PUBLIC SERVICE AND DEMOGRAPHIC CHANGE COMMITTEE

Oral and written evidence

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Action on Hearing Loss—Written evidence

About us
Action on Hearing Loss is the new name for RNID. We’re the charity working for a world where hearing loss doesn't limit or label people, where tinnitus is silenced – and where people value and look after their hearing.
Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term ‘people with hearing loss’ to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to be made public.

Summary
1. Hearing loss dramatically increases with age – over 40% of people aged over 50 will have some form of hearing loss, rising to over 70% of over 70 year olds. There are currently 10 million people living in the UK with hearing loss and due to the ageing population this figure will rise to 14.5 million by 2031. It is therefore essential that any debate about the future of public services in light of our ageing population fully encompasses the needs of people with hearing loss.

2. Unaddressed hearing loss has a significant impact on public services and early intervention is vital if this is to be reduced. Left unaddressed hearing loss can lead to social isolation, early departure from the workforce, and can impact upon the effective management of other health conditions. The introduction of a hearing screening programme for older people would help to overcome some of the barriers which are preventing people addressing their hearing loss, such as stigma and the failure by some GPs to refer correctly.

Does our culture about age and its onset need to change, and if so, how?
3. Of the 10 million people in the UK with a hearing loss, six million people could benefit from the use of hearing aids - yet we know that only two million people currently use them. This means that there are four million people in the UK living with an unaddressed hearing loss.

4. An unaddressed hearing loss can have wide implications on a person’s life. Evidence has shown a link to depression and also an increased risk of dementia. In the average of 10 years that it takes for someone to address hearing loss, people can become isolated from both the workplace and from social networks.

5. A barrier that prevents people from addressing a hearing loss is the stigma associated with the condition, largely due to the perception that wearing hearing aids makes someone look old and changes the way that people view them. A major step toward normalising hearing loss could be taken through the introduction of a national hearing screening programme for older people.

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1 Action on Hearing Loss, Hearing Matters, 2011
2 Ibid
3 Ibid
4 Ibid
Economic research commissioned by Action on Hearing Loss has shown that at a cost of £255m over 10 years, a hearing screening programme for over 65s could save £2bn\(^5\), representing a benefit cost ratio of more than eight to one. These projected savings to the public purse would be delivered through such factors as an increase in the number of people able to remain in the workplace and a reduction in the support that people with unaddressed hearing loss need further down the line.

6. It is essential that hearing loss stops being viewed as an inevitable part of the ageing process and is instead seen as a condition that can be addressed. We welcome the inclusion of hearing loss in the Government’s Long Term Conditions Outcomes Strategy as this could play a crucial role in ensuring that people with hearing loss are supported to live well with hearing loss at every stage of their lives.

Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

7. It is essential that in our changing culture of an older workforce and rising retirement age, addressing and adapting to hearing loss becomes a normal part of the workplace experience. In our recent report *Unlimited Potential*\(^6\) we found that many people who started to lose their hearing whilst of working age did not know what to do or where to turn for support. The report brings together over 4,000 responses to our annual survey, in which we asked Action on Hearing Loss members about their experience of hearing loss in the workplace, and is also based on in-depth interviews with 27 people who have acquired hearing loss. It explores the support they received from their employers as well as gaps in provision.

8. Both employees and employers are often unaware of the support that can be available to people with hearing loss in the workplace, such as the provision of specialist telephones and induction loops, some of which may be funded through Access to Work, or the introduction of simple working practices to enable people with hearing loss to lipread colleagues. The report found that people with hearing loss often take early retirement, miss out on training and promotion opportunities or even face redundancy as a result of the condition. The report also found that prospective employers were often dismissive of people with hearing loss.

9. The report made two recommendations to government that would help older people in the workplace. These were to raise awareness of Access to Work so that both employers and employees are better informed about what assistance is available to them and to promote the Equality Act 2010 and highlight the implications of this Act for employers.

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\(^5\) RNID and London Economics, 2010

Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

10. It is essential that public services are fully accessible to people with hearing loss, particularly in light of the growth in the number of people with the condition. One public service where there are significant barriers to access for people with hearing loss is the NHS. We know that more than a quarter of patients with hearing loss have difficulty getting an appointment with their GP, where surgeries won’t book appointments by email, web or text. Of those patients who see their GP, over a third are left unclear about their diagnosis after the visit because of communication difficulties.7

11. The attitude towards the diagnosis of hearing loss by health professionals also needs to change. As well as the introduction of a hearing screening programme for older people as outlined above, it is essential that GPs, at present the point of access to adult hearing services for people with hearing loss, improve the way in which they diagnose hearing loss. 45% of people who were fitted with hearing aids said they were not referred to an audiologist the first time they raised the condition with their GP8.

Do we need to redesign and transform public services for these challenges? If so, how?

12. It is positive that steps are already being taken to transform public services to respond to the needs of people with hearing loss. The introduction of Any Qualified Provider (AQP) to the delivery of adult hearing services has the potential to improve access to these services as they will be available in a community setting and without the need to go through a GP, helping overcome the challenge cited above.

13. However, it is important that AQP is not seen as a panacea for improving the diagnosis and ensuring people address their hearing loss. Some people will still choose to go through their GP – indeed, 24% of our members in 2010 said that they would choose to go to a GP surgery to get hearing aids fitted if this was an option.9

14. The Government’s Long Term Conditions Outcomes strategy is a further positive step, particularly as it will take a holistic view of an individual with a long term condition such as hearing loss and identify ways in which they can be supported throughout their life and across all areas of it. We are grateful for the opportunity we have had to work closely with the Department of Health on the strategy, with hearing loss being one of only two conditions with a separate companion document, and it is essential that the best practice outlined in the strategy is enacted locally by Health and Wellbeing Boards.

15. Away from health services there are other positive steps being taken that we would like to see replicated across all public services. In several areas Jobcentre
Plus has taken the step of working with us to successfully gain the Louder Than Words charter mark, an award that recognises businesses and services that are fully accessible to employees and customers with hearing loss. We would like to see all public services strive towards this standard of accessibility.

16. One area where there is an urgent need to transform services is in mainstream residential care. In October 2012 Action on Hearing Loss will be publishing a report examining the experience of people with hearing loss in this environment. The report, entitled *A World of Silence: The case for tackling hearing loss in care homes*, suggests that there is a high level of undiagnosed hearing loss among people entering care homes. It finds that staff are often unaware of the basic support that they can provide to residents with hearing loss and it recommends better guidance to ensure that people with hearing loss in mainstream care homes are able to enjoy the maximum possible quality of life. The report suggests actions that should be taken by providers, government and regulators to ensure that residents with hearing loss are not isolated from those around them. We will provide the Committee with a copy of the report on publication.

**What should be done now and what practical actions are needed?**

17. The one thing that could most significantly reduce the barriers faced by older people with hearing loss when accessing public services is to ensure that people acknowledge and address their hearing loss at as early a stage as possible. The introduction of a hearing screening programme for older people would represent a significant step towards ensuring that this happens; as outlined above this would not only help normalise hearing loss and help people to address the condition but would also represent savings to the public purse.

18. It is essential that as the number of older people with hearing loss continues to grow, cuts are not made to hearing services. A short-term cut in this area will lead to an increased cost burden on health services as people present later with more advanced hearing loss and with additional complications such as connected depression and dementia. Commissioners should continue to provide resource for important hearing services and ensure that NHS efficiency savings do not translate into rationing of hearing aids, poorer access to audiology services or poorer follow-up care for hearing aid users.

19. Cuts will also lead to an increased burden on other public services, such as those provided by the Department for Work and Pensions, as people struggle to remain in the workplace as a result of their hearing loss. Action on Hearing Loss will shortly be publishing a report showing where in the country cuts are impacting on services and in what way, to encourage practical action where it is most needed.

20. As cited above, there are a number of positive steps being taken that could help ensure that the impact of hearing loss on an ageing society is minimised. It is essential that the potential benefits of bringing adult hearing services closer to the community through the introduction of AQP are fully realised without quality being compromised, and that the Long Term Conditions Outcomes strategy delivers a holistic, cross-government response to ensuring that people
Action on Hearing Loss—Written evidence

with hearing loss are supported to live well with the condition in all areas of
their life.

31 August 2012
Age Cymru—Written evidence

1. Introduction
1.1. Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

1.2. We are pleased to provide written evidence to the House of Lords Committee on Public Service and Demographic Change. Age Cymru is an independent charity working in close partnership with Age Scotland, Age NI and Age UK across the 4 nations of the United Kingdom, including on UK public policy issues. We have developed this response in partnership with Age UK and have sought to complement their detailed response by focusing on the specific policy issues of relevance to Wales, including those in areas devolved to the National Assembly, local government and public services in Wales.

