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Analytical support on
social protection reforms and
their socio-economic impact

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Pensions, health and long-term care

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1 Executive Summary

Cutting public expenditure is a core element of the coalition government's economic and fiscal strategy. Pensioners to a large extent have been protected from fiscal cutbacks, whereas the National Health Service is confronted with the challenge of continued efficiency savings in order to meet its budget targets. The provision of adult social care by local authorities is also under severe financial pressure, due to the cutbacks by local governments as a consequence of substantial cutbacks the central government in the local government grants.

In the domain of pensions, the government is continuing on the policy path of the previous government and is implementing the auto-enrolment of all eligible workers into occupational pension plans. It is also proposing to introduce a single-tier pension in 2016.

Despite the decline in the proportion of pensioners living at the risk of poverty, the poverty rates for pensioners in Britain continued to be above EU average. Some groups, especially female pensioners above the age of 75, have not benefited from recent improvements, at least based on this outcome indicator. Hence, a key chellenge for the British public pension system continues to be the difficulty to provide pension income to residents sufficiently high to prevent poverty.

In the domain of healthcare the government is in the process of implementing a comprehensive reform of the organizational and governance structure of the NHS in England. The government has enacted a reform of the long-term care system in England, to be implemented in 2016.

The NHS in England has undergone significant organizational reform and is confronted with sustained efficiency targets. For the next couple of years it will be a challenge to maintain the level of service patients have become accustomed to. Clearly a major strength of the service is that it is generally easy to access free of charge; one of the weaknesses has been the failure to maintain a high level of quality care across the service.

The authority of funding, regulating and providing long-term care in the United Kingdom is devolved, with Scotland providing universal free access and care being means-tested in England. The implementation of a long-awaited reform of a new funding arrangement for long-term care in England will start in 2016. The quality of long-term care is not always of a very high standard and in order to improve standards it was even suggested to use hidden cameras.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The UK has a very distinctive pension mix, combining "one of the least generous state systems in the developed world" with one of the "most developed" voluntary arrangements (Pension Commission 2004: X). Pension reforms in the UK have been quite frequent. The current system can be characterized as a contributory State Pension scheme consisting of a flat-rate basic State Pension, an earnings-related additional State Pension (State Earnings-Related Pension Scheme (SERPS) and State Second Pension, that reformed SERPS from April 2002). A means-tested, tax-financed Pension Credit may be payable to persons who have reached State Pension age. The current government is committed to continue largely upon the trajectory laid down by the previous Labour government in its major pension reforms of 2007 and 2008.

Over the last couple of years the pension system has undergone a further reform process of the various pension pillars, with the aim of increasing adequacy as well as sustainability: a) access to the Basic State Pension has been improved and further reform seems to be likely to be enacted over the next couple of years; b) the state pension age will be increased and the default retirement age has been abolished, which should lead to a later de facto retirement age; c) beginning in 2012, the government has started to implement the auto-enrolment of every worker into an occupational pension, with the option to opt out.

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

Despite pursuing an overall strategy of public spending cuts, the elderly have been largely exempt from specific cutbacks. Moreover, the Conservative-Liberal coalition has decided to uprate the Basic State Pension by a triple guarantee of earnings, prices (using the CPI) or 2.5%, whichever is highest. A report published by the Fabian Society examined the situation of older people on middle incomes. It suggested that there was a 'legitimate worry' that older people had not been sharing sufficiently in public spending cuts. Policies that appeared to give special advantages to older people as a category should be reviewed (Harrop 2013).

However, significant changes were made to the tax relief system for personal and occupational pensions. Effective in April 2011 the annual allowance for tax-privileged pension saving was reduced from £255,000 to £50,000 and will be further cut to £40,000 from tax year 2014/15 onwards, and the lifetime allowance will be reduced from £1.8 million to £1.5 million. The measure implemented since April 2011 is expected to raise £4 billion per annum. It is targeted at those who make the most significant pension savings. According to the government, an annual allowance of £50,000 will affect 100,000 pension savers – 80% of those will have incomes over £100,000 (HM Treasury 2010). However, it has to be highlighted that the current annual allowance is still approximately twice the level of average income and thus continues to primarily benefit higher income groups (Stacey 2012).

2.1.2 System characteristics

The pension system is based on three 'pillars': an unfunded Basic State Pension, an additional State Pension and voluntary funded occupational and personal pension schemes. Pensioners with 30 qualifying years are entitled to a flat Basic State Pension of £110.15 per week. An additional State Pension is provided by the government for pensioners who have built up entitlements through employment (minimum annual earnings of £5,668) or qualifying periods of care (SERPS and the State Second Pension). In order to mitigate poverty in old age various means-tested programmes were introduced by the previous government. The Basic State Pension for pensioners on low income can be topped up through the receipt of the guarantee credit to a weakly income of £145.40 for a single pensioner and £222.05 for a coupled pensioner household. An increasing percentage of pensioners are dependent on means-tested pension supplements (cf. Seeleib-Kaiser et al. 2012).

