



HOUSE OF LORDS

Select Committee on Public Service and  
Demographic Change

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Report of Session 2012–13

# Ready for Ageing?

Report

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### *The Select Committee on Public Service and Demographic Change*

The Select Committee on Public Service and Demographic Change was appointed by the House of Lords on 29 May 2012 with the orders of reference “to consider public service provision in the light of demographic change, and to make recommendations.”

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See Appendix 1.

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References in footnotes to the Report are as follows:

Q refers to a question in oral evidence

Witness names without a question reference refer to written evidence



# Ready for Ageing?

## REPORT

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### Introduction

1. The UK population is ageing rapidly, but we have concluded that the Government and our society are woefully underprepared. Longer lives can be a great benefit, but there has been a collective failure to address the implications and without urgent action this great boon could turn into a series of miserable crises.
2. The Committee focused on the implications of an ageing population for individuals and public policy in the near future, the decade 2020–2030. Key projections about ageing include:
  - 51% more people aged 65 and over in England<sup>1</sup> in 2030 compared to 2010
  - 101% more people aged 85 and over in England in 2030 compared to 2010<sup>2</sup>
  - 10.7 million people in Great Britain can currently expect inadequate retirement incomes<sup>3</sup>
  - over 50% more people with three or more long-term conditions in England by 2018 compared to 2008<sup>4</sup>
  - over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.<sup>5</sup>
3. Longer lives represent progress, and the changes do not mean a great economic or general fiscal crisis.<sup>6</sup> Moreover the contribution to our society made by older people, which is already impressive, will be even greater as a result: 30% of people aged over 60 volunteer regularly through formal organisations.<sup>7</sup> However, as well as opportunities, the changes create major challenges for individuals, for employers, for our welfare services, and for the Government and all political parties. Others have looked at aspects of these changes, but the Committee's approach was holistic: surveying the landscape to highlight key issues for our society and encourage public debate.

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<sup>1</sup> Due to the effects of devolution, our focus is primarily on England, although many of the issues that we have highlighted may apply throughout the United Kingdom: see Annex 1.

<sup>2</sup> Central Government (Department of Health (DoH), Department for Work and Pensions (DWP) and Department for Communities and Local Government (DCLG)), written evidence. See Annex 2.

<sup>3</sup> Department for Work and Pensions, *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

<sup>4</sup> The King's Fund, supplementary written evidence.

<sup>5</sup> Professor Carol Jagger, Newcastle University.

<sup>6</sup> See Annex 4.

<sup>7</sup> See Annex 3.

4. To make a success of these demographic shifts, major changes are needed in our attitudes to ageing. Many people will want or need to work for longer, and employers should facilitate this. Many people are not saving enough to provide the income they will expect in later life, and the Government must work to improve defined contribution pensions, which are seriously inadequate for many. People need help to make better use of the wealth tied up in their own property to support their longer lives.<sup>8</sup>
5. The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall, the quality of healthcare for older people is not good enough now, and older people should be concerned about the quality of care that they may receive in the near future. England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population. Further fundamental reform to the NHS in the next few years would be undesirable, but radical changes to the way that health and social care is delivered are needed to provide appropriate care for the population overall and particularly for older people, and to address future demand.<sup>9</sup>
6. Social care and its funding are already in crisis, and this will become worse as demand markedly increases. The split between healthcare and social care is unsustainable and will remain so unless the two are integrated. Sufficient provision of suitable housing, often with linked support, will be essential to sustain independent living by older people.<sup>10</sup>
7. An ageing society affects everyone: these issues require open debate and leadership by the Government and all political parties. The challenges are by no means insuperable, but no Government so far has had a vision and coherent strategy; the current Government are no exception and are not doing enough to ensure our country is ready for ageing.<sup>11</sup>

### How will we support ourselves through later life?

8. Living for longer is to be celebrated. But our society needs to review how to pay for the risks and costs associated with lives that may be 10 or more years longer than previously: people can outlive their pensions and savings, suffer ill health and need social care. The Government cannot carry all these risks and costs, but there is much the Government can do to help people prepare: to make it attractive and possible to work for longer, to address the major deficiencies in our pensions system, to make it easier to harness the value in people's homes to support some of the costs and risks of later years, and to help people understand those costs and risks. **The Government should help people be better informed about healthy life expectancies, pension projections, the likelihood of needing social care and its cost, and how best to use their own assets, so that individuals and families can analyse their own situations and make their own informed choices** (see Annexes 3 and 6).

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<sup>8</sup> See Annexes 3, 5, 8, 7 for each point.

<sup>9</sup> See Annexes 9 and 10, 12 to 14, 13, 12 to 14 for each point.

<sup>10</sup> See Annexes 9 and 10, 12, 16 for each point.

<sup>11</sup> See Annexes 7 and 18.



*Later working*

9. By 2030, men aged 65 in the UK will expect to live another 23 years, to 88, and women another 26 years, to 91.<sup>12</sup> As people live longer they will need enough income to support a good quality of life; it would be naive to think that this can simply come from taxpayer-funded sources. But many are not saving enough to pay for a decent standard of living over a much longer retirement. People should therefore be enabled to extend their working lives if they wish to do so, as a vital part of the response to increased longevity.<sup>13</sup>
10. Working for longer would increase income from work, potentially increase savings, and reduce the time of dependence on those savings. Working for longer can often improve health and brings social and intellectual benefits. More people working for longer also help sustain economic growth and improve the country's fiscal position. Employing older workers can benefit employers by using the experience and knowledge of people who still have much to contribute.
11. Making working for longer possible will require changes to attitudes, as well as policy and practice (more fully explored in Annex 5):
  - The Government and employers need to work to end 'cliff-edge' retirement, by enabling more people to work part-time and to wind down work and take up pensions flexibly. It should be beneficial to defer taking state and private pensions. Employers need to be much more positive about employing older people. The Government should publicly reject the 'lump of labour fallacy' that wrongly argues this will disadvantage the young.
  - We must abandon the idea of a fixed retirement age implicit in many pension structures, employment practices, and tax and benefit thresholds: people should decide for themselves how and when they retire. Incentives in the tax, benefit and pensions systems to retire early should be reviewed.
  - Employers should help older people adapt, re-skill, and move to more suitable roles and hours when they want to do so, and should support those with caring responsibilities for older people to work part-time or flexibly.
  - The Government should, with employers, help support those in manual or low-skilled jobs, who might need to work longer but have most difficulty in doing so. Welfare to work policies should also address the needs of older people.
  - Age is no longer a good indicator of people's needs or income, so the Government should review whether age alone is a sensible determinant for tax liability, access to services or benefits.

*Reforming pensions and savings*

12. The UK has a worrying under-saving problem.<sup>14</sup> The Pensions Commission chaired by Lord Turner of Ecchinswell began a period of reform and when

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<sup>12</sup> Office for National Statistics (ONS), *Pension Trends – Chapter 2: Population change*, February 2012, data for figure 2.5.

<sup>13</sup> See Annexes 4 and 5.

<sup>14</sup> Department for Work and Pensions, *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

complete, this will represent progress. State pensions will be linked to earnings (at a minimum), preventing further erosion; pensions auto-enrolment will extend private pension coverage to many who are currently not covered; and the single-tier state pension will rationalise state provision and make it more generous for those with intermittent employment histories (see Annex 8). The Committee welcomes these positive steps.

13. But despite this, the current system of state and private pension provision is not adequate as many people, young and old, expect far more pension than they will get. While the poorest will be protected at a basic level by state provision, and the richest can afford to save enough in private schemes, there is a substantial gap for much of the rest of the population.
14. Under the current defined contribution pensions system, the individual does not know what income the pension will provide and therefore what he or she is saving for. Defined contribution pensions now dominate private pension provision, with risks and uncertainties, and are inadequate for many, especially women.
15. The Committee has concluded:
  - The Government were right to raise the state pension age, but they are now adopting a timetable of increases slower than that recommended by the Turner Commission and will have to revisit this with rising healthy life expectancy. Those who work beyond state pension age should clearly benefit if they defer taking their pension.
  - Auto-enrolment is a big step forward for people who would otherwise not be saving for a pension. However, while helpful, auto-enrolment alone will not solve the problem of under-saving. The scale of pension saving encouraged by this scheme, eventually 8% of an individual's earnings, will still result in a pension significantly below many people's expectations unless people save considerably more in addition.
  - But saving more is made less likely as the current defined contribution pensions system is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.
  - **The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contribution pensions and address their serious defects to make it clearer what people can expect to get from their pension as a result of the savings they make.**

*Using the value in our homes*

16. Many older people have seen the value of their homes increase considerably but have not viewed this as a partial solution to some of the challenges of living longer. The Committee considers that it is reasonable to expect those who have benefited in this way to support their own longer lives. People need to be able to use their assets to help pay for the cost of their social care, and to release money to adapt their homes and to support their incomes. Some schemes exist, but are little used.
17. **People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with the financial services industry to ensure such mechanisms are**

available, and to improve confidence in them. We explore this in Annex 7.

### Living independently and well

18. Older people are diverse; most enjoy life and want to live independently, in their own home for as long as possible. But eventually almost all of us will need healthcare, and two thirds of men and 84% of women currently aged 65 will need some social care before they die.<sup>15</sup>

### *Increasing pressures on health and social care*

19. **The NHS is facing a major increase in demand and cost consequent on ageing and will have to transform to deal with this. Because of this rising demand, without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably.**
20. A rapidly ageing society means many more older people living for more years, often with one or more chronic long-term health conditions; a consequence of this and other pressures is a large increase in health and social care costs. Predicted increases in demand for health and social care from 2010 to 2030 for people aged 65 and over in England and Wales include:
- people with diabetes: up by over 45%
  - people with arthritis, coronary heart disease, stroke: each up by over 50%
  - people with dementia (moderate or severe cognitive impairment): up by over 80% to 1.96 million
  - people with moderate or severe need for social care: up by 90%.<sup>16</sup>
21. The treatment and care of people with long-term conditions accounted for 70% of the total health and social care spend in England in 2010, so the large increases in the number of older people with long-term conditions will create significant extra costs.<sup>17</sup>
22. The Nuffield Trust has recently estimated that under the current healthcare system, the NHS in England will see a funding shortfall of £54 billion by 2021/22 if NHS funding remains constant in real terms, if no productivity gains are made, and if trends continue in current hospital utilisation by people with chronic conditions and in healthcare costs.<sup>18</sup> If the English NHS achieves unprecedented productivity gains of 4% a year in every year from 2010/11 to 2014/15, they predicted that this funding gap would be reduced to a potential shortfall of £34 billion. For comparison, the total budget for

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<sup>15</sup> *Impact of changes in length of stay on the demand for residential care services in England: Estimates from a dynamic microsimulation model*, Personal Social Services Research Unit (PSSRU) Discussion Paper 2771, 2011, J-L Fernandez and J Forder. The gender breakdown was supplied by the authors.

<sup>16</sup> Professor Carol Jagger, Newcastle University.

<sup>17</sup> Department of Health, *Improving the health and well-being of people with long term conditions: World class services for people with long term conditions – Information tool for commissioners*, January 2010.

<sup>18</sup> Nuffield Trust, *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*, December 2012.

the English NHS in 2010/11 was £107 billion.<sup>19</sup> If the system did not change and a shortfall on this scale materialised, it would have particularly serious consequences for older people, who are the biggest consumers of NHS spending (see Annex 10).<sup>20</sup> **The Committee has concluded that the current healthcare system is not delivering good enough healthcare for older people and is inefficient; there is an urgent need to change the current system to provide better healthcare more efficiently and this should help with the predicted funding shortfall.**

23. At the same time, public expenditure on social care and continuing healthcare for older people may have to rise to £12.7 billion in real terms by 2022 (an increase of 37% from £9.3 billion in 2010), just to keep pace with expected demographic and unit cost pressures (see Annex 10).<sup>21</sup>
24. Social care funding is already in crisis, and this will become worse as demand markedly increases. Many people needing social care now are not getting it as eligibility thresholds are tightened because of reduced local authority funding (see Annex 10). The Government's response to the proposals made by the Commission on Funding of Care and Support (the Dilnot Commission) is welcome and necessary but in our view will not be sufficient because it will largely benefit higher income groups by protecting them from depleting their housing assets rather than address the current funding crisis (see Annex 11). It does not bring extra funding into the system to tackle the current funding crisis or address the problem of expanding need in the coming decades—although we acknowledge that this was not the task given to the Commission.
25. There should be a sharing of responsibility for social care between individuals and the state. The implementation of the Dilnot Commission proposals makes this sharing explicit and puts a limit on individual risk. But many people do not have families who can provide care, nor the money to buy it, and cannot cope without care—and this situation will worsen as demand rises (see Annex 10). If the neglect of social care continues and these people are not properly supported in the community, they will end up with more severe needs, or will suffer crises and go into hospital, driving up healthcare costs.

*Care at home—whenever possible*

26. The Committee received expert evidence that a new system of health and social care is needed to:
  - be more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration, with much less use of acute hospitals (see Annex 12)

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<sup>19</sup> Nuffield Trust, *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*, December 2012.

<sup>20</sup> Department of Health, *Resource Allocation: Weighted Capitation Formula Seventh Edition*, 2011, Table 6 and Appendix I.

<sup>21</sup> Nuffield Trust with PSSRU at the London School of Economics (LSE), *Care for older people – Projected expenditure to 2022 on social care and continuing health care for England's older population*, December 2012.

- be centred on the individual person, with patients engaged in decisions about their care and supported to manage their own conditions in their own homes so that they can be prevented from deteriorating
  - have the home as the hub of care and support, including emotional, psychological and practical support for patients and caregivers
  - ensure older people only go into hospitals or care homes if essential, although they must have access to good specialist and diagnostic facilities to ensure early interventions for reversible conditions and prevent decline into chronic ill health.
27. A remarkable shift in NHS services will be needed to deliver this. Older people with long-term conditions need good, joined-up primary care, community care and social care, with effective out-of-hours services. Such services make it possible to minimise hospital stays. Time in hospital is often not what older people want or need, and is expensive.
28. This shift in NHS services would help move demand, and funding, from acute and emergency services (which consume nearly half of the NHS's budget<sup>22</sup>). This should allow more investment in services which prevent older people from going into hospital. Some of this released funding should flow into improving social care. It is obvious that if more older people could be treated in the community rather than admitted to hospital, expenditure on hospitals could be reduced. Improving the quality of hospital-based treatments through specialisation and rationalisation would also raise standards.
29. **To meet the needs of the population, and to achieve this shift in services, the health and social care system needs to work well 24 hours a day, seven days a week.** The Committee was heartened by the Secretary of State for Health's commitment to a 24/7 NHS, and calls on him within 12 months to set out how this will be made real. For this to have value, there will also have to be 24/7 community-based healthcare and social care.
30. **The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently. The Government and all political parties will need to rethink this issue.** We note the Government's commitment to introduce a national minimum eligibility threshold for social care from 2015: we consider that the consequence of this must be that the Government will address the public funding needed to make it possible, but we consider that health and social care integration is the longer-term solution for social care funding. **The health and social care systems also have to plan more systematically for changing long-term needs, so the Government should consider introducing a 10-year spending envelope for the NHS and publicly-funded social care.**
31. **The Government need to develop a new basis for health and social care for our ageing population and create a vision so that other decision-makers can work to bring it about.** Ministers told us the Government do not believe in top-down command and control, and that the

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<sup>22</sup> Department of Health, *Resource Allocation: Weighted Capitation Formula Seventh Edition*, 2011.



decentralisation of budgets and responsibilities to over 200 clinical commissioning groups and new Health and Wellbeing Boards would drive the necessary changes. The Committee has concluded that organic, bottom-up change has benefits, but that it will not by itself bring about the major changes to health and social care services that an ageing population will need (see Annex 12). **The Government must set out the framework for radically transformed healthcare to care for our ageing population before the general election in 2015. All political parties should be expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 election.**

32. Our older population should be concerned about the quality of care that they may receive in the near future, because the current system is in trouble now. It will require substantial changes to address both present needs and future demand, and this challenge is combined with an impending funding crisis. Nothing like enough is being done to face up to these challenges.

### *Personalised care*

33. The local delivery of health and social care does not serve older people well: services operate independently of each other and are peppered with negative incentives. The Committee congratulates heroic professionals such as those in Torbay and the North West London Integrated Care Pilots who are striving to make this poor system function.
34. The Government must act now to challenge the barriers that make it difficult for professionals to deliver the kind of personal, integrated care that our older population wants, such as by doing away with restrictions on sharing data between care professionals, and encouraging less risk-averse attitudes. This will require support for a transparent, good quality market in privately provided social care (see Annex 14). The Committee heard exciting examples of how person-centred commissioning, a single point of contact for care, pooled budgets, new payment systems and new technology can bring improvement. A culture that facilitates experimentation is needed, so that local authorities and clinical commissioning groups are pushed to innovate to find the best local solutions.
35. Publicly funded care alone has never met all the needs of older people who are frail, vulnerable, ill or isolated. As our society ages, more informal care from family and friends will be required, and more volunteers. The number of disabled older people in households receiving informal care in England will need approximately to double over the next 20 years so the Committee calls for employers to make it easier for employees to provide informal care (see Annex 5), and for the Government to promote how crucial this is.<sup>23</sup>
36. Older people contribute greatly to society, including through volunteering and informal care. Increasing lifespans offer a great opportunity for older people to play an even greater role in public life (see Annex 15). We recognise the very valuable work already done by a number of charities to support older people. **Central and local government should work together with the third sector to increase volunteering especially by older people to support older people.**

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<sup>23</sup> Central Government (DoH, DWP and DCLG), written evidence.

### *Housing and wider public services*

37. A better health and social care system to support people to stay living independently needs adequate housing and support in the home. The work done by housing adaptation and repair charities is commendable, but needs to become universal. The housing market is delivering much less specialist housing for older people than is needed. **Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people** (see Annex 16).
38. Other services such as urban planning, banking and product design will need to adjust to an older population and an older consumer base, and will have an important role in preventing the social isolation of older citizens. Older people must be involved in their design (see Annex 17).

### **Fairness**

39. There are likely to be considerable increases in public and private spending over the next two decades on services that are particularly important to older people: healthcare, pensions and social care. This is not a bad thing; over time, an increasingly affluent society (as, on the whole, we expect to become) is likely to want to spend more on improving the lives of its citizens, and an older society is likely to want to spend more on the priorities of older people. This increased spending can only be financed by individuals directly, or through taxes, social insurance, or cuts elsewhere: it must be financed fairly.
40. The welfare state has largely meant people paying in when they are young and drawing out when they are older; this should continue. But we have to be wary of shunting too many costs onto younger and future generations. In particular, the property boom has led to a very large transfer of wealth to older, better-off homeowners, which has increased housing costs substantially for younger generations. Younger generations will benefit from being part of a richer society in many ways in the future, but they will also have to service large public and personal debts and may often have poorer pensions (see Annex 7).
41. It does not seem fair to expect today's younger taxpayers—especially those not born to better-off parents—to pay more for the increased costs of an older society while asset-rich older people (and their children) are protected. For this reason too, an effective equity release market to unlock the housing assets held by older people is important.
42. Fairness within generations is also important: people's later lives are affected by their socio-economic background, and men's and women's experiences of older age are markedly different. Older women are the primary users of health and social care and particularly lose out when it comes to pensions (see Annex 7). These divergences must be taken into account.
43. There is a potential for inequalities in our society to increase considerably as the population ages because of inequalities in health, savings and pensions, with a growing divergence between those for whom longer life is comfortable and those for whom living longer involves greater exposure to risks while they have few assets to draw upon.

### Are the Government ready for ageing?

44. The Cabinet has not assessed the implications of an ageing society holistically, and has left it to Departments who have looked, in varying degrees, at the implications for their own policies and costs. The Government have not looked at ageing from the point of view of the public nor considered how policies may need to change to equip people better to address longer lives.
45. The ageing of the population is inevitable, and affects us all. The major changes this Report proposes may take a decade to bring about, and should inform the priorities for the next spending review. The Government must make the case to the public as to why changes are needed. If a government tries to move some age-related benefits onto different eligibility criteria without setting out a vision for our old age and committing to make major improvements in some areas, significant opposition would be inevitable. Our society is intelligent and pragmatic and is capable of understanding the arguments for change.
46. **The Government should set out their analysis of the issues and challenges, and their vision for public services in an ageing society, in a White Paper to be published well before the next general election.** There needs to be cross-party understanding of the importance of these choices, and an effort to seek as much consensus as possible. Progress will not be made if the solutions chosen by the Government change with each administration. So **the Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations: one to work with employers and financial services providers to examine how to improve pensions, savings and equity release, and one to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing population. Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation. We also conclude that when political parties are working on their manifestos, they ought to consider the wider implications of the ageing society for the balance of responsibilities between individuals and the Government.**

### Principal conclusions and recommendations

47. **The Government and employers need to work to end ‘cliff-edge’ retirement, by enabling more people to work part-time and to wind down work and take up pensions flexibly. It should be beneficial to defer taking state and private pensions. Employers need to be much more positive about employing older people. The Government should publicly reject the ‘lump of labour fallacy’ that wrongly argues this will disadvantage the young (paragraph 11).**
48. **The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contribution pensions and address their serious defects to make it clearer what people can expect to get from their pension as a result of the savings they make (paragraph 15).**
49. **People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with**



**the financial services industry to ensure such mechanisms are available, and to improve confidence in them (paragraph 17).**

50. **The NHS is facing a major increase in demand and cost consequent on ageing and will have to transform to deal with this. Because of this rising demand, without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably (paragraph 19).**
51. **To meet the needs of the population, and to achieve this shift in services, the health and social care system needs to work well 24 hours a day, seven days a week (paragraph 29).**
52. **The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently. The Government and all political parties will need to rethink this issue (paragraph 30).**
53. **The Government must set out the framework for radically transformed healthcare to care for our ageing population before the general election in 2015. All political parties should be expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 election (paragraph 31).**
54. **Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people (paragraph 37).**
55. **The Government should set out their analysis of the issues and challenges, and their vision for public services in an ageing society, in a White Paper to be published well before the next general election (paragraph 46).**
56. **The Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations: one to work with employers and financial services providers to examine how to improve pensions, savings and equity release, and one to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing population. Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation. We also conclude that when political parties are working on their manifestos, they ought to consider the wider implications of the ageing society for the balance of responsibilities between individuals and the Government (paragraph 46).**

## **ANNEX 1: OVERVIEW OF OUR WORK**

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57. The Committee on Public Service and Demographic Change was appointed by the House on 29 May 2012 “to consider public service provision in the light of demographic change, and to make recommendations”.
58. We decided to focus our work on ageing because it is the most substantial demographic change underway, will affect the whole population, and will have wide-reaching implications for individuals, public policy and public services.
59. The United Kingdom population is ageing rapidly. The Office for National Statistics (ONS) has projected that in England in 2030, compared to 2010, there will be 51% more people aged 65 and over, and 101% more people aged 85 and over.<sup>24</sup> This shift will have major implications for society’s attitudes and expectations and for the demands placed on many important services for the public, as well as for their affordability and the way they are delivered.
60. Our focus has been on the impact of ageing on public services in the medium term, looking ahead to 2020 and to 2030. Looking ahead by seven to 17 years gives enough distance to make the changes that are happening clear, yet this period is within the scope of realistic planning and allows for shifts in public policy and services to be made soon.
61. Many aspects of health services, social work and housing policy, along with other relevant public services, are devolved to the legislatures of Scotland and Wales, and transferred in the case of Northern Ireland. For this reason, the main focus of this Report is on England. However, many of the issues that we have highlighted apply throughout the United Kingdom.
62. The annexes that follow lay out in more detail the evidence that underpins the findings in our Report. They are designed to show how we came to our conclusions; highlighted in bold text are key findings relating to the proposals that we make in the Report. In the course of our inquiry, we heard oral evidence from 67 witnesses, and received a large quantity of valuable written evidence.
63. We are grateful to the many individuals and organisations that assisted in our work, and to the academics who undertook specific analyses for us.
64. We are particularly grateful to our Clerk, Susannah Street; our Policy Analysts, Tristan Stubbs and Tansy Hutchinson; our Specialist Advisers, Professor Howard Glennerster and Mr Jonathan Portes, for their expertise and guidance throughout this inquiry; and our Committee Assistant, Bina Sudra.

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<sup>24</sup> Central Government (DoH, DWP and DCLG), written evidence.

## ANNEX 2: DEMOGRAPHIC CHANGES (RELEVANT THROUGHOUT THE REPORT)

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65. The Office for National Statistics (ONS) has updated its projections up to 2021 based on the recent release of data from the 2011 Census. In England<sup>25</sup> in 2021, compared to 2011:
- There will be 24% more people aged 65 and over
  - There will be 39% more people aged 85 and over.<sup>26</sup>
66. The ONS has projected that in England in 2030, compared to 2010:
- There will be 51% more people aged 65 and over
  - There will be 101% more people aged 85 and over.<sup>27</sup>
67. Looking further into the future, Guy Goodwin, Director of Population and Demography Statistics, ONS, told us that over a 50-year period we can expect a doubling of the population in the UK aged over 65, and a very substantial—four times or more—increase in the main projection of those aged 85 and over.<sup>28</sup>
68. These demographic shifts are occurring for two different reasons. First, people are living longer; secondly, we are now reaping the consequences of significant changes in the UK’s birth rates in the period following the Second World War—the ‘baby boom’. The first is a long-run phenomenon. The second is beginning to hit now, and will last for around the next 30 years (see figure 1 below).

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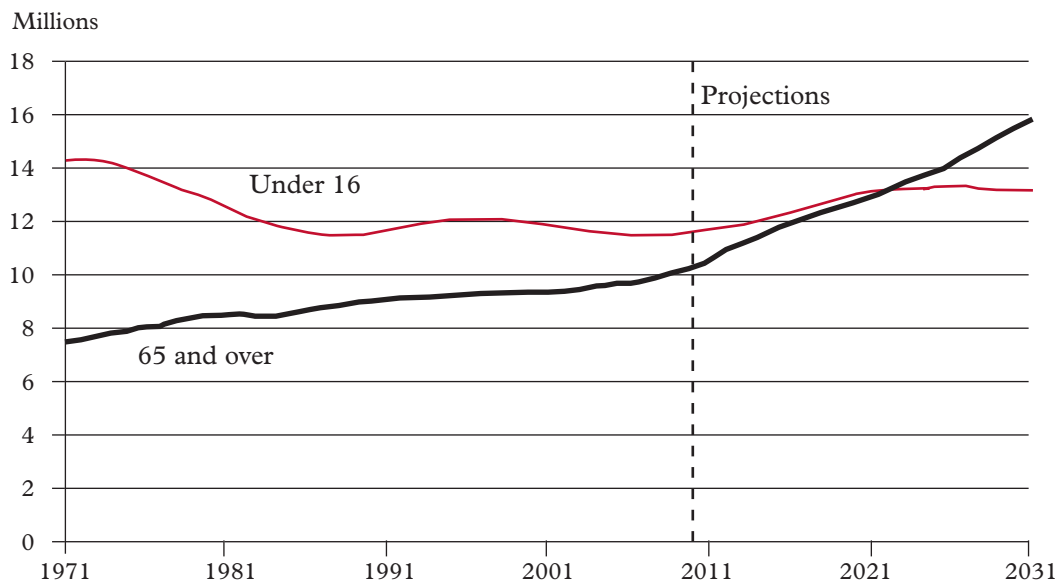
<sup>25</sup> Due to the effects of devolution, our focus is primarily on England: see Annex 1. Derek Jones, Permanent Secretary of the Welsh Government, wrote to the Committee stating that: “The impact of demographic change will have particular significance for Wales, which has the highest concentration of older people within the UK nations ... The numbers of those aged 85 and over are increasing at the fastest rate. Since 1983, their number has more than doubled and latest projections show it will double again up to 2033, by which time it will have reached 160,000, some 5% of the total projected population”.

<sup>26</sup> ONS, *Interim 2011-based subnational population projections: local authorities, counties, regions and England: single years of age, persons*.