2. Welsh strategic responses to an ageing population
2.1. Wales has a higher proportion of people of state pensionable age than other nations of the UK and the UK as a whole. In Wales 18.5% of the population was of state pension age in 2010, compared to a UK average of 16.5% and the proportion of people over the age of 80 was also higher. Within rural areas the ratio is generally higher, for instance in Conwy 24.5% of the population are aged 65 or over\textsuperscript{10}. This means that Welsh public services will potentially feel the effects of demographic change more acutely than other parts of the UK.

2.2. The Welsh Government has demonstrated a willingness to take a strategic national approach to ageing issues. In 2003 it published a Strategy for Older people, covering an initial 10 year period in two phases. The strategy sought to challenge discrimination and negative stereotypes of ageing and to celebrate longer life as an opportunity. It also placed a strong emphasis on the engagement, participation and empowerment of older people. It is a cross-departmental strategy for the Welsh Government and has also provided funding to the third sector and local government, upon which it relies to carry out many of the actions.

2.3. Over the past decade the Strategy has established a number of structures including: the appointment of a Government Minister with specific responsibility for older people; the appointment of Older Persons Strategy Coordinators (officer level) and Older Persons Champions (elected member level) within local authorities; and the creation and development of 50+ fora in each local authority area.

\textsuperscript{10} Population Estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2010, ONS
2.4. Phase 2 of the Strategy (2008-2013) has focused on the mainstreaming of ageing issues and consideration of the needs of older people across all policy areas in national and local government. Progress towards and achievement of this mainstreaming has varied in different parts of Wales, but a continued commitment to the Strategy for Older People (a third phase to cover the period up to 2023 is currently being developed) demonstrates a level of government commitment to strategic policy-making in this area.

2.5. Wales was also the first constituent part of the UK to create the post of an Older People’s Commissioner. The Older People’s Commissioner for Wales has a remit to be an independent champion for older people across Wales, and specific legal powers to hold public bodies and services to account in the way that they treat and consider older people.

3. **The impact of demographic change**

3.1. The potential financial costs of population ageing have been argued from a number of perspectives and we do not wish to repeat all the analysis provided by Age UK in response to the Office of Budgetary Responsibility’s *Fiscal Sustainability* report. However, we do want to support the point that an increase in spending on health care in particular is not inevitable as a result of increasing life expectancy. It is proximity to death, rather than age itself, which is the main determinant of the health care needs of an individual. The assumption that an ageing population necessarily results in higher expenditure in health care has been challenged by research analysis\(^{11}\).

3.2. In fact the latest figures released by the Office for National Statistics on 29 August 2012 indicate that in England and Wales the proportion of life spent in good health is increasing. The period 2005-07 to 2008-10 broadly reflected a period of compression of morbidity, with people spending longer periods of their lives in very good or good health and free from a limiting persistent illness or disability (though the figures were less positive for Scotland and Northern Ireland)\(^{12}\). This indicates health improvement and, whilst it should not lead to complacency, the figures should cast doubt on purely negative forecasts of the impact of population ageing.

3.3. It is also the case that a lot can be done to influence spending through service design and this is often not reflected in projections of the costs of demographic change. Focusing health and care systems towards detection and prevention through promoting independence and active ageing and identifying problems early (rather than just crisis management), should also be a cost-effective way to manage improved life expectancy.

3.4. Simply treating the ageing population as a ‘burden’ is to also miss the major contribution that older people make to society, both financially and in other respects. Older people are the primary providers of care in the UK, through the unpaid support they provide to spouses, other relatives and friends. Carers

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over the age of 60 have been estimated to provide up to £50 billion in unpaid family care\textsuperscript{13}. Increasing numbers of older people are also continuing in paid work and have been estimated to be providing £4bn in unpaid volunteering. The spending power of older people, the so-called 'silver pound', has also been estimated to be worth over £100 billion per year to the economy\textsuperscript{14}. Reporting of increasing life expectancy frequently appears to miss the point that having more fit, active, engaged older people who can carry on working, caring and contributing to communities is a good thing.

3.5. Truly investing in the ageing population and taking a life course approach would bring major benefits to individuals and to the public finances by:

- supporting individuals to make plans and save for their later life;
- encouraging employers across all sectors to make the most of the skills of an ageing workforce;
- ensuring that health and care services take a preventative approach to people's health, thus avoiding the need for more expensive crisis response in future.

3.6. To achieve this all three require concerted action and public services need to respond to growing numbers of older people, even if the additional years lived by individuals are generally characterised by reasonable health. We have highlighted several areas where we believe services need to respond including health, care and financial services.

4. Planning for later life

4.1. An important aspect of planning to meet demographic change is providing the right incentives, support and encouragement to people so that they can better prepare for their own retirement and later life. This is particularly vital in the areas of personal finances, health and care but in each of these the state must provide a minimum safety net and reassurance that allows individuals to make their own additional provision.

4.2. Many people currently drift into later life without considering how their lives might change as they age and what sort of environment and support they might need in the future. But this requires the right information and advice being available to people at each life stage. We need more financial tools, such as a simple and universal state pension and the caps proposed by the Dilnot Commission on social care costs, which would help people to prepare for and fund possible future needs. It is also important that services provide quality care and meet people's needs and expectations, as well as being designed to be effective and efficient.

4.3. It is also extremely important that there is a continuation of the type of public health awareness work which may have already delivered some improvements in healthy life expectancy. Health planners should always be looking to design interventions and services that seek to promote lifestyle change throughout the

\textsuperscript{13} Leeson, G. and Harper, S., HSBC, Future of Retirement, 2007

\textsuperscript{14} Calculation based on figures in Family Spending 2010, ONS
Age Cymru—Written evidence

lifecourse with the intention of further promoting healthy life expectancy. This requires supporting people to make healthy choices throughout their lives, though unfortunately public health has not traditionally paid much attention to the needs of people in later life\textsuperscript{15}.

4.4. It also means providing a safety net where they know that they will receive high quality health or care services at the right time, and will be supported with dignity by professionals. It is important that services themselves move towards a prevention and early intervention model, as opposed to being geared up mainly to react when things have reached a critical stage. This should bring efficiencies to spending but has been discussed for a number of years without being fully realised.

5. **Health services**

5.1. We strongly support the section in the Age UK evidence on the science of ageing and the importance of recognising the difference between chronological and biological age. Predictions of future health expenditure need to focus on the prevalence of age-related conditions as one aspect, but also to factor in the health profile of the population with a focus on chronic illness and proximity to death as key determinants of spending. Using chronological age alone does not necessarily reveal a great deal about the needs and cost of a growing older population across a number of public services areas.

**Mental Health services**

5.2. An area of health services we have held particular concerns about is in treatment of mental health. Ageist attitudes and practices among health professionals can currently prevent diagnosis of mental ill health in later life, and some of those who do receive a diagnosis are denied access to psychological therapies and other treatment options because of their age. We have even been informed of circumstances where people who have previously received treatment for mental health conditions being transferred to ‘older people’s services’, mainly set up to manage dementia or related conditions, upon reaching the age of 65 because they have passed an upper age limit.

5.3. The Welsh Government has recently consulted on a new cross-governmental strategy, Together for Mental Health, which seeks to adopt an “age inclusive” vision and includes an intention to end the current segregation of services upon age grounds. The Strategy also states that there will be no automatic transfer of older people with mental illnesses, such as depression or psychosis, to a specialist older people’s service. We are heartened by this intention to ensure older people with mental health problems have access to an equitable range of evidence-based services.

\textsuperscript{15} Age and Ageism in Primary and Community Care, Centre for Policy on Ageing, 2009.
Dementia

5.4. Together for Mental Health has also recognised the importance of improving services and support around dementia – which should be a major priority across the UK given future projections for increases in the number of people with dementia. Urgent action is required to further develop dementia support services in community settings and extend dementia training schemes. It is vital that knowledge and understanding of dementia is spread to general nursing staff, GPs and their staff, social workers and other professionals both inside and outside of health and social care. Within the health and social care sector we believe that dementia training should be mandatory.

5.5. Work is being progressed in Wales (and across the UK) on creating dementia-friendly communities. In Wales, the Alzheimer’s Society has worked with the Welsh Government to produce a National Dementia Vision for Wales with a long-term vision of creating ‘Dementia Supportive Communities’, which have the capacity to support people affected by dementia. We believe that progress must be built on in this area with dementia training a key component in ensuring that our communities and services are able to protect and support a potentially increasing number of people with dementia in future.

