Health Service Trust.[46]

Northern Ireland

The Northern Ireland Executive began consultation on proposals to reform health and social care. Key elements include: a new Regional Health and Social Care Board that would focus on financial management, performance management, and commissioning; and a new multi-professional Regional Public Health Agency to better tackle inequalities.[47] An audit report said that the health service in Northern Ireland was making good progress against many of its key targets. But public health issues such as obesity and suicide continued to need attention, as did the issue of health inequality.[48]

Access to health care

As stated in the introduction to this section, the health systems of all four countries provide universal access to health care. However, access to specific treatments might differ between

41 Conservatives (2008) *NHS Improvement Plan*. London: Conservative Party.
42 NHS Scotland (2007) *Better Health, Better Care: Action Plan.* Edinburgh: The Scottish Government.
43 The Bill is available at http://www.scottish.parliament.uk/s3/bills/13-HealthBoards/b13s3-introd.pdf.
44 Welsh Assembly Government (2008) *Proposals to change the structure of the NHS in Wales,* available at http://new.wales.gov.uk/consultations/healthsocialcare/nhswales/?lang=en&status=closed.
45 Mansel Aylward (2008) *Health Commission Wales: A Review*, Welsh Assembly Government, available at http://www.wales.nhs.uk/sites3/Documents/568/Health%20Commission%20Wales%20A%20Review%20(Eng%20Report).pdf.
46 Welsh Assembly Government (2009) *Unification of Public Health Services in Wales*. Cardiff.
47 Department of Health, Social Services and Public Safety (2008) *Proposals for Health and Social Care Reform*, available at http://www.dhsspsni.gov.uk/consultation_package.pdf.
48 National Ireland Audit Office (2008) *The Performance of the Health Service in Northern Ireland.* London: TSO.

and within countries. Co-payments for drugs are one example. Whilst patients in England, that are not exempt due to old age, pregnancy, disability etc., have to pay co-payments for drugs, drugs are free of charge in Scotland and Wales. But independently of co-payments certain drugs are available in one region and not in another. A recent case that hit headline news was access to a drug that treats wet age-related macular degeneration of the eye that only recently became available in England, but was available in Scotland for some time.[49] A recent survey conducted by the BBC shows wide disparities in access to certain cancer drugs within the four countries.[50]

England

Access to treatment has improved through the significant decline in waiting times (currently 18 weeks), as stated in the introduction to this section. 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.[51] 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."[52] Furthermore, patients who privately paid for certain treatments not available through the NHS were not entitled to be treated for the same condition through the NHS until very recently. After some public controversy the Secretary of State in 2008 commissioned a review[53] which was published in October 2008. Promptly acting upon the recommendations included in this review, the Secretary of State has now advised all medical directors that the policy should be stopped, i.e. that treatment should no longer be withheld.[54]

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49 See BBC News (2008) "Patients to get sight-saving drug," 27 August 2008, available at http://news.bbc.co.uk/1/hi/health/7582242.stm.

50 BBC News (2008) "Cancer drug access varies widely," 24 September 2008, available at http://news.bbc.co.uk/1/hi/health/7629753.stm.

51 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/information/educational_resources/exceptional_cases_funding_by_pcts/rcf_taking_exception.pdf.

52 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/kings_fund_publications/nhs_spending.html.

53 See the announcement by the Secretary of State for Health Alan Johnson in Parliament on 17 June 2008, available at http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080617/debtext/80617-0001.htm. For the debate see Anne Slowther (2008) "Co-payment for medical treatment," in *Clinical Ethics*, 3(4): 168-170.

54 See http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_090088.

Scotland

As mentioned in the introduction to this section, the Scottish Government has published a report entitled *Equally Well* in which it sets out its priorities in tackling health inequalities. Such an approach requires action from national and local government, and from other agencies including the National Health Service, schools, employers, and third sector. Priority areas are children, particularly in the early years; 'killer diseases' such as heart disease; mental health; and the harm caused by drugs, alcohol, and violence.[55] 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).[56]

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.[57] The differences between England and Wales have led to the fact that Welsh patients seeking treatment in an English hospital have to wait longer than English patients treated for the same illness (in case of non-emergency treatment).[58]

Northern Ireland

In Northern Ireland waiting times have also been reduced, but similar to Wales continue to be significantly longer than in England. The current waiting times target from GP referral to the start of treatment is 26 weeks, to be cut to 13 weeks by March 2009.[59] The Northern Ireland Executive announced plans to abolish prescription charges. The cost of a prescription would be reduced to GBP 3 in January 2009, and would be free of charge by April 2010.[60]

Quality of health care

All four countries give high priority to improving the quality of healthcare. The significant increase in health-care spending is indicative for this policy approach. All four countries are increasingly focusing on preventive care. As highlighted above, substantial regional differences in health outcomes persist, however, they do not seem to be primarily caused by regional disparities in the quality of health care. All four countries have mechanisms in place to systematically monitor quality, which has recently been reformed. The Health and Social

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55 The Scottish Government (2008) *Equally Well. Report of the Ministerial Task Force on Health Inequalities.* Edinburgh: The Scottish Government, available at http://www.scotland.gov.uk/Resource/Doc/226589/0061265.pdf.

56 Cf. http://www.scotland.gov.uk/News/Releases/2008/02/06093923.

57 House of Commons, Welsh Affairs Committee (2008) *The provision of cross–border health services for Wales: Interim Report*. London: The Stationery Office, available at http://www.publications.parliament.uk/pa/cm200708/cmselect/cmwelaf/870/870.pdf.

58 Ibid.

59 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.

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

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.[61]

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 were a small number of trusts 'trapped at a level of performance that was unacceptably poor'.[62] Furthermore, mixed-sex wards in hospitals were once again debated and the Government announced that hospitals that treated patients in mixed-sex accommodation would not be paid for their care from 2010.[63] In 2007-08, family doctor practices in England were awarded an average score of 96.8% achievement against a set of evidence-based indicators developed to assess the quality of care provided to patients. This compared with an average achievement of 95.5% in 2006-07.[64] In early 2009, the Government announced a package of measures designed to 'virtually eliminate' mixed-sex hospital accommodation, which has been a pledge of the Labour Party for some time. 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.[65]

Patients are increasingly involved in the governance structure of the health care system. The comparatively low percentage of the UK population reporting unmet need for medical care is a relatively good overall indicator for quality of the health-care system. Nevertheless, various reports have indicated that there is room for improvement in responding to complaints from patients. An audit report said that navigating the complaints systems in the NHS was not straightforward, and handling some complaints took too long. There was little sharing of lessons from complaints or evidence that services were improving as a result.[66]

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

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

62 Healthcare Commission (2008) *State of Healthcare 2008*. London: TSO. Also see Healthcare Commission (2008) *The Annual Health Check 2007/08: A national overview of the performance of NHS trusts in England*. London.

63 Department of Health, Press release 28 January 2009, available at http://nds.coi.gov.uk/content/detail.aspx?NewsAreaId=2&ReleaseID=391009&SubjectId=2.

64 NHS, Press release 30 September 2008, available at http://www.ic.nhs.uk/news-and-events/press-office/press-releases/september-2008/high-achievement-scores-for-gp-practices-against-national-contract-framework.