<sup>27</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>28</sup> Q 19

FIGURE 1

**Population aged under 16 and 65 and over, United Kingdom<sup>29</sup>****Living longer**

69. The same dynamics that have led to a higher proportion of older people in the population have also yielded a steady rise in our expectation of life at birth and at later ages. There are two principal methods to predict future life extensions: period life expectancy and cohort life expectancy. Period life expectancy assumes that a person will experience the age-specific mortality rates that hold at that time. The cohort method takes the predicted changes in those rates and builds them into the prediction. We have used the cohort method below, as it provides a more useful description of the length of life that individuals might expect.<sup>30</sup>
70. Babies that were born in 2011 can expect a median lifespan of 93.75 years for males and 96.7 years for females. Males born in 1991 can expect to live, after 2011, for another 71.0 years and females for another 74.3 years.<sup>31</sup> Professor Sarah Harper, Professor of Gerontology and Director, Oxford Institute of Population Ageing, University of Oxford, told us that if we use cohort life expectancy for the 2007-birth cohort, “you can say that 50% of that cohort will still be alive by the time they are 103”.<sup>32</sup>

**Confidence in projections**

71. Professor Philip Rees, Emeritus Professor, School of Geography, University of Leeds, explained that there is significant academic discussion about whether there will be continuing reductions in mortality and associated increases in life expectancy, with two polar views. The first, put forward by

<sup>29</sup> ONS, *Measuring National well-being, Social Trends 42 – population*, 17 January 2012, p.9. The graph was mid-year estimates for 1971 to 2010-based projections for 2011 to 2031. Source: ONS, National Records of Scotland, Northern Ireland Statistics and Research Agency.

<sup>30</sup> ONS statistical bulletin, *Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2004-06 to 2008-10*, 19, October 2011, p.16.

<sup>31</sup> ONS, *2010-based national population projections lifetable template: England and Wales*, p.16.

<sup>32</sup> Q 101

Jay Olshansky, was that we are approaching the limits to life expectancy, and that a number of disease trends (for example, increasing obesity leading to much higher rates of diabetes and associated mortality) will mean that we will not see the continuation in improvement in mortality rates at older ages.<sup>33</sup> The second, proposed by James Vaupel, was that the historical record of the countries with the best life expectancy records suggested no limits to improvements driven by progress in wellbeing and medical science. Professor Rees related how, by translating these optimistic views into future forecasts, studies have suggested that very high proportions of current birth cohorts in a sample of advanced countries will survive to be centenarians.<sup>34</sup> The Committee asked Professor Rees about the levels of confidence that it is possible to have in projections of the number of older people that we can expect to see in this country. His response, broadly, was that the older the age group under discussion, the less confidence it is possible to place in the projections.<sup>35</sup>

## Healthy life expectancy and disability-free life expectancy

### *Healthy life expectancy*

72. Healthy life expectancy is defined as expected years of remaining life in ‘good’ or ‘very good’ general health.<sup>36</sup> In 2008, UK men at age 65 had a healthy life expectancy of 9.9 years, and women of 11.5 years (see figure 2).<sup>37</sup> Guy Goodwin told us, however, that while the latest figures suggested that the healthy life expectancy for women was broadly increasing at the same rate as life expectancy, the healthy life expectancy of men was increasing at a lower percentage increase than life expectancy.<sup>38</sup>

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<sup>33</sup> Q 100 (Simon Ross, Population Matters).

<sup>34</sup> Professor Philip Rees, University of Leeds.

<sup>35</sup> Professor Philip Rees, University of Leeds.

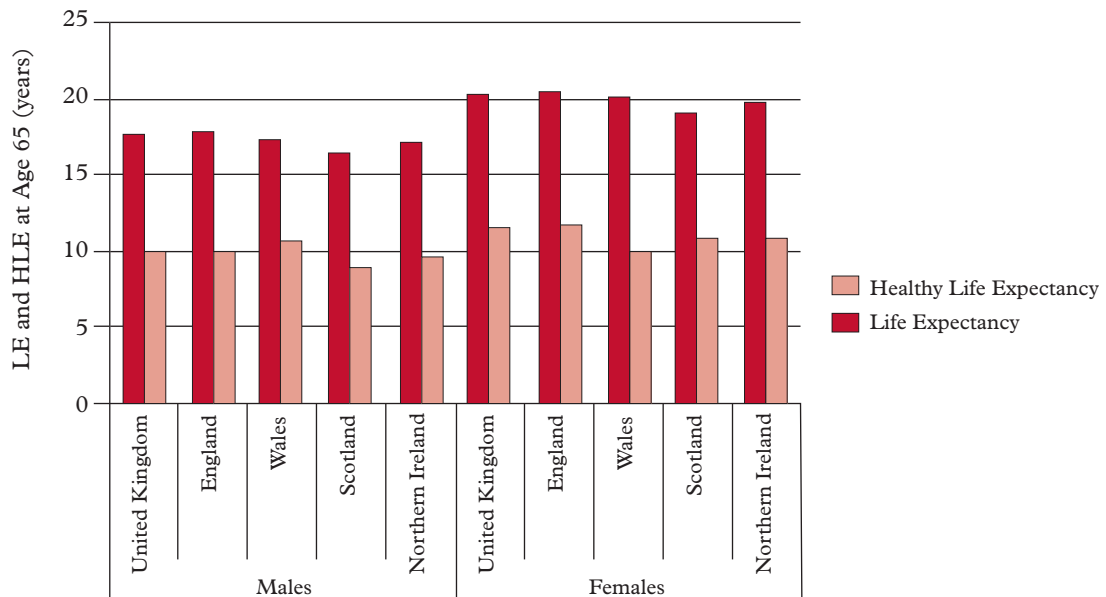
<sup>36</sup> ONS, *Pension Trends*, Chapter 3: Life expectancy and healthy ageing (2012 edition), 16 February 2012, 3-4. It should be noted that due to European Union requirements, the definition of healthy life expectancy has changed recently: the definition formerly was based on expected years of ‘fairly good’ or ‘good’ health.

<sup>37</sup> ONS, *Pension Trends*, Chapter 3: Life expectancy and healthy ageing (2012 edition), released: 16 February 2012, 3-8.

<sup>38</sup> Q 42 (Guy Goodwin and Ben Humberstone, Head of ONS Centre for Demography, ONS).

FIGURE 2

**Life expectancy and healthy life expectancy at age 65 for males and females (for the period 2007–09) with the UK’s constituent countries<sup>39</sup>**



Source: Government Actuary's Department

*Disability-free life expectancy*

73. Disability-free life expectancy is defined as expected years of remaining life free from a limiting long-standing illness or disability.<sup>40</sup> Professor Harper suggested that international data supported the notion that people were “delaying the onset of disability”. This meant that while life expectancy had increased, the number of years that people spend with disability had also increased. Thus, although people are seeing an increase in the number of years that they will spend with disability, this is decreasing as a percentage of their life.<sup>41</sup>
74. Drawing on a range of projections, Professor Rees found that population ageing will increase the population suffering from limiting long-standing illness by 39% between 2010 and 2050, but that if the decreasing trends of the last decade are reproduced in the next four decades, the increase will be clawed back to 6%.<sup>42</sup> Professor Rees also stressed that taking into account the specific disability suffered is very important. A significant challenge will arise from the projected growth in numbers of people with dementia. An 83% increase in the number of people with dementia by 2036 will place substantial extra demands on formal and informal care networks.<sup>43</sup> The Trades Union Congress (TUC) reported that the difference between the local authority areas with the highest and lowest levels of disability-free life

<sup>39</sup> The Scottish Parliament Finance Committee, 2nd Report, 2013 (Session 4): *Demographic change and an ageing population*, p.10.

<sup>40</sup> ONS, *Pension Trends*, Chapter 3: Life expectancy and healthy ageing (2012 edition), 16 February 2012, 3–4.

<sup>41</sup> Q 95

<sup>42</sup> Professor Philip Rees, University of Leeds, supplementary written evidence.

<sup>43</sup> Professor Philip Rees University of Leeds.



expectancy at 65 is 12.1 years for men, and 12.3 years for women (see Annex 7).<sup>44</sup>

### *Effect on length of working life and active ageing*

75. Professor Peter Taylor-Gooby of the University of Kent argued that if people living in the most deprived areas enjoyed the same rate of disability-free life expectancy as the most advantaged, they would have a further 2.8 million years of active life, in which they could contribute to society.<sup>45</sup> There are signs that older people's involvement in the labour market is showing consistent growth. Between April and June 2011, over a third of women in England aged 60 to 64 and nearly one-quarter of men aged 65 to 69 were still economically active.<sup>46</sup> For men, the estimate of average age of withdrawal from the labour market increased from 63.8 years in 2004 to 64.6 in 2010. For women, it increased from 61.2 years in 2004 to 62.3 years in 2010.<sup>47</sup> The number of people of state pension age and above in employment in the UK has doubled over the past two decades. Two thirds of these people work part-time.<sup>48</sup>

### **Past changes in fertility**

76. Our society is 'ageing' in another sense.<sup>49</sup> After the Second World War, the UK's birth rate rose and remained relatively high for two decades. The increase in the size of the working population that resulted as these cohorts entered the labour market helped to counteract the long-run economic effects of rising longevity. But those cohorts are now nearing retirement. Instead of mitigating the long-run impact of longevity they will add to it.<sup>50</sup> During the years on which this Report focuses, this will be of particular importance.<sup>51</sup> It underlies the economic and fiscal challenges outlined in Annex 4.

### *Effect on the old age support ratio (OSR)*

77. It is predicted that each person of the new full state pension age in 2035 will be supported by 2.87 people of working age, as compared to 3.22 people in 2015 (a decrease in the old age support ratio, or OSR, of 38%).<sup>52</sup> As the Central Government Departments' evidence to us suggested, "even with the

<sup>44</sup> Trades Union Congress (TUC).

<sup>45</sup> Professor Peter Taylor-Gooby, University of Kent.

<sup>46</sup> ONS, *Pension Trends*, Chapter 3: Life expectancy and healthy ageing (2012 edition), 16 February 2012, 3-9-3-10.

<sup>47</sup> ONS, *Pension Trends*, Chapter 4: The labour market and retirement (2012 edition), 16 February 2012, 4-9.

<sup>48</sup> ONS, *Older Workers in the Labour Market*, 2012, 13 June 2012, pp.1-4.

<sup>49</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>50</sup> *Pensions: Challenges and Choices. The First Report of the Pensions Commission*, 2004, pp.10-11.

<sup>51</sup> British Society of Population Studies. See Annex 4 for a definition of the 'dependency' ratio.

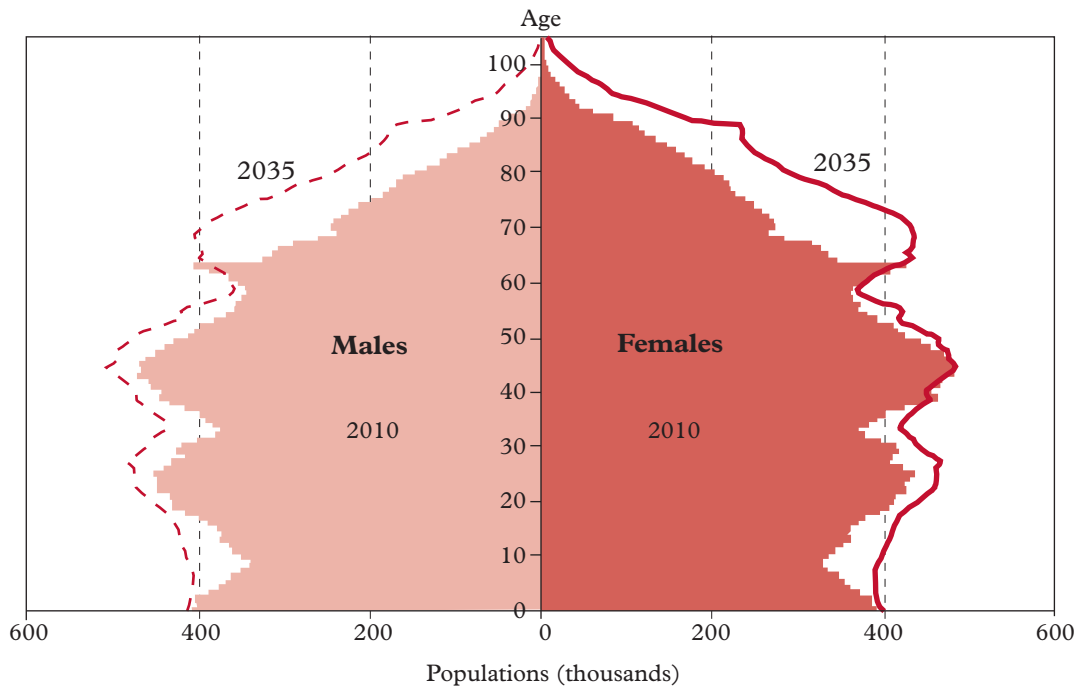
<sup>52</sup> ONS, *National Population Projections, 2010 - Based Statistical Bulletin*, 26 October 2011, [http://www.ons.gov.uk/ons/dcp171778\\_235886.pdf](http://www.ons.gov.uk/ons/dcp171778_235886.pdf); Professor Philip Rees, supplementary written evidence. These figures take into account projected changes to the state pension age, and as such are very sensitive to policy decisions. In their written evidence, the British Society for Population Studies told us that "If a fixed age threshold had been used, such as age 65, the OSR for the UK would have been 3.9 in 2010 and 2.6 in 2035 (based on the ONS 2010 principal projection)". Cf. Professor Philip Rees; Professor Anthea Tinker, King's College London (KCL).

proposed [state pension] changes, the support ratio declines in the future”.<sup>53</sup> Any future restrictions on immigration would also decrease the old age support ratio by reducing the pool of workers in the country.<sup>54</sup>

78. The structure of the UK’s population in 2035 as estimated before the recent Census was as follows. The estimates based on the 2011 Census are not yet available.

**FIGURE 3**

**Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035<sup>55</sup>**



79. Professor Rees also outlined changes in a ‘very old age support ratio’ (VOSR), which divides the number of people at ages 50–64 by the number of persons aged 85+, whose children mostly will be in the former age group. The VOSR decreases from a median of 8.32 in 2010 to 3.11 in 2050, a fall of 63%. Though there is a much greater uncertainty about the accuracy of the VOSR than there is about the accuracy of the OSR, Professor Rees suggested that this implied that more care will need to be provided by persons outside of the late middle age group of children of the very elderly.<sup>56</sup>

**Policy implications of demographic shifts**

80. The rising number of older and ‘older old’ people in the population (many of whom will have chronic health problems), and the effects associated with the post-War generations beginning to withdraw from full-time work, underpin this Report. The need to support this age group and the need to avoid unsustainable tax burdens falling on younger people will have an effect on

<sup>53</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>54</sup> Population Matters; Institute for Public Policy Research; British Society of Population Studies written evidence; Q 40 (Professor Ludi Simpson, University of Manchester); Q 34 (Suzie Dunsmith, Head of Population Projections Unit, ONS).

<sup>55</sup> ONS, National Population Projections, 2010-Based Statistical Bulletin, 26 October 2011.

<sup>56</sup> Professor Philip Rees, supplementary written evidence; Q 96.



how the Government and individuals need to think about saving and paying for older age (see Annexes 4, 5, 7 and 18).

81. As Annexes 9 to 15 lay out, greater numbers of older, often frail people will lead to significant challenges for the provision of healthcare and social care. The doubling by 2030 of the number of people aged 85+ will have a substantial impact on those public services that are particularly important for older people, an impact for which they are worryingly ill-prepared.

### ANNEX 3: ATTITUDES TO AGEING (SEE PARAGRAPH 8 OF THE REPORT)

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82. For most people, living longer is to be celebrated. Many people now enjoy fuller retirements than ever before, or continue to work well into their later life. Older people make a considerable contribution to society, bringing maturity and varied life experiences to bear.<sup>57</sup>
83. People’s definitions of what it means to be ‘old’ have changed, along with ideas about how dependent older people are. For a lot of people, being ‘old’ is a state of mind related to health and the ability to remain independent. The public does not necessarily associate being ‘old’ with retirement or the earlier 60s. Yet this is the age at which many public services, such as the free bus pass and winter fuel payments, are automatically handed out. Britons do not see themselves as elderly until they are approaching 70, and many in their 70s and beyond continue to be active and engaged in society.<sup>58</sup>
84. If being ‘old’ does not begin at an arbitrary age, perhaps it should not be associated with birthdays at all.<sup>59</sup> Society should move away from thinking about chronological age. Baroness Greengross, Chief Executive, International Longevity Centre-UK (ILC-UK), told us that society should “stop thinking about age itself as some sort of disease or handicap”.<sup>60</sup>
85. Employers often equate older age with retirement, and policy-makers tend to assume that when people reach traditional retirement age, they will need to be supported by younger taxpayers (see Annex 4). Age UK considered that there is “a tendency for people, including politicians and policy makers, to frame the debate on ageing within a dependency narrative which sees older people as a ‘burden’ and a ‘drain on the public purse’”.<sup>61</sup> Yet there is no reason why retirement and dependency should relate to a specific age. Much employment is physically less demanding than it traditionally was for many, and fewer people are incapacitated by diseases in later life. Society, the media, and policy-makers should continue to rethink what they mean when they refer to ‘old age’. Older age should be viewed as a spectrum, involving a smooth transition through different stages of life.
86. The Government have acted to legislate against age discrimination, through the Equality Act 2010 and the public sector equality duty which require equal treatment in access to employment and public and private services regardless of age. They have also abolished the default retirement age, so that retirement ages can only be set where they can be justified objectively.<sup>62</sup> We welcome these positive steps, but we also heard that negative attitudes and discrimination towards older age still abound.<sup>63</sup> Baroness Greengross told us that the “stigma” associated with older age results in age discrimination.

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<sup>57</sup> National Housing Federation.

<sup>58</sup> Ipsos MORI.

<sup>59</sup> Q 72

<sup>60</sup> Q 72; International Longevity Centre-UK (ILC-UK); The Saga Group; Q 639.

<sup>61</sup> Age UK written evidence; Q 72 (Professor Pat Thane, Research Professor, KCL and Fellow of the British Academy).

<sup>62</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>63</sup> Q 72, Q 75

Though the law has changed, attitudes will take time to catch up, as happened with previous anti-discrimination legislation.<sup>64</sup>

87. Rather than viewing ageing with horror, society should pay more attention to the large social and economic contributions that older people make, in areas such as volunteering, childcare, care of other adults, charitable giving, and support for younger generations (see Annex 15).<sup>65</sup> We heard that:
- 30% of people over 60 volunteer regularly through formal organisations
  - 65% of volunteers are aged 50 or over
  - 65% of those over 65 regularly help older neighbours, and
  - one in three working mothers rely on grandparents for childcare.<sup>66</sup>
88. Age UK have estimated that people aged 50 and over make an unpaid contribution to the economy of £15.2 billion per year as carers, £3.9 billion in childcare as grandparents and £5 billion as volunteers.<sup>67</sup> These unpaid inputs reduce public expenditure, enable other people to work, and help to make our society more cohesive. They remind us that many older people are anything but dependent (see Annexes 4 and 5).<sup>68</sup>
89. Many of our growing older population are in good health, will retire with a decent income and a strong social network, have much to offer society, and will want to combine work with new activities, volunteering and caring.<sup>69</sup> One way to promote public understanding that ageing will be a positive experience for most might be for the Government to produce a clear guide to the key facts and trends about living longer. There also needs to be a stronger recognition that older age, which can be conceived as including everyone from 60 to 120, covers a huge diversity of ages, levels of health and wealth, and economic and social activity.<sup>70</sup> **The Government should help people be better informed about how long they are likely to live in good health, the size of the pension that they are likely to receive, the likelihood of needing social care and its cost, and how best to use their own assets. By helping individuals and families analyse their own situation and make informed choices, the Government can give people some of the tools they will need to plan ahead.**
90. Providers of both public and private services need to meet the challenge of the ageing population. But acknowledging the changing role and diversity of older people puts new responsibilities on older people themselves: “We could start looking at older people as the same as everybody else. If they are wealthy, tax them; if they are frail, they should be able to access services that support them just like anybody else at any age”, John Kennedy, Director of Care Services, Joseph Rowntree Housing Trust, told us.<sup>71</sup>

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<sup>64</sup> Q 78; at Q78 see also Professor Thane.

<sup>65</sup> Q 75 (Caroline Abrahams, Director of External Affairs, Age UK); Q 100 (Professor Sarah Harper); Third Sector Research Centre.

<sup>66</sup> Q 72 (Professor Thane); Local Government Association, Association of Directors of Adult Social Services and Society of Local Authority Chief Executives (LGA/ADASS/SOLACE).

<sup>67</sup> Age UK.

<sup>68</sup> Age UK.

<sup>69</sup> Age UK.

<sup>70</sup> Fabian Society; Q 72 (Professor Thane); Age UK.

<sup>71</sup> Q 73

91. It is not always helpful or correct to consider older people as a homogenous group defined by chronological age. Age alone is no longer a good predictor of health, wealth, employment status or activity in society. The Government need to recognise this when considering how to design public services. The Government should also work to make society as a whole more aware of the truth about ageing. A better understanding of the needs and abilities of the older population should lead not only to better-targeted public services but also to a private sector that benefits from a growing market by producing goods and products that the older population really needs (see Annex 17).

## **ANNEX 4: ECONOMIC AND FISCAL IMPACTS OF THE AGEING POPULATION (SEE PARAGRAPHS 3 AND 10 OF THE REPORT)**

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### **Economic impacts of the ageing population**

92. Economic output (GDP) is broadly the product of the number of people working in an economy multiplied by their average productivity.<sup>72</sup>
93. Although GDP does not give the full picture of older people's contributions to the economy and society (as explored in Annex 3), an increased 'dependency' ratio will reduce GDP growth.<sup>73</sup> All other things being equal, GDP (and GDP per capita) will be higher if there are more people in work. Conversely, if the proportion of the population not working increases, this reduces growth output. So for economic reasons it is desirable to encourage older people to consider working longer, albeit perhaps part-time; this will boost per-capita GDP.<sup>74</sup> While there are additional health and social benefits to working longer (explored in Annex 5), we stress that the decision to continue working must represent an informed, independent choice, freely taken by individuals.
94. The result of an ageing population therefore does not necessarily mean that the country will be poorer: average productivity per worker will, barring economic disaster, grow very substantially over the next few decades.<sup>75</sup> But if ageing leads to a substantially higher 'dependency' ratio, this could mean that individuals will be significantly poorer in the future than they would have been if the 'dependency' ratio had stayed constant.
95. Improving pension provision, public and private, will not by itself get around this problem: current consumption has, by and large, to be paid for out of current production.<sup>76</sup> Fiscal policy and the way that we think about public and private savings will both need to respond.
96. While older people contribute much to society that measurements of GDP do not take into account, the Government need to take the potential impact of ageing on GDP growth seriously. Without Government action to mitigate the potential effects that an increased number of economically inactive older people would have on GDP growth, economic principles mean that the ageing of the country's population would stand theoretically to have a substantial negative impact on the health of our economy. This is not what we expect to happen: we explore the action that should be taken in Annex 5.

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<sup>72</sup> OECD, *Labour Productivity Growth, Factbook 2011-2012: Economic, Environmental and Social Statistics*.

<sup>73</sup> The 'dependency' ratio is the number of people over the state pension age being supported by those of working age. We note that, as discussed in Annex 3, many people over the state pension age would not consider themselves 'dependent'.

<sup>74</sup> Q 597 (Paul Johnson, Director, Institute for Fiscal Studies (IFS)).

<sup>75</sup> OECD, *Medium and long-term scenarios for global growth and imbalances*, Economic Outlook, Volume 2012/1.

<sup>76</sup> This is true as a matter of definition in the case of the world economy; in the case of the UK, while people could in principle save more now, invest the savings abroad, and consume more later with the proceeds, this is unlikely to be a viable economic strategy. The UK has not run a current account surplus since 1981.

### Fiscal impacts of the ageing population

97. The Office for Budget Responsibility (OBR) suggests that the direct fiscal impact of the ageing population will be significant, but manageable.<sup>77</sup> Tom Josephs, Head of Staff, OBR, told us that “In purely fiscal terms ... the adjustment that we think you might need to make over the course of the next 50 years is not a huge one, particularly if you were to do it gradually over time. The adjustment that has been made in the short term ... is much greater than the one that we are talking about for the future.”<sup>78</sup> Andrew Harrop, General Secretary, Fabian Society, did not believe that the long-term prognosis for UK public finances would be undermined by demographic change. In his view, although “the consequences of taking no action would not be benign ... the scale and urgency of the change required is modest”.<sup>79</sup>
98. However, other witnesses were more concerned. Michael Johnson, Research Fellow, Centre for Policy Studies, has contended that once the “deleterious impact of our ageing population ... is factored in, national debt is expected to fall back to 60% of GDP in the mid-2020s, and then climb inexorably through 100% of GDP (107% of GDP in 2060–61)”.<sup>80</sup> Patrick Nolan and others at Reform claimed that the country is in political denial of the problems that demographic change will bring.<sup>81</sup>
99. Others thought that the risk was not so much of an overall fiscal crisis driven by ageing, but that pressures for increased social spending (especially on pensions, health and social care), primarily resulting from demographic change, would squeeze out other important priorities (for example capital investment, which the OBR projections assume remains at a historically very low level), or leave us vulnerable to future crises. The Institute for Public Policy Research (IPPR) outlined how over the last 50 years, the Government have been able to fund rises in social spending through falls in spending on non-social areas such as defence, nationalised industries and debt interest payments, and by cutting capital spending. But healthcare, social security and education took up 60% of the public budget in 2008. The IPPR argued that “There is a risk that the impact of ageing on the public finances is overstated while other, equally important trends are given less attention in public policy”.<sup>82</sup> Similarly, the Social Market Foundation and the Royal Society of Arts have painted a bleak picture for most other Government Departments if health spending is protected on demographic or political grounds.<sup>83</sup> Dr Martin Weale, Professor at Queen Mary, University of London, pointed out that policy has to plan for possible future periods of substantial economic disruption.<sup>84</sup>
100. The Committee believes that the Government need properly to consider the potential long-term fiscal implications of the ageing population. Government

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<sup>77</sup> Office for Budget Responsibility (OBR), *Fiscal Sustainability Report*, July 2012; IPPR.

<sup>78</sup> Q 150

<sup>79</sup> Fabian Society.

<sup>80</sup> Michael Johnson, *Put the saver first: catalysing a savings culture*, Centre for Policy Studies, June 2012, p.3.

<sup>81</sup> Patrick Nolan et al., *Entitlement reform*, Reform, November 2012.

<sup>82</sup> IPPR.

<sup>83</sup> Ian Mulheirn et al., *Fiscal fallout: the challenge ahead for public spending and public services*, Social Market Foundation and the Royal Society of Arts, 12 November 2012.

<sup>84</sup> Q 122

and citizens have choices about how we respond to these trends, as laid out elsewhere in these annexes (see Annex 7). But **unless preparing for the ageing society begins in earnest, we risk a manageable policy challenge becoming an unmanageable public service crisis.**

101. The Government have a number of urgent decisions to make. Pressure on spending resulting from the ageing population will come primarily from increases in spending on health, social care and pensions (see Annexes 8 to 14).<sup>85</sup> How to manage the relative impacts of each of these spending pressures represents a choice. Improvements in technology in healthcare, and better public sector productivity in social care, potentially could improve the welfare of people using these services, but it will be a challenge to reduce spending pressures through productivity gains alone.<sup>86</sup> Further fiscal pressure would also result from any increase in the 'dependency' ratio, because a lower proportion of people in work means lower tax revenues, and, probably, higher public expenditure.
102. This still leaves the risk of additional pressures resulting from the 'political economy' of an ageing population: older people are more likely to vote, and they are growing in number.<sup>87</sup> This implies a growing pressure on the Government to provide improved state-funded services and benefits for older people. Such provision might be financed through higher taxes on the young and working population, through less spending on investment, or through both approaches, thereby increasing the size of intergenerational transfers (see Annex 7).

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<sup>85</sup> Confederation of British Industry (CBI).

<sup>86</sup> Q 668 (Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health).

<sup>87</sup> Patrick Nolan et al., *Entitlement reform*, Reform, November 2012.