6. Care

6.1. One of the biggest failures in regards to planning for, and reacting to, an ageing society has been the lack of significant reform of the social care system. The way in which we provide social care is one of the primary weaknesses of our public services and one of the biggest costs associated with an ageing population if changes are not made.

6.2. Chronic underfunding by national government over a number of years has resulted in increasing eligibility criteria for local government social services and significant levels of unmet need in communities across Wales. This financial pressure has, in turn, led to a race to the bottom in the quality of care many people receive from both residential and home care services. Private sector provision can make a valuable contribution to a healthy social care system but unfortunately our current system is characterised by disputes between providers and local government about fee levels, self-funders paying higher fees to subsidise local authority placements, and concerns over the viability of providers – an issue brought to the fore by the collapse of Southern Cross in 2011.

6.3. In the current social care system, individuals and their families bear the full risk and responsibility for the catastrophic cost of long term care needs. One in ten people will require over £100k worth of care in later life and currently have no effective way to protect themselves. As a result we see people with moderate incomes and savings losing nearly 90% of their assets, a situation many feel is unfair and penalises those who have been able to make even modest financial provision for their later life.

6.4. The private sector has consistently struggled to develop insurance products to meet people’s future care needs because of the uncertainty in state policy, the risk
of unlimited liability and the size of the risk pool. Even if the private sector
developed products to assist people in pooling the risk of paying for care, there
would still be people who could not afford those products and therefore a need for
the state to act as a final safety net. Only the state can use its unique capacities to
remedy these short comings and ensure that all citizens have access to high-quality
care regardless of their means or ability to contribute.

6.5. Under the current system, the fear of catastrophic cost and no reasonable way to
limit personal liability means that even the most conscientious of people struggle to
plan and prepare to meet the cost of their own care.

6.6. The Welsh Government only has the resources to tinker around the edges with
the system and cannot realistically enact the degree of system reform required. In
2011 it used its legislative powers to seek to limit the costs incurred by people
who use non-residential social care services and to limit regional variations in the
levels of fees charged. The so-called 'First Steps Improvement Package' resulting
from the Social Care Charges (Wales) Measure 2010, introduced a maximum
charge of £50 per week for non-residential care services provided by social
services in Wales. This took effect from April 2011 and an evaluation of the first
year is currently being undertaken. We welcomed the move which should have
removed some of the highest charges incurred by older and disabled people for
care they need, however it is only one step on the road towards the major reform
required in social care. Realistically, given the smaller scope of the Welsh
Government’s budget and its limited revenue raising powers, this reform must be
undertaken by the UK Government.

7. Finances in later life
7.1. The proposed single-tier state pension, set to be outlined in greater detail by the
UK Government in autumn 2012, would represent a step forward in the state
presenting a level of security and stability for individuals, above which there
would be a greater incentive for people to make their own additional provision.
It should provide a clearer minimum standard of income in retirement without
need to resort to means-tested support and create a clearer platform for
private saving. It would also provide many women, carers and lifetime low
earners with higher pensions than they receive currently.

7.2. Reducing reliance on means-testing could have important benefits. Many older
people currently rely on the support provided by benefits such as Pension
credit, yet many are missing out on their entitlements – up to a third of those
who would qualify. As the proposed single-tier pension would not apply to
current older people, governments must continue to look at ways to maximise
take-up of means-tested benefits. We are concerned that moves to place
support such as Council Tax Benefit within the remit of local authorities will
have exactly the opposite effect.

7.3. If we are to achieve greater individual preparation for later life more must be
done to encourage private pension saving. Currently only around half of all
employees save into a private or occupational pension. We believe that more
people will do so if they can be assured that they will get a reasonable return
from their savings when they realise them. The UK Government’s policy of
auto-enrolment could provide an important step forward in providing an easier route to private saving, but delays in its implementation and watering down of the scheme risk undermining its full potential impact.

7.4. The UK Government has brought forward the equalisation of the state pension age at 65 for men and women and the planned rise to 66 for both groups. It has also set out plans to accelerate a future increase to 67 and is planning to carry out regular reviews to take into account future increases in longevity. The aim is to control spending on state pensions and related benefits and to encourage longer working. The Government has also made the welcome move of abolishing the Default Retirement Age (DRA) which allowed employers to forcibly retire workers when they reached state pension age.

7.5. These changes are part of wider government moves towards encouraging people to lead longer working lives. We believe that it is reasonable to review state pension age as life expectancy increases but we would not support an automatic link. This is because of the need to consider the effects on disadvantaged groups who have a lower life expectancy than the average, and who would stand to lose a greater proportion of their retirement with every year the state pension is delayed. We also do not believe it is possible to consider linking retirement age with life expectancy more closely without also looking at: how we can help people work longer; understanding trends in the health of older people past the current retirement age (and how this may look in the future); and helping business prepare for the impact this may have on the needs of their workforce, such as through more flexible and part-time working.

7.6. Despite recent legislative reforms a step-change is still required in the attitudes of many employers towards employing and retaining older workers. This requires greater leadership from government to encourage flexible working and skills sharing/mentoring from older workers to new employees (things the best employers already offer). There is also a need to ensure that unemployment support and access to training is available to people in their 50s and 60s to help them to continue in work. In-house research carried out recently by the DWP\textsuperscript{16} acknowledged that older claimants, and in particular those in their 60s, can face a range of age related barriers to employment. These include a lack of modern job search skills, limited IT proficiency and more emotive issues such as confidence and a belief that employers routinely discriminate against older jobseekers. These issues must be tackled by support programmes which recognise and target the specific issues faced by people in their 50s and 60s, and the research came to the conclusion that further enhancements can be made to provision.

8. Age-friendly communities

8.1. Local communities, as the environment in which people live, are vitally important in supporting people in later life. The home and immediate external environment sets the tone for daily life and impacts on the health and wellbeing of older people. While many continue to play an active part in their community,

\textsuperscript{16} How ready is Jobcentre Plus to help people in their 60s find work? In-House Research No 11, DWP, 2012
problems with mobility, vision and memory can make their neighbourhoods difficult to navigate. We want to see greater recognition of the concept of age-friendly communities, which means designing and developing an inclusive environment for all ages.

8.2. All neighbourhoods are different and the older people who live in them have differing priorities and needs, however there are common issues that many older people report need to be improved to make their community age-friendly. Lack of public transport, or somewhere to sit down, or access to clean public toilets limits how far people are able to go. Poor quality pavements or street lighting can stop people feeling confident enough to go out at all.

8.3. Age Cymru undertook a detailed survey during 2010 of older people’s perceptions and experiences of how age-friendly their communities are. The Community Calculator was completed by over 800 older people in Wales and demonstrated that a number of factors are important in determining whether a local community or neighbourhood positively contributes to supporting older people, or whether it presents barriers to their participation. The provision of public toilet facilities was consistently felt to be the area most in need of improvement across Wales, whilst a third of respondents scored public seating poorly and 10% were critical of public transport.

8.4. Consistently the results demonstrated that without neighbourhoods and local services designed with older people in mind, people are much more likely to feel isolated and cut off from their local community and local services. This in turn can result in poorer health outcomes and an increasing reliance on public services.

9. Conclusion
9.1. We hope this evidence has been useful to the Committee in their consideration of this important issue. Wales can be seen to be increasingly taking a distinct direction in tackling ageing issues within devolved areas, though overall the primary issues and challenges remain comparable across the UK.

9.2. Whilst steps have been, and are currently being, undertaken to address some of these issues, many challenges and opportunities remain. We have sought to outline some of the foremost of these in this evidence paper, and overall we believe that there is still much greater scope to mainstream consideration of the issues affecting older people across all public sector organisations and services. Too many services have in the past appeared to consider the needs of older people as an afterthought – even the NHS despite the majority of patients accessing health services being in later life – and this must change if we are to respond effectively to an ageing population.

31 August 2012
Alzheimer’s Society welcomes the opportunity to provide evidence to the House of Lords Select Committee on Public Service and Demographic Change. As requested, in addition to our submission, please find attached a snapshot of quotes and experiences of people living with dementia relating to session 12: ‘Local practitioners’ roundtable: problems of joining up local-level services.

Alzheimer’s Society is the UK’s leading support and research charity for people with dementia, their families and carers. We provide information and support to people with any form of dementia and their carers through our publications National Dementia Helpline, website and more than 2,000 local services. We campaign for better quality of life for people with dementia and greater understanding of dementia. We also fund an innovative programme of medical and social research into the cause, cure and prevention of dementia and the care people receive.

1. Dementia
Dementia represents a major challenge to the health and social care system. There is urgent need for careful planning to ensure that the right care and support is available in the future.