65 Sheila Leatherman and Kim Sutherland, *The Quest for Quality: Refining the NHS reforms*. London: Nuffield Trust.

66 National Audit Office (2008) *Feeding Back? Learning from complaints handling in health and social care*. London: TSO, available at http://www.official-documents.gov.uk/document/hc0708/hc08/0853/0853.pdf. Also see Joanna Goodrich and Jocelyn Cornwell (2008) *Seeing the Person in the Patient: The Point of Care review paper*. London: King's Fund; Parliamentary and Health Service Ombudsman (2008) *Remedy in the NHS: Summaries of recent cases.* London: TSO.

in 2006, less than half the OECD average of 19.2.[67] 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.[68]

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. Although spending is projected to further increase in the coming years, the increases will be lower than previously envisioned. An audit report showed an overall picture of financial improvement for many NHS organisations in England during 2007-08. Half of the 302 NHS trusts assessed in England had performed well or strongly in the way that they had used their resources, and only 3% had failed to balance their books.[69] According to an audit report the financial position in the NHS in Scotland continued to improve overall, but that the service faced 'challenging times' in the near future.[70] The Audit Committee for Wales also acknowledged improvements and highlighted that the forthcoming reorganisation of the services represented a 'great opportunity' to further improve financial management.[71] 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.

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 were not commensurate to the increased spending and that the NHS needs to focus on increases in productivity.[72] 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. Overall, the UK still trails many of its European neighbours on a number of health (policy) dimensions.

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

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

69 Audit Commission (2008) *Auditors' Local Evaluation 2007/08: Summary results for NHS trusts and primary care trusts,* retrieved from http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=ENGLISH^574^SUBJECT^1490^REPORTS-AND-DATA^AC-REPORTS&ProdID=954ED1DA-2EEE-418b-8436-717F03963AD7.

70 Audit Scotland for Accounts Commission and Auditor General (2008) *Financial Overview of the NHS in Scotland 2007/08*. Edinburgh, available at http://www.audit-scotland.gov.uk/docs/health/2008/nr_081204_NHS_financial_overview.pdf.

71 Audit Committee/National Assembly for Wales (2009) *Are the Devolved Financial Management Arrangements in NHS Wales Effective?* Cardiff, available at http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-doc-laid.htm?act=dis&id=115462&ds=2/2009.

72 Bosanquet et al. op cit.

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. As a recent 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.[73] Although funding for social care has increased in real terms by 11% since 2003-04, and by 53% since 1998-99,[74] 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. People who did not meet the eligibility criteria managed as best they could – but often at great cost in financial, emotional, personal, and physical terms, both to them and to their family carers. The report made a number of recommendations designed to improve the operation of eligibility criteria. 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.[75]

Based on the unsatisfactory conditions of long-term care a substantive debate on the future of the financing, governance and provision arrangements of long-term care has begun in England. A report by the umbrella organisation *Caring Choices* argued that there was a need for a new system to pay for long-term care for older people, which combined a clear-cut entitlement to care and support with a sharing of costs between individuals and the state. The existing system of funding long-term care was 'not fit for purpose'. Better support for unpaid carers was also crucial.[76]

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

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73 Coalition on Charging (2008) *Charging into Poverty?* London, available at http://www.ncil.org.uk/uploads/pdf/Charging_Into_Poverty_FINAL.pdf. Also see Resolution Foundation (2008) *Mapping Long-term Care Markets*, available at http://www.resolutionfoundation.org/pdf/publication_reports/A-Z_Report.pdf.

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

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

76 Caring Choices (2008) *The Future of Care Funding: Time for a change*. Also see Joseph Rowntree Foundation (2008) *What Future for Care?* York; Resolution Foundation (2008) *A to Z: Mapping long-term care markets*. London: Resolution Foundation.

promoted independence, choice, and control for everyone who used the care and support system; ensured that everyone could receive the high-quality care and support they needed, and that government support should be targeted at those most in need. It said that the debate would culminate in the publication of a Green Paper.[77] The NHS Confederation has suggested the long-term solution could be a minimum package of entitlement paid for through a new *insurance system*.[78] The introduction of a long-term care insurance is also supported in a report by the *New Local Government Network*, an independent think tank founded by senior local government officials.[79]

The *Welsh Assembly Government* began 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 had been 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.[80]

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.[81] 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."[82]

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.[83]

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

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

78 NHS Confederation (2008) *Funding Tomorrow Today: Social care for older people and vulnerable adults*.

79 Giorgia Iacopini and Chris Leslie (2009) *Better With Age: Reforming the future of local social care for older people*, London: New Local Government Network. Also see James Lloyd (2008) *A National Care Fund for Long-term Care*. London: International Longevity Centre.

80 Welsh Assembly Government (2008) *Paying for Care in Wales: Creating a fair and sustainable system.* Cardiff.

81 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.

82 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.

83 For an overview of the social care system in England see Commission for Social Care Inspection (2008) *The State of Social Care in England*, available at http://www.csci.org.uk/PDF/20080128_SOSC_Summary_2007.pdf.

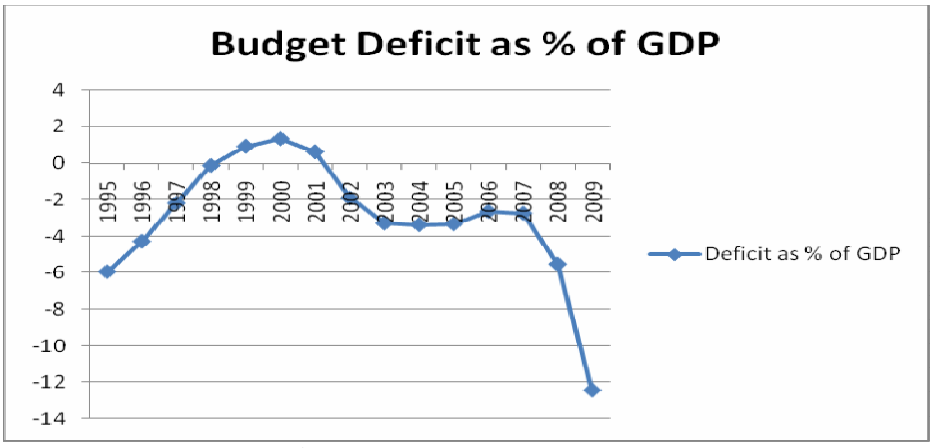
people living in their own homes receive informal care. An overwhelming majority of this care is provided by family members, such as the spouse or an adult child. Recent research concludes: "Demand for informal care by disabled older people is projected to exceed supply by 2017, with the 'care gap' widening 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."[84] 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.

3 Impact of the Financial and Economic Crisis on Social Protection

The greatest problem in assessing the impact of the current financial and economic crisis on social protection is *uncertainty*. As no one can predict the depth and the length of the crisis any assessment on its impact on social protection must be *preliminary*.

Deterioration of public finances

Since 2002, the Government has run an annual budget deficit to finance many of the investments needed for improvements in healthcare and education. Hence, it entered the current crisis with a substantial annual deficit of more than 2.5%. The annual public deficit is estimated to reach 12.4% in 2009/10. Although public debt was significantly below the EU average before the crisis, it is estimated to reach more than 70% of GDP by 2011/12. According to the IMF public finances are deteriorating at the fastest pace in the G20 countries.[85]



Note: 1995-2008 Eurostat data. 2009 UK Treasury projections.
Sources:
http://epp.eurostat.ec.europa.eu/portal/page?_pageid=2373,47631312,2373_58674404&_dad=portal&_schema=PORTAL, and
http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tsieb080
respectively. HM Treasury (2009) Budget 2009. London: TSO, p. 2.

[84] 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.

[85] Cf. HM Treasury (2009) *Budget 2009.* London: TSO, p. 2; Chris Giles/Alex Barker (2009) "Public debt set to compromise UK's standing," in: *Financial Times*, 23 March 2009, p. 1; Chris Giles (2009) "Public finances crumble under debt burden," in: *Financial Times*, 26 March 2009, p. 4.