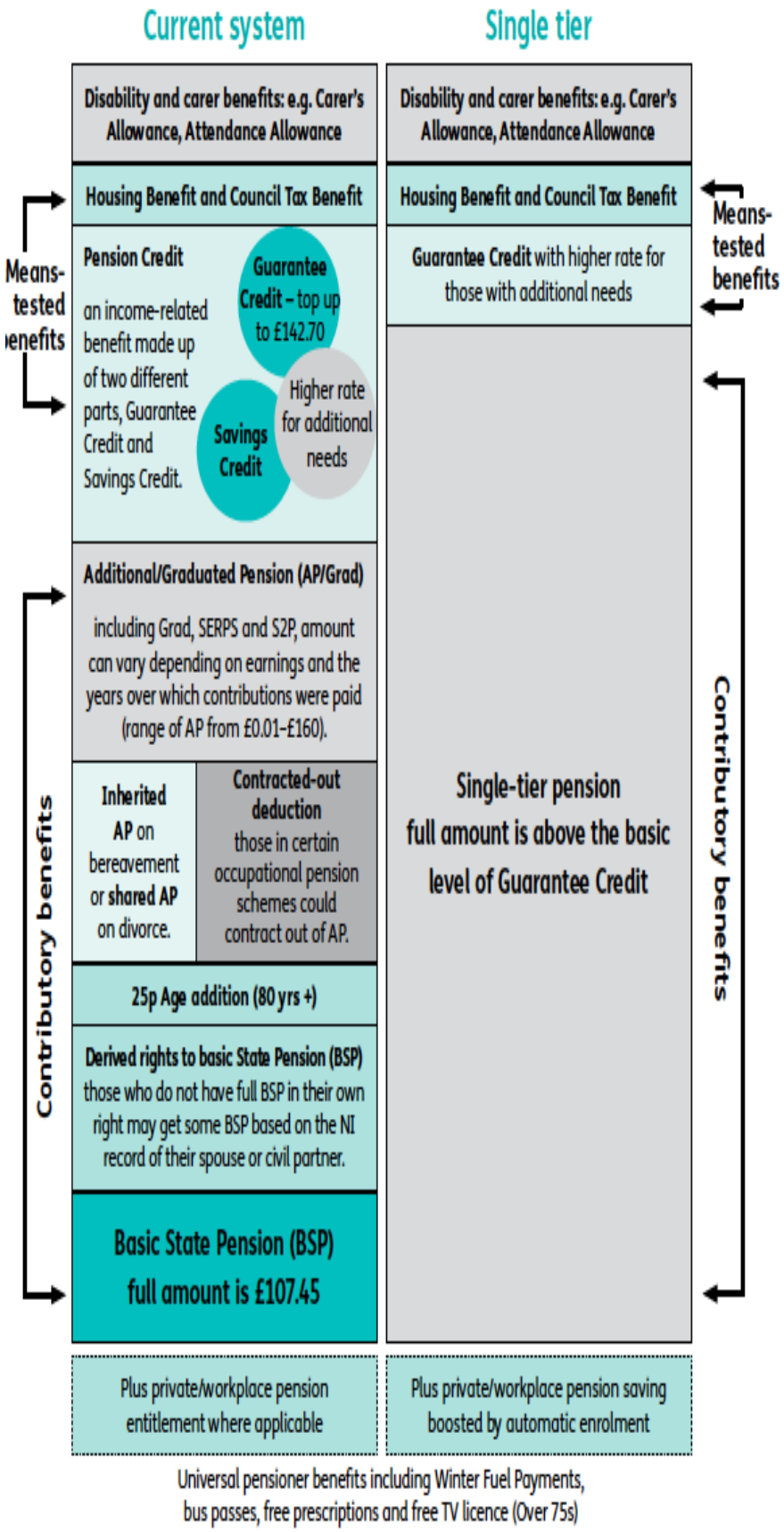
A core element for an adequate income, sufficient to maintain the living standard after retirement, is the receipt of an occupational or personal pension. While in the past the majority of these pension schemes have been defined-benefit schemes, there has been a clear trend towards defined-contribution systems in the private sector (for an overview of the pension system in the UK see Blake 2003 and Pension Commission 2004).

Overall, private pension savings have been declining in the UK for years and participation in occupational pensions varies hugely by sector and earnings level. To counter the trend of declining coverage, employers will have to auto-enrol all workers as part of the 2008 pension reform starting in 2012, to be fully implemented by 2018. Alongside auto-enrolment, the Government has introduced a low cost, defined contribution, pension scheme that employers can enrol their employees into (or individuals can opt-in to) called NEST (National Employment Savings Trust).

2.1.3 Details on recent reforms

As already mentioned the Conservative-Liberal government seems to be committed to further pension reforms. According to figures from the Department of Work and Pensions (DWP), about 45% of pensioners are eligible for Pension Credit to top up their state pension. Although the percentage is projected to fall to around a third by 2050, as more pensioners qualify for a full state pension in their own right and benefit from a more generous uprating of the Basic State Pension, the government is concerned, that it does not fall fast or far enough and that continued relatively high levels of means testing can deter people from saving. Furthermore, Pension Credit is not claimed by around a third of pensioners who are entitled to it, a proportion which has proved fairly resilient despite efforts by successive governments to encourage pensioners to take up their entitlement (DWP 2011: 21). Hence the government has decided to speed up the transition to combine the Basic State Pension and State Second Pension to create a single-tier state pension for future generations of pensioners set at a level above the Pension Credit standard minimum guarantee. The government has proposed to introduce a single tier public pension in 2016 with a weekly benefit of £144 per week after 35 years of contributions. This reform will also abolish the possibility of contracting out for those in certain occupational pension schemes. Overfall, this reform is intended to significantly simplify the current system (for a detailed description of the various elements see DWP 2013a). Figure 1 provides an overview.

Figure 1: Features of Current and Proposed Single-Tier Pension System



Source: DWP 2013a: 30.

The Public Service Pension Act of 2013 significantly reformed the pensions for public sector workers, who are currently covered by various occupational pension schemes based on the principle of defined benefits relating to their final salary. Starting 2015 workers can no longer accrue rights based on final salaries; although the act does not prescribe the exact nature of the design, most schemes will very likely be based on career average salaries (for an overview see GAD 2013).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Over the long-term, income of retired households has increased significantly. The average disposable income for retired households was £17,700 in 2010-11, which was over two and a half times higher in real terms than in 1977. More than half of the rise could be attributed to growth in income from private pension schemes (ONS 2012). Nevertheless, based on Eurostat data (see tables 1-5) older people in the United Kingdom continue to have a relatively high risk of poverty, despite the fact that the overall proportion of elderly affected by the risk of poverty has significantly declined since 2008 (partially as a result of declining median income). The gender gap, after slightly declining in previous years, has once again significantly increased since 2010. The decline in pensioners' poverty is also reflected in national data published by the Department of Work and Pensions (DWP 2013b). However, the rate of risk of poverty and especially (40 percent of median) for women 75+ has stayed stubbornly high and is more than twice as high as the European average.