The term ‘dementia’ describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer’s disease and damage caused by a series of small strokes.

Key statistics on dementia include:

- There are now 800,000 people with dementia in the UK.
- Over 17,000 younger people (65 years of age or below) have dementia and at least 11,000 people from black and minority ethnic groups have the condition.
- Two thirds of people with dementia are women.
- The proportion of people with dementia doubles for every 5 year age group.
- One third of people over 95 have dementia.
- 60,000 deaths a year are directly attributable to dementia and dementia is one of the top five leading causes of death in the UK.
- There are estimated to be 670,000 people in the UK acting as primary carers for people with dementia, which saves the state £8 billion per year.
- One-third of all people with dementia in the UK live alone in their own homes.

Because the size of the population is growing and people are living longer, by 2021 there will be over 1 million people living with dementia in the UK. This currently costs the NHS, local authorities and families £23 billion a year (Alzheimer’s Society, 2007, updated to reflect 2012 figures), and this will grow to £27 billion by 2018 (King’s Fund, 2008). Many people talk about the 'demographic time bomb' or 'tidal wave' of older people, which the state cannot afford to cater for. The Society believes that this is misleading. A steady, rather than dramatic growth is expected over the next 25 years. Furthermore, the term “time bomb” suggests a challenge that is in the future, rather than one which is happening now.

Despite the number of people living with dementia, and the associated costs, numerous reports from the National Audit Office (NAO)2021, Public Accounts Committee, regulators, NHS Atlas of variation (NHS Right Care, 2011) and Alzheimer’s Society show that many people with dementia are being let down. Despite the significant spend on dementia, this is not being developed effectively and too many people are not provided with good quality care and support that meets their needs and aspirations. Furthermore, the quality of care varies considerably across geographical areas.

2. Increase awareness, understanding and diagnosis
Early diagnosis is a critical first step in assisting people to live well with dementia. We need to ensure that everyone with dementia is diagnosed so that people receive the support, information and treatment they need to live well with dementia.

Yet, in England, only 41% of people who are living with the symptoms of dementia have a formal diagnosis. People often delay seeking help when they are concerned about memory problems and there is a perception that dementia is a natural part of ageing. Some health professionals have not received sufficient training to recognise and diagnose dementia, or do not see the value of a diagnosis. To change this, a major increase in public awareness and understanding of dementia is required to reduce stigma and encourage people to visit their GP with problems about their memory.

3. Improve health and social care systems
Many health and care services in the UK struggle to respond and cope with the challenge of dementia. As the symptoms of dementia progress, people need increasing amounts of care. Two thirds of residents in care homes have a form of dementia22 and up to a quarter of hospital beds are occupied by someone with dementia23. Yet there is unacceptable variation in the quality of dementia care provided across care settings.

People with dementia need to be placed at the centre of their care and emphasis shifted to investing in services in the community so that people can live in their own homes for longer. When care in care homes and hospitals is appropriate, attention must be focused on improving the quality of care provided including ensuring good quality end of life care that meets their needs.

It is of serious concern that Care Quality Commission’s recent report on the state of health and social care identified that 27% of services (3,617 locations) were not meeting at least one of its professional standard on 31 March 2012. Planning is required now to a robust and effective regulatory system is in place, ensuring the health and care services people with dementia use are of sufficient quality and action is taken where standards are not being met. Pressure is increased as this is placed in a context where older people are accounting for a bigger proportion of NHS hospital activity every year.\(^\text{24}\)

4. **Create inclusive and dementia friendly communities**

Work must be undertaken to understand what makes a dementia friendly community and how communities can best support people with dementia and carers to live well. Communities must be enabled to understand how to help people with dementia and carers live well within the community. Integration of health services is critical to this work. Support should also be provided to community agencies, for example, shops, businesses, the public sector and churches, as they contribute to developing dementia friendly communities.

People with dementia and carers must be at the heart of the dementia friendly communities work. They should be key partners, speaking out about their experiences of living well with dementia and the solutions they would like to see. There should be particular work to apply the thinking and practice of dementia friendly communities to health and social care services to ensure that social networks are maintained and developed.

5. **Recommendations**

In responding to the challenge ahead, commissioners across the UK need to prioritise the integration of health and social services in dementia.

Local authorities must play a key role by ensuring that there is independent provision of information about local services across the spectrum of the statutory, voluntary and independent sectors. This information should be presented in a format which is accessible to people with dementia and carers. Local authorities should also ensure that people with dementia have access to a named contact throughout their life with dementia.

Major improvements are required in the quality of care provided in all care settings, while also focusing on services to maintain people’s independence and ability to live in their own home for longer. Resources should be shifted from inappropriate acute and residential care for people with dementia into the community setting. This

Alzheimer’s Society – Written evidence

would help ensure that the right support is available for people with dementia and carers such as early intervention and prevention services, and respite care services.

The need to improve health and care staff understanding and skills on dementia is increasingly recognised. However, more work is needed to equip all staff with the skills to provide effective and efficient dementia care. Hospitals need to look at staff capacity for delivering high quality dementia care and prioritise workforce development budgets for dementia. Training for health professionals needs to be provided both pre- and post-registration.

The government should put forward plans to implement the recommendations from the Dilnot Commission on Funding of Care and Support (2011) but this will not go far enough to reform the social care system. Extra funding is needed to ensure that people with dementia and carers can access better quality as well as more care.

Alzheimer’s Society would encourage an open debate on areas where money could be released to fund the implementation of Dilnot and improve quality in social care could come from. Alzheimer’s Society also supports implementing areas of Dilnot’s recommendations which do not require legislation or extra funding more quickly, as long as there are guarantees that this is part of a wider programme. The key parts of the proposals, where fees are capped and the means test threshold are raised, must also be implemented.

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Appendix A: Local practitioners roundtable: brief overview and snapshot of experiences from people with dementia

1. Introduction
The document sets out the experiences and key learnings people living with dementia in regard to their care and the lack of integration of health and care services at the local level.

We understand that maintaining independence and quality of life are of key importance to people with dementia. Support and care received by people with dementia and their carers must be focused on empowering people with dementia to achieve these aspirations.

2. Aspirations for support and care
Research for the Dementia Action Alliance’s National Dementia Declaration identified that people with dementia wanted access to services that are designed around them and their needs. To support discussion by the roundtable on ideal systems for people with dementia, consideration could be given to a range of statements by people with dementia and carers that support the declaration. They are:

- I feel supported and understood by my GP and get a physical checkup regularly without asking for it
- There are a range of services that support me with any aspect of daily living and enable me to stay at home and in my community, enjoying the best quality of life for as long as possible
• I am treated with dignity and respect whenever I need support from services
• I only go into hospital when I need to, and when I get there staff understand how I can receive the best treatment so that I can leave as soon as possible
• Care home staff understand a lot about me and my disability – they know what helps me cope and enjoy the best quality of life every day
• My carer can access respite care if and when they want it, along with other services that can help support them in their role.

However, despite these aspirations and ambitions, 50% of carers and people with dementia say the person with dementia is not receiving sufficient support and care to meet their needs and co-ordination of care was still perceived to be an issue for many. Only 26% of respondents to the Support. Stay Save. report said they thought services worked well together. Those responding who said support was insufficient and did not meet needs reported negative repercussions on the person with dementia and carer’s physical and mental health.

The data used to inform Dementia 2012 found that a significant number of people with dementia did not always receive help to live as independently as they needed to. There are significant difficulties linking housing, health and social care services and support. Respondents to Dementia 2012 also reported that professionals do not always involve people with dementia in decisions about their care and support.

When asked what more could be done to make sure that care and support were more focused on what they wanted, several respondents said they wanted services better designed around their needs. One respondent reported:

‘[I want] a complete change in the way social services are run and a change in its focus. One size does not fit all and the forcing of clients into residential care is not the only solution. They did not listen to us and also wasted public money insisting on putting into place things that would never work for us. They were told not to do it but went ahead and these have proved a complete waste of money. A meeting with social services is a box-ticking exercise.’

Person with dementia

There was a clear perception among people with dementia responding to the survey that it is hard for them to exercise choice over their support services, or to influence decisions about their treatment and care. The evidence suggests ongoing problems accessing services and support, which may be reducing choice over the services people can receive. While there is evidence of a range of services that could support people with dementia, in many areas these are not available. The current funding system for social care severely limits access to services, and people often cannot access support until their needs reach crisis point (Alzheimer’s Society, 2008a).

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3. Recommendations

Alzheimer’s Society seeks that commissioners in Wales, England and Northern Ireland prioritise integration in health and social care services for dementia. In England, health and well-being boards should recognise that dementia represents a key opportunity for integration of care and support. In particular, the system must be adapted to meet the particular needs of people with dementia and carers, including commissioning of support brokerage services to facilitate access. Timely and appropriate information for people with dementia and carers must be provided.