## ANNEX 5: WORKING FOR LONGER (SEE PARAGRAPHS 4 AND 8–11 OF THE REPORT)

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103. As described in Annex 4, an increase in the number of retired people would affect the ‘dependency’ ratio, as well as having an impact on the economy and the fiscal choices that are available to the Government. But if the average retirement age rises as longevity increases, the ‘dependency’ ratio could be stabilised or reduced. This would result in a likely increase in GDP per capita (see Annex 4) and a boost in tax receipts.
104. More importantly, however, individuals choosing to work for longer would themselves benefit from additional income, the potential for more saving, a reduction in the length of time the individual is dependent on those savings and often an improvement in physical health, mental health, and in well-being.<sup>88</sup>
105. By employing older workers, employers would benefit from the fruits of older workers’ experience, knowledge and wisdom and a substantial implicit wage subsidy from employing people over state pension age, because they may undertake part-time work for a relatively low wage due to enjoying supplementary pension income.<sup>89</sup>
106. Wider social benefits related to people staying in work for longer include reduced levels of isolation and loneliness among older people, with accompanying healthcare savings.<sup>90</sup>
107. By 2030, men aged 65 in the UK will expect to live until they are over 88 (23.4 years past the age of 65), and women to the age of 91 (26 years past the age of 65).<sup>91</sup> **If our society and economy are to maximise the benefits of longer lives, older people must be enabled to stay in employment for longer.**<sup>92</sup> **Expectations of early retirement must change.**<sup>93</sup> **Employers and the Government should remove disincentives for older people to work for longer—although the choice to continue in work must remain entirely with the individual.** Possible incentives are discussed below.
108. The Committee considered that the following measures would do much to change attitudes to people working later in life:
- **The incentives in the tax, benefit and pensions systems for both early and fixed-date retirement should be actively reviewed. It should be beneficial to defer taking state and private pensions.** ILC-UK conducted a survey on the prospects for extended working lives that demonstrated a strong willingness across all age groups to work for longer in various circumstances. For example, 41% of men and 39% of women said they would consider delaying their retirement if they could

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<sup>88</sup> Q 330 (Ben Jupp, Director, Social Finance); B&Q.

<sup>89</sup> B&Q; Q 330. It should be noted, however, that salaries for older workers may be higher to begin with.

<sup>90</sup> B&Q; see Professor Peter Goldblatt at Q 542 for the connection between social isolation and ill health.

<sup>91</sup> ONS, *Pension Trends*, Chapter 2: Population change, February 2012.

<sup>92</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>93</sup> The Saga Group.



defer their state pension entitlement in return for higher payments later—which in fact they can already do.<sup>94</sup>

- **‘Cliff-edge’ retirement should end: a culture change is needed so that both individuals and employers end the expectation of retirement at an arbitrary age.** Flexible retirement and withdrawal from the workforce must be made a reality, by enabling people to downshift to part-time work, and wind down work while taking up pensions, benefits and tax relief more flexibly. ILC-UK reported that 46% of men and women would consider delaying retirement if their employer offered support for reducing their hours, or for more flexible working.<sup>95</sup> Dr Ros Altmann, Director-General, the Saga Group, described “a phase of life after full-time work where you are cutting down but not stopping altogether”.<sup>96</sup>
- **Employers need to be much more positive about employing older people.** Employers and employees should adopt a more flexible conception of how and when people move on from paid work as they get older, to their mutual advantage.<sup>97</sup> **Employers should demonstrate more flexibility towards the employment of older workers, and help them to adapt, re-skill and gradually move to more suitable roles and hours when they want to do so.**<sup>98</sup> The TUC argued that if employers paid more attention to flexible working, health and safety, retraining, and procedures against discrimination, employees would work for longer.<sup>99</sup> Kayte Lawton, Senior Research Fellow, IPPR, told us that while it is difficult to shift employers’ attitudes, it is possible to use “smart regulations” to open up opportunities for part-time work and flexible working. She proposed a right to return to a job “in a similar way as maternity leave works: if you have a period of ill health and you need to take a number of months off your employer then is required to take you back”.<sup>100</sup>
- As part of breaking down the outdated cultural expectation of cliff-edge retirement at an arbitrary age, the Government should look at moving away from using age as a defining measure for service or benefit eligibility. **Age is no longer a good indicator of need or ability to pay, so the Government should review whether age alone is a sensible determinant for tax liability, access to services or benefits.**
- **Employers should support those with responsibilities for caring for older people—particularly people in their 50s or 60s who care for elderly parents—to continue part-time or in flexible work.** Carers UK reported that by 2037, nine million people are projected to be caring for “an older or disabled loved one”, and that in the last 10 years the proportion of carers caring for over 50 hours a week has doubled.<sup>101</sup>

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<sup>94</sup> ILC-UK; Age UK; Q 135.

<sup>95</sup> ILC-UK; QQ 515-516 (Dianah Worman, Chartered Institute for Personnel Development (CIPD)).

<sup>96</sup> Q 465; TUC.

<sup>97</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>98</sup> Bernard H. Casey and Robert Lindley, *Older worker policy in the United Kingdom: a case of schizophrenia*, Institute for Employment Research, University of Warwick, August 2012.

<sup>99</sup> TUC.

<sup>100</sup> Q 155

<sup>101</sup> Q 277

Carers UK have found that more than 40% of carers who gave up work did so due to a lack of sufficiently reliable or flexible services. The average cost of recruitment, retraining and lost productivity is around £11,000 per staff member lost, according to the organisation's analysis.<sup>102</sup> Carers UK also reported that 41% of those who described themselves as looking after their home and family (85% of whom are women) said that "they would rather be in paid work, but services available do not make a job possible". The peak age for caring, 45 to 65, also often represents employees' peak age for training, skills and experience, which employers are at risk of losing at short notice if the social care system cannot enable families to juggle work and care.<sup>103</sup>

- The Committee received impressive evidence from employers such as BT and B&Q who are making notable strides towards creating a more favourable employment environment for older people, but was disappointed not to receive more evidence from employers' representatives about whether they also saw a need for similar shifts in other employers' attitudes and working practices.<sup>104</sup> The primary motivating factor for those companies that had introduced policies to enable people to stay longer in work was that this approach was beneficial to their profitability.<sup>105</sup> Employers should recognise that the employment of older workers is in their interests, as well as having a beneficial effect on economic growth.<sup>106</sup>
- **Welfare to work policies should also address the needs of older people.** Steve Webb MP, Minister of State for Pensions, proposed that the Work Programme could do more to get older people back into work.<sup>107</sup> The Department for Work and Pensions has for some time aimed to improve its service to those approaching retirement age, but its plans must be more ambitious and urgent.<sup>108</sup> Low-skilled and manual workers will face particular hurdles to continued employment and re-employment. Employers need to think imaginatively about how they can help this group of people to stay working in suitable jobs if they wish to. These workers should receive help to retrain; manual workers should be supported to shift to non-manual roles.<sup>109</sup> The Government should not neglect their responsibility to support the large numbers of people who, as a result of physically demanding working lives or due to co-morbidities associated with older age, will be too sick or disabled to continue in work.<sup>110</sup>

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<sup>102</sup> Carers UK.

<sup>103</sup> Carers UK; Q 517 (Dr Craig Berry, Pensions Policy Officer, TUC); QQ 524-5 (Caroline Waters, Director of People and Policy, BT); Central Government (DoH, DWP and DCLG), written evidence.

<sup>104</sup> CBI.

<sup>105</sup> B&Q; Q 530 (Professor John Philpott, Economist and labour market research analyst, former director of Employment Policy Institute and former Chief Economic Adviser at the CIPD), Q 688; Q 531.

<sup>106</sup> Central Government (Department for Work and Pensions) further, further supplementary evidence.

<sup>107</sup> Q 687; Central Government (DoH, DWP and DCLG), written evidence.

<sup>108</sup> Home Instead Senior Care; Central Government (Department of Health and Department for Work and Pensions), further supplementary written evidence.

<sup>109</sup> Q 517 (Dr Berry); Low Incomes Tax Reform Group (LITRG) and Tax Help for Older People; Older People's Commissioner for Wales; Vale Older People's Strategy Forum.

<sup>110</sup> TUC.

- The Government should communicate the benefits of people staying longer in the workforce. In particular, **the Government should publicly reject the ‘lump of labour fallacy’ that wrongly argues that more older people in work will disadvantage the young.** More older people in work will not mean fewer jobs for young people. A larger workforce, with more people in work and earning, creates its own demand; and we know that in practice the fallacy does not hold—previous attempts, both in the UK and abroad, to create jobs for young people by encouraging early labour market withdrawal have failed miserably. A 2008 report by the Institute for Fiscal Studies on early retirement and youth unemployment concluded “we find no evidence of long-term crowding-out of younger individuals from the labor market by older workers. The evidence, according to a variety of methods, points always in the direction of an absence of such a relationship”.<sup>111</sup> Permanent Secretary, Department for Communities and Local Government and Head of the Civil Service, Sir Bob Kerslake, confirmed to us that “It is absolutely clear that we will have to work longer”, but that while “the Government have faced up to that issue”, he was “not yet sure the country has faced up to that issue”.<sup>112</sup>
109. Extending working lives will be a vital part of the response to living longer. In addition, the country will still need to make important choices about public service delivery in order to ensure that the growing older population gets the public services that it will require. The following annexes outline these choices.

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<sup>111</sup> Institute for Fiscal Studies, *Releasing Jobs for the Young? Early Retirement and Youth Unemployment in the United Kingdom*, July 2008,.

<sup>112</sup> Q 639

## **ANNEX 6: WHY INDIVIDUALS, MARKETS AND GOVERNMENTS FAIL TO PREPARE ADEQUATELY FOR AGEING (RELEVANT THROUGHOUT THE REPORT)**

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110. In a world of perfectly informed consumers, well-functioning insurance markets, and far-sighted government, the growing number of older voters and consumers would get what they wanted (given a sustainable ‘dependency’ ratio). However, individuals can never know exactly how long they are going to live, and because people are naturally ill-disposed to thinking about getting older, part of people’s failure to prepare for older age derives from simple human nature. This is an inherent problem for policy-making: not every issue related to ageing can be solved through the provision of more information.

### **Individuals’ lack of preparedness for ageing**

111. Nevertheless, our population is far from perfectly informed about ageing. The Pensions Commission led by Lord Turner of Ecchinswell (the Turner Commission) found that people, on average, are unaware of or do not believe the projected increases in life expectancy, or even the best estimates of current life expectancy. In 2005, 30 to 39 year olds underestimated their own life expectancy by at least six years.<sup>113</sup> Ipsos MORI told us that “assumptions (based on little knowledge), a fear of the unknown, denial, and negative connotations of being a ‘pensioner’ mean that we put off our financial planning until we are forced to”.<sup>114</sup>
112. People tend to deny the likelihood that adverse life events or disability will affect them, and men are more likely to misjudge the risks associated with old age.<sup>115</sup> In particular, people are very unwilling to contemplate and provide for future disability or mental illness, even to the limited extent of adapting their houses to be suitable for older life.
113. Ipsos MORI found that generally, there is low awareness of, and there are common misconceptions about, who is responsible for looking after older people in need. The public often struggle to distinguish between social care services and health services provided by the NHS. Many assume that the state will provide for them in later life, meaning that people, particularly in younger age groups, generally give little thought to planning for their old age.<sup>116</sup> Furthermore, individuals often have a residual faith that their family will look after them in old age.<sup>117</sup> A presumption of substantial and growing levels of informal family care may not be realistic in a world in which the next generation of carers might need to remain in work, particularly in order to finance their own retirement (see Annex 5).<sup>118</sup>

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<sup>113</sup> *A New Pension Settlement for the Twenty-First Century. The Second Report of the Pensions Commission, 2005*, pages 90, 94.

<sup>114</sup> Ipsos MORI.

<sup>115</sup> Dr Joan Costa-Font, LSE.

<sup>116</sup> Ipsos MORI.

<sup>117</sup> Ipsos MORI. Dr Joan Costa-Font put the relative unpopularity of long-term care insurance schemes in Europe down to the fact that the provision of care for elderly dependants has traditionally been a family duty in most European countries.

<sup>118</sup> The Central Government’s (DoH, DWP and DCLG) written evidence related how the numbers of disabled older people receiving informal care are projected approximately to double over the next 20 years

114. People often do not act in their best interests. The Turner Commission identified procrastination, the power of inertia, poor understanding of risk and people's tendency to shy away from complexity as important factors in people's decisions on saving, or failure to save.<sup>119</sup>

### Market failures

115. Markets are failing to provide what is needed in the fields of long-term care insurance, pensions, and specialist housing for older people. The reasons for this market failure are related to the weaknesses in consumer knowledge and behaviour explored above. Although an insurer may know the likelihood that a person entering care today will stay for a certain length of time, such probabilities might change substantially over the period of an insurance contract, especially if the contract is entered into prudently early.<sup>120</sup> Medical progress might reduce the likelihood of people developing dementia, for example, but separate medical advances might increase the likelihood of an individual surviving disease but in a disabled state, with their care costs rising sharply as a result.<sup>121</sup> These factors make insurers very reluctant to offer long-term care products, with the result that markets for elderly people's healthcare insurance tend to be unaffordable. As of July 2011, no major financial services providers offered pre-funded insurance against social care costs.<sup>122</sup>
116. People suffer from a similar dearth of information when trying to decide which pension products they should take up. Pensions are associated with longevity risks (individuals do not know how many years they will need a pension for) as well as investment risks (individuals do not know how large their pension will grow). Many employers used to take on both of these types of risk when they promised a specified pension linked to an employee's final salary. But these risks eventually overwhelmed firms' capacity or willingness to provide such pensions (see Annex 8). Paul Johnson, Director, Institute for Fiscal Studies (IFS), explained: "We have moved from a world where the state, which is pretty good at bearing these kinds of risks ... was bearing most of the risk, through a period when employers were bearing most of the risk, to a situation for the current working generation where individuals are bearing most of the risk, and they are probably least well set up for bearing that risk".<sup>123</sup> As individuals become aware of the increased risk that is falling on their shoulders, this situation may not be politically or practically sustainable. The incomplete capacity of individuals to make good decisions for the long term, and of markets to cope with the uncertainties and risks of old age, is the fundamental reason why the Government have to take a

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if the probability of receiving this care remains constant. Professor Sarah Harper told us that children of parents needing support will often arrange for their own care to be substituted by others (Q 96). Dr Joan Costa-Font, *Family ties and the crowding out of long-term care insurance*, Oxford Review of Economic Policy 2010, Vol 26(4) pp. 691-712. Professor Sarah Harper told us that children of parents needing support will often arrange for their own care to be substituted by others (Q 96).

<sup>119</sup> *Pensions: Challenges and Choices – The First Report of the Pensions Commission*, 2004; Professor Nicholas Barr, London School of Economics and Political Science (LSE).

<sup>120</sup> Professor Nicholas Barr, LSE.

<sup>121</sup> Professor Nicholas Barr, LSE.

<sup>122</sup> *Fairer Care Funding – The Report of the Commission on Funding of Care and Support* (the Dilnot Commission), July 2011.

<sup>123</sup> Q 585



leading role in helping the country to adapt to and plan for its ageing population.

### Government progress

117. Successive governments have attempted to respond to the challenges posed by people living longer lives. Both the Turner Commission and the Commission on Funding of Care and Support (the Dilnot Commission) analysed some of the issues and presented ways forward.<sup>124</sup> Their proposals involved shifting more responsibility onto individuals and nudging or incentivising individuals to prepare financially for a longer life. Both reports showed what can be achieved by good analysis, impartially conducted, which engages public attention.<sup>125</sup> The Government have begun also to analyse problems related to the sustainability of services for older people at the local level.<sup>126</sup> However, neither the Turner Commission nor the Dilnot Commission recommendations have yet come to full fruition. Legislation based on the Turner Commission's pension plans was passed by Parliament in 2008, but is only just beginning to be implemented.
118. United Kingdom pension policy has adopted an unusual path.<sup>127</sup> Some countries, such as Australia or the Netherlands, either require employers to make pension contributions or make membership of occupational pensions virtually compulsory through collective bargaining.<sup>128</sup> The UK has never had a universal wage-related national pension scheme and the Government are currently proposing to incorporate the modest existing earnings-related state pension into a new single-tier flat rate pension (see Annex 8). The Government are not seeking to make membership of private schemes compulsory. Instead, they are working to incentivise individuals to join a regulated pattern of private schemes. In this regard, the UK's system is perhaps nearest to the one that has evolved in New Zealand.<sup>129</sup> With regard to social care, while other countries have introduced compulsory social insurance for long-term care, England's attempt to kick-start a private market in long-term care insurance, by the Government taking on the catastrophic risks associated with care (as recommended by the Dilnot Commission), will be highly innovative.<sup>130</sup> The UK with pensions, and England with long-term care, are following their own untried and as yet uncompleted paths to support an ageing population. While this does not mean that these paths are

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<sup>124</sup> *Pensions: Challenges and Choices – The First Report of the Pensions Commission*, 2004; *Fairer Care Funding – The Report of the Commission on Funding of Care and Support*, 2011.

<sup>125</sup> The Government have attempted continued engagement and communication with the public over pensions reform in particular, through TV, press and digital advertising and an *Automatic Enrolment and Pensions Language Guide*; Central Government (DoH, DWP and DCLG), written evidence.

<sup>126</sup> Sir Bob Kerslake, described in supplementary written evidence the community budgets initiative, which has involved civil servants being seconded to work with four pilot areas in order to help them develop new models for delivery of services that can improve services at lower costs.

<sup>127</sup> N. Barr and P. Diamond, *Reforming pensions: principles and policy choices*; *Pension: Challenges and Choices – The First Report of the Pensions Commission*, 2004 pp. 27–56.

<sup>128</sup> The Netherlands pension summary, website of the European Actuarial & Consultancy Services network (EURACS); 'Sweden', website of Pension Funds Online. Q 466, Q 472, Q 479, QQ 486–487, Q489, Q494 (Professor Noel Whiteside, Professor of Comparative Public Policy, University of Warwick). OECD, *Pensions at a Glance*, 2011.

<sup>129</sup> Q 486 (Professor Noel Whiteside); Professor Noel Whiteside, supplementary written evidence; Reform.

<sup>130</sup> Helga Riedel, *Private compulsory long-term care insurance in Germany*; Tony Sheldon, *Netherlands: long term care paid by compulsory insurance*, British Medical Journal.

misguided, these evolving strategies need to be kept under careful review to see if they are working. According to the European Commission's most recent set of projections on ageing pressures for member states, the additional spending pressure faced by the UK between 2010 and 2060 (3.3 per cent of GDP) will be slightly below the EU average (3.9 per cent of GDP); this is likely to be due at least partially to the measures already taken on state pensions by successive governments.<sup>131</sup>

### Government failure

119. In other ways, however, successive governments have failed to meet the challenges posed by an ageing population. The Committee heard how democratic governments are ill-equipped for long-term, joined-up thinking on this issue (see Annex 18). In particular, successive UK governments have struggled to deliver the necessary adaptations to long-standing public service delivery structures. As we explore in Annexes 12 and 13, long-embedded structural designs and divisions, such as the split between healthcare and social care, can become extremely difficult to change.
120. The incapacity of individuals and markets to be able to respond efficiently to an ageing future has been exacerbated by a coterminous failure by the state to adapt its institutions. The Government have begun to respond with the help of independent reviews like those conducted by the Turner and Dilnot Commissions, as well as through their own internal analyses and local experiments. But the Turner and Dilnot Commissions' recommendations are not yet fully implemented, and much wider public policy changes are also required (see Annexes 8 to 17). The whole mechanism through which the Government manage the process of adaptation to ageing needs to go much further and faster (see Annex 18).

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<sup>131</sup> OBR, *Fiscal sustainability report*, July 2012, p73.

## **ANNEX 7: FAIRNESS BETWEEN AND WITHIN GENERATIONS (SEE PARAGRAPHS 16 AND 17, AND 39 TO 43, OF THE REPORT)**

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### **What do people want?**

121. Older people expect a decent minimum income in later life, humane services that work together to meet their needs and to be enabled to live independently for as long as possible.<sup>132</sup> This happy position may best be achieved by a combination of state support and individuals making provision for their own future. For state support to be affordable, people must manage their own future—and the uncertainties and risks in that future—as far as possible, but some risks are best managed by the state. The balance struck between personalised provision and risk, and collectivised provision and risk, is a matter of political choice. It is a deal, or social contract, made between the state and the individual, and within and between generations.
122. The social contract in the UK—the welfare state—has depended on people in earlier adult life on average paying in, and people in later life on average drawing out.<sup>133</sup> The younger support the older, and expect to be supported in their turn when they become old. But with an ageing population, there are likely to be large increases in spending on services which are particularly important to older people, especially pensions, healthcare and social care.<sup>134</sup> The ‘deal’ between generations will change.
123. This change is not bad or something to be resisted; over time, a increasingly affluent society (as on the whole the UK is, in terms of long-term GDP growth) is likely to want to continue spending some of that wealth on improving the lives of its citizens, and an older society is likely to want to spend more on the priorities of older people. Welfare and wellbeing will be enhanced as a result.
124. However, these increases will have to be financed. This could be achieved through higher taxes or social insurance contributions, through cuts in services for younger people, or through more direct payment by individuals. What matters more than the balance between these sources of funding is a) the efficiency of the payment mechanism, and b) who pays when. If some generations paid more in to the system throughout life than they got out, while other generations drew more out of the system throughout the different phases of life than they paid in, this would be fundamentally unfair and therefore unstable.<sup>135</sup>
125. **As society ages and demands more spending on the elderly, our society must avoid unfairly shunting the costs on to future generations. So it is important to ensure that those who are benefitting from longer lives pick up at least part of the tab.**<sup>136</sup>

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<sup>132</sup> Q 170; WISE, supplementary written evidence; Care & Repair Cymru.

<sup>133</sup> Each succeeding generation since the 1920s has roughly self-funded the services it has gained from the state. Q 547 (Professor John Hills, LSE).

<sup>134</sup> Q 547

<sup>135</sup> Q 135 (Dr Martin Weale).

<sup>136</sup> Q 135 (Dr Weale).



### The need for a new deal

126. The deal laid out by the Beveridge Report in 1942 of “an insurance benefit adequate to all normal needs” in return for a lifetime of contributions, was never fully delivered.<sup>137</sup> The Government abandoned any attempt to provide a universal subsistence pension in the 1950s as too expensive a goal.<sup>138</sup> Pensions policy has been a major political battleground ever since: the resulting extremely complex system was described by the Turner Commission as “not fit for purpose”.<sup>139</sup> Nor was Beveridge’s proposed social contract ever complete: it did not include any right to state-provided long-term care, for example, while it did include state-provided healthcare. The deal proposed by Beveridge had wide appeal and was widely understood, but is now outdated.
127. The Turner Commission pointed out that the proportion of adult male life spent in retirement had grown steadily since the Second World War, from 18.0% in 1950 to an estimated 30.7% in 2005, with the proportion of adult female life spent in retirement rising from 26.1% in 1950 to an estimated 36.9% in 2000 and 36.4% in 2005.<sup>140</sup> The Commission argued that it would not be possible continuously to extend the proportion of adult life spent in retirement without either increasing taxes and savings or reducing the scale of pensions.<sup>141</sup> It proposed that the proportions of an average adult life spent in work and in receipt of state pensions should be stabilised. In return, the state would develop a more secure basis for retirement and nudge individuals to join pension schemes, while requiring more of their employers. But the implementation of this revised deal is not yet complete, and it covers only a portion of the needs of an ageing society. The implementation of the recommendations of the Dilnot Commission will clarify what help individuals can expect from the state in social care, but there is clearly further to go before it is clear what the social contract will look like for our older society.

### The need for a clear deal

128. Clarity is crucial. People find it difficult to take decisions about planning for later life, at least partly due to ignorance: as discussed in Annex 6, people have a poor understanding of the length of life, of the opportunities of later life, and of what the state will provide for them in retirement.<sup>142</sup> Because they assume that the state will provide for them in older age, younger people do little to plan ahead.<sup>143</sup> But in important ways, for example on the provision of free social care, this is a mistaken assumption and the sooner the public is disabused of this misconception, the more action people are likely to take to protect their future living standards.<sup>144</sup> The higher the level of public understanding of ageing and of what individuals can and cannot expect from

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<sup>137</sup> *Social Insurance and Allied Services*, Cmd 6404, paragraph 29, 1942.

<sup>138</sup> *Report of the Committee on the Economic and Financial Problems of Old Age*, Cmd 9333, 1954.

<sup>139</sup> *A New Pension Settlement for the Twenty-First Century – The Second Report of the Pensions Commission*, 2005.

<sup>140</sup> *Op.cit.* figure 1.44.

<sup>141</sup> *Op.cit.* p.12.

<sup>142</sup> *A New Pension Settlement for the Twenty-First Century – The Second Report of the Pensions Commission*, 2005, pp 90, 94; Ipsos MORI; Ipsos MORI.

<sup>143</sup> Ipsos MORI.

<sup>144</sup> Ipsos MORI.

the state, the more people will be in a position to plan their futures. Public debate and clarity on why changes to the deal may be necessary will also be essential when any such changes are made—if a government tries to make alterations to the criteria for receipt of benefits which are currently age-related, for example, without explaining why changes are necessary, opposition will be inevitable.

129. The state needs to make clear what its role will be, and the roles of individuals, families, communities and employers. This vision or contract needs to be well-understood and stable, so that younger generations can plan for later life.<sup>145</sup>

130. To prepare for a longer life span, people need:

- The state to be clear on what role it will play in individuals' pension and financial arrangements in older age, by giving some stability on or a clear rationale for:
  - The age at which they will receive the full state pension, and what they will get
  - How their savings and pensions will be taxed
  - How their assets will relate to their eligibility for state-funded social care
- Adequate warning of rises in state pension age and of other changes<sup>146</sup>
- Some predictability about their retirement income, achieved through careful regulation of private and occupational pension schemes, independent advice, incentives and 'nudges' to save (see Annex 8). A minimum state pension will not be enough for most people, as they will not wish to retire at a much lower standard of living than that to which they have been accustomed, but people need to be supported to save
- A good understanding of what payments and non-financial benefits they will be receiving from the welfare state in later life, including healthcare, social care, housing and other services such as free bus passes.

131. Complete predictability is not possible, but the more people understand what they can expect from the state in later life, the more they will be able to plan.

### **A fair deal between generations**

132. If a new deal is to be lasting, it will need to be seen to be fair. As the country gets richer, older generations should see some of the gains, but younger generations should not bear an unfair tax burden to pay for improving lifestyles among the retired.

133. Younger generations will, on average, benefit from being part of a richer society in many ways in the long term, but more is also being expected of younger generations than in recent decades. Younger generations will be expected to work for longer than previous generations, often to accrue much less generous pension rights (see Annex 8).<sup>147</sup> Professor James Sefton, Professor of Economics, Imperial College London, told us that there are “a

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<sup>145</sup> The Saga Group.

<sup>146</sup> Q 464, Q 474, Q 489

<sup>147</sup> Q 545 (Professor John Hills)

lot of transfers going on” from the young towards the old, and cited the transferral to future generations of the cost of rising Government debt due to bailing out banks to save the claims in pension funds, high rates of youth unemployment, and the transfer of more of the costs of higher education from the public purse to private payers.<sup>148</sup> The counter-argument is that current pensioners have suffered the impact of quantitative easing on their savings and annuities, while far fewer benefited from university education.<sup>149</sup>

134. The cost of fiscal retrenchment has often affected the young disproportionately.<sup>150</sup> Professor John Hills, London School of Economics and Political Science (LSE), cited the protection of the health service, state pensions, council tax benefit for pensioners, winter fuel payments, and free TV licences, and contrasted these with changes to working-age benefits, the education maintenance allowance, youth provision and child benefit.<sup>151</sup> We heard that the resulting spending balance may be less than efficient: Kayte Lawton told us that Nordic countries invest more in education, training, labour market programmes and childcare and that their spending is much more focused on long-term strategic priorities. She considered that “They have a sense that public spending should be there to drive jobs and growth, not just to respond to, ‘We’re getting older and richer, so we want better pensions and healthcare’.”<sup>152</sup> Andrew Harrop asked whether it was sensible that “we have privileged welfare and public service receipt in old age and have not safeguarded some very sensible examples of public spending on younger age groups”.<sup>153</sup>
135. Better informed public debate about intergenerational distribution and transfers is needed. Dr Weale wanted fewer Budget-day tallies of winners and losers, supplanted by the question “How does it affect different people over their likely remaining lifetime?”<sup>154</sup> Kayte Lawton was concerned that poor public debate led to bad choices, pointing out that it was easy to cut back on long-term investments for which there was not constant political pressure.<sup>155</sup> We believe that the Government and political parties need to make it clearer to the public what impact their policies will have on the balance of fairness between generations and over time (see Annex 18).
136. Professor Sefton singled out increasing property prices as a “huge transfer” from younger generations towards older generations.<sup>156</sup> The property boom has led to wealth being transferred to older, better-off homeowners. Many older property owners have seen large, tax-free capital gains over the past few decades due to the rising value of property. The house price boom has “masked what might have been expected to be the life cycle pattern of wealth accumulation followed by decumulation”. The median value of household

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<sup>148</sup> Q 135

<sup>149</sup> Professor Pat Thane, KCL. ‘Private transfers’ of funds from older generations to younger generations within families are also considerable; Q 547 (Professor Sara Arber, University of Surrey); Q 544. Q 135 (Professor Sefton).