Table 1: Percentage of Population 65 years + at Risk of Poverty (cut-off point: 60% of median equivalised income after social transfers)

GEO/TIME	2005	2006	2007	2008	2009	2010	2011
European Union (27 countries)	18.9	19.0	18.4	19.0	18.0	16.0	15.9
European Union (15 countries)	19.8	19.7	18.9	19.2	18.0	16.3	16.4
United Kingdom	24.8	26.1	26.5	27.3	22.3	21.3	21.8

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

GEO/TIME	2005	2006	2007	2008	2009	2010	2011
European Union (27 countries)	15.9	16.1	15.3	15.7	15.0	12.9	13.2
European Union (15 countries)	16.9	17.0	16.0	16.2	15.4	13.5	13.9
United Kingdom	21.9	22.4	23.4	24.4	20.0	17.6	18.2

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

GEO/TIME	2005	2006	2007	2008	2009	2010	2011
European Union (27 countries)	21.1	21.1	20.7	21.4	20.3	18.3	18.0
European Union (15 countries)	22.1	21.9	21.1	21.6	20.1	18.5	18.4
United Kingdom	27.1	29.0	29.0	29.7	24.1	24.4	24.9

Table 4: Percentage of Female Population 75+ at Risk of Poverty (cut-off point: 60% of median equivalised income after social transfers)

GEO/TIME	2005	2006	2007	2008	2009	2010	2011
European Union (27 countries)	23.6	24.5	23.1	24.3	22.7	20.7	20.1
European Union (15 countries)	24.9	25.7	23.9	24.8	22.5	21.1	20.5
United Kingdom	31.0	33.4	32.7	33.1	27.0	29.0	30.5

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

GEO/TIME	2005	2006	2007	2008	2009	2010	2011
European Union (27 countries)	5.0	5.6	5.3	4.7	4.1	4.1	3.7
European Union (15 countries)	4.8	5.7	5.1	4.5	3.9	4.1	3.9
United Kingdom	7.2	8.1	8.7	8.8	6.4	7.7	8.7

Source: EU-SILC retrieved on October 16, 2013 at http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/social_protection_social_inclusion/indicators/pension.

The relative median income ratio of older people (65+) has also significantly improved, jumping from 0.74 in 2008 to 0.81 in 2010. The aggregate replacement ratio (excluding other social benefits) was 0.48 in 2010, an improvement compared to previous years. Whether the recent 'success' in the reduction of poverty rates among older people was largely the result of declining incomes among the working age population during to the current economic crisis and/or government policies to protect incomes of pensioners (triple guarantee) is not fully clear.

The labour market participation of older workers, although slightly declining since the onset of the economic crisis in 2008, is still fairly high and clearly above the EU average as shown in the Table 2 below:

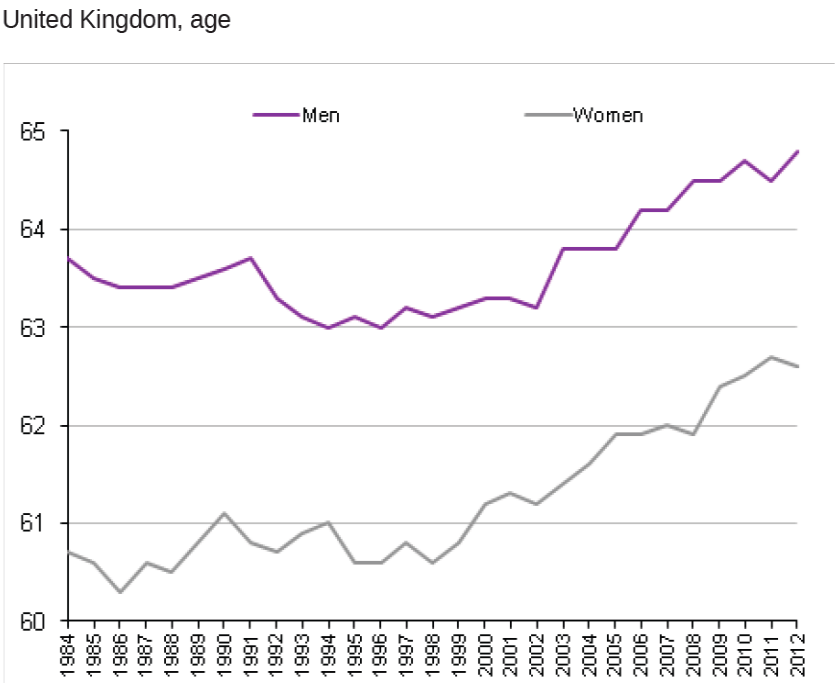
Table 6: Employment Rate of Older Workers (55-64)

	EU (27)	United Kingdom
2012	48.9	58.1
2011	47.4	56.7
2010	46.3	57.1
2009	46.0	57.5
2008	45.6	58.0
2007	44.6	57.4
2006	43.6	57.3
2005	42.6	56.8
2004	42.6	56.2
2003	41.7	55.4
2002	40.2	53.4
2001	38.8	52.2
2000	37.8	50.7

Source: Eurostat. Retrieved on October 18, 2013 at http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/social_protection_social_inclusion/indicators/pension.