People with dementia and carers should have access to a range of different types of services, including prevention, early intervention, reablement and intermediate care services. Timely information and effective coordination is a critical to ensuring a seamless transition between services. Specifically:

- Joined-up diagnosis and assessment services must be put in place to ensure early detection and intervention, which can be crucial in enabling people with dementia to remain at home for longer.
- NHS and social care should look at ways of promoting joint working above and beyond commissioning, including joint training and multi-disciplinary team working.
- Local joint dementia strategy implementation plans or joint dementia action plans should be produced by health and social care commissioning bodies in England, Wales and Northern Ireland. These should made publicly available and accessible so local communities can hold local authorities and NHS commissioners to account.
- Mechanisms for sharing best practice in providing good quality dementia care have to be expanded and exploited. Levers for encouraging use of existing mechanisms for sharing best practice, such as the Social Care Institute for Excellence (SCIE) Dementia Gateway, should be explored.
- People with dementia and carers should be involved in monitoring quality of care and support services. Where possible, such monitoring should involve more in-depth forms of feedback to ensure issues and criticisms are identified and the opinions of those with more advanced dementia are not excluded.
- Local commissioners should ensure first contact services are able to provide advice and information on housing and housing services, alongside information on social care and third sector services.

Please find below the following three sections:
A1: Web of Care
A2: Positive examples of joining up services and communities
A3: Quotes from people with dementia.
Integration is broadly very poor for people with dementia. Overall, it is highly challenging as it takes a lot of organisation, and brave and skilled commissioning to be effective. Where it works it can make a real difference and save money. Key here is also working with families, understanding and acting on the wishes of the person as expressed by their family.

The following diagram presents the range of services required by Malcolm, a person with dementia, and his wife Barbara. This illustrates the complexity involved in coordinating local care.
Appendix A2: Positive examples of joining up services and communities
Dementia friendly communities in urban and rural settings – Plymouth

Dementia friendly city

The University of Plymouth’s Dementia Research team (PDRT) worked with the City of Plymouth and Alzheimer’s Society to develop a Plymouth Dementia Action Alliance (PDAA). The PDAA is committed to becoming a Dementia friendly city by November 2012. To achieve this, over 30 organisations are continually assessing and improving their understanding of the needs of individuals with dementia and carers, with the aim of transforming quality of life. Membership of the PDAA also ensures that the organisations have:

- connection to a network of dementia experts, including senior officials in health and social care, researchers from the University of Plymouth and people from the voluntary sector working in the field of dementia
- receipt of the latest news and material on relevant dementia projects
- meetings and events throughout the year organised by the PDAA
- guidance on developing and implementing dementia friendly city approaches
- participation in discussions of best practices for building a dementia friendly city
- facilitation of partnerships or collaborative activities between other cities.

Dementia friendly rural parishes

As part of this work, a pilot project to help people with dementia and carers in rural communities to access support and services is being completed.

The steering group includes representatives from five parish councils, Alzheimer’s Society, Plymouth University Dementia Research team and others. The group has created a job description and person specification for a community development project worker. This person will raise awareness about dementia in the community, particularly with local businesses and organisations.

The aim will be to develop an inclusive community approach in the villages for people with dementia and their carers. This includes liaison with GPs and other health and social care professionals to develop individual services and opportunities, which will be done in consultation with people with dementia and carers from the community.

The PDRT will evaluate this innovative pilot project, with a view to using the model in other rural communities.
Appendix A3: Quotes from people with dementia

“Talk to carers please, or family members! Don’t assume you (hospital staff) know it all. You don’t!” (Carer for a person with dementia)

“There are a lot of people who don’t know how to get information. I’ve had problems previously, so I’ve had a good idea what doors to knock on” (person with dementia)

‘Mental health home treatment teams rarely arrive in the chosen 2- hour slot and with so many different members of the team visiting, and no continuity, it causes real anxiety to the patient.’ (Carer for a person with dementia)

“It seems clear to me that when my wife was in hospital most of the nursing staff failed to appreciate that dementia sufferers need a tailored care system, which was different from the regime which catered well enough for other patients.” (Carer for a person with dementia)

‘My wife was bedridden for two weeks. After leaving hospital, she was unable to walk although the discharging doctor said she was satisfied with my wife’s mobility’.

‘I feel that ‘holistic’ care is abandoned because the clients have a dementing illness, for example, choices should still be given to the client on what they would like to eat, what they would like to wear, what they would like to do with their day etc. Spiritual/religious beliefs should also be catered for.’

‘I wouldn’t want to put her into a care home. I want to stay with her for as long as possible. To part with her; I couldn’t do that. Unless it came to something serious and I couldn’t look after her.’

Carer of person with dementia in rented mainstream housing

‘There’s so many things out there you have to learn about and apply for. It’s a learning curve.’

Carer of person with dementia in mainstream housing

‘I rang the social services, but they weren’t interested, at least that’s the feeling I got. So I’m no further on in terms of social workers.’

Carer of person with dementia in mainstream housing

December 2012
Age UK—Written evidence

As our society ages it is important that the Government recognises and deals effectively with the opportunities and challenges of changing demographics. Age UK’s mission is to improve the lives of older people, making a practical difference to people today whilst working for a better later life in the future. We are a charity and a social enterprise driven by the needs and aspirations of people in later life. Our vision is of a world in which older people flourish and we believe that as well as confronting the challenges that come with an ageing society, we should also focus on maximising the benefits of living longer.

Below are our responses to the six questions that the Committee invited responses to.

I. Does our culture about age and its onset need to change, and if so, how?

- At present 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’. While many older people need support from the state – from those who have significant care and support needs to those who rely on the state pension for their income – later life is changing fast. Many of our growing older population are in good health, will retire with a decent income and a strong social network, and have much to offer society. Properly captured, this potential is enormous.

- Understanding the needs of older people today and the expectations of the rising generation is essential to inform the debate upon the role of the state and the design and delivery of public services.

- Some people will want to carry on working, perhaps flexibly, or take up some new activity; others will begin or increase voluntary work or want to spend more time with their grandchildren. Most will want to do a combination of these and many other things. For many, the idea of older age is not for now but for the future, and some, perhaps having seen or having supported their parents through their older age, will want to plan and prepare for it but may be frustrated by the relative lack of good independent information and advice that is currently available.

- Almost all put a high premium on remaining independent and utterly reject the idea of retirement as a period of narrowing horizons, failing health and a slide into dependency. A theme of this submission is that it will pay policymakers to work with that grain. Promoting independence spares our public services from otherwise costly interventions as well as releasing the skills and knowledge of the older population to enhance families and communities.

- Age discrimination is a major barrier and remains too prevalent. Older age is too often mocked and there is still too much explicit age discrimination in both the public and the private sectors. We are clear that the Equality Act 2010 and the Public Sector Equality Duty are hard won legislation and essential cornerstones for future progress.

- Those who talk about the ageing population as a ‘burden’ sometimes point to the increasing costs of paying state pensions and benefits to older people. However, Age UK believes it is important to balance the overall costs of state pensions and other support with the huge contributions that older people make through employment, volunteering, caring for partners and grandchildren and through the tax system. These contributions are often hidden and
difficult to calculate but are undeniably very substantial. Just consider how many working families would find life impossible without being able to rely on grandparents for childcare support.

- Generalisations about our ageing population are misplaced because they obscure the enormous variations which exist between older people. In no respect is this more the case than in terms of poverty and wealth: in the 55-64 cohort for example, the top decile holds household wealth of £1.3m whilst the poorest tenth has less than £28,000.

- Improving opportunities across the life course is crucial to improving outcomes in later life. The level of inequality that characterises the cohort of older people must be taken into account in policy development, particularly over decisions about raising the state pension age.

2. Do our expectations and attitudes to work, savings, retirement and independence need to change, and if so, how?

- Investing in an ageing population, taking a life course approach, designing health services to meet needs more effectively, encouraging employers to make the most of the skills of an ageing workforce and helping people to plan and save for retirement would together help to ensure that a long life is a good life. It is important that we support people to live reasonably well as they get older, not merely to get by.

- There is a view, offered most frequently by cash-strapped public service providers, that people should take more responsibility for their lives. In our experience older people are not necessarily unwilling to do this if they are able and helped to do so. But transferring that responsibility must not simply be a matter of arbitrarily stopping or severely curtailing support which people have had a legitimate expectation all their lives of receiving when they needed it. The plan for a single tier state pension with clear criteria for eligibility is a good example of building on and simplifying the present system.