<sup>150</sup> Q 547 (Professor Hills)

<sup>151</sup> Q 547 (Professor Hills)

<sup>152</sup> Q 137 (Kayte Lawton)

<sup>153</sup> Q 547 (Andrew Harrop); Q 547 (Professor Peter Goldblatt, University College London (UCL)).

<sup>154</sup> Q 137

<sup>155</sup> Q 137

<sup>156</sup> Q 135 (Professor Sefton). Q 135 (Dr Weale).

wealth in Great Britain, where the age of the head of household was initially 45–54, rose from £73,000 to £190,000 between 1995 and 2005 (2005 prices).<sup>157</sup>

137. This increase in wealth has benefited a large section of the population but not the poorest. It came about partly because of prudence and foresight exercised by many households, but also because of the tax-subsidised nature of owner-occupation, and good fortune (today's older people reaching property-buying age at an economically propitious time).<sup>158</sup> It therefore would be unfair to expect younger generations who have not enjoyed such gains (and who are obliged to pay higher rents and mortgages as a consequence) to pay more for the increased costs of an older society if asset-rich older people were entirely protected from those costs. (The case for protecting people from catastrophic costs arising from need for social care, as recommended by the Dilnot Commission, is discussed in paragraphs 25 and 25 of the Report.)
138. While understanding people's emotional attachments to their homes, these properties are part of their economic framework and represent investments as well as homes. **It is reasonable to expect those who have benefited from the property boom to support their own longer lives. We suggest that one way to address the current imbalance would be for more older people to consider unlocking housing wealth. Equity release could enable more people to use their assets to help pay for the cost of their social care (see Annex 11), to adapt their homes (see Annex 16), and to support their incomes. While equity release might impact on the inheritance of the children of wealthier parents and on people in areas where house values have increased most, older age still needs to be paid for. The Committee considers that it is right for those who have benefited from windfall gains to contribute to the costs of their longer lives through equity release, rather than for the full costs to be pushed to future generations.**
139. Some equity release schemes exist, but they are little used.<sup>159</sup> There are schemes that enable people to live in their own homes (many older, frail people do not want to move) but release money to pay for their needs in later life rather than passing the whole value on to their children (who will still benefit from any increase in house prices). People over state pension age in 2009 owned roughly £250 billion in home equity that was available to be released, and this figure could rise by 40% by 2030, in 2009 values and earnings levels, as the number of owner-occupiers in this age group rises.<sup>160</sup>
140. As James Richardson, Director, Fiscal and Deputy Chief Economic Adviser, Fiscal Group, HM Treasury told us, the equity release market suffers from

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<sup>157</sup> Francesca Bastagli and John Hills, *Wealth accumulation in Great Britain 1995-2005: The role of house prices and the life cycle*, CASEpaper166, London School of Economics, December 2012. If house prices had remained at 1995 real levels, mean wealth would have grown much less, and there would have been a much clearer life cycle pattern, with age groups initially aged 55-64 having unchanged real wealth, and older groups lower wealth in 2005 than they had in 1995.

<sup>158</sup> *Op.cit.*

<sup>159</sup> Care & Repair England; Q 60.

<sup>160</sup> Equity Release Council. Pensions Policy Institute, *Retirement income and assets: outlook for the future*, February 2010, p 45. These estimates were based on the fact that not all housing wealth is available to be released as equity. The estimates assumed that people are allowed to release equity up to the limits then allowed in lifetime mortgage products.

“quite considerable” market failures.<sup>161</sup> We have heard that older people lack confidence in the products that are available and that as a result commercial products have poor take-up. This has knock-on effects for both the market in suitable housing for older people, and older people’s ability to adapt their homes for older age (see Annex 16). The result is that those older people who wish to use their housing wealth to pay for care in older age face difficulties in doing so. Richard Humphries, Senior Fellow, Social Care and Local Government, The King’s Fund considered that “It is absurd really that even if you have got the money to pay for your own care, it is actually quite hard to do it.”<sup>162</sup>

141. We heard about ways in which these market failures could be addressed. Care & Repair England proposed that state support for social lending, possibly coupled with some grant help, could represent an important measure to ensure that equity release options become viable. This would need to be coupled with the strengthening of independent financial information and advice, they argued.<sup>163</sup> Gary Day, Executive Director for Land and Planning, McCarthy & Stone, told us that more communication is required: “We need to start talking about the positive beneficial implications of using equity in retirement planning” because “we are going to have to find something other than conventional pensions”.<sup>164</sup>
142. Paul Broadhead, Head of Mortgage Policy, the Building Societies Association, recommended the work of the Equity Release Council, which aims to lay down standards for equity release providers. He told us that subscribers to the Equity Release Council need to give a “no negative equity guarantee” to borrowers. This means that if people decide to release equity, they will not owe more than the amount that they have released even if their property value falls.<sup>165</sup>
143. **Because there is an urgent need for greater consumer confidence in the equity release industry, we propose that the Government should work with the financial services industry to encourage the growth of a safe and easy-to-understand equity release market.** The Government could put more emphasis on communicating the importance of equity release for paying for later life; they could promote reliable equity release products that offer ‘no negative equity guarantees’ and companies that have signed up to the Equity Release Council’s Code of Conduct.<sup>166</sup> The Government are taking action to improve access to Deferred Payment Agreements offered by local authorities to enable people to fund their social care needs.<sup>167</sup>
144. **It does not seem fair to expect younger taxpayers to pay more for the ageing society while asset-rich older people are protected.**<sup>168</sup> It could be argued that older people are undertaxed relative to their ability to pay and incomes, and they have often benefited from the boom in property prices.<sup>169</sup>

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<sup>161</sup> Q 60

<sup>162</sup> Q 493; Care & Repair England; Q 497.

<sup>163</sup> Care & Repair England.

<sup>164</sup> Q 212

<sup>165</sup> Q 500

<sup>166</sup> McCarthy & Stone; Equity Release Council.

<sup>167</sup> Sir Bob Kerslake, supplementary written evidence.

<sup>168</sup> Q 547 (Andrew Harrop).

<sup>169</sup> Q 547 (Andrew Harrop).



**We consider that the older generations now enjoying increased life expectancies should make a fair contribution to paying for the costs that come with longer lives.** As discussed above (see Annex 5), we expect part of the solution to come from people choosing to work for longer into their later lives; enabling older people to unlock their accumulated housing wealth in order to pay for their own costs will also be very important.

### **A fair deal between genders**

145. The deal underpinning the welfare state needs to take account of the differing common experiences of women and men in later life. Professor Sara Arber, University of Surrey, described some critical differences:

- The higher proportion of women whose continuity of work and rate of pay have suffered due to caregiving for children and older people<sup>170</sup>, leading to inequalities in pensions and income;<sup>171</sup>
- That nearly half of women over 65 are widowed, and over 80% of women over 85 are widowed, whereas a minority of men are widowed (about half of men are still married over 85). This has a major impact on caregiving and support. It also means that a higher proportion of older women live alone (nearly half of women over 65) and may need care from outside the household. The number of divorced older people has also risen, and older divorced women “are particularly disadvantaged because they do not have shared pensions”;<sup>172</sup>
- That older women have higher levels of disability, functional impairment and musculoskeletal problems than men.<sup>173</sup>

146. Some of these differences are due to the fact that women tend to live longer than men. This means that in discussing older people, “we are primarily talking about older women”: over the age of 85, there are about two and a half times more women than men; over 90, there are more than three times as many women. When the care needs of the oldest old are considered, the demographics mean that they are dominated by older women who are living alone and may be widowed or vulnerable.<sup>174</sup>

147. **As women’s and men’s experiences of older age are still, on average, different, it will be important to take into account the divergence in the situation of women and men in older age.**

### **A fair deal within generations**

148. Older people live markedly different lives, even taking account of gender. Health inequalities between older people are considerable, partly stemming from “lifestyle, diet, smoking, drinking ... [and] working conditions in the middle of people’s working lives and the long-term effects of job strain”.<sup>175</sup>

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<sup>170</sup> And grandchildren – Q 545.

<sup>171</sup> Professor Noel Whiteside, University of Warwick.

<sup>172</sup> Q 538 (Andrew Harrop); Q 538 (Professor Goldblatt)

<sup>173</sup> Q 538 and Q 539 (Professor Arber). At Q 538 see also Andrew Harrop. Q 541.

<sup>174</sup> Q 538 (Professor Arber).

<sup>175</sup> Q 540 (Professor Hills).



149. More important, though, is the relationship between wealth and health.<sup>176</sup> Professor Hills told us that “a single predictor of mortality rates for people aged over 50 is their wealth level. Obviously, that is capturing a lot of things that have happened earlier in people’s lives, which are linked to both health and wealth, but if you want to know one thing, wealth in itself tells you a lot about where people are heading, unfortunately. There are very considerable differences in mortality rates.”<sup>177</sup>
150. Poorer people arrive in older age “lacking wealth, in particular, but also with poorer pensions and having accumulated health disadvantage throughout their lives”, and “poorer people live shorter lives and spend more of those short lives with an illness or disability”, with those who arrive at pensionable age more likely already to have an illness or disability.<sup>178</sup> In addition, the process of developing ill health in older age can lead to both social impoverishment in terms of isolation and resource impoverishment due to care costs. The grim message is that “overall, it is the accumulation of health and social disadvantage during the life course that will make a premature death and the earlier development of illnesses more likely”.<sup>179</sup>
151. If you are working class, you are more likely to suffer from ill health but less likely to have the resources to support you through that ill health.<sup>180</sup> You are also more likely to need social care as “the requirement for social care is socially graded”, and the means test applied to determine receipt of free social care “is then inequitable because it always excludes some groups who are disadvantaged” but who are not quite as disadvantaged as those who meet the means test and receive the free care.<sup>181</sup> Meanwhile, richer individuals can pay for good care and live-in carers.<sup>182</sup>
152. Income differences at older ages are much affected by pension rights, but also by “the extent to which the state has assisted through usually generous tax reliefs in the accumulation of those pension rights”.<sup>183</sup> Professor Hills suggested that there was a contrast between professionals who were likely to have taken financial advice and built up tax-privileged pension rights, invested in an effectively tax-free house and so on, and to have passed money to their children tax-free, and people on lower incomes, who may not have been members of pension schemes, who may have saved in accounts with a very low return, and who are “hit by capital limits on the housing benefit and pension credit they are entitled to and spending on the contribution they are expected to make towards care”. He concluded, “by and large, the better off you are in your working life, the more the state is likely to have done.”<sup>184</sup>
153. Wealth in later life is also affected by other factors, such as the care costs of close relatives and inheritance.<sup>185</sup> Professor Arber emphasised the role of transfers from older to younger generations: richer parents could help their

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<sup>176</sup> Q 544

<sup>177</sup> Q 544

<sup>178</sup> Q 540 (Professor Goldblatt).

<sup>179</sup> Q 540 (Professor Goldblatt).

<sup>180</sup> Q 541 (Professor Arber).

<sup>181</sup> Q 548 (Professor Goldblatt).

<sup>182</sup> Q 550 (Professor Arber).

<sup>183</sup> Q 544

<sup>184</sup> Q 546, Q 544

<sup>185</sup> Q 544

children to avoid student debt, to get onto the property ladder, to avoid housing costs by living in the family home for longer, and with childcare. She concluded that “When we are talking about the younger generation being disadvantaged, it is because their parents do not have the financial resources to support them.”<sup>186</sup>

154. Geographical differences also have a significant impact on the health and wealth of older people. Professor Peter Goldblatt, UCL, told us that, according to neighbourhood affluence, there was “a seven-year difference in life expectancy and a 17-year difference in healthy life expectancy, meaning that people in poorer neighbourhoods are living much shorter lives, in poorer health”.<sup>187</sup> Rurality can also have an impact, especially on social isolation.<sup>188</sup> We also heard that while in Wales, life expectancy and proportion of life spent in good health is increasing, of the UK nations Wales has the lowest healthy life expectancy, the highest levels of deprivation, and the highest incidence rate of chronic disease.<sup>189</sup>
155. Professor Goldblatt highlighted that in poorer neighbourhoods, demand on public services is greater than in middle or high-income areas.<sup>190</sup> The migration of healthy older people to the south coast distorted demands for services, because “the middle-class, healthier old people on the south coast are very demanding”, resulting in resources being shifted there from poorer areas through the latest changes in resource allocation, creating a new or widening inequity.<sup>191</sup> Professor Hills also highlighted the geographical distribution of the reduction in local authority support: “The areas that appear to be losing most are the ones where the older population probably has the least resources to cope.”<sup>192</sup> The Government should ensure they pay sufficient attention to this issue and that the grant distribution formula sufficiently reflects levels of need.
156. Affluent areas tend to have the greatest proportion of people who volunteer.<sup>193</sup> Professor Arber suggested this might be because volunteers needed health capital, resources and energy. She was concerned that “the increasing emphasis on volunteers stepping in for everything may actually exacerbate the inequalities between areas, unless we use other mechanisms to foster volunteering in areas which, hitherto, have not had high levels of volunteering”.<sup>194</sup>
157. Whether people benefited from the property boom has created substantial differences, varying across the country but also within age groups.<sup>195</sup> Andrew Harrop saw the cost of housing as crucial to intergenerational inequalities:

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<sup>186</sup> Q 547

<sup>187</sup> Q 540 and Q 551

<sup>188</sup> Q 507 (Nick Leon, Head of Service Design, Royal College of Art and Dr Lynne Mitchell, WISE (Wellbeing in Sustainable Environments), University of Warwick); Care & Repair Cymru; Derek Jones, Permanent Secretary, Welsh Government; Welsh Local Government Association (LGA); University of the Third Age supplementary written evidence; Alliance Boots; Q 503.

<sup>189</sup> Derek Jones, Welsh Government.

<sup>190</sup> Q 551

<sup>191</sup> Q 551

<sup>192</sup> Q 552

<sup>193</sup> Q 415 (Steve Smith, Public Affairs and Manager for England, WRVS).

<sup>194</sup> Q 543

<sup>195</sup> Q 544; Q 540 (Professor Goldblatt).

“That drives all the inequalities between different generations, different classes, north and south, homeowners and landlords.”<sup>196</sup>

158. Other factors were also important in separating the experiences of different older people, including ethnicity,<sup>197</sup> mental health,<sup>198</sup> and social networks<sup>199</sup> such as employment networks.<sup>200</sup>
159. As policies towards older people are adjusted, it will be crucial that the diversity of older people is considered and inequalities are reduced. However, inequalities between older people may actually be widening. While we were told that income inequalities in older age are not increasing,<sup>201</sup> wealth disparities are increasing, due to higher saving rates for richer groups, house prices and other equity bubbles.<sup>202</sup> **We urge the Government to consider issues of inequality fully and directly as they develop public policy for our welfare state and services for the future.**

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<sup>196</sup> Q 547

<sup>197</sup> Q 538 (Professor Arber).

<sup>198</sup> Q 540 (Professor Goldblatt).

<sup>199</sup> Q 542 (Professor Goldblatt); Q 63; Q 79; Q 538; Q 541 (Andrew Harrop).

<sup>200</sup> Q 542

<sup>201</sup> Q 546

<sup>202</sup> Q 546 and Q 541 (Andrew Harrop).

## ANNEX 8: PENSIONS AND SAVINGS (SEE PARAGRAPHS 8 AND 12 TO 15 OF THE REPORT)

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### Reforming pensions and savings

160. The resources that older people use to sustain themselves after they cease earning come from the state (about half)<sup>203</sup>, individuals' savings (largely in private pensions), and other income. As the average lifespan has grown, the proportion of life spent in retirement has grown with it.<sup>204</sup> But in future it will not be realistic or desirable to expect the state—and younger taxpayers in particular—to pay for this (see Annex 7). We agree with the Turner Commission) that people will need to choose whether to work for longer, save more, or have a lower income in retirement.<sup>205</sup> They will need to make informed decisions to do so.
161. Our society will have to make difficult decisions about pensions and savings. There is already a major problem with individuals not saving enough for retirement, which demographic change will exacerbate.<sup>206</sup> Indeed, recent research suggests that UK residents are the “worst in the world” at saving for retirement.<sup>207</sup> Longer lives mean that many people are at risk of having insufficient income to pay for older age. Many people underestimate how long they will live and misunderstand what they will have to pay for, and so do not feel motivated to save (see Annex 6).<sup>208</sup> Where people do appreciate the need to save for later life, they are often bewildered by the complexity of the products available.<sup>209</sup>
162. The Government might consider developing a resource that will help people understand how much they need to save for older age, and the risks and benefits associated with investing in pensions and other savings vehicles. We were informed that in Finland a central Pensions Institute provides government and individuals with regular comprehensive information about pension trends and likely pension benefits; the US Department of Labor provides a ‘Top 10 Ways to Prepare for Retirement’ webpage.<sup>210</sup>
163. The Government are moving to incorporate the existing earnings-related state pension scheme into the new single-tier pension and are not seeking to make membership of private schemes compulsory. Instead, they plan to incentivise individuals to join a regulated pattern of private schemes. **We welcome the progress in pension reform that the Government have made, but consider that without urgent additional action to encourage saving more for retirement, demographic change will**

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<sup>203</sup> *Pensions: Challenges and Choices – The First Report of the Pensions Commission*, 2004, figure 4.1.

<sup>204</sup> *A New Pension Settlement for the Twenty-First Century: The Second Report of the Pensions Commission*, November 2005, p.96.

<sup>205</sup> *A New Pension Settlement for the Twenty-First Century: The Second Report of the Pensions Commission*, November 2005.

<sup>206</sup> Central Government (DoH, DWP and DCLG), written evidence: “current estimates suggest that 11 million people are not saving enough into a pension to meet their expectations of pension income in retirement”.

<sup>207</sup> HSBC, *The Future of Retirement: A new reality*, 2013.

<sup>208</sup> Ipsos MORI. See also Dr Joan Costa-Font, LSE; Q 592; Home Instead Senior Care.

<sup>209</sup> Dr Joan Costa-Font, LSE.

<sup>210</sup> [www.dol.gov/ebsa/publications/10\\_ways\\_to\\_prepare.html](http://www.dol.gov/ebsa/publications/10_ways_to_prepare.html).

**cause significant problems for many people's level of income in later life.**<sup>211</sup> According to OBR projections cited by the Confederation of British Industry (CBI), pensions expenditure will rise from 5.7% of GDP in 2011–12 to 8.2% of GDP in 2060–61.<sup>212</sup>

### Pension problems

164. Our pensions system is beset by major problems, many of which were identified by the Turner Commission<sup>213</sup>:

- Defined contribution (DC) pensions now dominate private pension provision. Since the Commission reported, the proportion of people with defined benefit (DB) pension schemes has continued to fall, and “by and large the private sector has become a DB desert”.<sup>214</sup> Recent figures from the National Association of Pension Funds (NAPF) announced that 13% of final salary pensions were open to new joiners in 2012, a drop of a third from 2011, and the steepest fall since comparable data began in 2005, when 43% were open.<sup>215</sup> **While the defined benefit pensions system has proved to be unsustainable, we consider that for many savers defined contribution pensions are seriously inadequate.** They shift longevity and investment risks from employers to employees, who are the least able to bear those risks (see Annex 6).<sup>216</sup> The link between the sacrifices that a person makes in order to put money into a pension scheme, and the rewards from their saving that they can look forward to receiving when they retire, effectively has been broken.<sup>217</sup> Savers cannot know the scale of pension that they might end up with in a DC plan, and many employees are ill-equipped to understand or bear the risks that accompany this uncertainty.<sup>218</sup> When even a sizeable pension pot might buy only a small pension, it is less likely that people will feel that it is worth the sacrifice to pay into it. The big shift to DC pensions therefore carries risks and uncertainties largely unappreciated by the public, and sharply differentiates those who are able to look forward to the outputs of DB schemes from those who are not.
- Although our society has done better than some other countries at providing a safety net to keep older people out of poverty, the uncertainty over future pension income from DC schemes means that many of those on middle and lower incomes have uncertain or inadequate incentives to save.<sup>219</sup> For these and other reasons, the Government have estimated that

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<sup>211</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>212</sup> CBI.

<sup>213</sup> *A New Pension Settlement for the Twenty-First Century: The Second Report of the Pensions Commission*, November 2005.

<sup>214</sup> *A New Pension Settlement for the Twenty-First Century: The Second Report of the Pensions Commission*, November 2005, p.122; Q 603 (Rt Hon Lord Warner, Commissioner, Commission on Funding of Care and Support, Dilnot Commission).

<sup>215</sup> NAPF, *Final salary pensions shut at record rate in private sector*, 28 January 2013.

<sup>216</sup> Age UK.

<sup>217</sup> Q 585

<sup>218</sup> Q 465; Q 466 (Dr Ros Altmann).

<sup>219</sup> OECD, *Pensions at a glance 2011: retirement-income systems in OECD and G20 Countries*, 2011, p.149; Q 465; Q 471; QQ 482–483 (Dr Altmann); QQ 466–467 (Joanne Segars, Chief Executive, National Association of Pension Funds (NAPF)).

10.7 million people in Great Britain (excluding Northern Ireland) can expect inadequate retirement incomes.<sup>220</sup>

- People who are still in DB schemes (mostly public sector workers), and high earners who can use savings vehicles for defined contribution schemes, are likely to be reasonably well-served by the current system.<sup>221</sup> But while public sector DB pensions offer certainty to savers, they shunt substantial costs to later taxpayers.<sup>222</sup> It is likely that both public and private sector DB pensions in the future will pay out less than they have in the past.<sup>223</sup>
- The current pensions framework also creates gender-based disadvantages. Women who have fluctuating work records due to maternity and childcare responsibilities, and those who have periods as carers of children or elderly people (of which a disproportionate amount are women) stand to do worse than men in the new defined contribution world. In particular, women face disadvantages in the annuities market.<sup>224</sup>

165. The result of this framework and the incentives that it engrains is that replacement rates in older age—the percentage of a worker’s pre-retirement income that is paid out by a pension programme upon retirement—are lower in the UK than in most other advanced economies.<sup>225</sup>

### Policy responses

166. For many years the basic state pension was allowed to fall in relation to median incomes, though topped up for a while by the state second pension. Then DB schemes went into decline and, as the Turner Commission pointed out, most people had to rely on means-tested state support in retirement.<sup>226</sup> The Commission’s report stimulated a period of reform under different governments, with cross-party support. Later retirement, the first part of the implicit bargain that the Commission proposed, is now being implemented.<sup>227</sup> **The Government are taking positive steps in pension reform, and when complete, the current reforms to the pensions system will represent progress, which the Committee welcomes.** State pensions will be linked to earnings (at a minimum), preventing further erosion; the National Employment Savings Trust (NEST) and auto-enrolment have now been established, extending private pension coverage to many who were not covered previously; and the single-tier state pension, which will rationalise state provision and make it more generous for those with intermittent employment histories, is under consultation.<sup>228</sup>

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<sup>220</sup> Department for Work and Pensions (DWP), *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

<sup>221</sup> See Andrew Warwick-Thompson, *High earners new models*, Pensions World, March 2010.

<sup>222</sup> Q 602 (Paul Johnson).

<sup>223</sup> Q 545

<sup>224</sup> Professor Noel Whiteside, University of Warwick.

<sup>225</sup> Department for Work and Pensions, *Older people and employment*.

<sup>226</sup> IFS briefing note 105, *The history of state pensions in the UK from 1948 to 2010*, A Bozio, R Crawford and G. Tetlow, Institute for Fiscal Studies, 2010, figure 7.1. *Pensions: Challenges and Choices – The First Report of the Pensions Commission*, 2004, figure 4.1.

<sup>227</sup> Department for Work and Pensions, *Older people and employment*.

<sup>228</sup> Central Government (DoH, DWP and DCLG), written evidence.



167. With auto-enrolment, the Government are attempting to incentivise people to take out DC pensions by requiring employers to offer and automatically enrol employees in a scheme, to which the Government then contributes. NEST provides a default for employees if they decide not to save with one of the other schemes on offer. The flat-rate state pension seeks to replace means-testing for certain state pension entitlements with a single state pension for all recipients.<sup>229</sup> Joanne Segars, Chief Executive of the National Association of Pension Funds (NAPF), told us that this reform would give people “a very clear indication of how much they will get and how much they need to save on top of that. Importantly, it means their private savings will not be means tested away, which currently does act as a disincentive”.<sup>230</sup>
168. The Government also intend to introduce cost-stabilisers for public sector DB pensions<sup>231</sup>, and have begun to reform rules on the requirement to annuitise pensions.<sup>232</sup> This means that the state will now have more understanding of the risk to which taxpayers are exposed in paying for public sector pensions, and DC pension investors will have a better understanding of their final settlement.
169. But further action will be required. The most recent pensions White Paper departed from the Turner Commission recommendations in laying out how the new full state pension age would not be linked automatically to increases in life expectancy: the Government told us that this is because the rate at which life expectancy is increasing has accelerated.<sup>233</sup> **We consider that, due to rising healthy life expectancy, it will only be a matter of time before the Government will have to revisit this decision.**
170. Moreover, it is not yet clear whether auto-enrolment will ensure pension coverage for employees who currently do not have pensions. The likely take-up and drop-out rates under this scheme are uncertain.<sup>234</sup> Even if take-up is high, it does not follow that the resulting pension income will be sufficient for all participants.<sup>235</sup> We consider that although it would be a major advance if those paying into pension schemes (employers, employees and tax relief) eventually contribute 8% of earnings into auto-enrolment schemes, as the Government have proposed, this will not represent enough for a decent pension income, even on top of the Government’s newly suggested flat-rate pension.<sup>236</sup> Since the Turner Commission recommended a combined default contribution rate of 8%, life expectancy has risen and is very likely to rise further (see Annex 2). Moreover, returns on savings and annuities have

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<sup>229</sup> DWP White Paper: *The single-tier pension: a simple foundation for saving*, January 2012

<sup>230</sup> Q 468

<sup>231</sup> Public Service Pensions Bill, introduced 13 September 2012.

<sup>232</sup> The Government announced in their June 2010 Budget that the requirement to purchase an annuity by age 75 would end from April 2011.

<sup>233</sup> DWP, *The single-tier pension: a simple foundation for saving*, Cm 8528, January 2013, p.66; Central Government (DoH, DWP and DCLG), written evidence.

<sup>234</sup> Q 466 (Professor Whiteside); Q 472 (Joanne Segars); Central Government (DoH, DWP and DCLG), written evidence.

<sup>235</sup> Q 464 (Joanne Segars); Q465 (Dr Altmann).

<sup>236</sup> Q 685: Steve Webb MP, Minister of State for Pensions, outlined how auto-enrolment should mean a minimum 8% savings rate for employees paying into their pensions, “The minimum contribution for the employee will end up at 4 per cent, but it turns into 8 per cent overnight with the mandatory employer contribution plus tax relief ... I accept that 8 per cent is volatile and unpredictable and you do not know what pension it will buy you, but you have a damn good start if your four has become eight”.

fallen. Well-managed defined benefit schemes that offer half pay or better on retirement usually require much higher rates of contribution (on average, 20% to 25%), whereas DC contribution rates tend to be, on average, between 5% and 15%.<sup>237</sup> People may also need to assume that they will have some periods of interrupted earnings with no or low pension contributions because of caring responsibilities and uncertainty in the job market. In the not too distant future, therefore, the 8% default rate will need to be reassessed. Though Joanne Segars welcomed auto-enrolment because it will give six to nine million people—many of them women, low-paid workers and part-time workers who have been excluded from pensions in the past—the opportunity to save in a pension for the first time with an employer contribution, she outlined how individuals also needed a “decent foundation for that private saving” in the form of a flat-rate state pension.<sup>238</sup> Professor Hills considered that the flat-rate state pension and auto-enrolment would help with offsetting the recent decline in pension accumulation, but they would “get only part of the way to what people would regard as being an adequate income in later life”.<sup>239</sup>

171. The capacity of individuals to access additional sources of income is restricted if they are “old, disabled and poor”.<sup>240</sup> In general, people have varying opportunities to build on the platform that the Turner Commission proposed by working in later life. Those with caring responsibilities (often women), as well as people with interrupted job histories, may find it very difficult either to retire later or to supplement their retirement by doing extra work (see Annex 5).<sup>241</sup> Public policy responses to encourage older people to save should therefore focus more strongly on these groups. Furthermore, pensions should not be considered in a vacuum. Wider policy choices include the provision of more employment opportunities, support for independent living, and flexible retirement. At present, the Government do not seem to be paying sufficient attention to these important policy areas (see Annex 5).
172. **The Committee concludes that despite significant progress, the current system of state and private pension provision is still not adequate for a large proportion of the future elderly population.** Many people, young and old, expect far more than they will get: society is behind where it needs to be.<sup>242</sup> The savings crisis for older age is exacerbated by a lack of clarity about what DC pensions will deliver, and concerningly weak pensions for many women and for many on middle and lower incomes. While the poorest will be protected at a basic level by state provision, and the richest can afford to save enough in private schemes, there is a substantial gap for much of the rest of the population. **While progress is being made on state pensions, we conclude that the current DC pensions system is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.**

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<sup>237</sup> DWP, *Defined Contribution Pension Provision*, Research Report No. 608, C. Dobson and S. Horsfield, 2009, see figure 5.3. A very crude ‘rule of thumb’ is that individuals should save at a rate of half their age—i.e. a 44 year old should save 22% of gross income including tax relief, employers’ contributions etc. See also <http://www.pensioncalculator.org/pension-information/suggested-pension-contributions/>.