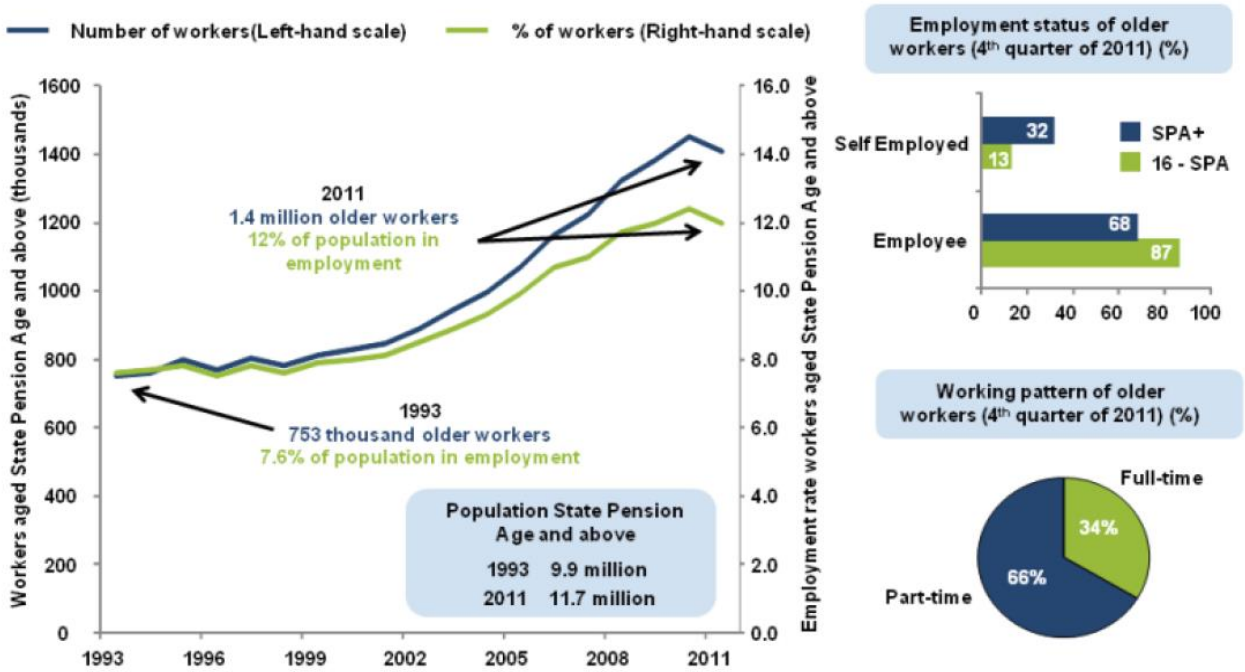
People are working longer than they used to. The average age at which people leave the labour market – a proxy for average age of retirement – rose from 63.8 years to 64.6 years for men and from 61.2 years to 62.3 years for women between 2004 and 2010 (ONS 2013: Chapter 4). Partly this increase in the de facto retirement age might be related to the fact that it is no longer possible to draw a penion before the age of 55 (cf. Cohen 2012). However, not only has the de facto retirement age increased, but the employment of senior citizens above State Pension Age has continued to increase, although it declined somewhat very recently.

Figure 2: Average age of withdrawal from the labour market, UK



Source: ONS (2013): chapter 4, page 17, retrieved from http://www.ons.gov.uk/ons/guide-method/method-quality/guide-to-pension-statistics/pension-trends-publications/index.html, October 18, 2013.

Figure 3: Employment Levels and Rates of Older Workers, Annual Averages 1993-2011, UK



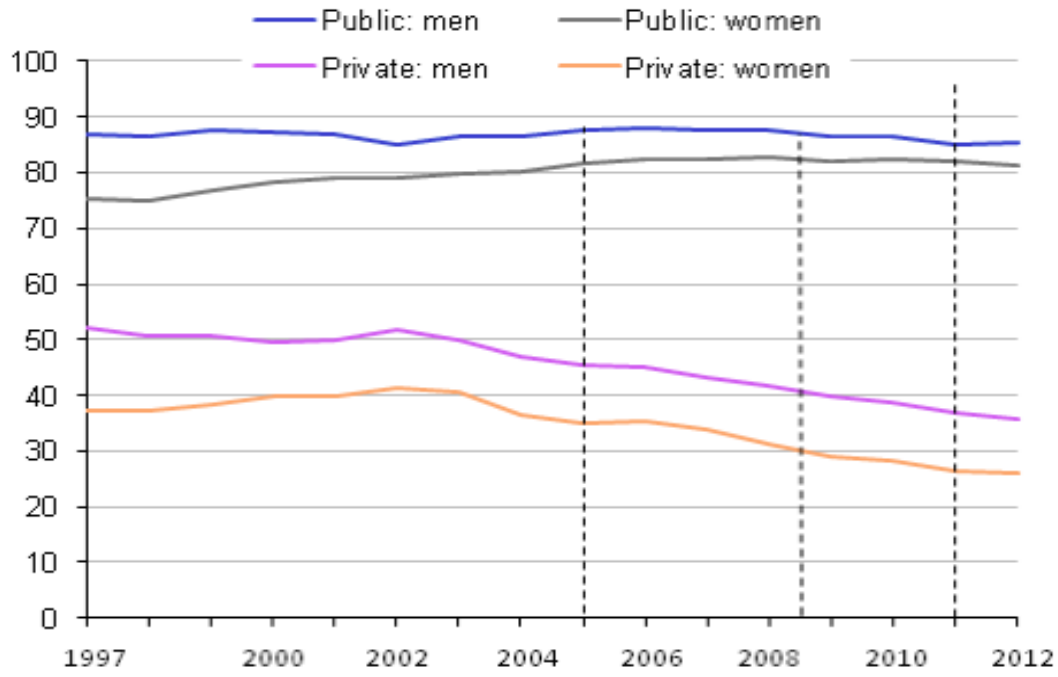
Source: Labour Force Survey - Office for National Statistics (2012) *Older workers in the labour market – 2012*, retrieved on October 18, 2013, http://www.ons.gov.uk/ons/dcp171776_267809.pdf.

2.2.2 Private pensions

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

Overall, private pension savings have been declining in the UK for years. According to the most recent the numbers contributing, or having contributions paid into a occupational pension scheme (active members), continues to fall. In 2012 there were 7.8 million active members of occupational pension schemes compared to 8.2 million in 2011 and 12.2 million at the peak in 1967. Approximately 5.1 million active members were in public sector schemes and 2.7 million were in private sector schemes. For private sector defined benefit schemes, the average contribution rate in 2012 was 4.9% for members (employees) and 15.2% for employers. For private sector defined contribution schemes, the average contribution rate in 2012 was 3.1% for members (employees) and 6.6% for employers (ONS 2013: chapter 6). The following Figure 4 provides a brief overview of the differences between the private and public sector occupational pension coverage since the late 1990s.

Figure 4: Employee Membership of Workplace Pensions by Gender and Sector



Source: Annual Survey of Hours and Earnings; ONS 2013 (chapter 7, p. 15).