- It is important to recognise that much risk that was previously borne by the state or by employers has already been transferred to individuals. For example, the shift in the private pensions market from defined benefit to defined contribution pensions means that most current pension savers bear both investment and longevity risks. The state still has an important role to play in facilitating the pooling of risk and ensuring that all citizens can access essential services that the market cannot or will not provide.

- The NHS is the obvious example, and social care as it stands is the obvious anomaly, one we think it is crucial to address as a matter of urgency. One in ten people will require social care exceeding £100,000 in older age and consequently we see those people who are unfortunate enough to develop this need losing nearly 90% of their assets, if they have only modest incomes and savings. The Government should provide a framework for individuals and markets to plan ahead for these costs by implementing the proposals of the Dilnot Commission and ensuring that all citizens have access to high quality and affordable care.

- The private sector has struggled to provide satisfactory care and care funding services. Better regulation, a clear and transparent legal framework and improved provision of information by local authorities as proposed in the recent Social Care White Paper all have a role to play in compensating for market failures and in helping markets to thrive.

- Given longevity gains it is entirely reasonable to review state pension age, but any decisions must be based on analysis carried out by an independent pensions’ commission of the most important variables, including health inequalities and employment trends.

- It is the Government’s responsibility to ensure that the barriers to a 50+ working population staying in employment are properly addressed. For example, there is a clear
need for older people to have more access to unemployment support, training and flexible working. Ageist attitudes among some employers and, unfortunately, some Jobcentre Plus staff also need challenging. It is important to note however that not everybody will be able to work for longer. This could be because of illness or disability, or because of caring responsibilities. Financial support must continue to be there for these people – we cannot rely on work alone to provide for everyone in later life.

3. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

- This question implies that the ‘extent’ and/or the ‘nature’ of public services are financially unsustainable and need to change. We think these assumptions are incorrect. In our view recent projections from the Office for Budgetary Responsibility that appear to support this view are inappropriately based on a simple multiplication of demographic change and existing expenditure in three key areas – pensions, the NHS, and social care. They do not contemplate significant changes in key areas, for example, improvements in medical care. For this reason Age UK believes they are generally too pessimistic, as explained more fully below.
- The growth of the state pension budget is a fairly robust calculation. Promises made and rights accrued are guarantees which cannot be lightly overturned.
- In health and social care, however, there is no similar rigidity. Focussing our health and care systems away from crisis management and towards detection and prevention could offer cost-effective measures that promote independence and active ageing. Increasing years of life expectancy must not translate into increased years of ill-health; we believe that it is essential that we work to prevent this and that there is a good prospect of success if we do.
- The NHS does not always deliver optimum health outcomes for older people and frequently fails to commission precisely the care they need. For example, there are well known deficits in cancer care, despite older people being the most at-risk group. The National Cancer Equality Initiative notes barriers to treatment including poor understanding of older people’s health needs, assumptions based inappropriately on chronological age, and lack of information for older patients. There is also evidence of under-treatment and barriers to treatment in heart disease, stroke and diabetes care.
- There is an emerging debate around universal versus means-tested benefits. Universal, age-based benefits such as Winter Fuel Payments, the bus pass and free television licences have attracted criticism from some who suggest they are unaffordable at a time of austerity. However, we believe that such assertions understate the very real needs that these benefits often meet and the problems associated with more targeted approaches. For example, for a number of reasons universal benefits undoubtedly reach the very poorest older people much more effectively than means-tested measures. They also smooth the cliff-edge of means-testing, reaching people whose modest savings de-bars them from those benefits.

4. Do we need to redesign and transform public services for these challenges? If so how?

- The potential cost of an ageing society is not the only reason why we need public sector reform. Services need to be changed because they were often designed for a wholly different world and need re-configuring to reflect the ageing population we have today and will have tomorrow.
• The starting point must be a much fuller and more open and honest engagement with older people themselves. This is not necessarily straightforward because many older people have been ‘consulted’ on numerous occasions and are cynical about whether anything ever changes as a result. A real effort will be needed to shift their perception; it is one we definitely believe to be worth making.

• The most significant challenges for health (and especially public health) strategies are the urgent need to tackle the issue of managing chronic conditions and to support the growing numbers of people living longer with multiple physical and mental long term conditions – including dementia - which limit their lives. These and other needs presented by older people must be fully reflected in the Joint Strategic Needs Assessments, and acted upon by Health and Wellbeing Boards and Clinical Commissioning Groups. If we can improve the NHS’s performance in these ways the impact on older people’s health outcomes would be truly transformational and scarce public funds would be much better spent.

• The design of neighbourhoods, with adequate transport provision and appropriate local services, is important to prolonging independence. This idea is picked up in the phrase ‘age-friendly neighbourhoods’ and refers to the importance of designing an inclusive environment that works for all ages. Lack of seating and public lavatories, and poor street lighting and broken pavements all contribute to preventing older people feeling confident about going out and about. There is a clear relationship between the quality of the neighbourhood and social isolation in later life and equally clear links between loneliness and isolation and declining physical health. For these reasons there is a compelling case for neighbourhood design to be taken much more seriously than it is at present; the NHS would be a major beneficiary.

• The Government has set out some important over-arching ambitions as the context for public service reform. Many of the Government’s ideas are welcome but there’s a need to make sure that they really are suitable for an ageing society. Regular impact assessments might be the most helpful tool.

• Often, a model of co-production between the state and the individual generates the best results. For example, many older people with modest lifetime incomes will never be in a position to build up adequate resources from private provision alone, so the state will always have a role in retirement income provision. Likewise, many will never save the resources necessary to fund the potential costs of long term care. Without state support and encouragement such individuals may elect not to make any provision at all, which would be a perverse outcome and result in the state spending more to meet needs arising from dependency or a crisis.

• One of the areas of reform which offers the opportunity for significant efficiency gains is the move to digital technology, meaning not just electronic communications and information provision but also telecare, telehealth and assistive living technologies. But before public services invest too heavily in digitalisation they need to take care to understand exactly how older people will actually engage with it. Issues of access, confidence and cost all need to be taken into account. With only 56% of people aged 65-plus ever having used the internet, Government will need to make significant investments for the foreseeable future in digital inclusion and in offline methods of accessing public services.

• More generally, it is important to note that chronological age is often used as a proxy for biological age, yet we know that the two are not synonymous. The Government must ensure the adult population is not simply divided crudely into those above or below a specific chronological age such as 65 when developing policies.
5. What should be done now and what practical actions are needed?

- Age UK’s annual policy review ‘Agenda for Later Life’ presents a snapshot of how our older population is faring. It also outlines the action that we believe Government needs to take in respect to money matters, health and wellbeing, home and care, travel & lifestyle and work & learning. Many of these priorities require action from the wider community as well as from government: from local government, third sector bodies, private sector organisations and older people themselves. Our policy review aims to articulate a vision of ‘active ageing’ that allows people to participate in society and realise their potential for physical, social and mental wellbeing throughout life, while providing adequate protection, care and security when needed.

- Government departments need to review their budgetary and accountancy practices to encourage and enable spending in one area which results in savings in another. This is particularly important in the context of health, social care and housing, all of which are crucial in supporting people to live well in later life and all of which demonstrably improve older people’s outcomes, but not always in linear ways that are susceptible to simple accounting procedures.

- Promoting age equality and providing age-friendly services requires a public service to have a good understanding of the barriers facing older people, both as staff and service users.

6. How can we stimulate national debate about these issues?

- Political parties must exploit the opportunities offered by the spending review and the next general election to pick up these and other issues and to engage with the public on them. Together with stimulating debate on some of these specific themes politicians must also consider and encourage discussion on how we should address ageing more broadly, thinking about what an ageing - as opposed to an older people’s – strategy would look like.

- Language matters in these debates. Policymakers need to take responsibility for how they talk about the impact of an ageing population and be aware of how the public may respond to the terms they use, especially value laden phrases words such as ‘burden’. Politicians need to recognise that an ageing society is likely to impact on politics, just as it is on most other areas of life. It is in their interests as elected politicians to take action to understand the views and perspectives of older people and to begin to incorporate these into policy development in a more effective way. We are not suggesting that older people be granted a priority that is unfair to other age groups, merely that they are given due consideration, in accordance with their numbers and their needs. There is some ‘catching up’ to do in this respect.

4 September 2012
Jenny and James

I'm 63 and James is 73. We’d looked forward to spending our retirement together, but shortly after I retired, James was diagnosed with Lewy Body dementia. After a long spell in hospital I was told he had to go into a care home. With a nursing background, I believed I could provide the care needed, but no one listened to what we wanted.