<sup>238</sup> Q 466

<sup>239</sup> Q 545

<sup>240</sup> Q 472

<sup>241</sup> Professor Noel Whiteside; Q 538.

<sup>242</sup> Central Government (DoH, DWP and DCLG), written evidence.

### Policy proposals

173. **The Government should review how to strengthen incentives for saving.**
174. The Government should persist with the implementation of reforms set out by the Turner Commission. State pension reform must continue, ensuring the provision of a decent basic pension, although there will need to be further work on finding cross-party agreement on the basis for determining what a decent minimum level should be. The Government should continue to support auto-enrolment. But implementing the Turner Commission proposals alone will not be enough—as the Turner Commission report made clear. Many of the assumptions made in the report, for example those on expected longevity, have already changed (see Annex 2).<sup>243</sup>
175. Because of the cost to future taxpayers of public sector DB schemes, the Government must keep the Independent Public Service Pensions Commission reforms under review. This would enable the Government to track longevity changes, and assess if over time public sector pensions are fair and sustainable.
176. **We urge the pensions industry, employers and the Government to tackle the lack of certainty in DC pensions and address their serious defects, and to work together to re-design DC schemes to create better options so that people are clearer about how much they can expect to get from their pension as a result of the savings that they make.** The pensions industry needs quickly to find ways of improving the outcomes from DC schemes. The industry should more effectively align retirement income expectations with actual outcomes from DC plans, and seek better to manage the risk that these income goals are not realised. The industry needs to think more creatively about the basic architecture of DC schemes to avoid the risk that auto-enrolment fails to produce a greater take-up of retirement income planning. This is the whole point of auto-enrolment; we suggest that the inadequate performance of DC schemes to date poses the greatest risk to our savings culture and the move towards re-invigorating pensions saving.
177. The Committee welcomes the Government's recent proposal to consider a 'defined ambition' pensions regime which would "seek to give greater certainty for members than a DC pension about the final value of their pension pot and less cost volatility for employers than a DB pension".<sup>244</sup> Through such proposals, the Government are moving away from a focus on reforming DB pensions towards a more pressing issue for many taxpayers—how to make the DC market work. We consider that the 'defined ambition' proposal represents a positive step forward. More active Government intervention in this market is likely to be necessary to secure better outcomes for savers. Unless such an innovation comes about, there is a risk of fundamental and permanent damage to NEST and the settlement laid out by the Turner Commission. We urge the Government to make their plans concrete as soon as possible.

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<sup>243</sup> Central Government (DoH, DWP and DCLG), written evidence.

<sup>244</sup> DWP, *Reinvigorating workplace pensions*, Cm 8478, November 2012, p.4; Q 685.

178. Unless these actions are taken, incentives for saving will continue to be inadequate. People cannot adapt their life plans unless the Government help to make pensions and savings choices and their implications much clearer.
179. Given present longevity trends, the Government need to do much more to communicate to the public the importance of planning for an adequate income in older age.
180. People need to consider using a variety of sources of funds and ways of saving for later life.<sup>245</sup> More people working for longer will be part of the solution (see Annex 5), as will be unlocking the value in our homes. Many older people have seen the value of their homes increase considerably, but have not seen this rise as offering even a partial solution to the challenges of paying for longer life, or have been unable to gain easy access to the increased value (see Annex 7). **The Government should make it easier for people to use a variety of routes to save for their retirement, including equity build-up and release.**

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<sup>245</sup> Q 464 (Dr Altmann); Q 210-211, Q 212; Q 478 (Richard Humphries); Equity Release Council; McCarthy & Stone.

## **ANNEX 9: INCREASING DEMAND FOR HEALTH AND SOCIAL CARE (SEE PARAGRAPHS 2, 19 AND 20 OF THE REPORT)**

181. Extended life expectancy is one of the greatest triumphs of the twentieth century. The NHS has had great successes in extending life: so much so that it is a victim of its own success.<sup>246</sup> People are now living for more years with multiple long-term conditions and need for long-term care.<sup>247</sup> This results in increases in the demand for, and the costs of, health and social care.
182. Eventually almost all of us will need healthcare, and two thirds of men and 84% of women currently aged 65 will need some social care before they die.<sup>248</sup> The box below gives some illustrations of the impact that the ageing society will have on demands for health and social care and informal care.

### **BOX 1**

#### **Increasing pressures on health and social care**

Care for older people is more expensive than care for younger adults, and the number of older people is rising:

- The number of people aged over 75 is expected to grow from 5.4 million in 2015 to 8.8 million in 2035.
- The demand for hospital and community service spending by those aged 75 and over is in general more than three times the demand from those aged between 30 and 40, although this varies with other supply and needs factors. The primary care GP workload incurred by those aged 75 and over is roughly three times that of the 45–64 age group.<sup>249</sup>

The number of long-term conditions increases with age, and they account for much of health and social care spending:

- As of January 2010, there were 15.4 million people in England with at least one long-term condition (around 30% of the population); and it is estimated that by 2025 this number will rise to 18 million.<sup>250</sup>
- In 2010 it was estimated that the treatment and care of people with long-term conditions accounted for 70% of the total health and social care spend in England.<sup>251</sup>
- In 2010 people with long-term conditions accounted for more than 50% of all GP appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days in England.<sup>252</sup>

<sup>246</sup> Q 217

<sup>247</sup> QQ 216-217; Q 562

<sup>248</sup> *Impact of changes in length of stay on the demand for residential care services in England: Estimates from a dynamic microsimulation model*, Personal Social Services Research Unit (PSSRU) Discussion Paper 2771, 2011, J-L Fernandez and J Forder. The gender breakdown was supplied by the authors.

<sup>249</sup> ONS, *National Population Projections 2010 Based Statistical Bulletin*, Oct 2011, Table 4; The King's Fund supplementary written evidence; Department of Health, *Resource allocation: Weighted Capitation Formula Seventh Edition*, Table 2 and Table 12, 2011.

<sup>250</sup> Department of Health, *Improving the health and well-being of people with long term conditions: World class services for people with long term conditions – Information tool for commissioners*, January 2010.

<sup>251</sup> Department of Health, *Improving the health and well-being of people with long term conditions: World class services for people with long term conditions – Information tool for commissioners*, January 2010.



- By 2018 the number of people in England with three or more long-term conditions is predicted to grow from 1.9 million in 2008 to 2.9 million.<sup>253</sup>
- It is forecast that in England and Wales, the number of people aged 65 and over with diabetes will increase by over 45% from 2010 to 2030, and the numbers with arthritis, coronary heart disease and stroke all by over 50%
- It is also forecast that the number of people in England and Wales aged 65 and over with dementia (moderate or severe cognitive impairment) will increase by over 80% between 2010 and 2030, to 1.96 million.<sup>254</sup>

Rates of limiting long-standing illness give an indication of the number of people with a long-term health problem which limits their daily activities or work:

- If rates hold constant at 2010 levels, by 2030 the number of UK people aged over 65 with a limiting long-standing illness could rise by 44% from 4.2 million to 6 million.<sup>255</sup>
- If trends in limiting long-standing illness rates over 2000 to 2010 are projected to 2030 then the number may be limited to 5.7 million (a 36% rise).<sup>256</sup>

Rates of disabled people requiring care:

- It is estimated that by 2022, the number of people in England aged 65 and over with some disability will increase by 40% to 3.3 million.<sup>257</sup>
- The number of people in England and Wales aged 65 and over who have a level of disability meaning that they cannot put on shoes and socks, have a bath or all-over wash, or transfer to and from bed—or in other words, who need at least daily assistance from another person—is projected to rise from 1.0 million in 2010 (11.1% of the population) to 1.9 million in 2030 (14% of the population), an increase of 90%.<sup>258</sup>
- It is estimated that under current funding arrangements total spending (public and private) on long-term care for older people would need to more than

<sup>252</sup> Department of Health, *Improving the health and well-being of people with long term conditions: World class services for people with long term conditions – Information tool for commissioners*, January 2010.

<sup>253</sup> The King's Fund, supplementary written evidence.

<sup>254</sup> Professor Carol Jagger, Newcastle University. See also Alzheimer's Society.

<sup>255</sup> Professor Philip Rees, supplementary written evidence.

<sup>256</sup> Professor Philip Rees, supplementary written evidence.

<sup>257</sup> Department of Health, *Improving the health and well-being of people with long term conditions: World class services for people with long term conditions – Information tool for commissioners*, January 2010.

<sup>258</sup> Professor Carol Jagger. See also Central Government (DoH, DWP and DCLG), written evidence; LGA/ADASS/SOLACE. We received a range of estimates of the predicted increase in the number of people with disabilities requiring care or support, all suggesting a substantial increase in the period up to 2030. Professor Jagger's estimates project the prevalence of different diseases with disabling consequences, assuming no change in age-specific prevalence rates, merely changes in the age of the population. The PSSRU incorporated other work by Professor Jagger which did take account of recent rising trends in some conditions in their work for the Nuffield Trust report *Care for older people*, December 2012. The Government's written evidence estimated the number of older people unable to perform at least one instrumental activity of daily living or having problems with at least one activity of daily living rising by 61% between 2010 and 2030, from around 2.5 million to around 4.1 million, and the number of older people needing help with one or more activities of daily living rising from around 1 million to around 1.6 million in 2030. These were the same figures as used in the PSSRU evidence to the Dilnot Commission. They rest on prevalence rates calculated from answers to the General Household Survey 2001/2.



double in real terms by 2030 to sustain standards. Public spending would need to double, and private spending to rise by nearly 150%.<sup>259</sup>

- For England between 2010 and 2022, the number of older people with moderate or severe disability is forecast to rise by a third if prevalence rates remain the same, and rise by over a half if they rise as they have in the recent past.<sup>260</sup>

Demand for unpaid care provided by families and friends:

- There are already twice as many unpaid carers—nearly 6.4 million—as there are paid staff in the health and social care systems combined.<sup>261</sup>
- The numbers of older people with disabilities receiving informal care would need to nearly double over the next 20 years if the probability of receiving care is to remain constant—but it is not clear that the supply of informal care will rise to keep pace with demand. Demand for informal care provided by adults to their parents is projected to rise by over 50% between 2007 and 2032, whereas the supply of this care is projected to rise by only 20%.<sup>262</sup>
- By 2017 we will reach a “tipping point” for care when the numbers of older people needing care will outstrip the numbers of working age family members currently available to meet that demand.<sup>263</sup>

183. These are very large increases in a short time. If new treatments cause a welcome reduction in the impact of some long-term conditions, it is likely that there will still be large demand increases coming onto the system from others.

184. **It is possible that medical advances will reduce the numbers needing long-term care over the coming decades. However, as we cannot predict the future, policy must be designed using the trends that we can calculate, which show major increases in the level of demand falling on the healthcare and social care system.**<sup>264</sup> It is important to note that the number of people requiring care is not the only factor driving increasing health and social care costs: pressure for better quality care is another important factor.<sup>265</sup>

<sup>259</sup> *Projections of Demand for and Costs of Social Care for Older People in England 2010 to 3030, under Current and Alternative Funding Systems*, PSSRU Discussion Paper 2811/2, 2011, Table 1.

<sup>260</sup> Nuffield Trust with PSSRU at the LSE, *Care for older people - Projected expenditure to 2022 on social care and continuing health care for England's older population*, December 2012.

<sup>261</sup> Carers UK.

<sup>262</sup> Personal Social Services Research Unit (PSSRU).

<sup>263</sup> Carers UK.

<sup>264</sup> Professor Nicholas Barr, LSE.

<sup>265</sup> Q 129; Q 150 (Tom Josephs).

## ANNEX 10: FUNDING PRESSURES ON HEALTH AND SOCIAL CARE (SEE PARAGRAPHS 21 TO 23 OF THE REPORT)

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185. Demographic projections suggest that a substantial increase in demand is about to hit the healthcare system, adding to other long-term cost pressures (see Annex 9). This great increase in demand will naturally create a great increase in cost.
186. The Nuffield Trust has recently estimated that under the current healthcare system, if the real-terms funding freeze for the NHS is extended to 2021/22, if no productivity gains are made and if rates of hospital utilisation by people with chronic conditions and the rising cost of providing healthcare continues, then by 2021/22 the NHS in England will see a funding shortfall of £54 billion for the NHS as a whole.<sup>266</sup> If the English NHS achieves unprecedented productivity gains of 4% a year in every year from 2010/11 to 2014/15 but no further, they predicted that this funding gap would be reduced to a potential shortfall of £34 billion. For comparison, the total budget for the English NHS in 2010/11 was £107 billion. Yet continuing this rate of unprecedented productivity growth for a whole decade would be very difficult. Many of the ‘savings’ so far achieved are the result of a wage and salary cap that would be difficult to sustain for a decade. Even a constant real terms budget would be difficult to sustain into the next spending round, as it would result in heavy cuts to other departmental budgets.<sup>267</sup>
187. **If the current healthcare system did not change and the large NHS funding gaps for 2021/22 estimated by the Nuffield Trust materialised, this would have particularly serious consequences for older people, as the biggest consumers of NHS spending.<sup>268</sup> The NHS will have to be transformed, in service delivery terms, in order to deal with changing needs more efficiently; this transformation should help with the predicted funding shortfall.**
188. There is already a crisis in social care funding. The Dilnot Commission concluded in July 2011 that the current English social care system is inadequately funded and that “People are not receiving the care and support that they need and the quality of services is likely to suffer as a result”. The Dilnot Commission calculated that demand had outstripped expenditure by around 9% over the previous four years in England.<sup>269</sup> The Nuffield Trust cited estimates which suggested that even without reform, spending on social care would have to rise from £14.6 billion in 2010/11 to £23 billion by 2025/26.<sup>270</sup> The Trust has calculated that with the number of people in England with moderate or severe disabilities projected to increase by 32% by 2022, public expenditure on social care and continuing healthcare for older people will have to rise to £12.7 billion in real terms (an increase of 37%

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<sup>266</sup> Nuffield Trust, *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*, December 2012.

<sup>267</sup> Nuffield Trust, *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*, December 2012.

<sup>268</sup> Department of Health, *Resource Allocation: Weighted Capitation Formula Seventh Edition*, 2011.

<sup>269</sup> *Fairer Care Funding - The Report of the Commission on Funding of Care and Support*, July 2011.

<sup>270</sup> Nuffield Trust, *Reforming social care: options for funding*, May 2012.

from £9.3 billion in 2010), to keep pace with expected demographic and unit cost pressures.<sup>271</sup>

189. Recent cuts to social care budgets have intensified an underlying mismatch between funding and demand, so that a growing number of people on low incomes are no longer eligible for state support.<sup>272</sup> The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Society of Local Authority Chief Executives (SOLACE) told us that, following the capping of council tax, councils have managed demand by tightening eligibility thresholds and raising income via increasing fees and charges. Eighty-five per cent of English councils are now implementing a threshold at ‘substantial’ or ‘critical’ needs, resulting in a growing level of unmet need, with people unable to access support until their needs reach crisis point.<sup>273</sup> Many older people with moderate needs are therefore already suffering, and the situation is likely to continue to worsen without significant real terms increases in funding.<sup>274</sup> The result is further strains on public spending, as well as personal suffering: we heard from Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) that the NHS and social care are now in a very clear symbiotic relationship: “if you tighten the screws on the funding of social care, you put an extra load and burden on the NHS”.<sup>275</sup>
190. Cuts to social care budgets are also driving down what local authorities pay private providers. Evidence suggests that the level of local authority funding is in many cases already below what residence in a care home costs. This means that “within a home, you often have private patients subsidising local authority-paid people”.<sup>276</sup> This is a hidden tax on those who are funding their own care.
191. **There should be a sharing of responsibility for social care between individuals and the state, although on a basis that is less worrying for older people, as the Dilnot Commission proposed (see Annex 11). But there are many people who do not have families who can provide care, or the money to buy it, but who cannot cope without care—and this situation is likely to worsen considerably with greatly increasing numbers needing such care in the coming years. If the neglect of social care continues and these people are not properly supported in the community, they will end up with more severe needs or will suffer crises and go into hospital, which is likely to be contrary to their wishes, not in their best interests, and more expensive.**<sup>277</sup>

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<sup>271</sup> Nuffield Trust, *Care for older people – Projected expenditure to 2022 on social care and continuing health care for England’s older population*, December 2012.

<sup>272</sup> Nuffield Trust, *Reforming social care: options for funding*, May 2012.

<sup>273</sup> LGA/ADASS/SOLACE; Alzheimer’s Society; Age Cymru.

<sup>274</sup> LGA/ADASS/SOLACE.

<sup>275</sup> Q 588

<sup>276</sup> Q 573 (Tony Watts, Independent Chair, South West Forum on Ageing); Q 573; Q 422 (William Laing, Laing & Buisson (Consultancy) Ltd).

<sup>277</sup> LGA/ADASS/SOLACE; Q 457; Q 75 (John Kennedy, Chief Executive, Joseph Rowntree Housing Trust); Q 588; Nuffield Trust, *Reforming social care: options for funding*, May 2012.

## **ANNEX 11: CHANGING HOW WE PAY FOR HEALTH AND SOCIAL CARE? (SEE PARAGRAPHS 24 AND 28 TO 30 OF THE REPORT)**

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192. There is a serious public funding gap in social care in England, despite the fact that under current systems, massive costs for social care can also fall on the individual.<sup>278</sup> In response to the Dilnot Commission's report, the Government are proposing to raise the asset limit at which people must pay for all their care to around £123,000 in 2017/18 prices.<sup>279</sup> The Government are also proposing that individuals should not be called upon to pay more than £75,000 in 2017/18 prices in reasonable care costs over their total time receiving care.
193. We consider that the Dilnot Commission's proposals are far from a panacea for social care funding. The Government have estimated that the costs of their proposals in response to the Dilnot Commission will be £1 billion a year by the end of the next Parliament (i.e. 2020).<sup>280</sup> The major gainers will be the relatively better-off, who will be protected from depleting their housing assets,<sup>281</sup> and those who immediately gain will be the generation who have benefited from increases in housing wealth on an unprecedented scale over the past half-century (see Annex 7).
194. **The main advantages of the Dilnot Commission proposals were that they made clear to individuals the need to plan for the likely costs of long-term care, put a limit on the risks that individuals face, and would encourage the private insurance and pensions sectors to enter this market. The Committee considers that the Government's response to the Dilnot Commission proposals is a welcome step in the right direction, and necessary, but it will not be sufficient. The proposals are primarily concerned with redistributing the costs of care. They do not bring extra funding into the system to tackle the current funding crisis, avert the tightening of eligibility criteria for care access, or address the problem of expanding need in the coming decades—although we acknowledge that this was not the task given to the Commission.**
195. We have already argued (in Annex 7) that those who have benefited most from the housing boom should make a fair contribution to the rising costs of their own care. We consider that enabling people to access the value locked up in their homes through equity release will be crucial to helping older people to fund the care costs they may face.

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<sup>278</sup> The Dilnot Commission estimated that while a quarter of people aged 65 will need to spend very little on care over the rest of their lives, half can expect care costs of up to £20,000, and one in 10 can expect costs of over £100,000. *Fairer Care Funding - The Report of the Commission on Funding of Care and Support*, July 2011.

<sup>279</sup> Adult care services provided by local authorities are funded partly by central government, partly by revenue raised locally and partly by fees charged to users. The age of an authority's population and other factors affecting local need for services are taken into account in determining the size of the central government grant. People with savings and assets over £23,250 currently pay in full for local care services (and those with assets in a band lower than this threshold have to run down those assets to help pay for care); someone receiving care in their own home does not have their housing assets taken into account, but in residential care they do unless a partner or dependent is living in the relevant home; an assessment of the individual's income will also determine what charges the local authority makes for its services.

<sup>280</sup> DoH, *Policy statement on care and support funding reform and legislative requirements*, 11 February 2013.

<sup>281</sup> *Fairer Care Funding - The Report of the Commission on Funding of Care and Support*, figure 11, July 2011.

## ANNEX 12: HEALTH AND SOCIAL CARE: STRUCTURAL CHANGE? (SEE PARAGRAPHS 26 TO 32 OF THE REPORT)

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### What kind of health and social care do older people want and need?

196. **Older people are not well served by the current health and social care systems, and we have grave concerns for the future efficacy of these services as demands increase.**<sup>282</sup> Older people experience health and social care services as fragmented, underfunded, and not centred on their needs. The systems are peppered with perverse incentives, fractured by different funding streams, and feature a baffling array of different access levels, assessments and accountabilities.
197. The Health Service Ombudsman for England told us that “the NHS is failing to treat older people with care, compassion, dignity and respect”.<sup>283</sup> According to Professor Chris Ham, Chief Executive, The King’s Fund, “there is a long way to go before we can be confident that we are providing the right standards to all older people, wherever they come into contact with the health and social care system”, as “public services for older people have not had the same priority in many parts of the country as other services in the NHS”.<sup>284</sup> Professor David Oliver, the Royal Berkshire Trust, Department of Health and City University London, considered that “we are palpably failing” to deliver the evidence-based interventions required to achieve the desired outcomes for older people’s care.<sup>285</sup> He explained that “There is endemic evidence of discriminatory attitudes from staff; of older people getting a worse deal than younger people when they have the same condition; of common conditions of ageing being neglected—dementia is now an exception, because there is a big policy push around dementia—and also of, historically, far less investment and fewer policy levers around the care for older people.”<sup>286</sup> He also referred us to problems with patient safety amongst older people and with a lack of respect and dignity in the treatment of older people and their carers.<sup>287</sup>
198. We heard that a new model of care is needed, more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration.<sup>288</sup> Older people need care that is joined-up around the needs of the individual.<sup>289</sup> It must be person-centred, with patients engaged in decisions about their care and supported to manage their own conditions.<sup>290</sup> The home must become the hub of care and support, including emotional, psychological and practical support for patients and caregivers.<sup>291</sup> Older

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<sup>282</sup> Q 216

<sup>283</sup> Parliamentary Ombudsman and Health Service Ombudsman for England.

<sup>284</sup> Q 216

<sup>285</sup> Q 237 (Professor Oliver gave us fulsome references to the evidence to support his statements, which are published as footnotes to his oral evidence.)

<sup>286</sup> Q 239

<sup>287</sup> QQ 238-239

<sup>288</sup> The King’s Fund; Q 277 (Caroline Abrahams, Age UK).

<sup>289</sup> Q 671 (Rt Hon Jeremy Hunt MP); Q 216.

<sup>290</sup> Q 277 (Caroline Abrahams); Q 508; Royal College of Physicians; Joseph Rowntree Foundation; Q 222, Q 270; Q 241; Q 248; Q 285.

<sup>291</sup> Q 270; Q 277 (Caroline Abrahams).



people should only go into hospitals or care homes if appropriate care at home is not possible, but must have access to good specialist and diagnostic facilities when needed to ensure early interventions for reversible conditions and thereby prevent decline into chronic ill health.<sup>292</sup> Attitudes that view older people as a burden must be rejected.<sup>293</sup>

199. A remarkable shift in NHS services will be needed to deliver this new model of care. Older people with long-term conditions want good primary care, community care and social care, joined up around them regardless of clinical categories or structural splits between healthcare on one hand and social care on the other. They want good out-of-hours services, so that their conditions can be managed in their own homes and prevented from deteriorating, and to make it possible to minimise upsetting, disruptive and expensive episodes in hospital. This is not the system we have.

### **The fundamental problem: the split between healthcare and social care**

200. Older people in need of healthcare and social care often experience a complex combination of differing frailties, conditions and illnesses. Their care requires a mix of closely intertwined services from the NHS, their local authority and private providers, all centred on meeting the best interests of the individual (and, where relevant, their family and carers).<sup>294</sup> However, administrative structures, professional divisions and financial incentives in the current systems are making co-operation very difficult.
201. There is huge variability in the current performance of health and social care services for older people, with examples of excellent practice, average services, and services that are unacceptable. Many witnesses argued that one of the reasons for this variation and for poor quality care is fragmentation, including organisational separation between local authorities and the NHS, as well as separation between mental health providers, acute hospital providers and primary care, a historical division between GPs in the community and specialists in hospitals, and split funding streams.<sup>295</sup> Professor Ham argued that the key to unlocking better quality and more consistent care for older people was “tackling the fundamental problem of fragmentation”.<sup>296</sup> Norman Lamb MP, Minister of State for Care and Support, acknowledged that there was “institutionalised fragmentation” and that there were divisions between mental health and physical health, primary care and secondary care, healthcare and social care. The divides were “not very rational from the patient’s point of view”.<sup>297</sup> According to Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent, having two inter-dependent systems that are not organised or run in partnership or collaboration results in “the potential for

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<sup>292</sup> Q 618 (Professor Chris Ham and Dr Chai Patel, Chairman, HC-One); Q 598; Q 581 (Tony Watts); Q 294; Q 649; Q 99 (Professor Rees); Dr Chai Patel, HC-One.

<sup>293</sup> Q 239; British Academy; Dr Chai Patel, HC-One; Professor Pat Thane, KCL, supplementary written evidence; Parliamentary Ombudsman and Health Service Ombudsman.

<sup>294</sup> Q 216, Q 290, Q 613

<sup>295</sup> Q 216, Q 219

<sup>296</sup> Q 216, Q 219

<sup>297</sup> Q 680



inefficiencies, inappropriate services, and inappropriate balance between the services”.<sup>298</sup>

202. The separations between NHS money, local authority money and private money are partly behind this fragmentation, and there is a strong argument for bringing the social care and healthcare funding streams together, at least on the ground.<sup>299</sup> Phil Pegler, Chief Executive, Carewatch Care Services, argued for a joined-up budget, and Geoff Alltimes, NHS Future Forum Joint Lead and former Chief Executive, Hammersmith and Fulham Council, argued for “the integration of the totality of the money, the main programme money”.<sup>300</sup> Mike Farrar, Chief Executive, NHS Confederation, wanted the integration of not just community social care funding and community healthcare funding, but also primary care funding, through GP practices.<sup>301</sup> Professor Forder told us that pooling resources was only part of a gamut of solutions to integrated care, but advocated personal budgets which “facilitate [a] care manager pulling resources from different parts of the system”, and might thereby result in integrated provider services.<sup>302</sup> However, others were sceptical about whether elderly people concerned about their own wellbeing would want to be worrying about personal budgets.<sup>303</sup>
203. Governance and accountability rules also currently limit the capacity for integrated care. Professor Elisabeth Paice, Chair, North West London Integrated Care Management Board, told us that “accountability is not shared but is allocated to different departments, people and organisations”.<sup>304</sup> Dr Shane Gordon, CEO, North East Essex Clinical Commissioning Group, considered that unless differences of priorities were resolved between the different people he accounted to, it would be hard to continue with joined-up commissioning, especially when funding is under pressure.<sup>305</sup> For Professor Forder, mechanisms to bring the money together were less important than the values and lines of accountability of the separate parts of health and social care meaning that “those parts of the system charged with a certain set of activities are going to focus on those activities and not necessarily take into account what is going on elsewhere”.<sup>306</sup>
204. Divisions embedded deeply into professional cultures can also be a barrier to integrated working.<sup>307</sup> Professor Forder told us that you can facilitate joint working by integrating structures and budgets, “but until people want to use those budgets in an integrated way around the patient and the service user, we are still going to get problems.”<sup>308</sup> Professor Paice emphasised the importance of training to cultural change: “We do not train healthcare professionals necessarily to be collaborative but to be independent,

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<sup>298</sup> Q 290; Andrew Harrop, Fabian Society.

<sup>299</sup> Q 555, Q 557, Q 578 (Professor Elisabeth Paice); Q 81.

<sup>300</sup> Q 296; Q 312

<sup>301</sup> Q 313

<sup>302</sup> Q 306, Q321

<sup>303</sup> Q 316

<sup>304</sup> Q 555

<sup>305</sup> Q 562; Q 578 (Dennis Holmes, Deputy Director of Adult Services, Leeds City Council and Dr Shane Gordon).

<sup>306</sup> Q 314

<sup>307</sup> Q 608; Q 303 (Mike Farrar).