In order to reduce budget deficit and debt in future years, cutbacks in various programmes seem inevitable. However, none of the major political actors so far has identified specific cuts. Both major parties will be reluctant to propose major cuts before the next general election, which is scheduled to be held in June 2010 at the latest. Nevertheless, local councils plan for worst case scenarios for the next spending round starting in 2011. The President of the Society of Local Authority Chief Executives, Trish Hanes, recently stated: "People are talking about possible reductions in public spending of 10 to 15%, even up to 30%."[86]

Impact on pensions

a) Public pensions

There is no immediate impact on public pension finances as these are largely financed through general revenue and do not rely on separate pension trust funds or social insurance funds. 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 GBP 95.25 instead of GBP 90.70. The Pension Credit, a means-tested programme supporting poor pensioners, will increase from GBP 124.05 to GBP 130 per week. In addition, the Government has provided each pensioner with a special Christmas bonus of GBP 60, equivalent to bringing forward uprating of the basic State Pension from April to January.[87] Furthermore, the Government has substantially increased the Winter Fuel Payments for the past winter. Pensioners have received an additional payment between GBP 50 (over 60) and GBP 100 (over 80).[88] In the recent budget the Government announced that Pension Credits will be extended to those with savings of GBP 10,000, rather than only those with less than GBP 6,000. It is estimated that this will entitle an additional half million pensioners. Furthermore, the Basic State Pension will rise by 2.5% next year, regardless of inflation.[89]

Based on a pension reform enacted last year, workers retiring in 2010 will only need 30 years of employment to receive the full state pension. This will lead to a significant increase in public pension benefits, especially for women and workers with interrupted work histories.

Finally, it is questionable whether the Basic State Pension will be uprated based on earnings increases as initially intended by 2012. As this part of the pension reforms was made dependent on the affordability and fiscal position in that year, it now seems likely that the change will be implemented by 2014.

86 Cited in Nicholas Timmins (2009) "Town halls look for deep cuts in services," in: *Financial Times,* 19 March 2009, p. 5.

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

88 DWP (2008) Changes to the amount of Winter Fuel Payment for winter 2008/09, retrieved from http://www.dwp.gov.uk/resourcecentre/publishedwinterfuelpayments-080814.pdf.

89 Elaine Moore (2009) "Worse off given more of a helping hand," in: *Financial Times*, 23 April 2009, p. 15.

b) Private pensions

British pensioners rely to a large extent on occupational pensions in order to have an adequate retirement income as state pensions are comparatively low; pensioners receive between 20 and 30% of their income through private pensions. Hence, the meltdown in equity prices that we have witnessed over the past year will have a significant impact on future pensioners. Currently about 37% of workers employed in the private sector rely on some form of occupational pension for their future retirement income. According to the OECD real pension fund returns in the UK were negative, approximately -17% for the period from January to October 2008. As of now, it is impossible to assess the full impact of the crisis; this will only be revealed once the annual reports for 2008 have been submitted to the authorities.[90] Nevertheless, the UK Government has changed the tax relief for higher income earners. Under the new system, tax relief on pension contributions will be tapered down from 40% for those with incomes of up to GBP 150,000 to the basic rate of 20% for those with incomes over GBP 180,000. This will lead to 'significant' losses for high-income earners.[91]

Defined benefit plans

The current situation has led to a significant increase of the deficits in many defined benefit plans. The total deficits of UK defined benefit schemes are estimated to be GBP 228 billion as of February 2009. It is very likely that the current situation will lead to further closures of these plans. However, the Pensions Regulator has recently indicated some flexibility for companies to balance their books. According to a recent survey about 60% of pension schemes do not know how the recession is impacting their funding position. In addition, the Pension Protection Fund, i.e. the agency that is to step in should funds become insolvent, currently has a deficit of GBP 500 million.[92]

Defined contribution plans

Although the argument that the average rate of return for private and occupational pensions is higher than for public old-age insurance might still hold in the long run, the important issue is not the average rate of return, but the rate of return for an individual starting to invest in these products at a certain point in time and starting to rely on payments from these at the time of retirement, which to some extent will also be a fixed date. As Gary Burtless from the Brookings Institution has shown, we can anticipate cohort effects.[93] In other words those that have started to invest in the late 1990s so far have not seen much of an increase, but have suffered severe losses. Even before the recent meltdown in equities, the average rate of return for the period from Dec. 2000 – Dec. 2005 was only 1.9%.[94] Nevertheless, this cohort is still some years away from retirement. Very much will depend on fast the equity markets will regain some of their value within the foreseeable future.

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90 OECD (2009) *Private Pensions Outlook 2008.* Paris: OECD, p. 16.

91 Matthew Vincent (2009) "Pension providers warn of unintended consequences," in: *Financial Times*, 23 April 2009, p. 14.

92 Elaine Moore (2009) "Fears for pension safety net," in: *FT Weekend Supplement Money*, 21/22 March 2009, p. 1.

93 Burtless op. cit.

94 Pablo Antolin (2008) "Pension Fund Performance," OECD Working Papers on Insurance and Private Pensions, No. 20, p. 9.

Impact on social services and health care

During the current crisis the national government has continued to expand public sector employment. Employment in the NHS has risen by 59,000 workers during the past year to 1.56 million.[95] Building on record levels of investment in public services since 1997, the Government has decided to bring forward GBP 3bn of capital spending from 2010-11 into 2009-10 and 2008-09 in a number of sectors including health.[96] Nevertheless, next year's budget has been cut from a planned GBP 104.6bn to GBP 102.3bn, but that will still represent GBP 4bn in growth over this year. The Government believes that these savings can largely be achieved through 'efficiency savings'; for instance GBP 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.[97]

Local authorities, responsible for delivering social services, including long-term care have reduced their workforces by 12,000 to 2.9m employees during the past year.[98] Furthermore, it seems plausible that local authorities will further reduce the number of their employees within the coming years. Due to the expected severe cuts in public spending, representatives of local councils fear deep cutbacks in social and health services might become necessary. Trish Haines, President of Solace, recently stated: "If we have to take 40% out of those sorts of budgets [social care] we would have to tell Government that it would have to change the statutory framework, and think not about maximum standards but what would be the minimum standards for a safety net service."[99]

To sum-up: The state of public finances seems bleak. However, it is not yet clear how severe the situation is and which areas of social protection might be retrenched in future years. What seems certain, however, is that the Government cannot continue on its past trajectory of spending increases; moreover, it will have to rely on increases in productivity and a cost-neutral rebalancing of resources to address the goal of improving outcomes.

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95 Andrew Taylor (2009) "More than 2 m jobless as private sector hit," in: *Financial Times*, 19 March 2009, p.4.

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

97 Cf. Nicholas Timmins (2009) "Healthcare plans bear brunt," in: *Financial Times,* 23 April 2009, p. 17; HM Treasury (2009) op. cit., p. 135.

98 Andrew Taylor (2009) "More than 2 m jobless as private sector hit," in: *Financial Times*, 19 March 2009, p.4.

99 Cited in Nicholas Timmins (2009) "Town halls look for deep cuts in services," in: *Financial Times,* 19 March 2009, p. 5.

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.

[R5] AGE CONCERN, «*Out Of Sight, Out Of Mind: Social exclusion behind closed doors*», London: Age Concern, 2008.

The report argues that over 1 million older people – including 1 in 5 people aged over 80 – suffered from severe social exclusion. 56% of severely excluded people aged over 50 were in poor health, and 40% were lonely. Method: Secondary data analysis; qualitative research.

[R5] AGE CONCERN ENGLAND, «*Flagship or Flagging? The impact of pension credit five years on*», London: Age Concern, 2008.