As occupational pension coverage among current workers has significantly declined over the past decade, we will very likely witness reduced adequacy of pension incomes for certain cohorts in future years. Currently, only core insiders in the private sector and public sector workers, with some exceptions, are provided with the opportunity to build up occupational pension entitlements, a process that can be characterized as dualization (Seeleib-Kaiser et al. 2012). A study by Aviva, an insurer, and Deloitte, an accountancy firm, estimated that British workers are saving about £320bn too little into their pensions, a bigger gap than any other European country (Stacey 2013). In the long-term, it is hoped by the government that the decline in occupational pension coverage will be reversed due to auto-enrolment, which has started in 2012. Nevertheless, much will depend on the assumption that low and middle income employees will not opt out. A recent study has suggests that the opt-out rate is much higher than initially estimated by the government; 40 percent of companies that have newly enrolled workers witnessed opt-out rates of more than 10 percent (Cumbo 2013). Another recent study concluded that even workers with median earnings, who save for a long time, only have a 49 percent chance to achieve a replacement rate of two-thirds of their pre-retirement earnings. Observers suggest to make retirement savings mandatory (Cohen 2103). Furthermore, with the shift from DB to DC schemes pension adequacy will depend on the development of financial markets and as Burtless (2009) has shown we are very likely to be witnesses of cohort effects. Furthermore, if the current trend of declining employer contributions continues, it is very likely that income from occupational or supplemental pensions will decline.

2.2.3 Summary

Despite the decline in the proportion of pensioners living at the risk of poverty, the poverty rates for pensioners in Britain continued to be above EU average. Some groups, especially female pensioners above the age of 75, have not benefited from recent improvements, at least based on this outcome indicator. Hence, a key chellenge for the British public pension system continues to be the difficulty to provide pension income to residents sufficiently high to

prevent poverty. Part of the challenge continues to be the low take up of means-tested programmes, which to a large extent is due to unawareness of eligibility (Radford et al. 2012). The theoretical replacement rates suggest the average share of occupational and supplementary pensions to be about 38 percent of income for pensioners with an average career. However, what is not taken into account in these calculations is that the distribution is quite unequal and that about 40 percent of recent pensioners do not receive any occupational pension (Seeleib-Kaiser 2011).

2.3 Reform debates

In addition to policy reforms discussed in section 2.1.3, it is noteworthy that the UK government plans to increase the state pension age further and to link it to increases in life expectancy (cf. Neville 2012). The EU Commision has referred the UK to the European Court of Justice for the incorrect application of EU social security safeguards, as the government applies a 'right to reside test' in addition to habitual residency test (EU Commission 2013).

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The National Haelth Service was created in 1948. It has undergone significant reforms since the 1980s, which included the introduction of quasi markets, more patient choice and private provision. In 2012/13 the governance structure of the NHS England was completely overhauled against the opposition of key stakeholders (Klein 2013; Timmins 2012; for details see section 3.1.3).

3.1.2 System characteristics

The core principle of the NHS is that it is universal and free at the point of use. The share of GDP allocated to health has increased strongly in the United Kingdom over the past decade. It went up from 8.4% in 2007 to 9.4% of GDP in 2011 (compared to an EU average of 9%). Per capita health spending between 2000-2009 grew in real terms by 4.9%, more than the EU average of 4.6%, before declining 0.5% between 2009 and 2010. The UK's annual spending on health per person of EUR 2636 in 2010 is above the EU average of EUR 2171 (in PPP). 82.8% of total health expenditure was public spending. The NHS directly provides the bulk of health care in the United Kingdom. There is little reliance on out-of-pocket expenditure to finance health care as in a number of EU countries (cf. OECD 2012).

In parallel to the expansion of public healthcare spending, private expenditure on healthcare more than doubled between 1997 and 2008, rising from £10.8 billion to reach £24.4 billion in 2008. However, as a result of the economic crisis private expenditure fell significantly between 2008 and 2010 to £23.0 billion, before once again recovering in 2011 (Office of National Statistics 2013). In January 2009, 12.4% of the UK population had private medical insurance; however, this has droped to 11.1% of the UK population or approximately 6.9 million people in January 2011. This is largely due to redundancies caused by the recession, a reduction on corporate paid PMI, and the squeeze on domestic budgets. The number of employer funded policies has fallen by 8% to 2.95 million. The number of self-funded policies has fallen by 9.5% to 1.01 million (Private Healthcare UK 2012; also see Gray 2013).

Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations. As has been pointed out in Seeleib-Kaiser (2011), the NHS in England has to make significant efficiency savings, equating to up to £20 billion by 2014-15. These savings are intended to be delivered through the NHS quality and efficiency improvement work, known as the Quality, Innovation, Productivity and Prevention (QIPP) challenge. However, it is feared that the savings required by the government will potentially have a negative impact on the quality of care provided.

3.1.3 Details on recent reforms

The NHS is undergoing major changes in its core organizational and governance structure; most changes took effect on April 1 2013 (for an overview of the most important changes see http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx; accessed November 1, 2013). The Department of Health (DH) will be responsible for strategic leadership of both the health and social care systems, but will no longer be the headquarters of the NHS, nor will it directly manage any NHS organisations.

Primary care trusts (PCTs) and strategic health authorities (SHAs) will be abolished and replaced by new organisations such as clinical commissioning groups (CCGs). Primary care trusts (PCTs) used to commission most NHS services and controled 80% of the NHS budget. On April 1 2013, PCTs were abolished and replaced with CCGs. CCGs have taken on many of the functions of PCTs and in addition some functions previously undertaken by the Department of Health. All GP practices belong now to a CCG and the groups also include other health professionals, such as nurses. CCGs commission most services and can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers. A new regulator (Monitor) will oversee and regulate these new arrangements (for more information on this new regulator see http://www.monitor-nhsft.gov.uk/about-monitor-0; accessed November 1, 2013). It is expected that the vast majority of hospitals and other NHS trusts will become foundation trusts by 2014; foundation trust will have more ‘freedom’ and a different structure than NHS trusts (for more details see http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/what-are-nhs-foundation-trusts; accessed November 1, 2013).

In addition, local authorities are tasked to take on a bigger role, which is in line with the political aim of greater overall responsibility at the local level. Local authorities are intended to assume responsibility for budgets for public health. Health and wellbeing boards will have duties to encourage integrated working between commissioners of services across health, social care, public health and children’s services. A new organization, Public Health England (PHE), will provide national leadership and expert services to support public health.