<sup>308</sup> Q 314, Q 299; Q 614

autonomous beings. Instead of the lonely hero, we need to develop a culture of collaboration.”<sup>309</sup>

205. Joint working had to be approached from the bottom up rather than at the strategic level, according to Professor Forder. The solution had to be focused “around the individual person”, rather than on the distinction between health services and social care services.<sup>310</sup> Professor Forder argued that person-centred care is facilitated by mechanisms like personal budgets, and an outcomes framework that recognises the whole care needs of the person rather than separate performance mechanisms for the health service and for the social care service.<sup>311</sup> Incentives had to be changed to bring health and social care workers together. For Geoff Alltimes, it would only work on a local basis, with the coming together of GPs and local councillors.<sup>312</sup> They will also have to overcome some defensiveness within professionals: Dennis Holmes, Deputy Director of Adult Services at Leeds City Council, feared that “there is a risk from the NHS perspective that any pooling will help in some way to cross-subsidise council services.”<sup>313</sup>
206. We heard from Geoff Alltimes that Health and Wellbeing Boards, bringing together local government and Clinical Commissioning Groups, may help with integration, as he believed that the signs showed that people were beginning to recognise that in order to solve their financial problems and achieve improvements in care they would need to work together and commission joined-up services.<sup>314</sup> Professor Les Mayhew, Cass Business School and Andrew Bonser, Director of Public Policy, Alliance Boots, were hopeful that Health and Wellbeing Boards might help in spotting and taking opportunities for improving services.<sup>315</sup> However, Dennis Holmes raised concerns about working with multiple Clinical Commissioning Groups and a community healthcare trust rather than a single Primary Care Trust.<sup>316</sup> Mike Farrar told us that with the recent NHS reforms, “we stepped backwards from integrated commissioning, because effectively in these reforms we have taken primary care spend and moved it to a National Commissioning Board; we have moved specialist care spend into a different bit of the National Commissioning Board; community hospital and community services’ health spend has gone into the CCGs; and local government has health improvement spend in one bit of it, and social care for adults and social care for children in different bits.”<sup>317</sup> However, he was hopeful that commissioning support units, by uniting the technical support to these various commissioning bodies, might be able to secure integrated care.<sup>318</sup>
- 207. The barriers to integrated health and social care explored above, and the inter-dependent nature of health and social care, have driven the Committee to conclude that the structural and budgetary split**

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<sup>309</sup> Q 555

<sup>310</sup> Q 291

<sup>311</sup> Q 291, Q 314; Q 565 (Professor Elisabeth Paice); Q 578 (Tony Watts).

<sup>312</sup> Q 312, Q 319; Q 617 (Dr Jennifer Dixon, Director, Nuffield Trust).

<sup>313</sup> Q 558; Q 557

<sup>314</sup> Q 303

<sup>315</sup> Q 358; Q 358

<sup>316</sup> Q 558

<sup>317</sup> Q 303

<sup>318</sup> Q 318

between them is not sustainable. We urge the Government to accept that the structural split is a major obstacle to the effective and efficient delivery of the care our older society will need. Healthcare and social care must in the future be commissioned and funded jointly, so that professionals are enabled to work together more effectively and resources can be used more efficiently. Further major structural upheaval of the healthcare system at this point would be undesirable and counter-productive.<sup>319</sup> However, we consider that the Government and all political parties will need to rethink this issue.

### Encouraging innovation in the meantime

208. There are some excellent examples of innovation despite the structural barriers that currently exist.<sup>320</sup> Professor Paice, who chairs two integrated care pilots in north-west London, told us how on dementia and the care of those aged 75 and over, they brought together acute and primary care, mental health, social care, patients' organisations and community trusts in a voluntary "club" with shared governance.<sup>321</sup> The Torbay and Southern Devon Health and Care Trust has co-located multidisciplinary teams of occupational therapists, physiotherapists, social workers and social care professionals, community nursing teams and community matrons, all working with clusters of GP practices, and enabling both GPs and the public to reach the whole team through a single point of contact.<sup>322</sup> Local decision-making allows access to both health and social care funding streams, although the Trust has to account for the money to its different sources separately.<sup>323</sup> Leeds City Council is also encouraging collaboration through co-locating adult social care workers with community NHS staff, coalesced around GP practices, and through collective spending aimed at outcomes shared with the NHS.<sup>324</sup> The council is fostering "social capital" through the use of volunteers and voluntary groups providing friendly visits to older people, and using a "whole-council approach" which includes engaging with housing provision and planning.<sup>325</sup> We also heard about a pilot for community budgeting in north-east Essex.<sup>326</sup>
209. Such examples of integrated service provision demonstrate ways of achieving better experiences and outcomes for older patients. We concur with Dr Jennifer Dixon, Director, Nuffield Trust, that "we have to put more effort into trying new and radical experiments", and with Mike Farrar that "in the financial circumstances ... and given the demographic pressures, we need to be achieving this at scale".<sup>327</sup> Sir Bob Kerslake agreed that there was not "some single dealbreaker barrier" obstructing co-operation, and that progress could be made within the existing framework.<sup>328</sup>

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<sup>319</sup> Q 320 (Mike Farrar); Q 557 (Professor Paice); Q 558, Q 582 (Dennis Holmes).

<sup>320</sup> Q 680

<sup>321</sup> Q 554, Q 555

<sup>322</sup> Q 554, Q 560

<sup>323</sup> Q 560, Q 561

<sup>324</sup> Q 554, Q 558, Q 578, Q 579

<sup>325</sup> Q 558

<sup>326</sup> Q 554, Q 562

<sup>327</sup> Q 608; Q 292

<sup>328</sup> Q 650

210. The Nuffield Trust has found a common experience of initiatives with a high level of goodwill which fizzle out after a short while.<sup>329</sup> Dr Dixon argued for central assistance to keep momentum alive and to “help the most promising sites accelerate”.<sup>330</sup> Central support might consist of leadership, information, thinking about the financial physiology across providers, or more community-based services. She also recommended centralised help with evaluating integrated projects.<sup>331</sup> Sir Bob Kerslake has suggested the creation of a ‘what works institute’ to facilitate learning from innovation.<sup>332</sup>
211. Norman Lamb MP told us that he wished to see “a culture that facilitates ... experimentation” within a vision of what the system needs to achieve.<sup>333</sup> **In the absence of counter-productive systemic change in the near future, and because full integration cannot be achieved immediately, there needs to be significant experimental work at the local level over the next five years. Local authorities and clinical commissioning groups must be allowed licence to experiment, and they must be pushed to innovate, especially with new forms of cross-service outcome-based commissioning, despite the local variations that would emerge. Innovation will be crucial to solving the problems of service integration, but innovation will not happen without an encouraging climate.**<sup>334</sup> The Government must act now to challenge the barriers to effective and efficient collaboration, some of which we explore in Annexes 13 and 14, in order to free up the good people working in health and social care to innovate, deliver the kind of personal, integrated care that our older population wants, and reduce waste and inefficiency.

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<sup>329</sup> Q 625

<sup>330</sup> Q 608, Q 625

<sup>331</sup> Q 608

<sup>332</sup> Q 641

<sup>333</sup> Q 677

<sup>334</sup> Q 650

## ANNEX 13: HEALTH AND SOCIAL CARE: ADJUSTING TO CHANGING PATTERNS OF NEED (SEE PARAGRAPHS 26 TO 32 OF THE REPORT)

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### The current NHS model is outdated

212. The current form of NHS provision is not fit for managing the needs of the older population we have now, let alone coping with the greatly increased demand coming soon.
213. The current NHS model is simply outdated. We heard from Professor Oliver that “when the NHS was founded, 48% of the population died before they got to 65” but that this figure had now been “constant at 18% for the past two decades”.<sup>335</sup> Professor Oliver quoted the Chairman of the House of Commons Health Select Committee, the Rt Hon Stephen Dorrell MP: “Systems designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long-term conditions”.<sup>336</sup> Professor Mayhew and Professor Ham concurred.<sup>337</sup> Our health system, and the funding that flows through it, is dominated by the acute hospital sector.<sup>338</sup> Dr Gordon told us that “if we carry on funding and preserving a sickness service, we will very soon not be able to afford it” because the knock-on effect will be a lack of funding for social care with the consequence that more people will “become sick and add to the burden”.<sup>339</sup>
214. The emphasis of the NHS, and its funding, needs to shift to take better account of the needs of older people. The core business of health and social care is now older people with complex needs.<sup>340</sup> Enhancing the quality of life for people with long-term conditions is “the biggest challenge of the 21<sup>st</sup> century”, according to Dr Martin McShane, Director, Domain 2, NHS Commissioning Board.<sup>341</sup> Mike Farrar told us that in the community, “what we really need to do is have a care service with a medical adjunct rather than a medical service with a care adjunct”, while Professor Ham urged “a reinvestment in primary care services and community-based services”.<sup>342</sup>
215. The two most recent Governments saw record year-on-year investments in the NHS, but nearly all the extra spend went into acute care.<sup>343</sup> However, research suggests that more than a quarter of people in acute hospitals do not need to be there.<sup>344</sup> Unnecessary inpatient stays bring the risk of hospital-acquired infections and the institutionalisation of older patients who then lose the ability to look after themselves.<sup>345</sup> Sir Bob Kerslake acknowledged the need to “prevent emergency admissions to hospital ... [and] that pattern,

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<sup>335</sup> Q 237

<sup>336</sup> Q 239

<sup>337</sup> Q 340, Q 217

<sup>338</sup> Q 588

<sup>339</sup> Q 562

<sup>340</sup> Q 239

<sup>341</sup> Q 248

<sup>342</sup> Q 291, Q 217

<sup>343</sup> Q 243

<sup>344</sup> Q 618 (Professor Ham), Q 598.

<sup>345</sup> Q 581 (Tony Watts), Q 618 (Dr Patel), Q 294.



that cycle that often happens that leads to people losing independent living”.<sup>346</sup> Despite this, we heard that older people comprise 70% of bed nights and 50% of the people who are in hospital at any one time.<sup>347</sup>

216. **General, acute and accident and emergency hospital services absorb nearly half of the NHS’s budget.**<sup>348</sup> **We consider that some of that money could be better invested in supporting older people to live well and independently in the community.** The key is to consider how to shift resources and staff into the community. Professor Martin Knapp, London of Economics (LSE) and PSSRU, told us that we need to “incentivise ... the system to get money out of acute wards or out of acute hospitals” because “It is the acute sector that is stopping things happening”.<sup>349</sup> Professor Ham agreed.<sup>350</sup> This shift will have to involve reducing capacity in acute hospitals: we heard from Professor Mayhew that when a care co-ordination service in Brent achieved substantial reductions in days in hospital, the rate of hospital admissions stayed level because “the Health Service was just admitting people into the beds that were vacated”. His conclusion was that “You have to take capacity out of one system to realise savings in another part of the system.”<sup>351</sup>
217. Reducing capacity in acute hospitals may be necessary, but it is never popular. The Secretary of State for Health, the Rt Hon Jeremy Hunt MP, acknowledged that “every time a politician of any party has tried to paint a picture about why it is necessary to close hospitals, the public have not believed them”.<sup>352</sup> Professor Knapp summed up the problem: “Politicians do not like using the word ‘ration’ and they do not like using the words ‘close and hospital’, but I think that is what you are going to have to do.”<sup>353</sup> For Dennis Holmes, closing some acute hospital facilities is “a real political challenge for locally elected members and non-executive directors in local NHS organisations which we will need to confront.”<sup>354</sup>
218. **NHS professionals must be supported by politicians publicly to make the argument that rationalisation and specialisation of hospitals will improve the quality of hospital-based treatment, as well as allowing a shift in funding to improve community-based care.**<sup>355</sup> Professor Oliver told us that there is a need for an honest discussion about reconfiguration of services rather than “hanging on to small units that are not providing high quality care.”<sup>356</sup> Lord Warner believed the medical specialists would support

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<sup>346</sup> Q 649

<sup>347</sup> Q 75 (John Kennedy). Sir David Nicholson, Chief Executive of the NHS Commissioning Board, in an interview for the 20 January 2013 edition of *The Independent*, said that hospitals are “very bad places for old, frail people”.

<sup>348</sup> Department of Health, *Resource Allocation: Weighted Capitation Formula Seventh Edition*, 2011.

<sup>349</sup> Q 359

<sup>350</sup> Q 618

<sup>351</sup> Q 332, Q 601

<sup>352</sup> Q 676

<sup>353</sup> Q 361, Q 77, Q 558

<sup>354</sup> Q 558

<sup>355</sup> Q 591

<sup>356</sup> Q 246. In a letter to *The Guardian* published on 24 January 2013, Mike Farrar, Professor Terence Stephenson (Chairman, Academy of Royal Medical Colleges), Jeremy Taylor (Chief executive, National Voices), Dr Hilary Cass (President, Royal College of Paediatrics and Child Health), Dr Clare Gerada (Chair, Royal College of General Practitioners), and Professor Norman Williams (President, Royal College



change but needed to be given political permission to drive such an agenda.<sup>357</sup> The Committee asked the Government for examples of Ministers publicly making the argument as to why the structure of our health and social care system needs to change, and they did not supply a single example of a Minister making the case for the closure of a hospital on clinical grounds.<sup>358</sup>

**Politicians must take the lead, clearly explaining why changes in the way that NHS services are delivered will be in the public interest, and publish a clear vision of the care services we should aim for and a description of the framework that will achieve them.**

219. One option which might be more politically palatable would be to move the conversation from ‘closing’ hospital facilities to transforming them into units better suited to the needs of our ageing society. Professor Mayhew argued for “small community hospitals that look after older people for short periods until their condition is stabilised”.<sup>359</sup> Baroness Greengross argued that we should “cut out 20% of our acute hospitals and transform them into primary-care-led hospitals.”<sup>360</sup>
220. A public case needs to be made for helping people manage their long-term conditions at home. This will also require local strategic planning. Some double-running costs will be involved initially as there is a limit to how much it is possible to reduce the capacity of acute hospitals while replacement services are built up so planners will need to keep their focus on longer-term savings.<sup>361</sup>

### Using financial incentives intelligently

221. The way that financial incentives currently operate in the NHS is reinforcing the prioritizing of acute care over primary and community care. About 60% of acute hospitals’ funding is under payment-by-results; for every activity the hospital attracts a set fee, whether or not that activity adds value to the patient’s outcome.<sup>362</sup> Dr Gordon told us that current healthcare funding systems fund hospitals preferentially in comparison to other services, obstructing an effective shift of care, and Sue Redmond, Corporate Director of Adult Services, Wiltshire Council, agreed.<sup>363</sup> While hospitals are paid according to the number of filled beds, beds will continue to be filled—Professor Knapp even told us of a hospital not wanting to continue with an intervention that reduced the use of health services “because it was taking money away from them.”<sup>364</sup>

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of Surgeons) argued that “some hospital services need to be centralised so that, for example, people requiring urgent stroke care get access to the best doctors and nurses 24 hours a day”. Professor Sir Bruce Keogh, the Medical Director of the NHS in England, told *The Guardian* on the same day “I really need the help of our political colleagues at times to step above their local interests and think of the other interests of the NHS”.

<sup>357</sup> Q 595, Q 601, Q 592

<sup>358</sup> Central Government (DoH and DWP), further supplementary written evidence.

<sup>359</sup> Q 333, Q 364

<sup>360</sup> Q 72, Q 83

<sup>361</sup> Q 574, Q 595

<sup>362</sup> Q 579

<sup>363</sup> Q 574, Q 456, Q 77

<sup>364</sup> Q 601, Q 362

222. Norman Lamb MP agreed that the financial incentives were a barrier to progress, saying that for people with long-term chronic conditions, payment-by-results is “not fit for purpose and discourages ... good innovation at the local level.”<sup>365</sup> To deal with long-term conditions, he said, we needed to be “more sophisticated than that and create incentives to manage people’s care much better out of hospital.”<sup>366</sup> Sue Redmond suggested that money should flow to the person who comes out of hospital, and Dr Gordon told us that a change in the funding mechanism to a capitated budget for a year of a patient’s care, or their lifetime of care, would change the dynamic of healthcare.<sup>367</sup>

### Preventing unnecessary hospital admissions of older people

223. If healthcare funding did not incentivise “more and more activity” in acute hospitals, more money could be spent on preventing older people needing to go to hospital.<sup>368</sup> Dr Dixon told us that “there are a lot of older people who are in hospital whose admission would have been prevented had the care been better co-ordinated upstream”, and John Kennedy and Professor Paice agreed.<sup>369</sup> The Government concurred that “too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place”.<sup>370</sup> Earlier intervention can stabilise the older person’s condition to reduce or prevent the next step down in their condition, rather than having “older people drifting into hospital avoidably”.<sup>371</sup> Better advance care planning and shared care in nursing homes can also prevent people dying in hospital instead of at home, against their wishes.<sup>372</sup>

224. Torbay’s multidisciplinary intermediate care service (see paragraph 208) gives an excellent example of what can be done: if a GP rings the service regarding a patient, the service can attend quickly and offer an alternative to hospital admission, deploying support in the home, or using block-contracted beds in local residential and nursing homes.<sup>373</sup> Care plans kept in the older person’s home allow anyone visiting, including the emergency services, to be informed about the patient and access contingency plans to avoid emergency admissions.<sup>374</sup>

225. Funding structures may be crucial to incentivising investment in preventive community-based care. Social impact bonds could have a role in setting up preventive services which are only paid for if they prove successful. If the preventive service does not reduce hospital admission, the funds are still

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<sup>365</sup> Q 692

<sup>366</sup> Q 671

<sup>367</sup> Q 456, Q 580

<sup>368</sup> Q 692

<sup>369</sup> Q 608, Q 75, Q 574

<sup>370</sup> Central Government (DoH, DWP and DCLG), written evidence and Central Government (DoH and DWP), further supplementary written evidence. The evidence on the cost-effectiveness of preventive strategies is inconclusive.

<sup>371</sup> Q 618 (Dr Patel), Q 239, Q 553.

<sup>372</sup> Q 242

<sup>373</sup> Q 560

<sup>374</sup> Q 560

available to spend in the hospital.<sup>375</sup> Current budgetary silos and funding structures can act as a disincentive: if social care investment saves money for the NHS, but social care budgets do not benefit, “the fruits of one’s labour land in another person’s garden”, of which social care professionals can be expected to tire.<sup>376</sup> Sir Bob Kerslake told us that what is needed is a local flow of funds so that those who invest in preventive care see the benefit.<sup>377</sup>

226. **A crucial aspect of the shift to a new system of health and social care, more focused on managing long-term conditions and with much less use of acute hospitals, is adequate access to primary and community-based care. To meet the needs of our ageing population, and to achieve this shift, the health and social care system needs to work well 24 hours a day, seven days a week.** Currently, the health and social care system fails outside working hours on working days. People go by default to a hospital because it is the only part of the system that is open 24/7.<sup>378</sup> This results in unnecessary inconvenience and suffering, and means that “We have people in hospital that could be more appropriately looked after elsewhere.”<sup>379</sup> Lord Warner told us that correcting this would require “a much more robust approach to the GP contract in terms of what they are expected to do”.<sup>380</sup> We need “a model that can be as responsive in the community as those emergency services in hospitals.”<sup>381</sup>
227. We agree with the Royal College of Physicians that the healthcare system must “ensure the availability of primary care services whenever they are needed, including at the weekend and at night”.<sup>382</sup> One way of achieving something close to this was outlined by Professor Ham, who told us about areas that have pooled their budgets, and used what is nominally NHS funding to increase investment in social care and create rapid response teams available for extended hours who can be called in when there is a crisis in the care of an older person to avoid hospital admission.<sup>383</sup> **We were pleased that the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, agreed that “we have to have a 24/7 NHS”. We are heartened by his commitment to 24/7 health services, and we call on him within 12 months to set out how this will be made real.**<sup>384</sup> For this to have value, there will also have to be 24/7 community-based healthcare and social care.
228. **We consider that the shift in the health and social care system away from acute and emergency services and towards preventing older people from going into hospital should also help with the funding pressures facing social care. Some of the funding released from acute**

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<sup>375</sup> Q 343, Q 426, Q 81

<sup>376</sup> Q 650

<sup>377</sup> Q 650; Q 331 (Professor Les Mayhew).

<sup>378</sup> Q 618 (Professor Ham); Q 77.

<sup>379</sup> Q 618

<sup>380</sup> Q 598

<sup>381</sup> Q 312; Q 427 (Martin Green, Chief Executive, English Community Care Association). Where appropriate, community pharmacies should also be used to improve access to healthcare during the hours and in the locations that suit local communities. Q 365.

<sup>382</sup> Royal College of Physicians.

<sup>383</sup> Q 618

<sup>384</sup> Q 679

**and emergency services should flow into improving social care, as part of reducing the hospitalisation of older people who could be better treated in the community. We also note the Government's commitment to introduce a national minimum eligibility threshold for social care from 2015: we consider that the consequence of this must be that the Government will address the public funding needed to make it possible, but we consider that health and social care integration is the longer-term solution for social care funding.**

229. Helping older people to leave hospital as soon as possible is also important. Late assessments, a lack of step-down services, and the restrictions on social care funding all delay hospital discharge, and can result in older people going straight from hospital into care homes.<sup>385</sup> Again, opportunities exist for local innovation: Torbay uses hospital discharge co-ordinators that are able to start discharge planning with the patient almost as soon as they are admitted, and discuss putting the necessary care in place with community teams.<sup>386</sup> Carers UK run "hospital to home schemes", but they are dependent on being kept well-informed by the hospital.<sup>387</sup> Baroness Greengross referred us to the Scandinavian model of hospital hotels for post-operative care.<sup>388</sup> Again, local professionals should be encouraged to explore these types of integrated solutions.

### **The need for leadership**

230. This fundamental shift in the focus of the health and social care system will require great leadership. When we pushed the Secretary of State for Health on how to bring about the re-configuration of services to cope with the needs of older people the response was, in essence, that the Government do not believe in top-down command and control, and that the decentralisation of budgets and responsibilities to over 200 clinical commissioning groups and new Health and Wellbeing Boards would drive the necessary changes.<sup>389</sup>
231. **In the light of the many local initiatives we have heard about, we have concluded that organic, bottom-up change has benefits and should be encouraged, but it will not by itself bring about the major changes to health and social care services that an ageing population will need.** Innovation must be combined with strategic management of the whole health and social care system, managing the complex balances and interrelations between the two halves of the whole so that hospitals provide care for people who are acutely ill while primary and social care keep people out of hospitals.<sup>390</sup> **Bottom-up change cannot by itself bring about the major shifts that we rapidly need if we are to cope with the considerable increases in demand. The Government need to develop a new basis for health and social care for our ageing population and create a clear vision so that other decision-makers can work to bring it about. The Government must set out the framework for radically transformed healthcare to care for our ageing population as a matter of urgency,**

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<sup>385</sup> Q 581 (Tony Watts), Q 239, Q 264.

<sup>386</sup> Q 560

<sup>387</sup> Q 415

<sup>388</sup> Q 74

<sup>389</sup> Q 671, Q 676, Q 598; Central Government (DoH, DWP, DCLG), written evidence.

<sup>390</sup> Q 77

**and before the general election in 2015. All political parties should be expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 election.**

- 232. This vision for the long term must not be undermined by short-term budgetary cycles. The health and social care systems need to be enabled to plan more strategically and systematically for changing long-term needs. We conclude that the Government should consider introducing a 10-year spending envelope for the NHS and publicly-funded social care.**
- 233. Our older population should be concerned about the quality of care that they may receive in the near future, because the current system is in trouble now. It will require substantial changes to address both present needs and future demand, and this challenge is combined with an impending funding crisis. Nothing like enough is being done to face up to these challenges.**

## ANNEX 14: HEALTH AND SOCIAL CARE: IMPROVING LOCAL CARE IN PRACTICE (SEE PARAGRAPHS 33 AND 34 OF THE REPORT)

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234. As well as shifting more focus onto the needs of older people in the community with long-term conditions, there are many other ways in which the delivery of health and social care to older people could be improved.

### Reducing duplication and improving service

235. We have already discussed the need for health and social care to be better integrated. Older people do not want to have to repeat the same information to different professionals, or have their needs fall down the gaps between different systems.<sup>391</sup> We heard the case for care managers, who know the systems, can help people navigate through them, pull together funding streams, and advise people with personal budgets or help those who are paying for services privately.<sup>392</sup> Julie Foster, Associate Director for Adult Social Care, Torbay and Southern Devon Health and Care Trust, told us that Torbay's care co-ordinators are "the single biggest factor in making us more successful at integration", and Dennis Holmes did not think that integrated systems could work without a single point of contact.<sup>393</sup> Better co-ordination of care is crucial, and nominated lead care workers could help to bridge gaps between systems and make things happen, as well as ensure that older people feel informed and in control of their care.<sup>394</sup> We also encourage the health and social care services to consider how to ensure that professionals feel responsible for the whole care of the individual for whom they provide care.
236. Making sure that those delivering care can help to support that older person in a holistic way could save money and enhance wellbeing. Professor Mayhew told us that, in one study on intermediate care, he found there were, potentially, 22 different health services alone, excluding social care, which could be aimed at a person needing care at home. He questioned whether this was suitable, and suggested that a more multi-skilled care worker, who could undertake care tasks but also basic health tasks like taking blood pressure and blood samples, would improve the efficiency of home care.<sup>395</sup> Professor Paice agreed.<sup>396</sup>

### Sharing data

237. Joined-up services cannot work without joined-up information.<sup>397</sup> If health and social care systems cannot easily share data about an individual, the result is inefficiencies, delays, duplications and suffering.<sup>398</sup> Professor Paice, Dennis Holmes, Dr Gordon and Dr Dixon all identified the lack of data

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<sup>391</sup> Q 239, Q 560, Q 658

<sup>392</sup> Q 312, Q 321; Q 565 (Professor Elisabeth Paice).

<sup>393</sup> Q 582 (see Julie Foster and Dennis Holmes).

<sup>394</sup> Q 624 (Dr Patel).

<sup>395</sup> Q 346

<sup>396</sup> Q 574

<sup>397</sup> Q 622

<sup>398</sup> Q 333



sharing as a key obstacle to integration.<sup>399</sup> A fuller care record for each individual would enable better analysis of their case history to support better decision-making.<sup>400</sup> Better data sharing would also enable better planning of services.<sup>401</sup>

238. Some practitioners have made heroic efforts to join up the dots. Professor Paice told us that when the North West London Integrated Care Pilots brought together data across organisational boundaries, it had to ask 24,000 people for their consent, and only 300 objected.<sup>402</sup> In Torbay, the same computer system is being used across health and social care.<sup>403</sup> An electronic palliative care co-ordination system in London has resulted in the number of people in the system who die in hospital falling to half what it is across the rest of London.<sup>404</sup>
239. **Enabling more data to be shared is crucial. Constraints must be removed, risk-averse attitudes must be reduced, and myths which result in people feeling unnecessarily restricted must be challenged.**<sup>405</sup> **If necessary, legislation must be introduced. The Secretary of State for Health told us that he was going to dictate from the centre on this issue, requiring hospitals to update GP records so that they contain full acute, tertiary and social care trails.**<sup>406</sup> **We welcome this approach.**

### *Using technology*

240. Technologies, including telecare and telehealth, also have the potential to save money and improve the quality of care that older people experience, as well as prevent accidents and crises. We heard about fire alarms, movement sensors, alarm pendants, temperature alerts and programmes to manage complex medication regimes.<sup>407</sup> Professor Oliver warned us that a recent survey of European experts had found that of every country in Europe, “the UK was the least confident about its ability to use telecare, telehealth, new technologies.”<sup>408</sup>
241. New technologies are not a panacea—they have to be used carefully to work well and be cost-effective. Telecare and assistive technologies have to be well-designed from the user perspective.<sup>409</sup> Caution is needed to ensure that older people do not feel increasingly marginalised by digitalisation and automation, and to ensure that an expanding reliance on telecare does not increase loneliness.<sup>410</sup> The use of technologies must also keep up with the high pace of change in this sphere.<sup>411</sup>

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<sup>399</sup> Q 555, Q 558, Q 562, Q 620

<sup>400</sup> Q 277 (Caroline Abrahams).

<sup>401</sup> Q 623

<sup>402</sup> Q 555

<sup>403</sup> Q 560

<sup>404</sup> Q 251

<sup>405</sup> Q 279

<sup>406</sup> Q 694

<sup>407</sup> Q 308; Independent Living.

<sup>408</sup> Q 280

<sup>409</sup> Q 509

<sup>410</sup> Age UK; Older People’s Commissioner for Wales; Low Incomes Tax Reform Group and Tax Help for Older People.