Key findings of this report are: Awareness of Pension Credit remains generally high, although one in eight pensioners are still unaware of it. There has also been a noticeable increase in positive attitudes towards Pension Credit among those claiming it. However, the research also reveals significant problems, with take-up levels remaining low and people still experiencing major barriers to claiming. In 2003 around a third of those entitled to Pension Credit failed to claim – around a third are still missing out today. Methodology: This report presents the findings of a survey of 2391 people aged 60 and above (a weighted base of 2278 people), including nearly 432 Pension Credit recipients (a weighted base of 443 people). This research was conducted by telephone by ICM on behalf of Age Concern between 6–31 August 2008

[R4] BLEKESAUNE, Morten, BRYAN, Mark, & TAYLOR, Mark, «*Life-course Events and Later-life Employment*», Research Report 502, London: Department for Work and Pensions, 2008.

Researchers examined relationships between men's and women's life-course experiences and their employment trajectories between the ages of 50 and 70, using the British Household Panel Survey and the ONS Longitudinal Study. They looked at the effects on employment after 50 of both earlier life-course events (such as educational achievement, labour market entry, and family formation) and later life determinants (such as health and disability, individual pension savings and pension entitlements, and job characteristics such as physical strains and job autonomy). They compared the importance of early and later life factors, and also investigated how early life-course events acted indirectly through their influence on later life determinants of employment exit.

[R5] DEPARTMENT FOR WORK AND PENSIONS, «*Households Below Average Income: An analysis of the income distribution 1994/95-2006/07*», London: Department of Work and Pensions, 2008.

The annual report shows that the number of pensioners in relative poverty rose by 300,000 to 2.5 million (BHC) and by 200,000 (AHC) to 2.1 million in the same period.

[R5] DEPARTMENT FOR WORK AND PENSIONS, «*The Pensioners' Incomes Series 2006-07*», London: Department for Work and Pensions, 2008.

The annual report provides estimates and interpretation of trends in the levels and sources of pensioners' incomes, based on two household surveys. Net income for pensioner units grew by 29% in real terms between 1996-97 and 2006-07, whereas average earnings rose by 16% over the same period.

[R2] HORACK, Sarah, WATMOUGH, Margaret; WOOD, Andrew, & DOWNER, Kate «*Information Needs at Retirement: Qualitative research focusing on annuitisation decisions*», Research Report 515, London: Department for Work and Pensions, 2008.

The report presents findings on the understanding and perceptions of the annuitisation process among people with defined-contribution pensions at or around the point they were making decisions about retirement and annuitising their pension fund, focusing on the information they received and used. The study examined, in depth, how well individuals understand choices and tradeoffs about when and how to annuitise; how decisions about annuitisation are being made now; whether and where individuals coming up to annuitisation go for information and/or advice; what people need, and want, to know in order to make sound choices given their own circumstances and when and how best to communicate information to individuals about annuities and the annuitisation process. It is important to emphasise that the research is qualitative in nature. It does not provide statistical data relating to the frequency of experiences and views across the general population.

[R1; R21 OFFICE FOR NATIONAL STATISTICS, «*Pension Trends*», updated annually

Pension Trends draws together statistics from ONS, a number of government departments and other organisations to highlight the complex issues that shape trends in pension provision in the UK. Key chapters are updated annually, with others appearing less frequently.

[R1; L] PENSION POLICY INSTITUTE, «*How much will pensions and long-term care cost in the future?*» PPI Briefing Note Number 46. London, 2008.

To help improve the understanding of the complex relationship between pensions and long-term care, the New Dynamics of Ageing programme is funding the Modelling Ageing Populations to 2030 Research Group, an inter-disciplinary team, bringing together the PPI with experts from the London School of Economics, the University of East Anglia, the University of Leicester and the London School of Hygiene and Tropical Medicine. This Briefing Note sets out some preliminary results and highlights the importance of considering both pensions and long-term care cost. Public expenditure public expenditure on long-term care is projected to increase by nearly 1% of GDP by the middle of this century. Public expenditure on state pensions is projected to increase by nearly 2% of GDP over the same period. Using projections from existing models, it shows that around 8% of GDP will be spent by Government providing pension income and care to older people by 2050, compared to less than 6% of GDP today.

[R5] RICHARDSON, Dominic, & BRADSHAW, Jonathan, «Variations in the take-up of Pension Credit», Benefits, Volume 16, Number 3, October 2008 , pp. 235-244

This article explores variation in the take-up of Pension Credit using secondary analysis of the Family Resources Survey 2004/05. Respondents under-report receipt of Pension Credit. As a result of an exercise undertaken by Department for Work and Pensions statisticians to match respondents with administrative data on receipt of Pension Credit, it was possible to explore the differences in the characteristics of those who do and do not

report receipt. Variations in actual take-up rather than reported take-up are then explored. Using logistic regression, variations are found in actual receipt by pensioner characteristics and by the type of area they live in. These findings raise doubts about the reliability of using benefit receipt in the income domain of the Index of Deprivation.

[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, regional 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] Disability

[H4] ABBOTT, Stephen, PROCTER, Susan, & IACOVOU, Nicci, «NHS purchaser-provider relationships in England and Wales: the view from primary care», *Social Policy and Administration,* Volume 43 Number 1, 2008, pp. 1-14.

This research examines the views of primary care personnel on their relationship with hospital services providers. The relationship was regarded as being 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 the wishes of primary care organisations. Top-down pressure by Government was more important than commissioning power in shaping hospital services. Methods: The data were obtained as part of a study of PCOs that comprised a literature review, three qualitative case studies of Primary Care Organisations (PCOs), and a documentary analysis of a sample of PCO board papers. The article draws on case study data only, selecting those data that specifically refer to PCOs' role as purchasers of hospital care. Data were gathered by semi-structured interviews with key personnel (officers, clinicians, board members) in three case study sites, two Primary Care Trusts and one Local Health Board.

[H3] ADSHEAD, Fiona, & THORPE, Allison «Health inequalities in England: advocacy, articulation and action», *Perspectives in Public Health,* Volume 129 Number 1, 2009, pp. 37-41

There is a long history of people expressing concern about the health, lifestyle and well-being of our population and of proposals for action to address the inequitable experiences between groups within this population. Over time, our understanding of both the problem and its causal connections has changed considerably. This is reflected within an increasingly explicit articulation of the issues and a progressively more sophisticated and determined cross-sectoral approach to tackling health inequalities. This paper reflects on the progress we have made in England in addressing this challenge, suggesting that we need to engage more proactively with our population and with our international partners, taking a systematic partnership approach to inform policy, practice and delivery on the ground.

[H1] AUDIT COMMISSION, «*Auditors' Local Evaluation 2007/08: Summary results for NHS trusts and primary care trusts*», London: Audit Commission.

The Auditors' Local Evaluation was introduced in 2005/06 and this is the third year of results. The overall picture is one of significant improvement over the three years assessed. Performance has improved strongly in 2007/08 and this success can be attributed primarily to the return to financial balance of all but a small minority of NHS

bodies. Half of the 302 NHS trusts assessed in England had performed well or strongly in the way that they had used their resources, and only 3% had failed to balance their books.

[H3] BELLIS, Mark, HUGHES, Kay; ANDERSON, Zachary; TOCQUE, Karen, & HUGHES, Sarah «Contribution of violence to health inequalities in England: demographics and trends in emergency hospital admissions for assault», *Journal of Epidemiology and Community Health*, Volume 62 Number 12, 2008, pp. 1064-1071.

Violence is increasingly recognised as a major public health issue yet health data are underutilised for describing the problem or developing responses. English emergency hospital admissions for assault over four years are used to examine assault demography and contribution to health inequalities. Methods: Geodemographic cross-sectional analyses utilising records of all individuals in England (n = 120 643) admitted between 1 April 2002 and 31 March 2006. Results: Hospital admission and A&E data identify a direct contribution made by violence to health inequalities. Levels of violence inhibit other interventions to improve people's health through, for instance, outdoor exercise or delivery of health-related services in affected areas. Despite being considered primarily a judicial issue, violence, or the threat of violence, has major repercussions for the health of individuals and communities. Annual costs of violence against adults (including violence against the person, sexual offences and common assault; excluding robbery) to health services are estimated to be GBP 2.2 billion, which are comparable to, or in excess of, estimates for other recognised public health priorities such as obesity (up to GBP 1.2 billion in 2002) and alcohol (up to GBP 1.7 billion in 2000/01).