However, none of these changes should affect how individuals access NHS services in England. Healthcare will remain free at the point of use, funded from taxation, and based on need and not the ability to pay (Klein 2013). Nevertheless, it is expected that the implementation will not be without challenges (Timmins 2012).

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

As indicated at the beginning of this section, universal and free access to health care are the core principles within the UK. Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations. Per head Northern Ireland spends the most on health services (£2,213 per head in 2009/10) and England spends the least (£1,875 per head). The following table provides an overview of spending in the four nations (Harker 2011).

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

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

Source: Harker 2011: Tab. 3.

Although fighting health inequalities is a proclaimed priority in the four nations of the UK, health inequalities in the United Kingdom remain stubbornly high, as highlighted in previous Annual Reports (Seeleib-Kaiser 2011; 2012). Without further significant reductions in inequality and poverty it does not seem likely that health inequalities will narrow substantially. A recent study on health inequalities in Scotland indicated further increases, it states: "Recent Scottish evidence demonstrates that inequalities in mortality are increasing between social classes and between more and less deprived areas, partly due to increases in diseases relating to alcohol and drug use in deprived areas and, at the same time, reductions in ischemic heart disease in affluent areas" (Craig 2011: 3; for a recent analysis of health inequalities in England see Mackenbach 2011).

As has been pointed out in Seeleib-Kaiser (2011), the NHS has to make significant efficiency savings, equating to up to £20 billion by 2014-15. These savings are intended to be delivered through the NHS quality and efficiency improvement work, known as the Quality, Innovation, Productivity and Prevention (QIPP) challenge.

3.2.2 Quality and performance indicators

Although the UK has seen an overall improvement during the past two decades, the UK's performance in terms of premature mortality was persistently and significantly below the mean of European countries, and required additional concerted action. Further progress in tackling premature mortality would probably require improved public health, prevention, early intervention, and treatment activities. The growing burden of disability needed an integrated and strategic response (Murray et al. 2013). The NHS is struggling to meet the efficiency targets, especially in emergency care, where waiting times are at the highest level since 2004. Despite the pressures in emergency care, other NHS performance measures are continuing to hold up well. Waiting times for referral to treatment in hospital, the number of health care-acquired infections and delays in transferring patients out of hospital all remain stable (King's Fund 2013). As highlighted in previous annual reports, healthcare provision and quality differs within the UK (also see The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). A recent report highlighted that for instance amputation rates for diabetes patients are 10 times higher in some parts of England than in others. Researchers say the figures highlight the importance of ensuring the right specialist care (Holman et al 2012).

In 2013, the new Chief Inspector of Hospitals announced 'radical' changes to the way in which hospitals in England were inspected. The inspections would be a mixture of unannounced and announced, and they would include inspections in the evenings and weekends (when it was known that people could experience poor care) (CQC 2013).

3.2.3 Sustainability

NHS managers are pessimistic that the NHS as a whole will meet its £20 billion productivity target by 2014/15; 94 per cent thought there was a 50/50 chance of failure or worse on this programme. Furthermore, as Councils are planning to reduce their budgets on adult social care by another £800 million this year, a cumulative cut of 20 per cent since 2010, nearly a third of directors of adult social services think this will place more pressure on the NHS (King's Fund 2013). A £30bn funding gap will open up in the NHS over the next seven years without "radical" changes, including more centralisation of hospital services, according to the chief executive of NHS England (Gainsbury/Brew 2013). Some other observers suggest the introduction of user charges (Neville 2013).

3.2.4 Summary

The NHS in England has undergone significant organizational reform and is confronted with sustained efficiency targets. For the next couple of years it will be a challenge to maintain the level of service patients have become accustomed to. Clearly a major strength of the service is that it is generally easy to access free of charge; one of the weaknesses has been the failure to maintain a high level of quality care across the service.

3.3 Reform debates

The Europe 2020 strategy had no direct impact on health policy debates. However, the freedom of movement and the social rights of EU citizens were explicitly questioned. 'Welfare tourism' by various groups of migrants, especially EU migrants, has increasingly become the focus of domestic social policy debates. For instance, The Daily Telegraph (quickly followed by the Daily Mail) has claimed that "an EU study has found 600,000 unemployed migrants are living in Britain at a cost of £1.5bn to the NHS alone" (cited in Portes 2013; see also Parker 2013). The Department of Health has commissioned a report to identify the costs of migrants for the NHS. As was to be expected this report was used for political purposes; however, what the report made very clear was that NHS personnel was not necessarily aware of the social rights of EU migrants and that the organization was not effectively charging health insurance providers of EU visitors (Creative Research 2013).

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The current care system has grown more or less 'organically' in England and Wales; measures to significantly reform the system have been discussed for decades. Scotland has introduced a free and universal system in 2002 (for details of the legislation see http://www.scottish.parliament.uk/visitandlearn/Education/15870.aspx, accessed Oct 18, 2013). The Deparment of Health, Social Services and Public Safety in Nothern Ireland has

recently carried out a consulation on adult social care reform (for further details see http://www.dhsspsni.gov.uk/showconsultations?txtid=58501, accessed Oct. 18, 2013).

4.1.2 System characteristics

Unlike health care in England and Wales, social care is strictly means-tested by the majority of local authorities. Care support is provided only for those with the highest needs and the lowest means. In terms of financial eligibility for residential care, for example, currently an individual must have assets less than £23,250 in England to qualify for local authority placement into a care home. Hence, much of the needed care is provided informally. There are approximately six million unpaid carers in the UK with important variations among this dedicated group of people. 1.5 million are themselves over 60, 60% are women, and there are particularly high instances of caring in some black, minority and ethnic communities (twice as many Pakistani women, for example, are carers compared to the national average) (Centre for Social Justice 2010). In Scotland care is provided free to everyone in need (further information about the Scottish system is available at http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/Free-Personal-Nursing-Care, accessed October 18, 2013), while Northern Ireland is considering the introduction of free care. Access to care is usually determined by councils, based on very broad national frameworks, leading to rather varied provision.