We were financially assessed as self funders and left to deal with everything ourselves. With no advice or support I began organising a care package. I set about contacting various care providers and arranged a care package, which included carers who arrive during the day, and those who spend the night so I can catch up on missed sleep. But it was a complicated task to do with no guidance. Luckily, I'm able to use the internet but I dread to think how I would have sorted anything without it. From the moment James wakes up he needs help with everything, from moving and dressing, to washing and going to the toilet. Luckily his language skills and ability to recognise people are unaffected at the moment.

Being a carer is exhausting. When I don't have night cover I’m up about 4 times a night and can’t sleep during the day as James needs someone with him all the time. Because we hired the carers independently, not through the local authority, we have the same carers each week. I think that’s really beneficial to James, as changing faces can be particularly disorientating for someone with dementia and the carers perform very personal tasks so I know James wouldn’t be comfortable if it was a new person each time.

The care package costs about £500 a week. A small portion is covered by James’ pension and attendance allowance, which leaves us about £1,000 short each month to top up out of his savings. I take James to a day centre twice a week. This means I can do some shopping, try to relax or meet a friend. Unfortunately, because of local authority funding cuts the centre will close next year.

Every six weeks I put James in respite care for a week, to give me a break. On his most recent trip when I collected him he had no shoes on, his glasses were missing and he was wearing someone else’s clothes. He was frightened, had bruises on his body and had lost 8lbs in 7 days. That shouldn’t be acceptable and I haven’t felt I could put him there since.

I feel I’ve come to terms with my feelings of loss and bereavement concerning James, which were overwhelming at the start. I just have to get on with things. I try not to think about the future. James is getting weaker, and I'm getting older so I don’t know how long I’ll be able to manage or what will happen when our money runs out.

Dean and Pat

At only 68, mum already had substantial physical needs. The local authority where she lived assessed her for seven consecutive years, and concluded her needs were ‘substantial’, funding carers to go into her home both day and night. As time went on, mum started
forgetting things and became disorientated, occasionally hallucinating. Her GP and psychiatric consultant said she had early stage Alzheimer’s.

As mum’s needs increased she moved to live in more suitable accommodation, under the control of a different authority, which insisted on re-assessing her. I showed them the last 7 years of assessments, but, the new council concluded her level of need was only ‘moderate’. They determined she was independent other than doing housework, recommending she pay a cleaner. We were astonished, and couldn’t believe they’d reached this conclusion.

In recent years mum has been completely dependent on others for specific tasks. She has arthritis, is hard of hearing, had two knee replacements and can’t use one hand very well, which causes trouble when she tries to dress, carry cups or cook. At times she is incontinent and finds showering impossible by herself. Her mobility is poor so she can’t go out of the house unaccompanied and she’s very prone to falls. She can’t give herself the right medicine, which can be very dangerous. Often she’s not sure what day or time it is. Evenings are particularly traumatic for her in terms of her confusion and she regularly rings family in the early hours of the morning in distress.

With the diagnosis of Alzheimer’s and vascular dementia on top of her physical limitations, her level of need should have been at least the same as it was before the house move, if not higher.

I’ve challenged the council’s analysis by requesting assessments from an independent social worker and another authority. Both concluded that mum has ‘substantial’ and ‘critical’ care needs. Despite this, mum’s new local authority still refused to provide any support. It doesn’t seem fair that because mum moved a few miles down the road, there’s such a drastic change in the care she’s entitled to.

Because the council do not acknowledge that she has care needs, they will not give us any financial assistance. Mum doesn’t have any savings or own her house. I have to rely on other people to help, which is getting harder and harder as time goes on. I paid a carer to come for sixteen hours a week, but that didn’t even touch the sides as far as the care mum needed, and the carer has now left the role as it was too demanding. Mum is worse each month. She’s disappeared 3 times, set fire to the toaster twice and had two falls. She is occasionally violent and has severe hallucinations, regularly believing people are in her house.

I’m so anxious about her all the time and this has been going on for over two years. I often stay on her sofa, to be there for her despite my own disability. I’ve never seen a person left in such conditions. I find it unbelievable that different authorities have such different policies in place with how they assess people and what funding they offer. It’s so frustrating for the family of those who need care, the system doesn’t make any sense.

David

My condition means that I have great difficulty moving around. I can only manage a few steps with a walking frame. And it is hard for me to do even the simplest of tasks like picking things up or opening an envelope.
I rely on carers four times a day to help me with my personal care – morning, noon, afternoon and night-time. My local authority has already had to pare down my home care service as much as it can. For instance, the carers are already hard pushed to get me out of bed, washed, toileted, dressed and breakfasted, with the bed made, in the allotted 45 minutes time. It’s a tough job for the carers because my mobility is so restricted.

It’s a double whammy – a reduction in time with the carers and a big increase to the charges I pay for the care. I share my home care costs with the local authority and my contribution has recently gone up from around £260 to £324 a month. I struggle with my payments – on top of my rent and bills – from my pension and dwindling savings.

I’m worried that the local authority is pushing for the ‘Big Society’ option where the emphasis is to push my care more and more onto friends and family. This is not an option for me. My relatives don’t live nearby. What I want is a proper “carers” service.

Joanna

Mum had vascular dementia which had got progressively worse. She was assessed for continuing care, but didn’t qualify. She was doubly incontinent, had regular falls, didn’t know who people were and couldn’t be left alone. I don’t know who does qualify if mum didn’t.

I eventually had to arrange for mum to enter a care home. After a while there was a change in management and a total breakdown in quality and communication. Mum was not stimulated by staff or encouraged to take part in activities. The home was not clean and one day I went into mum’s room and it stank. Her dressing gown was hanging up and soaking wet with excrement, no one had removed or touched it, it had just been left there. I realised that many residents and their partners were terrified of repercussions and wouldn’t challenge the situation.

I knew mum had to be moved and arranged for an assessment from a new home but she then had a fall. The home called but said she was fine. I went to see her after work and she was in a really bad state when I went over to her she did not respond. I went to the office where the nurses sit and asked what had happened, they didn’t know there had been any change in her state and were quite dismissive. When they finally saw her they were clearly shocked by her appearance. An ambulance was called, she had suffered a severe stroke and had a chest infection, no-one at the home seemed to have noticed.

Shortly after her return from hospital the nurse from the new home came to do her assessment and was shocked to find her in such a bad state. She examined her and asked if anyone had spoken to me about the prognosis. I told her no and it was only then that it was explained she was not going to recover. The nurse went into the staffroom of the current care home to speak to the nurses, when she came back she was visibly shaken. She told me that I had to demand, as next of kin, that the staff call a doctor as they wouldn’t do it at her request.

Mum developed pneumonia and was given morphine. My brother and I stayed with her that night and when one of the morphine pouches ran low and an alarm went off we alerted the nurses that the bag needed to be changed. However it was clear that they had done this incorrectly and the pain relief was not reaching mum. We called the nurse back a number of times and were made to feel very stupid about the whole thing. The staff member was rude
and made us feel we were putting her out. Eventually we insisted that she call a colleague and the drip was fixed. Mum died the next day, so that was our last evening with her. She was only 74.

**Marion**

We started to arrange care for Dad to give my stepmother Pearl a break. Dad was set in his ways, being in the RAF, and things had to be done on time and meals on time. But the carers often arrived late to give him breakfast.

We needed someone to sleep over, to make sure Dad did not fall out of bed when Pearl had to be away overnight. They often did not arrive until very late. On one occasion, the carer had not turned up by 10pm so we were frantically phoning round. Because of the uncertainty of carers turning up, Pearl looked after Dad herself, as it caused more worry to her wondering if they had turned up.

When Dad’s condition deteriorated, he was moved to a nursing home. Sometimes he was well looked after, he was changed regularly and turned in his bed to avoid bedsores. But I found that weekends he would not be dressed and got out of bed as that was when they have staff shortages.

His room often smelt of urine. It was very strong and took your breath away; I could not sit next to him. Dad was always a very clean man and I just hope that he did not know what was happening to him.

The staff in the nursing homes are underpaid and made to do the work of two, which means they cannot take people to the toilet when asked, which results in some cases – like my Dad’s – in them having accidents in their chairs, which is distressing.

The reason for working in the caring profession should be that you want to, not that it is the only job going and it brings in the money. I still have flashbacks of some of the things that went wrong and I know that without something being done now it can only get worse.

31 October 2012
I enjoyed reading John’s and Pat’s responses to the Committee’s question about whether we should deliberately scare people about the need to save more or, in many cases, at all, for their old age, and broadly speaking I share their views: I too am not persuaded that it makes sense to scare people as a deliberate tactic.