[H5; H1] BOSANQUET, Nick, HALDENBY, Andrew, & RAINBOW, Helen, «*NHS Reform: National mantra, not local reality*», London: Reform, 2008.

The report argues that the performance of the National Health Service was well behind that of other countries' healthcare systems. Improving patient care would need new investment in many areas: but taxpayer funding was (and should be) restricted. Greater productivity was the answer to this strategic challenge. There should be an 'economic constitution' for the NHS which defined duties to 'create value' at all levels of the service. Method: Secondary data analysis.

[H2] BOYCE, Tammy, ROBERTSON, Ruth, & DIXON, Anna, «*Commissioning and Behaviour Change*», London: King's Fund, 2008.

The research examined the effectiveness of different types of public health programmes to tackle smoking, alcohol misuse, poor diet, and lack of exercise. The National Health Service would fail to tackle the rising tide of obesity- and tobacco-related illnesses unless it adopted more sophisticated techniques, including those employed by commercial advertisers, to help people to live healthier lifestyles. Methods: secondary literature review, expert seminars.

[H2] COMMISSION FOR HEALTHCARE AUDIT AND INSPECTION AND AUDIT COMMISSION, «*Are We Choosing Health? The impact of policy on the delivery of health improvement programmes and services*».

This joint inspectorate report examines the impact government policy has had on narrowing health inequalities; improving sexual and mental health; and reducing smoking, alcohol misuse, and obesity. The Government's public health programme had helped to significantly improve overall life expectancy and reduce mortality from the big killers. There had also been advances in tackling smoking, and improving sexual health, two areas where health inequalities were significant. Teenage conceptions were at their lowest level in over 20 years. But these rates of improvement had not been matched in the

areas of alcohol misuse and obesity. Method: Data analysis based on information held by the Healthcare Commission and Audit Commission, generated through assessments of performance and inspections of local healthcare organisations and councils.

[H3] DEPARTMENT OF HEALTH, «*Tackling Health Inequalities: 2007 status report on the programme for action*», London: Department of Health, 2008.

The Government published a progress report on its strategy for reducing health inequalities. The latest data for 2004–06 show that the relative gap in life expectancy between England as a whole and the fifth of areas with the worst health and deprivation indicators was wider than at the baseline (1995–97) for both males and females. For males, the relative gap is 2% wider than at the baseline (the same as 2003–05) and for females it is 11% wider than at the baseline (compared with 8% wider in 2003–05). Furthermore, the data show a further slight narrowing of the infant mortality gap between the routine and manual socioeconomic group and the population as a whole. Life expectancy in some spearhead areas is increasing faster than the average. Method: Descriptive statistics and secondary data analysis.

[H3] DEPARTMENT OF HEALTH, «*Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target*», London: DH, 2008.

The report provides an update on progress to meet the health inequalities target for 2010 (in England). For infant mortality, the latest figures (for 2005-2007) showed a further slight narrowing in the gap between the 'routine and manual' group and the population as a whole. But for life expectancy the gap had not narrowed. Method: Descriptive statistical analysis.

[H4; H1; H5] DEPARTMENT OF HEALTH, «*High Quality Care For All: NHS Next Stage Review Final Report*» [Darzi Review], Department of Health, London: TSO, 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 healthcare 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 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. A draft NHS constitution was published alongside the report, enshrining in law citizens' access to free treatment, and asserting patients' rights to dignity, privacy, confidentiality, and the opportunity to get a second opinion from another doctor; it also provided a universal right to approved treatments if they were clinically appropriate for individual patients. A separate report was also published alongside the review on the future of the NHS workforce.

[H3] DORAN, Tim, FULLWOOD, Catherine, KONTOPANTELIS, Evangelos, & REEVES, David, «Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework», *The Lancet,* Volume 372, Issue 9640, 2008, pp. 692-694.

The article examines the relation between socio-economic inequalities and quality of clinical care in the first 3 years of the quality and outcomes framework (a financial incentive scheme that remunerates general practices for their performance against a set of quality indicators). The results suggested that financial incentive schemes had the

potential to make a substantial contribution to the reduction of inequalities in the delivery of clinical care related to area deprivation. Method: The analysis is based on data extracted automatically from clinical computing systems for 7637 general practices in England, data from the UK census, and data for characteristics of practices and patients from the 2006 general medical statistics database. Practices were grouped into equal-sized quintiles on the basis of area deprivation in their locality.

[H1] FARRINGTON-DOUGLAS, Joe, & COELHO, Miguel Castro, «*Private Spending on Healthcare*», London: Institute for Public Policy Research, 2008.

The report examines the role of private spending in health. Attempts to meet the challenge of sharply rising healthcare budgets by shifting costs from the public to the private purse are said to be unlikely to make the health service more efficient. Public funding for the National Health Service was likely to have to continue increasing to reflect public preferences for improved levels of healthcare.

[H1] FURNESS, David et al. «*SMF HealthProject: Background Paper 2. Demography and Technology: External Pressures for Change*», London: Social Market Foundation, 2008.

This paper identifies and analyses the main financing pressures likely to confront the health system in England over the next 10–15 years. The aim of the authors has been to lay a solid, empirically grounded foundation for the subsequent work of the SMF Health Project in suggesting the ways in which England's health system ought to change in order to meet these challenges. Methods: review of the published literature; interviews with experts and key stakeholders.

[H4] FURNESS, David et al., «*SMF Health Project: Background Paper 1. An Overview of Health Systems Reform and the NHS*», London: Social Market Foundation, 2008.

This report provides as systematic overview of the main themes of healthcare reform in England, addressing issues of planning, financing and organisation. Methods: review of the published literature in the field; interviews with experts and key stakeholders.

[H2] LE GRAND, Julian, «The giants of excess: a challenge to the nation's health», *Journal of the Royal Statistical Society: Series A,* Volume 171, Part 4, 2008, pp. 843–856.

An article said that one of the main problems of public health initiatives was that the costs of most unhealthy activities were felt in the future, whereas the benefits from them occurred in the present. Policies had to be developed that either brought some of the costs from unhealthy activities (or the benefits from healthy ones) back from the future, or reduced some of the benefits from unhealthy activities (or reduce the costs of healthy ones) in the present. To avoid the danger of the 'nanny state', they should also not affect individual freedom or autonomy too greatly. Promising ideas that met these criteria included smoking permits and exercise hours. Method: Secondary analysis, literature review.

[H4] GREER, Scott, & TRENCH, Alan, «*Health and Intergovernmental Relations in the Devolved United Kingdom*», London: Nuffield Trust, 2008.

Knowing how devolution in health really works – who can do what – matters much more now that all four UK governments are different political colours, increasingly disagree about major issues, and are more likely to be in conflict. This report explains the legal and administrative underpinnings of devolution and how they shape the policies pursued in England, Scotland, Wales and Northern Ireland; identifies the various kinds of tension building up along administrative and physical borders, and the likelihood of major intergovernmental conflict; explains the administrative and political dispute resolution

mechanisms. The analysis is followed by recommendations for improvements that will have beneficial consequences for health policy. Method: qualitative analysis, making use of extensive interviews.

[H4] GREER, Scott, & ROWLAND, David (eds.), «*Devolving Policy, Diverging Values? The values of the United Kingdom's National Health Services*», London: Nuffield Trust, 2008.