<sup>411</sup> Q 69

242. The Secretary of State for Health argued for better use of technology in terms of getting patient information to professionals' fingertips, and letting patients access the NHS as easily as they access banks or book airline tickets.<sup>412</sup> The Department of Health has embraced the rolling out of telecare, telehealth and assistive technology, and we welcome this.<sup>413</sup>

### Improving standards in social care

243. Scandals in the recent past have highlighted that standards can fall below acceptable levels in care homes and hospitals, but standards of care delivered within the individual's home are equally important and are difficult to monitor. The state has a fundamental duty to ensure that the vulnerable are protected, including when care is privately provided.
244. William Laing, Chief Executive, Laing and Buisson (Consultancy) Ltd, told us that a large survey of recipients of social care funded by local authorities, run by the Information Centre for Health and Social Care in early 2012, had found that 71% of respondents using residential care had been very or extremely satisfied with their care; this figure fell to about 55% for users of home care.<sup>414</sup> This survey also found that while 30% of residential care or community-based care users felt they had as much control over their daily life as they wanted, 25% felt they had not enough or no control over their daily life. 6% felt less than adequately clean or presentable or not at all clean or presentable. 5% reported that they did not always get adequate or timely food and drink, including 1% who felt that this posed a risk to their health. 7% felt less than adequately safe or not at all safe with regard to abuse, falling or other physical harm. 25% said that care and support services did not help them feel safe. Regarding dignity, 8% reported that the way they were helped and treated sometimes undermined the way they thought and felt about themselves, and 1% reported that it completely undermined this.<sup>415</sup>
245. Low rates of pay for care workers who look after some of our most vulnerable citizens are part of the problem. Sue Redmond said that an important change would be to value what care workers do more highly: "They are doing the most intimate and the most amazing work for people and their status and their pay is very low."<sup>416</sup> Tony Watts, Independent Chair, South West Forum on Ageing, argued that because local authorities do not pay sufficient money to the care homes for each resident, staff are not paid properly, with the result that "You do not get proper training, you do not get the right staff and people go into it as a low-skilled, low-fulfilment job".<sup>417</sup> Lord Warner agreed that "the pay of this work force is being squeezed to really quite potentially dangerous levels".<sup>418</sup> Higher pay rates might encourage more workers into the sector, and could encourage a focus on care as an important growth sector for the UK economy, as in France.<sup>419</sup>

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<sup>412</sup> QQ 678–Q 679

<sup>413</sup> Department of Health, *A Vision for Adult Social Care* and White Paper on reforming care and support.

<sup>414</sup> Q 386

<sup>415</sup> The Health and Social Care Information Centre, *Personal Social Services Adult Social Care Survey, England 2011-12* (Final Release), 2012.

<sup>416</sup> Q 399, Q 401; Carers UK; Dr Chai Patel, HC-One; Q 638, Q 129.

<sup>417</sup> Q 573

<sup>418</sup> Q 594

<sup>419</sup> Carers UK, Q 288 (Steve McIntosh, Policy and Public Affairs Manager, Carers UK).

246. The way in which some care workers are expected to deliver care is also inefficient and an obstacle to good care. Care workers commissioned to deliver care during a 15-minute visit (travel time permitting), or to deliver a process such as getting a person up, are likely to become de-motivated and disengaged.<sup>420</sup> Wiltshire Council is now paying care workers according to “outcomes” for the people they care for, such as “I want to get on with my life’ or ‘I want to be able to go and see my daughter’”. Another aspect of Wiltshire’s commissioned outcomes is reducing social isolation: introducing the older person to their local voluntary organisations or groups, or taking them to the library, so that the provider is incentivised to meet the outcomes that will directly improve the older person’s quality of life.<sup>421</sup>
247. The Government should be careful that their actions do not work to suppress a healthy market in high-standard privately-provided social care. Phil Pegler told us that he wanted to stop providing care funded by local authorities, because the funding is too low to allow him a profit as the national minimum wage increases. He wanted to provide “a different type of offering that ... will suit the local community and provide a better provision and be more cost effective”, but the market is too inhospitable.<sup>422</sup> The Government therefore need to be aware of the impact of local authorities’ funding settlements on the private care market.

*Opening up the social care sector*

248. Ensuring high standards of social care has to go wider than pay, commissioning or funding restrictions. Social care—whether delivered by the public sector or privately—has to be opened wide to public scrutiny and state inspection if the care market is to work well in the interests of its customers.
249. Older people and their carers need better information on privately-run care homes. When people buy care it is often a “distress purchase”, and buyers are not well-informed because the data do not exist or because they do not know where to find the data.<sup>423</sup> Steve McIntosh, Policy and Public Affairs Manager, Carers UK and Martin Green, Chief Executive, English Community Care Association, both regretted that the Care Quality Commission (CQC) does not provide star ratings for care services. Martin Green told us that “what we have now is you are either a pass or a fail service and there is no way to identify whether or not a service is of a much higher quality”, although David Behan, Chief Executive, CQC defended the quality of the CQC’s reports.<sup>424</sup> The Secretary of State for Health confirmed that he would “like to introduce Ofsted-style ratings across the care home sector, across hospitals, across GP surgeries, the works”, as long as it was done in a way that was academically and clinically rigorous.<sup>425</sup>
250. Regulation alone is not enough to create transparency and fully monitor or drive up quality, as David Behan, Sue Redmond and Norman Lamb MP acknowledged.<sup>426</sup> We heard that there is also a role for local authorities, in

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<sup>420</sup> Q 375, Q 559, Q 377

<sup>421</sup> Q 377, Q 399

<sup>422</sup> Q 315

<sup>423</sup> Q 628

<sup>424</sup> Q 223, Q 375, Q 384, Q 629; Q 266 (Philip King, Director of Regulatory Development, CQC).

<sup>425</sup> Q 696

<sup>426</sup> Q 627, Q 377, Q 695

commissioning the care that they fund, to assist the majority who are paying for themselves.<sup>427</sup> In Wiltshire, 70% of social care is bought privately, but Wiltshire Council has used its commissioning power for the other 30% to monitor and influence the standard of the private providers it contracts with, giving an effective quality stamp that people buying privately can trust.<sup>428</sup> The Council also provides information to private buyers on what to look for, and advice through financial planning advisers.<sup>429</sup> Leeds City Council's social workers will also help self-funders construct care plans.<sup>430</sup> Dennis Holmes highlighted the power of withdrawing contracts, telling us that such a decision would be advertised online for the benefit of self-funders.<sup>431</sup> These are examples of excellent practice, but they are not consistently followed, meaning that being able to make an informed choice is "just pot luck".<sup>432</sup>

251. While local authorities can influence the social care market, they are limited as to how much information they can provide self-funders. Sue Redmond told us that social services could not advise people paying for their own care on whom they should use, due to competition law.<sup>433</sup> But users of these services are free to share information with each other. David Behan considered that "the voice of people that use services" is one of the most important influences on the quality of care.<sup>434</sup> When we discussed the idea of an informal system of care home monitoring by older people, Sue Redmond confirmed it was established practice in a number of local authorities, and that Wiltshire already had older people assessing all of its care agencies, with training and support.<sup>435</sup> Dennis Holmes described "dignity champions" who help to monitor care homes in Leeds, and Martin Green told us that something similar was also happening through the Experts by Experience programme which the CQC has developed, but that it "needs to get more traction and needs to be part of, perhaps, every inspection."<sup>436</sup> Tony Watts confirmed that it was already working in parts of the country, often led by older people's groups, but that many of these groups were closing down because of a withdrawal of funding.<sup>437</sup>
252. As well as welcoming visitors in, care homes should engage more with their local communities. This would have a triple benefit: these homes would be more open to scrutiny, would be able to spread knowledge about effective practice to local informal carers, and would improve their own profile.<sup>438</sup> Dennis Holmes and Norman Lamb MP also highlighted the role of local Healthwatch organisations in supporting the CQC with monitoring care.<sup>439</sup>

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<sup>427</sup> Q 266

<sup>428</sup> Q 379, Q 381

<sup>429</sup> Q 383

<sup>430</sup> Q 564

<sup>431</sup> Q 564

<sup>432</sup> Q 398

<sup>433</sup> Q 394, Q 402, Q 403

<sup>434</sup> Q 627

<sup>435</sup> QQ 395-396

<sup>436</sup> Q 572, Q 385

<sup>437</sup> Q 567

<sup>438</sup> Q 419

<sup>439</sup> Q 572; Q 695

253. The users of care services are increasingly able to share more information with each other, which should also improve openness and help self-funders to find good quality care. Sue Redmond told us that “Older people, people who use the services, rating them themselves is the best advice you can get”, so local authorities are starting to set up versions of a TripAdvisor-type website forum to allow these people to share their experiences.<sup>440</sup> Martin Green talked of a similar set-up being piloted by the private care sector using a user experience questionnaire.<sup>441</sup> Tony Watts agreed that the idea had potential, as did William Laing, who argued that the private sector was best placed to take this forward.<sup>442</sup> Norman Lamb MP told us that the Government were already creating quality profiles of individual care homes, which include the CQC rating and are intended to include the new quality rating, and which could include user reviews: these “could be an incredibly powerful driver towards improving standards because information is power.” He also raised the possibility of requiring all care homes to maintain a direct link on their websites to their CQC rating.<sup>443</sup>
254. **We are encouraged that the Government are looking at how to improve the private social care sector, and urge them to provide support for a transparent, good quality private social care market.**

*Spreading good practice*

255. **We have explored a number of ways in which pioneers on the ground are moving health and social care for older people forward. We congratulate heroic professionals such as those in Torbay and the North West London Integrated Care Pilots who are striving to make the poor system function. Innovative experiences need to be learned from, shared and copied.**

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<sup>440</sup> Q 397

<sup>441</sup> Q 397, Q 403

<sup>442</sup> Q 572, Q 403, Q 404

<sup>443</sup> Q 696



## ANNEX 15: INFORMAL CARE (SEE PARAGRAPHS 35 AND 36 OF THE REPORT)

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256. Publicly funded care has never been able to meet all the needs of the minority of older people who are frail, vulnerable, ill or isolated. The bulk of care is and has always been provided within families, with twice as many unpaid carers in the UK—nearly 6.4 million—as there are paid staff in the health and social care systems combined.<sup>444</sup> As our society ages and these needs increase, yet more informal care from family and friends will be required. The number of disabled older people receiving informal care in England will need approximately to double over the next 20 years if supply is to keep pace with demand.<sup>445</sup> Carers UK told us that it has been estimated that nearly 3.5 million additional carers will be needed in the UK by 2037.<sup>446</sup>
257. Demands on carers are already high. Steve McIntosh told us that the number of carers is rising rapidly, coupled with an increase in the intensity of the caring that they are providing: in the last decade the proportion of carers caring for over 50 hours a week has doubled.<sup>447</sup> Elderly parents may only have one child to care for them, and that child may no longer live nearby.<sup>448</sup> Currently one in seven employees combine work with caring responsibilities, and one in four carers has given up work to care, at an annual cost to the economy of £5.3 billion.<sup>449</sup> Pressure is also increasing on older carers. More men in their 70s and 80s are now looking after disabled wives, and Professor Rees told us that the age group of 55–69 year-olds, “the kind of age group that is going to be looking after their parents aged 80, 90 or 95”, is projected to see very low growth, “while that of the people who need the care will grow very substantially.”<sup>450</sup>
258. The support provided to older people by informal carers is massively valuable to UK society, as well as to the economy. One valuation, from Carers UK, is that their contribution across the UK is worth £119 billion a year, more than the cost of the NHS.<sup>451</sup> Informal carers deserve our society’s support for the work that they do, and such support will improve older people’s wellbeing and carers’ wellbeing, as well as result in savings in health and social care spending. Mike Farrar told us that “the most strategic use of the resources available to help care for older people” would involve “spending not a lot of money but spending it very effectively supporting partners and carers to have a higher level of skill”. He concluded that “some of that money should be spent by the state in helping them to be able to care for their loved ones maybe six months longer than otherwise”, allowing the older person to stay in their own home for longer, and saving six months of hospital or care home costs.<sup>452</sup> Professor Knapp highlighted carer support and looking after the health and wellbeing of carers as one of the areas of intervention for which

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<sup>444</sup> Carers UK.

<sup>445</sup> Central Government (DoH, DWP, DCLG), written evidence.

<sup>446</sup> Carers UK.

<sup>447</sup> Q 277

<sup>448</sup> Q 96 (Professor Harper).

<sup>449</sup> Carers UK; Age UK.

<sup>450</sup> Q 96 (Professor Rees).

<sup>451</sup> Carers UK, *Valuing Carers 2011*, L. Buckner and S. Yeandle.

<sup>452</sup> Q 307



there is the strongest evidential case.<sup>453</sup> **The Committee calls for employers to make it easier for employees to provide informal care, and for the Government to promote how crucial this will be as demand rises. We welcome the Government’s recent focus on supporting carers in the draft Care and Support Bill, and urge them to continue to actively address how informal carers can best be supported and trained, including by care professionals.**

259. As we have explored above and in Annex 3, the contribution being made to our society by older people is already vast, but our increasing lifespan offers a fantastic opportunity for older people to play an even greater role in public life, and we must not miss it.<sup>454</sup>
260. We recognise the very valuable work already done by a number of charities such as Age UK, WRVS, Alzheimer’s Society and Carers UK, to support older people. Voluntary and community engagement can support people to stay connected to their communities, reducing social isolation and loneliness.<sup>455</sup> Professor Goldblatt argued for the benefits of the “young elderly” supporting the “older elderly”, forming a mutually beneficial network that reduces isolation as people move through older age.<sup>456</sup> Loneliness and isolation have an important impact on quality of life, and a very harmful effect on physical and mental wellbeing—we heard from Shaun Gallagher, Acting DG for Social Care, Local Government and Care Partnerships, Department of Health, that together they were “one of the biggest risk factors for people needing care and support”.<sup>457</sup> Norman Lamb MP agreed that “Just a bit of companionship keeping the mind active can do an enormous amount to maintain independence and happiness, which is quite an important concept and can reduce the cost to the system”.<sup>458</sup>
261. Mr Lamb stressed the need to recognise that “People in retirement so often want to give, want to help, want to give back, but often do not know how to”. It is also important to ensure that risk-aversion does not get in the way of volunteering, as Martin Green argued.<sup>459</sup> Mr Lamb was enthusiastic that “We can unleash the power of people in their communities”, especially to combat isolation.<sup>460</sup> **The Committee recommends that central and local government should work together with the third sector to increase volunteering especially by older people to support other older people.** The Government promoted the taking up of over a million youth volunteering opportunities through the ‘v’ programme.<sup>461</sup>

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<sup>453</sup> Q 328

<sup>454</sup> National Housing Federation; Age UK; Q 100 (Professor Harper).

<sup>455</sup> Q 63 (Shaun Gallagher); Q 501 (Len Street, University of the Third Age (U3A)).

<sup>456</sup> Q 543

<sup>457</sup> Q 393; Joseph Rowntree Housing Trust supplementary written evidence; Q 502 (Dr Mitchell); Cambridge Past, Present and Future; Age UK; Older People’s Commissioner for Wales; Q 62.

<sup>458</sup> Q 682; the Government’s Campaign to End Loneliness was described in the Central Government (DoH and DWP), further supplementary written evidence.

<sup>459</sup> Q 414

<sup>460</sup> Q 682

<sup>461</sup> vInspired.

## ANNEX 16: HOUSING PROVISION (SEE PARAGRAPH 37 OF THE REPORT)

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### Preserving independence

262. If preserving independence is to be a central goal, appropriate and safe housing will become increasingly important.<sup>462</sup> Well-designed housing can also be cost-effective. For example, by providing a warm environment or making adaptations to prevent falls, investment in housing can reduce hospital admissions.<sup>463</sup>
263. Services that help older people adapt their own homes to allow them to live there for longer will become more important in the coming decades as the population ages. We heard impressive claims from Care & Repair Cymru about the cost-effectiveness of their Rapid Response Adaptations scheme, which makes small adaptations to housing to keep people out of hospital, or get them discharged more quickly, following referrals from professionals. Chris Jones, Managing Director, Care & Repair Cymru, told us that they had calculated that in Wales over the past 10 years, “the scheme has saved the NHS around £100 million through the reduced cost of hospital stays and hospital beds, and stopping accidents, which equates to £7.50 saved for every £1 spent”.<sup>464</sup> **The work done by housing adaptation and repair services such as Care & Repair Cymru is commendable and must be supported.**<sup>465</sup> **Similar schemes should also be made accessible across England: currently only around 85% of residents in England have access to a home improvement agency.**<sup>466</sup> **Government, including local government, also have a role to play in providing advice on how to access housing adaptation services.**<sup>467</sup>
264. The Government can incentivise older people to adapt their homes by simplifying funding options such as the Disabled Facilities Grant process. There is currently some concern that the process for accessing Disabled Facilities Grants is too long and bureaucratic.<sup>468</sup> **The Government should support the development of housing adaptation services across England and Wales, both by ensuring adequate public funding and by encouraging the growth of a secure and easy-to-understand equity release market that can unlock funds to pay for housing adaptations (see Annex 7).**
265. The Government could also support research into initiatives such as life-long homes and the use of technology in the home to support older residents.<sup>469</sup> New assistive technologies can, for instance, monitor older people remotely

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<sup>462</sup> Q 170

<sup>463</sup> Home Instead Senior Care; Policy Fen; Anchor.

<sup>464</sup> Q 202

<sup>465</sup> Central Government (DoH, DWP and DCLG), written evidence; Care & Repair England.

<sup>466</sup> The website of Foundations, the (English) national body for home improvement agency and handy person services ([www-foundations.uk.com](http://www-foundations.uk.com)).

<sup>467</sup> Central Government (DoH, DWP and DCLG), written evidence; Central Government (DoH and DWP), supplementary written evidence.

<sup>468</sup> Q 170

<sup>469</sup> In their written evidence, Carers UK urged the establishment of a ‘Health and Care Technology Taskforce’.

for falls. Telecare products (also discussed in Annex 14) can help people keep on track with complex medication regimes. Independent Living suggested that such schemes could save local authorities and the NHS significant amounts of money.<sup>470</sup> Age UK agreed.<sup>471</sup> Professor Anthea Tinker of King's College London (KCL) related how "quite small" changes to the home can be cost-effective, and improve the lives of older people. These might include simple aids and devices to support both older people and their carers, such as small and easy-to-lift kettles and easy-to-use tin openers.<sup>472</sup> While local authorities should consider assistive technologies as part of their preventive care strategies, they should not lose sight of less expensive adaptations that could bring cost benefits. In addition, local and central government should support schemes such as Neighbourhood Watch and Meals on Wheels that mobilise local people, many of them older people themselves, to assist and keep an eye on frail elderly people in their own homes.<sup>473</sup>

### Ensuring adequate housing provision

266. According to Care & Repair England, while the majority of older people's homes are in a reasonable state, poor housing conditions remain. This is especially true for the 'older old'; low-income, long-term resident homeowners; and private tenants. Falling property values (outside London, parts of the South East and a few high-demand areas), combined with a stagnant market due to lack of mortgage availability and rising unemployment, will impact on 'moving on' or 'downsizing' options.<sup>474</sup>
267. Some local authorities and private housing developers provide staffed 'extra care housing', which offers more assistance than traditional 'sheltered housing'.<sup>475</sup> While cost-effective, this type of housing usually requires support or funding from other agencies. Encouraging stronger links between social care authorities and health providers such as home nurses could help to ensure that there is enough funding and service provision to meet care needs. In addition, private developers might ask users to 'buy in' using capital freed from selling their old home, or from other sources.<sup>476</sup> Housing associations potentially have a major role to play in providing access to extra care housing. Those associations that take on residents could likewise use the housing capital that has been released by the tenant moving from their own home. Or they could acquire the resident's property, manage it and collect rental income in order to pay for long-term care needs.<sup>477</sup>
268. At present there is little scope for housing associations to get involved. In countries that have direct, person-based long-term care and social health insurance (the Netherlands for example), not-for-profit housing agencies can

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<sup>470</sup> Independent Living.

<sup>471</sup> Age UK.

<sup>472</sup> Professor Anthea Tinker, KCL.

<sup>473</sup> Torbay Unitary Council, Q 558, Q 564, Q 415.

<sup>474</sup> Care & Repair England.

<sup>475</sup> Care Services Improvement Partnership, *The extra care housing toolkit*.

<sup>476</sup> Care & Repair Cymru; Central Government (DoH, DWP and DCLG), written evidence; Housing21; National Housing Federation; ILC-UK; McCarthy & Stone; Professor Anthea Tinker, KCL.

<sup>477</sup> Such a scheme was described by Jon Bright, Director of Homelessness and Support, Building Regulations and Climate Change, Department for Communities and Local Government, Q 60.

enter this market because the individual has an assured flow of cash once they are independently assessed to be in need of a certain level of care.<sup>478</sup> Budget constraints and uncertainty about the levels of care provision that English local authorities can offer mean that promises made by authorities to fund tenants' long-term care may carry commercial risks. This is likely to become especially true as the overall demand for care rises as the population ages. Not-for-profit housing associations are unable to provide the necessary levels of care when faced with such liabilities. Individualised budgets and a national pattern of assessment may change this situation, but fragmented care provision and funding uncertainty make this unlikely.<sup>479</sup>

### Stimulating the market in housing for older people through better planning

269. Many localities have a need for greater provision of more suitable housing for older people, with more support services.<sup>480</sup> The 2006 Wanless Social Care Review reported that 27% of older people would consider specialist housing if it were available.<sup>481</sup> In February 2012, a YouGov poll for Shelter concluded that 33% of people over 55 were interested in specialist housing, which equates to more than six million people.<sup>482</sup>
270. Despite growing demand for specialist housing and the substantial wealth held by some older people (see Annex 7), there is a gap in the market.<sup>483</sup> There are just 106,000 units of specialist housing for home ownership and 400,000 units for rent in the UK as a whole. Build rates are lower now than in the 1980s. In 2010, just 6,000 units for rent and 1,000 for ownership were built, whereas in 1989, 17,500 units for rent were built as well as 13,000 for ownership. These figures do not compare well with other countries. Just 1% of over-60s in the UK are estimated to live in retirement homes compared to 17% in the United States and 13% in Australia.<sup>484</sup> Shelter noted that if demand for retirement housing remained constant, supply would have to increase by more than 70% in the next 20 years.<sup>485</sup> McCarthy & Stone told us that "This is not going to happen without reform of the planning system".<sup>486</sup>
271. This is an issue not just for older residents but for the whole population. The Government have made efforts to improve access to housing for younger

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<sup>478</sup> OECD, *Help wanted? Providing and paying for long-term care*, June 2011.

<sup>479</sup> Draft Care and Support Bill, July 2012. The draft Care and Support Bill (Cm 8386) provides specifically for personal budgets and is expected to be amended to implement the 'cap' on care costs, announced as part of care and support funding reform. This will require the creation of individual 'care accounts', so that costs towards the cap can be measured over time. The draft Bill also places the assessment of needs for both carers and the person cared for on a statutory footing, and makes provision for regulations to establish eligibility criteria. The Department of Health has said that its intention is to use these regulations to establish a national minimum threshold for care and support provision for all individuals, <http://careandsupportbill.dh.gov.uk/home/>.

<sup>480</sup> Professor Anthea Tinker, KCL.

<sup>481</sup> McCarthy & Stone; The King's Fund, *Servicing Good Care for Older People: Taking a long-term view*, D. Wanless, 2006.

<sup>482</sup> McCarthy & Stone; Shelter, *A better fit? Creating housing choices for an ageing population*, 2012.

<sup>483</sup> Q 174 (Ilona Haslewood, Programme Manager in the Ageing Society Team, Joseph Rowntree Foundation).

<sup>484</sup> McCarthy & Stone.

<sup>485</sup> McCarthy & Stone; Shelter, *A better fit? Creating housing choices for an ageing population*, 2012.

<sup>486</sup> McCarthy & Stone.

people, but if the country had an adequate supply of suitably located, well-designed, supported housing for older people, this could result in an increased release onto the market of currently under-occupied family housing, expanding the supply available for younger generations. **Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people.**<sup>487</sup>

272. Major developers have not geared up for delivering developments of specialist housing for older people.<sup>488</sup> Gary Day explained that there are major barriers to entry into this market, and that “Public policy does not proactively encourage innovation and increasing supply in this sector”.<sup>489</sup> Developers working in the market often lose out to businesses such as supermarkets and car park operators when applying for planning permission.<sup>490</sup> An efficient and trusted equity release market could provide some of the capital needed to stimulate the market in housing for older people, but many consumers do not have confidence in equity release schemes (see Annex 7).
273. **Local government should signal their intention to ensure better housing provision for older people by insisting that local planning agents both encourage the private market in housing provision for older people, and by making specific mention of older people’s needs when drawing up their planning strategies.**<sup>491</sup> Developers of housing for older people would also benefit from a more favourable regulatory environment. Gary Day told us that the Community Infrastructure Levy (CIL) and Code for Sustainable Homes have serious cost implications. He argued that home builders were competing for sites against others who were not subject to the same obligations: for example, supermarket developers did not have enhanced building costs, because there was not an equivalent sustainability code for supermarkets, and did not have an obligation to provide affordable housing. He pointed out that in some instances supermarkets’ CIL charges were lower, because the local authority wanted to encourage retail activity. This illustrated that housing developers were not operating on a level playing field for land acquisition, despite the growing need to ensure specialist housing supply.<sup>492</sup> Anchor, a care homes provider, told us that “new housing for older people should be exempt from the planning restrictions that apply to mainstream housing”.<sup>493</sup>
274. Sites for older people’s housing are best located either in urban centres, or at least in non-remote areas that have easy access to town or city centre amenities and activities.<sup>494</sup> The National Planning Policy Framework of March 2012 signalled that it is important to consider future demographic

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<sup>487</sup> Q 190 (Ilona Haslewood).

<sup>488</sup> Q 169

<sup>489</sup> Q 169

<sup>490</sup> Q169, Q176, Q180

<sup>491</sup> See Q 169, Q173, Q 176, Q 181, QQ 186-188 (Gary Day).

<sup>492</sup> Q 188

<sup>493</sup> Anchor.

<sup>494</sup> Q 172



change when making planning decisions.<sup>495</sup> The Framework said that it is also crucial to “address the needs of people over retirement age, including the active, newly-retired through to the very frail elderly, whose housing needs can encompass accessible, adaptable general needs housing for those looking to downsize from family housing and the full range of retirement and specialised housing for those with support or care needs”.<sup>496</sup> However, the Committee heard that the Framework’s mention of older people’s housing needs was too vague to address the demand for suitable housing provision.<sup>497</sup>

**Central and local government should jointly review how the National Planning Policy Framework’s suggestions might be clarified and tightened to do more to ensure sufficient housing provision for older people.**

275. Bad housing has knock-on costs for the NHS. We heard from Care & Repair England that the costs to the NHS of poor housing are over £600 million per year. Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions. The housing-health link becomes more important with age, they suggested, as people become more prone to trips and falls and more susceptible to cold or damp-related health conditions, while poor thermal standards are a quantifiable contributor to excess winter deaths.<sup>498</sup> Professor Anthea Tinker concurred, arguing that damp housing can cause, or, exacerbate breathing and other health problems, inadequately heated homes can lead to hypothermia, and badly maintained homes can cause accidents.<sup>499</sup> **Health and Wellbeing Boards, on which local planners should be represented, should draw up plans for how communities can prepare themselves for older populations and involve housing associations and private developers to ensure that there is enough specialist housing, adequate transport and other easily accessible facilities for older people. Health and Wellbeing Boards should consider housing in tandem with health and social care provision because well-designed housing, as well as older people’s capacity to avoid social isolation, are strongly linked to better health outcomes.**<sup>500</sup>

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<sup>495</sup> Department for Communities and Local Government, *National planning policy framework*, p.13; Central Government (DoH, DWP and DCLG), written evidence.

<sup>496</sup> Department for Communities and Local Government, *National planning policy framework*, p.54.

<sup>497</sup> WISE, supplementary written evidence.

<sup>498</sup> Care & Repair England.

<sup>499</sup> Professor Anthea Tinker, KCL. The Department of Health has made available to the Homes and Communities Agency a sum of £160 million capital funding over five years from 2013/14 to create a ‘Care and Support Specialised Housing Fund’. Department of Health and Homes and Communities Agency *Care and Support Specialised Housing Fund prospectus*, October 2012.

<sup>500</sup> Q 163 (Jake Eliot, Policy Leader for Care and Support, National Housing Federation).