4.1.3 Details on recent reforms in the past 2-3 years

The UK parliament enacted legislation, which will comprehensively reform the system of long-term care in England. It will be implemented over the next couple of years. The legislation includes the following: A cap on care costs will be introduced from April 2016. If someone is assessed by their local authority, as having eligible care needs, they will be informed how much it will cost the local authority to meet those needs with local services. These costs count towards their cap. So, however great a person's costs become, once they have reached the cap the state will step in and provide financial support. The Government is introducing a cap that is equivalent to around £61,000 in 2010/11 prices –above the £25,000-£50,000 range originally recommended by Andrew Dilnot, who chaired a commission on long-term care reform (Dilnot Commission). This is equivalent to £75,000 in 2017/18 prices. The government expects up to 16% of older people to face costs of £75,000 or more.

People of working age who develop care needs before retirement age will benefit from a cap that's lower than £75,000. People who have care needs before they turn 18 will effectively have their cap set at zero.

Currently only those with assets of less than £23,250 get help with paying for their care costs. The government's changes will mean that those with property value and savings of £100,000 (in 2010/11 prices) or less will start to receive financial support, with the Government paying a proportion of their residential care costs on a sliding scale. £100,000 was the amount recommended by Andrew Dilnot, and is equivalent to around £123,000 in 2017/18 prices. (DH n.d.).

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Due to the fragmented structure of adult social care it is very difficult to provide a comprehensive overview with robust data. The following section will largely focus on England, where long-term care has been among the most debated social policy issues (Comas-

Herrera, Wittenberg, Pickard 2010). Much of the care in England is provided through informal care of relatives, neighbours and friends (Pickard 2008). Access to publicly funded services is mainly through an assessment of care needs coordinated by local authorities, leading to a great variability within a national framework of eligibility criteria. Those that have been assessed as eligible are then subject to a means test. In terms of financial eligibility for residential care, for example, currently an individual must have assets worth less than £23,250 in England to qualify for local authority placement into a care home. In most localities only people with the highest care needs and lowest means are eligible for services. This development has been exacerbated by the austerity policies of the current Conservative-Liberal government, leading local authorities to cut social care by 20 percent since 2010 (Association of Directors of Adult Social Services 2013).

According to estimates in 2006, 325,000 older people, or 4 percent of the older population, are residents of care homes in England, of which 192,000 are funded by local authorities, 105,000 are privately funded residents and 29,000 are NHS-funded residents. 650,000 older people are receiving local-authority funded community-based services, including some 300,000 seniors receiving home care services. Older people in need can opt for so-called personal or individual budgets, to enable choice and control over support services. Approximately 150.000 severely disabled older people purchase home care privately (Comas-Herrera et al 2010: 380).

The following table shows the number of estimated adult social care establishments for the time period from 2009 to 2011, indicating a small increase.

Tab. 8: Estimated Number of Adult Social Care Establishments, 2009-2011

	Estimated totals			% change	
Service type	2009	2010	2011	2009-10	2010-11
Residential establishments	23,100	23,000	23,900	-0.4%	+3.8%
Non-residential establishments	23,900	25,300	25,800	+5,6%	+2.3%
All establishments	47,100	48,300	49,700	+2.6%	+3.0%

Source: Skills for Care 2012: 8.

Overall we can identify shifts towards greater private provision and funding. Of the approximately 480,000 places in residential and nursing care homes 92 percent are provided through private and voluntary service providers. Independent providers delivered about 170 million hours of home care, whereas local authority provision has dropped below 25 million hours in 2012. Approximately 43 percent of older and physically disabled residents of independent care homes fund the entire cost of their care; the percentage is significantly higher for residents of nursing care homes (49 percent) than for residents in residential care homes (39 percent) (Laing/Buisson 2013 as referenced by Humphries 2013).

4.2.2 Quality and performance indicators

The quality of adult social care is not always of the highest standard. Moreover, the provision of care was plagued by a series of scandals, among them those at a private care home operated by Castlebeck, which were revealed by a BBC documentary (BBC 2011). However, the noncompliance with quality standards is not limited to institutional care homes. As an investigation by the Equality and Human Rights Commission concluded the poor quality of home care for many older people was breaching their human rights (Equality and Human

Rights Commission 2011). After a number of investigations into the work of the Care Quality Commission, which was only established in 2009 to oversee the quality of care within the NHS and social care, its Chief Executive, Cynthia Bower, resigned in February 2012 (for an overview see Campbell 2012). A report by the National Audit Office (2011) concluded that the Care Quality Commission had had a difficult task in establishing itself, and had not achieved value for money in regulating the quality and safety of health and adult social care in England. The trust in the quality of care and the system of quality assurance is at such a low point that the adult social care chief inspector Andrea Sutcliffe the option of using hidden cameras and mystery shoppers - where people posed as individuals looking for care for a loved one - in the coming months, with providers, councils and the public (Triggle 2013).

4.2.3 Sustainability

There would seem to be a brought consensus that the current system of long-term care in England is unsustainable, as it heavily draws on informal care arrangements, hospitalization in the absence of a accessible care system for the non-poor and huge costs associated with long-term care. Pay and conditions are quite low, attracting a relatively high proportion of employees with no qualifications, especially among private providers that are dominating the care sector. Systematic prevention, rehabilitation and independent living policies for elderly people with long-term care needs are underdeveloped in the United Kingdom. The current government has promised significant improvements in the context of the recent legislation reforming the provision and financing of adult social care in England (cf. Department of Health 2012).

4.2.4 Summary

The authority of funding, regulating and providing long-term care in the United Kingdom is devolved, with Scotland providing universal free access and care being means-tested in England. The implementation of a long-awaited reform of a new funding arrangement for long-term care in England will start in 2016. The quality of long-term care is not always of a very high standard and in order to improve standards it was even suggested to use hidden cameras.

4.3 Reform debates

Current reform debates largely focus on elements of the implementation regime of the long-term care reform legislation in England (Cumbo 2013b).

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THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, HC 898, London: TSO retrieved November 3, 2013 from http://www.midstaffspublicinquiry.com/report.

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Annex – Key publications

[Pensions]

HARROP, Andrew (2013) *A Presumption of Equality: The changing face of old age and what it means for fairness*. London: Fabian Society; retrieved on Nov 3, 2013 from http://www.fabians.org.uk/publications/a-presumption-of-equality/.