A report examined the values embedded in the health services and policies of England, Northern Ireland, Scotland, Wales, and the European Union. It highlighted some very different entrenched values, including commitments to: 'collaboration and collectivism' in Scotland; the very similar 'communication and collectivism' in Wales; democratic participation, neutrality, and the new public health in Northern Ireland – 'having a say rather than having a choice'. All stood apart from England in their commitment to communities and participation rather than markets and technical solutions. Method: Qualitative research based on expert seminar discussions.

[H4; H5] HEALTHCARE COMMISSION AND AUDIT COMMISSION, «*Is the Treatment Working? Progress with the NHS system reform programme*», London: Audit Commission, 2008.

Individual elements of the reform programme have been implemented to different extents. This variation is also reflected in other national surveys and reports. While the new workforce contracts and to a certain degree "Payment by Results" are almost universal across the NHS, patient choice is in reality not always offered; practice based commissioning has yet to be fully embedded; less than half of trusts have achieved foundation trusts status; and there are few independent sector treatment centres. Given the controversy that has surrounded the reform programme, its ambition and the scale of the NHS, it is not surprising that more progress has not been made. The report is based on fieldwork that was undertaken between May and November 2007. This included: a literature review; national and local data analysis; national workshops in four local health economies; interviews with strategic health authorities (SHAs), primary care trusts (PCTs), FTs, acute trusts, health commentators, providers, regulators, commissioners, strategists and independent sector providers. It also draws on other work including major national studies undertaken by the Audit Commission and Healthcare Commission.

[H5; H4] LEWIS, Richard, SMITH, Judith, & HARRISON, Anthony, «From quasi-market to market in the National Health Service in England: what does this mean for the purchasing of health services? », *Journal of Health Services Research and Policy,* Volume 14 Number 1, 2009, pp. 44-51.

The article argues that since 2002 reforms to National Health Service purchasing in England had begun to transform a quasi-market into a 'real' market – with greater diversity of suppliers, including from the private sector; a payment regime designed to reward additional hospital activity; and new rights for patients to choose their provider. Evidence from the quasi-market era suggested that the purchasing function had had little significant impact on services for patients or shifts in the pattern of hospital provision. The new market reforms, in theory, provided an opportunity to overcome prior weaknesses in the purchasing function. Method: Review of secondary literature.

[H1] MARTIN, Stephen, RICE, Nigel, & SMITH, Peter, «Does health care spending improve health outcomes? Evidence from English programme budgeting data», *Journal of Health Economics,* Volume 27 Issue 4, 2008, pp. 826-842.

Empirical evidence has hitherto been inconclusive about the strength of the link between health care spending and health outcomes. This paper uses programme budgeting data

prepared by 295 English Primary Care Trusts to model the link for two specific programmes of care: cancer and circulatory diseases. A theoretical model is developed in which decision-makers must allocate a fixed budget across programmes of care so as to maximise social welfare, in the light of a health production function for each programme. This yields an expenditure equation and a health outcomes equation for each programme. These are estimated for the two programmes of care using instrumental variables methods. All the equations prove to be well specified. They suggest that the cost of a life year saved in cancer is about GBP 13,100, and in circulation about GBP 8000. These results challenge the widely held view that health care has little marginal impact on health. From a policy perspective, they can help set priorities by informing resource allocation across programmes of care. They can also help health technology agencies decide whether their cost-effectiveness thresholds for accepting new technologies are set at the right level.

[H2] MASON, Anne, HILL, Roy Carr, MYERS, Lindsey, & STREET, Andrew, «Establishing the economics of engaging communities in health promotion: what is desirable, what is feasible? », *Critical Public Health*, Volume 18 Number 3, 2008, pp. 285-297.

The article examines the economic evidence relating to planning, design, delivery, and governance of health promotion interventions. There was tentative evidence that community engagement as part of a multifaceted approach to health promotion might have positive effects and could be cost-effective. To improve the evidence base for community engagement, future studies needed to involve communities more closely at all stages of the research, in order to fully capture the community's priorities and perspectives, and appropriately assess the value added and opportunity cost of engagement. Method: Systematic review.

[H3] MITCHELL, Richard, & POPHAM, Frank, «Effect of exposure to natural environment on health inequalities: an observational population study», *The Lancet,* Volume 372, Issue 9650, 2008, pp. 1655 – 1660.

Studies have shown that exposure to the natural environment, or so-called green space, has an independent effect on health and health-related behaviours. The authors hypothesise that income-related inequality in health would be less pronounced in populations with greater exposure to green space, since access to such areas can modify pathways through which low socioeconomic position can lead to disease. Methods: The author classified the population of England at younger than retirement age (n=40 813 236) into groups on the basis of income deprivation and exposure to green space. Health inequalities related to income deprivation in all-cause mortality and mortality from circulatory diseases were lower in populations living in the greenest areas. There was no effect for causes of death unlikely to be affected by green space, such as lung cancer and intentional self-harm. Populations that are exposed to the greenest environments also have lowest levels of health inequality related to income deprivation. Physical environments that promote good health might be important to reduce socioeconomic health inequalities.

[H4] MOL, Annemarie, «*The Logic of Care: Health and the problem of patient choice*», London: Routledge, 2008.

The author argues that creating more opportunities for patient choice would not improve healthcare. Good care was not a matter of making well-argued individual choices, but was something that grew out of collaboration and technological improvements. Method: Qualitative Analysis.

[H1] NATIONAL AUDIT OFFICE AND AUDIT COMMISSION, «*Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08*», London, TSO, 2008.

The National Health Service had a surplus of GBP 1.67 billion in 2007-08, representing approximately 2% of total available resources. At the start of the financial year, the Department set the NHS the target of delivering a combined surplus and contingency of around GBP 0.9 billion. During the year the contingency was not required and the surplus grew as a result of NHS organisations exceeding savings plans and a reduction in the price of generic medicines. The surplus has been carried forward into 2008-09 and the Department has committed to making it available to the NHS for spending in future years. A key change from 2006-07, when a surplus of GBP 515 million was reported, is that in 2007-08 only 11 of 340 NHS organisations, or 3%, reported a deficit. The increase in the surplus has coincided with an improvement in the standard of financial management in the NHS. Evidence collected as part of the Audit Commission Auditors' Local Evaluation shows that almost double the proportion of NHS organisations were performing well or strongly in financial management compared to 2006-07.

[H1] OFFICE OF HEALTH ECONOMICS, «*Compendium of Health Statistics (20th Edition)*», Office of Health Economics: London, 2009.

The OHE Compendium of Health Statistics is a one stop statistical source specially designed for easy use by everyone interested in the UK health care sector and the NHS. It contains over 300 tables and charts accompanied by explanatory notes, source details and full commentary on a wide collection of topics related to UK health, health care and health spending. The Compendium is divided into four main sections: Demographics, including population, morbidity and mortality; UK health care expenditure and costs of the NHS; Hospital services; and Family health services. Information is updated annually and ranges from age structure, to detailed information such as death rates by cause, and NHS expenditure on pharmaceuticals. Compiled independently by the Office of Health Economics, the Compendium of Health Statistics draws together data from numerous scattered sources. It also includes comparisons with other economically developed nations. The UK data are broken down into England, Scotland, Northern Ireland and Wales, and many contain figures from the first full year of the data series NHS.

[H3] SIEGLER, Veronique, LANGFORD, Ann, & JOHNSON, Brian, «Regional differences in male mortality inequalities using the National Statistics Socio-economic Classification, England and Wales, 2001–03», *Health Statistics Quarterly,* 40, Winter 2008, pp. 6-17.

This article represents the first use by the Office for National Statistics of the National Statistics Socio-economic Classification (NS-SEC) to analyse regional variations in inequalities in male mortality. It is part of a series of articles on social inequalities in mortality by NS-SEC. Deaths in the years 2001–03 among men aged 25–64, from all causes and selected major cause groups, are examined in each of the Government Office Regions of England and in Wales. The results provide insights into both social gradients in mortality within regions, and regional differences in mortality for each NS-SEC class. The socioeconomic differences in mortality were more marked for men in Wales, the North East and the North West. The regional differences in mortality were small for the most advantaged classes and greatest for the least advantaged classes.