## ANNEX 17: SERVICE DESIGN AND DELIVERY (SEE PARAGRAPH 38 OF THE REPORT)

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276. As Annexes 7 and 16 suggested, the goal of developing services for older people should be to support the happy independence of older people.<sup>501</sup> Focusing directly on the needs of older people can be an effective route to service delivery. Nick Leon, Head of Service Design, Royal College of Art, told us that designing services should be about taking a user-, customer- or citizen-centric approach, and figuring out how to deliver a much richer and transformed user experience, “instead of looking at how one simply configures the service delivery resources in order to deliver what we have today with a modest, simple improvement”. He suggested that: “If you design for the old, you can include the young. If you design for the young ... you will almost certainly exclude the old”.<sup>502</sup>
277. A focus on older people’s needs is particularly important when designing health services. Public service delivery mechanisms should have as a key aim how services might best contribute to preventive strategies in health and social care (see Annex 13), and, where possible, involve older people in their design.<sup>503</sup> A formal way to involve older people in the design and delivery of health and social care would be to encourage their representation on structures that have emerged from the recent reorganisation of the health system. Annex 16 proposed a potential role for local planners on Health and Wellbeing Boards. It is important that older people’s representatives also have a standing position on Health and Wellbeing Boards, to ensure that the design of health and social care provision meets older people’s needs.<sup>504</sup>
278. Urban planning is also important in ensuring that older people have access to the services that they need, and do not feel isolated. Housing developments suited to older people, with gardens, entertainment, and medical or fitness facilities are much needed.<sup>505</sup> Leeds City Council adopted a strategy that involved older people in local planning, which alerted planners to issues that will become even more pressing as the population ages.<sup>506</sup> **Urban planning and building design should respond to the needs of an older population.** The provision of disabled access and well-designed public toilets will be of growing importance.<sup>507</sup>
279. **Access to public transport, transport routes, types of transport provided and parking restrictions should all take the needs of older people into account, including considering their level of access to shopping and entertainment facilities.**<sup>508</sup> **This will be especially necessary for older people who live in rural communities.**
280. Older people can find themselves living at a distance from essential services and amenities, or living on large housing estates where they can feel

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<sup>501</sup> Q 501 (Len Street).

<sup>502</sup> Q 507

<sup>503</sup> Alliance Boots.

<sup>504</sup> Q 559, Q 558

<sup>505</sup> The Saga Group.

<sup>506</sup> Q 575 (Dennis Holmes), Q 558.

<sup>507</sup> Q 507; see also the All Party Parliamentary Group For Continence Care report, *Cost-effective commissioning for continence care*.

<sup>508</sup> Q 501, Q 503, Q 506

isolated.<sup>509</sup> We heard arguments that older people's housing ideally should be situated in areas of high population density, where people can walk to the shops, there is easy access to social activity and there is good public transport.<sup>510</sup> Action is required before needs become more urgent, as the lead time for such changes is substantial.<sup>511</sup>

281. Providers of vital private sector services accessed by older people should also consider how their services should adapt to the ageing population. There is evidence that lazy assumptions about older people's needs and desires mean that providers of goods and services are missing out on the expanding older consumer market, which is projected to grow by 81% on 2005 by 2030.<sup>512</sup> However, change is happening in some sectors. We were told by the Building Societies Association that some building societies are adapting. One in the north-west of England provides a drive-through branch, because the majority of their customers are elderly and cannot walk very far, but are drivers. Other branches have lower counters to enable frail customers to sit down while they are taking their money out or putting it in.<sup>513</sup> More fundamentally, however, there is a need to simplify financial products catering to people who are planning for older age. The products that provide for retirement, for example, are extremely complex, and few people are able to judge between them properly.<sup>514</sup>
282. The way that essential services are delivered will also have to adapt to the ageing population. **As more and more services are delivered online, service providers should take steps to ensure that older people, who might not be as computer-literate as people from other age cohorts, do not suffer from inadequate service provision.** Though the evidence that the Committee received is inconclusive about the extent to which current and future older people risk being 'digitally disenfranchised', public and commercial operators with a potential user or customer base among older people would be wise to avoid introducing services that are only available online, at least until the trends are clearer.<sup>515</sup> Government might consider supporting initiatives to provide education and skills training for older people, not just for those who wish to work in later life but also those seeking guidance on how to keep up with a changing technological world. We heard evidence that training and education have significant health and social benefits for older people, because they help to keep people stimulated and connected to wider society.<sup>516</sup>
283. **The continued growth of the country's older population means that action to combat isolation, loneliness and social deprivation among older people has acquired a new urgency. The Government have a responsibility to support older people to gain equal access to public and private services and to continue to engage closely with the rest of society.**

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<sup>509</sup> Age Cymru; Q 558, Q 575 (Dennis Holmes).

<sup>510</sup> Q 507 (Dr Mitchell).

<sup>511</sup> Q 506 (Len Street)

<sup>512</sup> ILC-UK, *The golden economy—the consumer market place in an ageing society*, David Sinclair, December 2010.

<sup>513</sup> Q 502. Such counters may also be wheelchair-accessible.

<sup>514</sup> N. Barr and P. Diamond, *Reforming pensions: principles and policy choices*, chapter 4. Professor Nicholas Barr, The Saga Group.

<sup>515</sup> Q 502, Independent Living, LITRG, Age UK.

<sup>516</sup> Q 501 (Len Street).

## ANNEX 18: STRATEGIC PLANNING, KEY CHOICES AND POLITICAL LEADERSHIP (SEE PARAGRAPHS 44 TO 46 OF THE REPORT)

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284. Given the short-term nature of electoral and budgetary cycles, there are very weak political incentives for long-term thinking in the formulation of government policy.<sup>517</sup> Governments have been better at acting to limit their exposure to increasing costs as a result of ageing, such as in the field of pensions, than planning for improvements in the quality of the services that they deliver, commission or support. Although the Government have acted to reduce the amount that they will have to spend on state and public sector pensions (see Annex 8), they have been less successful at changing the quality of healthcare provision for older people (see Annex 12), ensuring the development of better private sector pensions (see Annex 8), or transforming the funding of high-quality social care (see Annex 11).<sup>518</sup>
285. Even where the Government have made progress in these areas, this progress has often been patchy, and the implementation of improvements dilatory. The problems for the future that the Turner Commission identified, such as a fall in the relative value of the state pension and the end of defined benefit pension schemes, were evident in the 1990s or earlier.<sup>519</sup>
286. **The Committee was disappointed to find how little the Government have done to initiate a long-term, coherent strategy to deal with the consequences of population ageing. We heard little evidence that the Government have the capacity, inclination or incentives to do the sort of planning that this issue requires.** The collapse of cross-party talks on social care before the last general election serves as confirmation that it is politically difficult for political parties to discuss the long-term implications of an ageing population, and the public spending choices that this demographic change might entail. In fact, electoral pressures tend to incentivise parties to avoid discussing long-term issues, which might involve confronting voters with unpalatable truths.<sup>520</sup> There are a few mechanisms in place to encourage the Government to think about the long term, such as the fiscal sustainability reports published by the OBR. While these reports are a welcome innovation, we are concerned that they have tended to have little impact on policy. The Government are not obliged to respond, there are no associated targets for the Government to meet, and the reports themselves receive far less attention in media and policy circles than the OBR's short-term economic and fiscal forecasts.

### Important choices

287. **The ageing of the country's population means that the Government and all political parties may need to consider choices about the welfare state and what we want from our social settlement for the future, in the face of the rising demands that an ageing population and other pressures will bring.**

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<sup>517</sup> Q 656. See also HM Government, *The Civil Service reform plan*, June 2012.

<sup>518</sup> Central Government (DoH and DWP), further supplementary written evidence.

<sup>519</sup> Government Actuary's Department, *Occupational pension schemes 1991*, ninth survey by the Government actuary, 1994.

<sup>520</sup> Q 62

288. The Government need to expose the options and communicate the choices to the public.

### **The current state of Government planning**

289. The Cabinet has not initiated a process to assess the implications of an ageing society but has left the various relevant departments to lead. Caroline Abrahams, Director of External Affairs, Age UK, argued that “there is not an overall vision” and the response to ageing was “all fairly piecemeal”.<sup>521</sup> While we acknowledge that the Government are doing some high-level thinking about the implications of an ageing society and some effective cross-departmental work, we feel that the Government have not looked at ageing from the point of view of the public nor considered how policies might need to change to ensure that people are better equipped to address their longer lives.<sup>522</sup>
290. **Without a collective understanding of the implications of ageing, and commitment to key Government actions, responses by individual departments will be insufficient—especially as responding to ageing requires services to work well together.** This Report has suggested a number of major changes that are needed. These new approaches—such as those that we have argued for in health and social care—may take a decade to bring about, and should inform the priorities for the next spending review, which will need to support the investment that some changes will require. Ministers must take the lead, and make clear to the civil service that inertia in planning for long-term issues such as demographic change is not acceptable.
291. **The Government also need to make the case to the public for why any changes are needed. If a government tries to move some age-related benefits onto different eligibility criteria without setting out a comprehensive vision for older age, explaining why changes are necessary, and committing to make major improvements to services in some areas such as healthcare, significant opposition would be inevitable.** Our society tends to be pragmatic—there was little opposition to raising the state pension age—but the Government do need to treat people as capable of understanding the issues and the arguments for change.

### *Central and local leadership*

292. **Politicians in all parties need to face up to these issues, and ageing is not only a matter for those in Government. Governing parties are also not sufficiently incentivised to address the long-term decisions necessary unless all parties face up to these difficult choices. The Committee considers that a vision is needed for the long term, with a broad approach to the public policy response to ageing to which all major parties should ideally subscribe. We conclude that when political parties are working on their manifestos, they ought to consider the wider implications of the ageing society for the balance of responsibilities between individuals and the Government.**

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<sup>521</sup> Age UK.

<sup>522</sup> Sir Bob Kerslake supplementary written evidence; Central Government (DoH and DWP), further supplementary written evidence; Q 649; Q 61 (Trevor Huddleston, Chief Analyst, DWP).

293. The ageing population will introduce further significant resource pressures at local government level, too. Local councils currently are not required to produce medium to long-term plans about how they will cope with increasing numbers of older residents in their area but need to do so nevertheless. The impact of ageing at the local level can be even more dramatic.<sup>523</sup> Each local authority should look at ONS projections for the number of people in their areas who will be 65 and over and 85 and over in 2020 and 2030. They should then consider what action they need to take through their housing, planning, social care and wider services provision, and through their joint planning for health and wellbeing. Each local authority should assess thoroughly the implications of their forecast population. Joint planning for these changes will be needed from local authorities, health providers and civil society, and public health strategies will be crucial.

*Demonstrating political leadership*

294. **The Government should address urgently the implications of an ageing population for public policy and services in a White Paper to be published well before the next general election. This White Paper would analyse the issues and challenges laid out in this Report. It would set out their vision for future public service delivery against the background of the ageing population.**

295. It will also be crucial for all political parties to signal to the electorate that they are taking demographic change seriously. **There needs to be cross-party understanding of the importance of the challenges that the ageing society poses and the choices involved, and an effort to seek as much consensus as possible. Progress will not be made if the solutions chosen by the Government change with each administration. The Committee therefore proposes that the Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations:**

1. **A commission to work with employers and financial services providers to examine how to ensure adequate pensions and savings for our society's older people, and to improve equity release, and**
2. **A commission to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing society.**

296. **Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation.**

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<sup>523</sup> The Saga Group.



## APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

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### Members

The Members of the Committee which conducted this Inquiry were:

Lord Bichard  
 Baroness Blackstone  
 Earl of Dundee  
 Lord Filkin (Chairman)  
 Baroness Finlay of Llandaff  
 Lord Griffiths of Fforestfach (joined July 2012)  
 Lord Hutton of Furness (joined November 2012)  
 Lord Mawhinney  
 Baroness Morgan of Huyton  
 Baroness Shephard of Northwold  
 Lord Tope  
 Lord Touhig (May 2012–October 2012)  
 Baroness Tyler of Enfield  
 Viscount Younger of Leckie (May 2012–June 2012)

### Declaration of Members' Interest

Lord Bichard  
*Adviser, Ten Lifestyle*  
*Adviser, Gorin Consultancy*  
*Chair, Solace Foundation Imprint*  
*Vice President, Local Government Association*

Baroness Blackstone  
*Chair, Orbit Group*

Earl of Dundee  
*None relevant to the inquiry*

Lord Filkin (Chairman)  
*Adviser, Serco plc*  
*Adviser, Capgemini UK and Global*  
*Adviser, NSL plc*  
*Founder and Chairman of 2020 Public Services Trust, registered charity and think-tank*

Baroness Finlay of Llandaff  
*NHS Consultant in Palliative Medicine*  
*Chair of Palliative Care Strategy Implementation Board for Wales*

Lord Griffiths of Fforestfach  
*None relevant to the inquiry*

Lord Hutton of Furness  
*Advisory Director, Dimensional Fund Managers*  
*Trustee, Social Market Foundation*

Lord Mawhinney  
*None relevant to the inquiry*

Baroness Morgan of Huyton  
*Chair, OFSTED*  
*Member, Advisory Board, Virgin Holdings*



*Vice-Patron, Smile Children's Hospice*

Baroness Shephard of Northwold

*None relevant to the inquiry*

Lord Tope

*Councillor, London Borough of Sutton*

*Liberal Democrat Spokesperson on Culture, London Councils*

*Local Government Pension Fund Authority - Pensioner*

*Member, EU Committee of the Regions*

*Co-chair, Liberal Democrat CLG Parliamentary Committee*

Lord Touhig

*None relevant to the inquiry*

Baroness Tyler of Enfield

*Chair of CAFCASS (Children and Families Court Advisory Service)*

Viscount Younger of Leckie

*None relevant to the inquiry*

A full list of Members' interests can be found in the Register of Lords interests:

<http://www.publications.parliament.uk/pa/ld/ldreg.htm>

Professor Howard Glennerster (Specialist Adviser)

*None relevant to the inquiry*

Jonathan Portes (Specialist Adviser)

*Director, National Institute of Economic and Social Research (NIESR)*

## APPENDIX 2: LIST OF WITNESSES

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Evidence is published online at [www.parliament.uk/public-services-committee](http://www.parliament.uk/public-services-committee)

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Witnesses marked with \* gave both oral and written evidence. Witnesses marked with \*\* gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

### Oral evidence in chronological order

**	QQ 1–55	Office for National Statistics (ONS)
*		Professor Ludi Simpson, University of Manchester
	QQ 56–71	Central Government Departments:
*		Department for Communities and Local Government
*		Department of Health
*		HM Treasury
*		Department for Work and Pensions
*	QQ 72–93	Age UK
*		International Longevity Centre – UK
*		Joseph Rowntree Housing Trust
*		Professor Pat Thane FBA, King’s College London
*		British Academy
*	QQ 94–103	Professor Sarah Harper, University of Oxford
*		Population Matters
*		Professor Philip Rees FRGS FBA CBE, University of Leeds
*	QQ 104–158	Institute for Public Policy Research (IPPR)
**		Office for Budget Responsibility (OBR)
**		Professor James Sefton, Imperial College London
**		Dr Martin Weale, External Member of the Bank of England Monetary Policy Committee and Queen Mary University of London
*	QQ 159–214	Care & Repair Cymru
*		Joseph Rowntree Foundation
*		McCarthy & Stone
*		National Housing Federation
*	QQ 215–288	Age UK
*		Care Quality Commission
*		Carers UK
*		The King’s Fund

- \*\* NHS Commissioning Board
- \*\* Professor David Oliver, The Royal Berkshire NHS Foundation Trust, Department of Health and City University London
- \*\* QQ 289–326 Geoff Alltimes, NHS Future Forum Joint Lead
- \*\* Carewatch Care Services
- \* Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent
- \*\* NHS Confederation
- \* QQ 327–372 Alliance Boots
- \*\* Professor Martin Knapp, London School of Economics and Political Science (LSE) and Personal Social Services Research Unit (PSSRU)
- \* Professor Les Mayhew, Cass Business School
- \*\* Social Finance
- \*\* QQ 373–462 English Community Care Association
- \*\* Laing & Buisson (Consultancy) Ltd
- \*\* Wiltshire Council
- \*\* WRVS
- \* QQ 463–495 The King’s Fund
- \* National Association of Pension Funds
- \* The Saga Group
- \* Professor Noel Whiteside, University of Warwick
- \*\* QQ 496–513 Building Societies Association
- \* Dr Lynne Mitchell, WISE (Wellbeing in Sustainable Environments), University of Warwick
- \*\* Royal College of Art
- \* Len Street OBE, Former Chair, University of the Third Age (U3A)
- \*\* QQ 514–536 BT
- \*\* Chartered Institute for Personnel Development
- \*\* Professor John Philpott, Economist and Labour Market Analyst
- \* Trades Union Congress
- \*\* QQ 537–553 Professor Sara Arber, University of Surrey
- \*\* Professor Peter Goldblatt, University College London (UCL)
- \* Fabian Society
- \*\* Professor John Hills, London School of Economics and Political Science (LSE)

- \*\* QQ 554–582 Leeds City Council
- \*\* North East Essex Clinical Commissioning Group
- \*\* North West London Integrated Care Management Board
- \*\* South West Forum on Ageing
- \* Torbay and Southern Devon Health and Care Trust
- \*\* QQ 583–606 Michael Johnson, Centre for Research Studies
- \*\* Institute for Fiscal Studies (IFS)
- \*\* Rt Hon the Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010–11
- \* QQ 607–638 Care Quality Commission
- \* The King’s Fund
- \*\* Nuffield Trust
- \* Dr Chai Patel CBE FRCP, HC-One
- \* QQ 639–667 Sir Bob Kerslake, Permanent Secretary, Department for Communities and Local Government and Head of the Civil Service
- \*\* QQ 668–697 Rt Hon Jeremy Hunt MP, Secretary of State for Health, Department of Health
- \*\* Norman Lamb MP, Minister of State for Care and Support, Department of Health
- \* Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions

### Alphabetical list of all witnesses

- Action on Hearing Loss
- Age Cymru
- Alzheimer’s Society
- \* Age UK
- \* Alliance Boots
- \*\* Geoff Alltimes, NHS Future Forum joint lead
- Anchor
- \*\* Professor Sara Arber, University of Surrey
- Audit Commission
- B & Q
- Barchester Healthcare
- Professor Nicholas Barr, London School of Economics and Political Science(LSE)
- Bedfordshire Fire and Rescue Service

- \* British Academy
- British Society of Population Studies
- \*\* BT
- \*\* Building Societies Association
- Cambridge Past, Present and Future
- \* Care & Repair Cymru
- Care & Repair England
- \* Care Quality Commission
- \* Carers UK
- CarewatchUK
- \*\* Chartered Institute for Personnel Development (CIPD)
- Cheshire Fire and Rescue Service
- Chief Fire Officers Association
- Confederation of British Industry (CBI)
- Dr Joan Costa Font, London School of Economics and Political Science (LSE)
- Paul Durkin
- English Community Care Association
- Equity Release Council
- \* Fabian Society
- \* Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent
- \*\* Professor Peter Goldblatt, University College London (UCL)
- \* Professor Sarah Harper, University of Oxford
- \*\* Professor John Hills, London School of Economics and Political Science (LSE)
- Home Instead Senior Care
- Housing21
- Independent Living
- \* International Longevity Centre—UK
- \* Institute for Public Policy Research (IPPR)
- Ipsos MORI, Social Research Institute
- \*\* Michael Johnson, Centre for Policy Studies
- \*\* Institute for Fiscal Studies
- \* Joseph Rowntree Foundation
- \* The King's Fund
- \*\* Laing & Buisson (Consultancy) Ltd
- Howard Lewis, UK Older People's Advisory Group

Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Society of Local Authority Chief Executives (SOLACE)

Low Incomes Tax Reform Group and Tax Help for Older People

- \* Professor Les Mayhew, Cass Business School
- \* McCarthy & Stone
- \*\* NHS Commissioning Board
- \*\* National Association of Pension Funds
- \* National Housing Federation
- \*\* NHS Confederation
- \*\* Nuffield Trust
- \*\* Office for Budget Responsibility (OBR)
- \*\* Office for National Statistics (ONS)
- Older People's Commissioner for Wales
- \*\* Professor David Oliver, The Royal Berkshire NHS Foundation Trust, Department of Health and City University London
- \* North West London Integrated Care Management Board
- \* Dr Chai Patel CBE FRCP, HC-One
- UK Parliamentary Ombudsman and Health Service Ombudsman for England
- Pensions Advisory Service
- Personal Social Services Research Unit (PSSRU), London School of Economics and Political Science and Health Economics Group (LSE), University of East Anglia (UEA)
- PolicyFen
- \* Population Matters
- \*\* Royal College of Art
- Reform
- \* Professor Philip Rees FRGS FBA CBE, University of Leeds
- \*\* Professor John Philpott, Economist and Labour Market Analyst
- Royal College of Physicians
- \* The Saga Group
- \*\* Professor James Sefton, Imperial College London
- \*\* Professor Ludi Simpson, University of Manchester
- Social Institute for Excellence
- \* Len Street OBE, Former Chair, University of the Third Age (U3A)
- Professor Taylor-Gooby, University of Kent
- Ten Professional Support
- \* Professor Pat Thane, King's College London (KCL)



- Third Sector Research Centre  
Professor Anthea Tinker, King's College London (KCL)
- \* Torbay Unitary Council
  - \* Trades Union Congress (TUC)
  - Vale Older People's Strategy Forum
  - \*\* Rt Hon the Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010–11  
Derek Jones, Permanent Secretary, Welsh Government  
Welsh Local Government Authority
  - \*\* Wiltshire Council
  - \* Dr Lynne Mitchell, WISE (Wellbeing in Sustainable Environments),  
University of Warwick
  - \* Professor Noel Whiteside, University of Warwick
  - \*\* WRVS

### APPENDIX 3: CALL FOR EVIDENCE

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The House of Lords Committee on Public Service and Demographic Change, chaired by Lord Filkin, was set up on 29 May 2012 “to consider public service provision in the light of demographic change, and to make recommendations”.

The main, though not the only, demographic change is the very significant increase in the older population of the United Kingdom now and over coming decades. Living longer and healthier lives is to be welcomed, but it increases the need for and cost of public services, as the Office for Budget Responsibility (OBR) set out in its *Fiscal Sustainability Report*, July 2012.

If current policies go unchanged, the OBR advises that the cost of public services will increase to unsustainable levels. We cannot borrow more, yet there is a limit to how much extra society is willing to pay in taxes. This forces us to consider wider ways to respond.

There have been official inquiries into aspects of this. What has been lacking is an overall consideration of the implications of demographic change and an ageing population, for publicly funded services, individuals and localities.

An ageing population will pose challenges and choices for individuals, families and government and requires a re-thinking of attitudes and expectations about work, retirement, savings and the welfare state.

It is also necessary to consider whether the services, funding and support for older people are ready and able to cope with this major change, and the efficacy of wider public services.

The Committee will look as far ahead as 2040, but will pay particular attention to the next 10–15 years.

We invite you to contribute written evidence to this inquiry by 1<sup>st</sup> September 2012.

The scope of the inquiry is wide-ranging, so respondents should select from the issues below according to interest and expertise.

The Committee is exploring the implications of an ageing society for public services<sup>524</sup> through the following six questions which it considers are fundamental. We invite you to address them.

- (1) Does our culture about age and its onset need to change, and if so, how?
- (2) Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?
- (3) Do the extent and nature of public services need to change? If so, how, and how should they be paid for?
- (4) Do we need to redesign and transform public services for these challenges? If so, how?
- (5) What should be done now and what practical actions are needed?
- (6) How can we stimulate national debate about these issues?

The appendix gives some background, but respondents should not be limited by this.

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<sup>524</sup> Public services are defined broadly to encompass all publicly funded actions including welfare payments. The welfare state itself takes about 2/3 of public expenditure net of debt payments.

## Appendix

### *A. What challenges will an ageing population pose?*

- (1) The population projections from the Office for National Statistics show the very significant growth of the older population, and there will be many social benefits from this. But the OBR's recent Fiscal Sustainability Report, July 2012, forecasts a worsening fiscal deficit as a consequence. Do these forecasts capture the challenges or underestimate them?
- (2) If life expectancy rises further but healthy or disability free life expectancy does not there will be costs for health and social care, for state pensions and for public sector pensions. Are these risks and costs adequately shared?
- (3) Raising productivity in the NHS and in public services generally is fundamental to coping with the immediate fiscal challenge. Do you think it will happen? If not, what are the implications for the coming demographic challenges?
- (4) What will an ageing society be like? What might this imply for individuals, families, and communities? What are the implications for individuals' capacity to work longer and live independent lives, and for productivity, competitiveness and inequality?
- (5) Do the additional fiscal deficits caused by an ageing society, the increased demand for services and better outcomes require a radical re-think by central and local government and the NHS to prepare and change to address them? What should be done?

### *B. What strategic choices need to be addressed?*

- (6) There are many benefits from an ageing population, but growing public sector demands and a growing fiscal challenge are consequences too. If society will not accept substantial tax increases what are the big choices for what the state does and what individuals do? Who should pay for what?
- (7) The increasing cost of an ageing population could put great pressure on expenditure on other priorities and investment. Will free health services, improved social care and decent state pensions all be affordable? What are the choices?
- (8) We will be better off in the future but there will still be a need to re-shape our expectations and our welfare state for an ageing population. Which attitudes and expectations need to change about our welfare state, about retirement, the age of retirement and inheritance?
- (9) Do we need greater clarity about what the state will and will not fund for the future, and a more explicit contract between the state and individuals? What should this be?
- (10) Do the dates when the state pension age rises reflect these coming changes? Are the risks and costs of public sector pensions shared fairly between beneficiaries and taxpayers?
- (11) How might inter-generational fairness be achieved? If we need to encourage younger people to save more for their own retirement, their social care and their higher education, can they also pay more taxes for an ageing population?
- (12) How are countries with similar ageing populations adapting?

*C. What reforms to public actions are needed?*

*General*

- (13) The additional demands and fiscal challenges caused by an ageing society, plus dissatisfaction with current services and outcome, require all public services to change for the better. Is this recognised, is it happening, if not what must be done?
- (14) Fundamental service re-designs may be needed. What might be the principles behind such re-design and are there attitudinal, structural and cultural impediments to making them happen such as silo structures and budgets, lack of preventative actions?
- (15) Where is it important for the state to reduce demand or transform its actions? Should we look at where expenditure is high yet outcomes are poor such as the management of long term conditions?
- (16) Which preventive programmes are most needed? Could new funding mechanisms such as social impact bonds make this happen?

*Older people*

- (17) How good are current services for older people? Services for older people are highly fragmented and subject to unhelpful financial incentives. What evidence is there of good practice in resolving these issues in the UK or abroad?
- (18) How should labour markets, employment law and practices change to enable older people to work?
- (19) How might government best stimulate and regulate markets to respond to the varied risks faced by vulnerable elderly people? What are the limits to such markets?
- (20) How can public actions help extend individuals' health and independence in older age? How can voluntary and community actions contribute more? How should housing services change better to support independent older living?
- (21) Funding constraints have already squeezed the resources available to private providers of long term care and NHS geriatric care. There have been concerns about standards in all sectors. What more should be done to improve standards and public confidence?

*D. What should be done now?*

- (22) Addressing these challenges requires public debate about choices, attitudes, and expectations. How can this happen? How can the public be stimulated to address the likelihood that they will live longer?
- (23) What should central government and local government and the NHS be doing now to address these challenges?
- (24) Changes to state priorities and efficacy for the medium term should arguably be significant considerations in the next public spending round. Is this happening?

The deadline for written evidence is **1 September 2012**.

## APPENDIX 4: ABBREVIATIONS AND ACRONYMS

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ADASS	Association of Directors of Adult Social Services
CAFCASS	Children and Family Court Advisory and Support Service
CBI	Confederation of British Industries
CIPD	Chartered Institute for Personnel Development
CQC	Care Quality Commission
Dilnot Commission	Commission on Funding of Care and Support
DCLG	Department for Communities and Local Government
DoH	Department of Health
DWP	Department for Work and Pensions
GDP	Gross domestic product
HMT	Her Majesty's Treasury
IFS	Institute for Fiscal Studies
IPPR	Institute for Public Policy Research
JRF	Joseph Rowntree Foundation
KCL	King's College London
LGA	Local Government Association
LITRG	Low Incomes Tax Reform Group
LSE	London School of Economics and Political Science
NAPF	National Association of Pension Funds
NHF	National Housing Federation
NHS	National Health Service
NIESR	National Institute for Economic and Social Research
OBR	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
PSSRU	Personal Social Services Research Unit
SOLACE	Society of Local Authority Chief Executives
TUC	Trades Union Congress
UCL	University College London
U3A	University of the Third Age
UEA	University of East Anglia