The report published by the Fabian Society examined the situation of older people on middle incomes. It suggested that there was a 'legitimate worry' that older people had not been sharing sufficiently in public spending cuts. Policies that appeared to give special advantages to older people as a category should be reviewed.

ONS (2012) *Income of Retired Households, 1977–2010/11*. London: ONS, retrieved Nov. 3, 2013 at http://www.ons.gov.uk/ons/dcp171776_284355.pdf.

A report examined key trends in the income of retired households between 1977 and 2010-11. The average disposable income for retired households was £17,700 in 2010-11, which was over two and a half times higher in real terms than in 1977. More than half of the rise could be attributed to growth in income from private pension schemes. Income inequality between retired households had increased rapidly between 1977 and 1991, but had fallen gradually since then.

ONS (2013) *Pension Trends.* 2013 edition. London: ONS; retrieved Nov. 1, 2013 at http://www.ons.gov.uk/ons/rel/pensions/pension-trends/index.html.

Most comprehensive statistical report covering all important dimensions relevant for pension policies. It looks at changes in pension provision over time in the context of social and economic developments and changes in the policy environment.

RADFORD, Lucy; Taylor, Lisa and Claire Wilkie, (2012) *Pension Credit Eligible Non-Recipients: Barriers to Claiming*, Research Report 819. London: Department for Work and Pensions; retrieved on November 3, 2013 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214374/rrep819.pdf.

The study examined the barriers to claiming pension credit. The findings supported previous research showing perceived ineligibility to be a primary barrier, with barriers related to process and stigma as secondary barriers.

[Health care]

KLEIN, Rudolf (2013) "The twenty-year war over England's National Health Service: a report from the battlefield," *Journal of Health Politics, Policy and Law,* Volume 38 Number 4, pp. 849-869.

The article examined the coalition's programme of reform for the National Health Service in England. The programme was characterized by its wide scope and the organizational upheavals involved, and by the fact that it was being introduced at a time when the NHS faced unprecedented financial pressures. The legislation faced strong political, public, and professional hostility – both from those who saw it as a crime against the founding principles of the NHS and from those who saw it as a disruptive blunder that created more problems than it solved. The essential, defining characteristics of the NHS were not in fact under threat:

it would continue as a publicly funded service, freely available to all, and was not being privatized. But it was moving toward a more pluralistic system.

MURRAY, Christopher *et al*. (2013) "UK health performance: findings of the Global Burden of Disease Study 2010," *The Lancet*, Volume 381, Issue 9871, pp. 997 - 1020.

The article examined the patterns of health loss in the United Kingdom, the leading preventable risks that explained some of these patterns, and how outcomes compared with a set of comparable countries in the European Union and elsewhere in 1990 and 2010. For both mortality and disability, overall health had improved substantially in absolute terms from 1990 to 2010. But the UK's performance in terms of premature mortality was persistently and significantly below the mean of European countries, and required additional concerted action. Further progress in tackling premature mortality would probably require improved public health, prevention, early intervention, and treatment activities. The growing burden of disability needed an integrated and strategic response.

SPEED, Ewen; Gabe, Jonathan (2013) "The Health and Social Care Act for England 2012," *Critical Social Policy*, Volume 33 Issue 3, pp. 564-574.

This article argues that the 2012 Health and Social Care Act did not represent a radical break with the past; instead it was an extension of the previous Labour government's of the public sector.

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, HC 898, London: TSO retrieved November 3, 2013 from http://www.midstaffspublicinquiry.com/report.

The report was published of a public inquiry (led by Robert Francis) into serious failings in care by the Mid Staffordshire NHS foundation trust. Years of abuse and neglect at the hospital between 2005 and 2008 had led to the unnecessary deaths of hundreds of patients. The report made 290 recommendations, saying 'fundamental change' was needed to prevent the public losing confidence in the National Health Service.

TIMMINS, Nicholas (2013) *The Four UK Health Systems: Learning from each other*. London: King's Fund, retrieved Nov 3, 2013 from http://www.kingsfund.org.uk/publications/four-uk-health-systems-june-2013.

Timmins' report examined the differences between the United Kingdom's four separate health systems. England's adherence to and extension of market-like mechanisms in managing health differentiated it most dramatically from the other three services. In order to learn from each other the four health departments should agree specific indicators, establish which data was needed to make comparisons, and identify how best to collect that data.

WOOD, Claudia (ed.) (2013) *Health in Austerity*, London: Demos, retrieved Nov. 3, 2013 from http://www.demos.co.uk/files/DEMOS_Health_in_Austerity_-_web.pdf?1379898927.

The collection of essays examines the impact of austerity on health policy. It looked at the public health impact of economic decline that had a direct effect on the National Health Service. Although existing budget restrictions might be tough for those working at the frontline, the longer-term trend of an ageing population that would prove to be the NHS's biggest challenge.

[Long term care]

GEORGHIOU, Theo et al. (2012) *Understanding Patterns of Health and Social Care at the End of Life*, London: Nuffield Trust, retrieved November 3, 2013 from http://www.nuffieldtrust.org.uk/sites/files/nuffield/121016_understanding_patterns_of_health_and_social_care_full_report_final.pdf.

The study published by the Nuffield Trust examined how people in England used publicly funded health and social care services during the previous months of their lives. It concluded that social care might prevent the need for hospital admission.

MORAN, Nicola et al. (2013) "Older people's experiences of cash-for-care schemes: evidence from the English individual budget pilot projects," *Ageing and Society*, Volume 33 Issue 5, pp. 826-851.

The article by Moran et al. examined the impact and outcomes for older people of individual budget (IB) pilot projects in England (2005-2007). Older people spent their IBs predominantly on personal care, with few resources left for social or leisure activities. They had higher levels of psychological ill-health, lower levels of well-being, and worse self-perceived health than older people in receipt of conventional services. Potential advantages of IBs included increased choice and control, continuity of care worker, and the ability to reward some family carers: but older people reported anxieties about the responsibility of organizing their own support and managing their budget. For older people to benefit fully from cash-for-care schemes they needed sufficient resources to purchase more than basic personal care, and access to help and advice in planning and managing their budget.

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