[H4] SMITH, Katherine E., HUNTER, David J., BLACKMAN, Tim, ELLIOTT, Eva, GREENE, Alexandra, HARRINGTON, Barbara E., MARKS, Linda, MCKEE, Lorna, & WILLIAMS, Gareth H., «Divergence or convergence? Health inequalities and policy in a devolved Britain», *Critical Social Policy*, Vol. 29, No. 2, 2009, pp. 216-242.

Since the advent of political devolution in the UK, it has been widely reported that markedly different health policies have emerged. However, most of these analyses are based on a comparison of health care policies and, as such, only tell part of a complex and evolving story. This paper considers official responses to a shared public health policy aim, the reduction of health inequalities, through an examination of national policy statements produced in England, Scotland and Wales respectively since 1997. The analysis suggests that the relatively consistent manner in which the `policy problem' of health inequalities has been framed combined with the dominance of a medical model of health have constrained policy responses. The findings differ from existing analyses, raising some important questions about the actuality of, and scope for, policy divergence since devolution. Method: This paper is based on the discourse analysis of national policy statements and it does not aim to capture the views of local or national actors, which may well tell a different story. Nor can it explore how the differing structures of the NHS and local government in each country impact on the way in which policies are implemented.

[H2] STAFFORD, Mai, NAZROO, James, POPAY, Jennie, & WHITEHEAD, Margaret, «Tackling inequalities in health: evaluating the New Deal for Communities initiative», *Journal of Epidemiology and Community Health*, Volume 62 Number 4, 2008, pp. 298-304.

The objective of this study was to assess health improvement and differential changes in health across various sociodemographic groups in New Deal for Communities (NDC) areas. Evidence from a two-year follow-up did not support an 'NDC effect', either overall or for particular population groups. Residents with lower education experienced the least favourable health profiles at baseline and the smallest improvements. Small overall improvements were seen on all domains in NDC areas but similar improvements were also seen in comparator areas. In NDC areas, higher educational groups were more likely to stop smoking and less likely to develop a limiting long-term illness. Method: A longitudinal survey of 10 390 residents in New Deal for Communities (NDC) areas and 977 residents in comparator areas in England. Changes on several outcomes across five domains (health, unemployment, education, crime and the physical environment) were assessed by sex, age, educational and ethnic group.

[H4, H5] TIMMINS, Nicholas (ed.), «*Making It Happen: Next steps in NHS reform – Report of an expert working group*», London: King's Fund, 2008.

This report is based on the deliberations of an expert working group established by the King's Fund to examine the systems and incentives involved in the current National Health Service (NHS) reforms in England, and their state of play, as a contribution to Lord Darzi's NHS Next Stage Review. The recommendations of the expert working group include: Professionals and managers should be given much greater freedom at the next stage in National Health Service reform: they should be allowed to innovate and develop services that were responsive, cost-effective, and improved the quality of care. Ministers and the Department of Health should focus on setting standards, goals, and priorities for the National Health Service, and on holding local organisations to account for what they delivered. Day-to-day operational matters, and decisions about precisely how those goals were achieved, should become a matter for the local health service. The National Health Service should increasingly become a commissioning rather than a providing organisation.

[H4; H5] TAYLOR-GOOBY, Peter, «Trust and Welfare State Reform: The Example of the NHS», *Social Policy and Administration*, Volume 42, Issue 3, 2008, pp. 288-306

This article discusses the impact of New Public Management on public trust in welfare state institutions, using the example of NHS reform. Discussion of trust in public

institutions across political science, psychology and sociology indicates that it is based on both rational/objective considerations (competence and capacity to deliver the service) and affectual/subjective factors (shared values, belief that the trustee shares the trustor's interests). The New Public Management foregrounds individual responsibility and incentives for both suppliers and users of services, in the NHS example in quasi-markets, management by target and patient choice. These accord with an individualised market rational-actor model rather than with affective considerations. Analysis of attitude survey data on the NHS confirms that rational/objective and affectual/subjective factors contribute to public trust in this field. However, a comparison between perceptions in England, where the internal market has been vigorously pursued, and Scotland, where the purchaser/provider split was discarded after devolution, indicate that the market does not offer a royal road to perceptions of superior quality in the objective factors. Conversely, the more market-centred system can make progress in relation to the more subjective affectual factors. Method: Analysis of data from British Social Attitudes Survey 2001.

[H3] WHYNES, David «Deprivation and self-reported health: are there 'Scottish effects' in England and Wales? », *Journal of Public Health,* Volume 31 Number 1, 2009, pp. 147-153.

Although the association between poor health and deprivation is well-founded, a 'Scottish effect' has been observed, whereby the level of health appears even poorer than Scotland's higher level of deprivation should warrant. We consider whether 'Scottish effects' also occur within the regions of England and Wales. Method: Using ward-level data from the national census, the author regresses healthy life expectancies relative to total life expectancies on Carstairs deprivation scores, households' average disposable incomes, geo-spatial characteristics and regional dummy variables. Results: There exist differences in relative health expectancies between the regions of England and Wales, which are not fully explained by the differences in socio-economic circumstances. Conventional deprivation measures tend to understate the poorer health performances of the more deprived regions (Wales and the north of England), and the understatement increases with deprivation. The exception to the rule is London, where health expectancies are superior to those which deprivation leads us to expect.

[L] Long-term care

[L] AUDIT SCOTLAND FOR ACCOUNTS COMMISSION AND AUDITOR GENERAL, «*A Review of Free Personal and Nursing Care*», Edinburgh, 2008

The audit report points out that free personal and nursing care in Scotland needed to be better planned, managed, and funded for it to continue to benefit older people in the future.

[L] CARING CHOICES C/O KING'S FUND, «*The Future of Care Funding: Time for a change*», London, 2008.

Caring Choices, a coalition of 15 organisations from across the long-term care system, has engaged with more than 700 individuals at events across England and Scotland and through an interactive website throughout 2007. The findings are based on the discussions at the Caring Choices events and from a survey of those attending the events, web visitors and a number of partner organisation contacts. There was almost no support for the current funding system. 90% of participants at the events rejected the use of a means test to determine whether or not an individual receives any state-funded care. In other words, they supported a stronger 'universal' element, determined by care need rather than by people's income or wealth. The vast majority of Caring Choices participants wanted a simpler system, in which entitlements are clearer and people are

able to plan ahead with greater understanding of what will be on offer. Almost all Caring Choices participants (99% of those who completed the questionnaire) believed that more money needs to be spent on long-term care – regardless of what kind of funding system we have in place or where that money comes from. Just under three-quarters of all participants believed that the costs of long-term care should be shared between the Government and the individual, although there was a range of views on how that could be organised and what the balance should be.

[L] GLASBY, Jon, «*Who Cares? Policy proposals for the reform of long-term care*», Health Services Management Centre/University of Birmingham, Birmingham, 2008

This research report argues that long-term care for older people was in need of urgent reform. It recommended sweeping changes to the existing system, giving patients access to personal budgets and far greater control over their own care.

[L] GLENDINNING, Caroline «Increasing Choice and Control for Older and Disabled People: A Critical Review of New Developments in England», *Social Policy and Administration,* Volume 42, Issue 5, 2008, pp. 451-469.

This paper critically examines new policies currently being implemented in England aimed at increasing the choice and control that disabled and older people can exercise over the social care support and services they receive. The development of these policies, and their elaboration in three policy documents published during 2005, are summarised. The paper then discusses two issues underpinning these proposals: the role of quasi-markets within publicly funded social care services; and the political and policy discourses of consumerism and choice within the welfare state. Despite powerful critiques of welfare consumerism, the paper argues that there are nevertheless very important reasons for taking choice seriously when considering how best to organise and deliver support and other services for disabled and older people. A policy discourse on consumerism, however, combined with the use of market mechanisms for implementing this, may be highly problematic as the means of creating opportunities for increased choice and, on its own, risks introducing new forms of disadvantage and social exclusion.

[L] GLENDINNING, Caroline, & Bell, Davidm, «*Rethinking Social Care and Support: What can England learn from other countries?*», York: Joseph Rowntree Foundation, 2008.

This report examines the experiences of social care reform in other countries, and set out a number of principles that should underpin reform of care and support arrangements in England. Responsibility for funding and providing social care was a collective, welfare state responsibility rather than an individual, private responsibility. Social care arrangements in many other countries were founded on principles of universality. Method: Literature review, secondary analysis.

[L] IACOPINi, Giorgia, & LESLIE, Chris, «*Better With Age: Reforming the future of local social care for older people*», London: New Local Government Network, 2009.

The report argues that future social care for older people required a radical new combined social insurance scheme. Existing local funding strains were unsustainable, and too many frail elderly people were being forced to sell and move out of their homes.

[L] LLOYD, James, «*A National Care Fund for Long-term Care*», International Longevity Centre, London, 2008.

The report develops an approach for the future funding of long-term care for older people, based around the model of a social insurance fund. A proposed 'National Care Fund' would have several key features including: payment of a one-off contribution fee at

a level determined by means assessment, with resulting entitlement to a standard package of care paid for by the fund; automatic enrolment to ensure high levels of participation; complete flexibility for older people as to when and how they would pay their contribution, including the option to defer until after death in the form of a charge levied on their estate; state support for those unable to pay.

[L] MATOSEVIC, Tihana, KNAPP, Martin, & LE GRAND, Julian, «Motivation and commissioning: perceived and expressed motivations of care home providers», *Social Policy and Administration*, 42 (3), 2008, pp. 228-247.

Commissioning of social care for older people has seen major changes since the early 1990s. Considerable responsibility now rests with local authority staff, whose views of care home providers' motivations, their perceived strengths and weaknesses as service providers, will have a bearing on commissioning decisions. The authors examine commissioners' views of provider motivations in eight English local authorities and compare their perceived motivations with providers' expressed motives. Data were collected through semi-structured face-to-face interviews with commissioners and care home providers. Providers are generally perceived by commissioners as highly altruistic, but also relatively financially motivated individuals. Further analysis revealed significantly different views towards profit-maximising, which commissioners perceive as very important, while providers consider it to be of little motivational value. Private sector providers are described by commissioners as significantly more motivated by personal income. Associations are found between commissioners' perceptions of motivations and the nature of their relationships with providers. Perceptions of providers' motivations appear important within the commissioning framework.

[L] NEWMAN, Janet, GLENDINNING, Caroline, & HUGHES, Michael, «Beyond modernisation? Social care and the transformation of welfare governance», *Journal of Social Policy,* Volume 37, Issue 4, pp. 531–557.

This article reflects on the process and outcomes of modernisation in adult social care in England and Wales, drawing particularly on the recently completed Modernising Adult Social Care (MASC) research programme commissioned by the Department of Health. The authors begin by exploring the contested status of 'modernisation' as a descriptor of reform. They outline some of the distinctive features of adult social care services and suggest that these features introduce dynamics likely to shape both the experiences and outcomes of policy ambitions for modernisation. Furthermore, the authors reflect on the evidence emerging from the MASC studies and develop a model for illuminating some of the dynamics of welfare governance. Finally, they highlight the emerging focus on individualisation and on user-directed and controlled services and argue that the current focus of modernisation involves a reduced emphasis on structural and institutional approaches to change and an increased emphasis on changes in the behaviours and roles of adult social care service users. This focus has implications for both the future dynamics of welfare governance and for conceptions of citizenship.

[L] RESOLUTION FOUNDATION, «*Navigating the Way: The future care and well-being of older people*», London: Resolution Foundation, 2008.

The report calls on the Government to improve care for all older people through wholesale reform of the social care system. The key reforms needed were: a clear national framework – a national minimum entitlement that limited the existing 'postcode lottery' of care; a new strategic role for local authorities; and a care navigation service available to everyone – a 'first stop shop' to end confusion and uncertainty when care was needed.

5 List of Important Institutions

Age Concern *and* Help the Aged

Age Concern England

Contact person: Gordon Lishman (Director)
Address: Astral House, 1268 London Road, London, SW16 4ER
Phone: 0044 (0) 20 876 572 00
Webpage: www.ageconcern.org.uk/

Age Concern Northern Ireland

Address: 3 Lower Crescent, Belfast, BT7 1NR
Phone: 0044 (0) 28 902 457 29
Fax: 0044 (0) 28 902 354 79
Webpage: http://www.ageconcernni.org

Age Concern Scotland

Contact person: David Manion (Director)
Address: Causewayside House, 160 Causewayside, Edinburgh, EH9 1PR;
Phone: 0044 (0) 845 833 0200
Fax: 0044 (0) 845 833 0759
Webpage: http://www.ageconcernscotland.org.uk/

Age Concern Wales

Contact person: Rob Taylor OBE
Address: Ty John Pathy13/14 Neptune Court, Vanguard Way, Cardiff, CF24 5PJ
Phone: 0044 (0) 29 2043 1555
Fax: 0044 (0) 029 2047 1418
Webpage: http://www.accymru.org.uk

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
E-mail: 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
E-mail: 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
E-mail: 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
E-mail: 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 healthcare 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 healthcare 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).

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

The Pension Protection Fund

Address:	Knollys House, 17 Addiscombe Road, Croydon, Surrey, CR0 6SR
Phone:	0044 (0) 845 600 2541
Fax:	0044 (0) 20 8633 4910
E-mail:	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
E-mail: 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
E-mail: 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
E-mail: 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 healthcare providers. The stated aim of the organisation is a health system that delivers first-class services and improved health for all. The NHS Confederation works with members to ensure an independent driving force for positive change by: influencing policy, implementation and the public debate; supporting leaders through networking, sharing information and learning; and promoting excellence in employment. Its most important publication is The NHS Handbook. This guide to the NHS

contains essential and up-to-date information, combining expert commentary with detailed analysis in an easy-to-read format.

National Institute for Health and Clinical Excellence (NICE)

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

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

The Nuffield Trust

Contact person:	Dr Jennifer Dixon (Director)
Address:	59 New Cavendish Street, London, W1G 7LP
Phone:	0044 (0) 20 7631 8450
Fax:	0044 (0) 20 7631 8451
E-mail:	info@nuffieldtrust.org.uk

The Nuffield Trust is one of the leading independent health policy charitable trusts in the UK. The Trust's mission is to promote independent analysis and informed debate on UK healthcare 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

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

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

Modelling Ageing populations to 2030 and beyond (MAP 2030) in collaboration with researchers at the University of Essex, University of Leicester, London School of Hygiene and Tropical Medicine, and the London School of Economics. The three year study began in January 2007. The MAP 2030 website can be found at http://www.lse.ac.uk/collections/MAP2030/.

Social Market Foundation

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

The Social Market Foundation is a leading UK think tank, developing innovative ideas across a broad range of economic and social policy. It champions policy ideas which marry markets with social justice and takes a pro-market rather than free-market approach. Its work is characterised by the belief that governments have an important role to play in correcting market failures and setting the framework within which markets can operate in a way that benefits individuals and society as a whole. The Social Market Foundation is politically independent, and works with all of the UK's main political parties. 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 healthcare.

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

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

For more information see:
http://ec.europa.eu/employment_social/progress/index_en.html