I think, like others, that this is likely to be less effective than the campaigns to wear seatbelts or to take precautions against AIDS. There are two main reasons for my view: firstly I think it is really hard to persuade younger people even to contemplate the idea of being old - it feels like another planet when you are say 25! This isn’t just a matter of denial; it is also because even at a time of growing longevity there is always a question as to whether you will make it to a ripe old age and it can feel a little presumptuous to assume you will. All of us, I’m sure, have contemporaries who died in their 20s and 30s due to accidents, violence or indeed wars; and more from killer diseases in their 40s, 50s and 60s. So especially for people of working age who are under financial pressure, there are partly rational reasons for deciding not to save for an old age that may never arrive.

The second reason for my view is that, like Pat, I think there is a genuine question about how many people can afford to put aside. The Resolution Foundation produced a very interesting report on Living Standards last week - I’m sure you saw it, it got lots of media coverage. Among their findings these two were especially striking; they were along the lines firstly that one in five workers in the UK earns less than the living wage; and secondly that when you strip out the impact of tax credits the living standards of the average worker did not rise at all during the last decade. So basically we are collectively far less well off than we probably thought we were and of course the recession and the cuts have made things worse.

So for these reasons I don’t think a deliberate scare campaign would work - and that’s without even considering whether it would be feasible politically, which I rather doubt.

So what should governments do? Basically I think they should tell us the truth about where we are heading unless we save more as individuals, together with policies to help improve matters. These policies would probably need to be ones whereby the State and the individual contribute together, with a greater State contribution for those in most need. I.e. pretty much what we have now, but perhaps packaged more attractively, eventually a flexible pot spanning everyday living costs (pensions) and money for social care, if needed, together; and with a greater range of options available as regards types of contributions (e.g. with caring properly counted?) than we have now. There might be some element of ‘stick’ within a policy of this kind but the ‘carrots’ should be rather more pronounced, in my view.

This is not a worked up Age UK policy idea I should stress, merely my personal guess as to what might be possible - though much depends on what happens to our economy of course - and also reasonably attractive to an anxious public. I hope so anyway, as this would essentially be a progressive system within which risk would be pooled, rather than a ‘winner takes all’ approach which would tend to magnify rather than reduce the significant amount of
inequality that exists among our older population - inequality that on present trends is set to grow.

November 2012
TUESDAY 16 OCTOBER 2012

Members present:

Lord Filkin (Chairman)
Lord Bichard
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Caroline Abrahams, Director of External Affairs, Age UK, Baroness Greengross, President and Chief Executive, International Longevity Centre, John Kennedy, Director of Care Services, Joseph Rowntree Housing Trust, and Professor Pat Thane, Research Professor, King’s College London, and Fellow of the British Academy.

Q72 The Chairman: Good morning and welcome. Thank you all very much indeed for coming, and thank you all for the very interesting evidence that you personally or your organisations submitted to us. I think you can see our names; you probably know who most of us are, so I will not introduce us all. We have read your biographies and we have read your papers, so I think we are broadly well-sighted on who you are. Would you bear with me if we did not do a lot of introductions but cut to the chase and went into the process? Could I start off with the first question? What vision of old age do you think is embodied or implicit in current Government policy and, if there is something implicit, is there anything right or wrong in that? How should Government think about growing older?

What I should say is that some questions are clearly directed to individual members of the Panel; do not feel obliged to respond to every question if you broadly agree with what has been said, but do disagree if you violently disagree so that we receive a flavour of the debate. It will be tedious for you if we have to go along the row. Who would like to respond to that one first?
Baroness Greengross: The Government is going down the right track. We have an emphasis on localism, primary-care-led budgets and integrated services. These are all being thought about and introduced, though probably not fast enough. The vision of old age should change: we just have to get used to an older population and stop thinking about age. My dream—from when I used to run Age Concern, now Age UK—would be a time when these organisations are no longer necessary. That would be the real victory: when you stop thinking about age itself as some sort of disease or handicap, because what goes wrong in people’s lives is due to illness and frailty, not actually chronological age. A lot of old people are remarkably healthy and active. It is not very reliable to think only about the number of birthdays people have had. We have to get over that, and look at the different aspects of life that you will no doubt be looking at, we have to change our perspective, think of a life-course approach, about preparing much earlier for later life, and take up the notion that age is something we are not taking account of on the whole—many people are now older and are thankfully still with us. We need to get rid of the stigma associated with old age that is still there. People think of old age, dying and vulnerability in one breath. It is very stigmatising; therefore, there is a lot of age discrimination still. The Government is doing well to have legislation to ban it now in goods, services and facilities as well as employment, but that has to be enforced. I do not think we will have time to go into all that, but there are ways of doing that.

What we want are preventative policies: for example, cut out 20% of our acute hospitals and transform them into primary-care-led hospitals to look after the real illnesses that are going to need to be covered. Dementia is the biggest challenge of all, probably. Primary care is excellent; we must make it work. We must get integrated care but we have to look, as well, at employment, education, the built environment, housing and all of those sorts of areas of life where we can actually succeed if we have the vision to do so. We can get this right but we have to have the vision, and I do not think I have time to say what my vision is.

The Chairman: Drop us a note if you would like to; we would welcome that.

Professor Thane: I agree with that. I think there is a danger of promoting a vision of old age that is very generalised and very negative, as though everyone past retirement is the same: decrepit and dependent. It is the most diverse of age groups; it is vast—from 65 to past 100. There are very fit and—sadly—very decrepit people. I also think there is a danger of being very negative, in presenting older people as always dependent and not making enough of the hugely positive inputs that many older people make—including some in this room—to society. They are hugely important in the voluntary sector. Others must know this much better than I do. They are very important in supporting their children and grandchildren. For about one-third of working mothers, their children are looked after by grandparents. They look after sick and disabled relatives, saving the state a great deal of money. I think the positive inputs of older people need to be promoted and valued.

Caroline Abrahams: To directly answer your question about what vision is embodied in current Government policy, to be honest I am not sure there is one. I think there are different bits of Government policy coming out of different Government Departments, many of which are very good, but there is not an overall vision. It is all fairly piecemeal. It sometimes feels to me that the ageing society is the slowly ticking time-bomb in the corner of the room. Busy officials and Ministers are fixated on the grenade that is spinning in front of them. On occasions there is this sort of hope that they can leave some of the bigger questions to the next people coming along because there are some big challenges. That is the other thing where I entirely agree with my colleagues: there tends to be more of a focus on the challenges than on the opportunities, of which there are many.
The Chairman: What does a vision mean? What would you have thought a “good” one looked like?

Caroline Abrahams: Exactly—what does “good” look like in later life? What do we want and how do we want life to be for the older people in our society? I do not think that has been clearly spelled out by this Government; I do not think it is implicit, either, in the sets of policies coming out of different Departments. There have been attempts now and then to articulate it but it is a rapidly changing position. At the moment, because of the financial situation it is difficult for that vision to be a particularly positive one. If we were having this debate in different financial times it would feel rather different and you would get different language being used to describe it.

Q73 Lord Mawhinney: Let us forget about the financial situation for the moment. That was extremely interesting but extremely general. What would you like to see at the heart of a vision?

Caroline Abrahams: I would like to see a positive vision: where older people are able to lead good, fulfilling lives; where they have good access to the public services that they need; where they have the information and confidence to manage their own conditions; and where, rather than cliff edges between different elements of getting older—such as suddenly stopping work and suddenly becoming retired—there is a much smoother transition for people, with people earlier on having the information and the support to be able to plan for later life and to put money aside in a reasonable way.

Lord Mawhinney: What part in that fairly general statement would you expect Government to play?

Caroline Abrahams: I think Government has an overarching leadership role. It can prompt debate and look further ahead. It is much better placed than anybody else. There is some good work going on in some think-tanks, of course, including the one Baroness Greengross is president of. Government can think much further ahead: there are some big brains in the Treasury and elsewhere that I would like to think were having the opportunity to think much further ahead about what kind of country we might look like in a few years’ time and what that will mean for all the elements of Government policy, whether that is planning health services, employment policy such as flexible working, pension provision or regulation. One of the issues—of which I am sure you are all too aware from this exercise—is that this obviously covers huge numbers of different policy areas.

John Kennedy: I agree broadly, but what we have not grasped is the fundamental demographic sea-change that has happened in society. 100 years ago, to be old was a rare thing. Our view of old people as frail and the infantilisation that can happen are often consequences of that thinking, going back many years. It is very different now; Government and people have a responsibility. I do not think a Government policy of any description or even a Government vision will help in itself: the silver bullet is not there. We constantly keep putting this in the “too difficult” box, which is a horrible phrase. It constantly goes in there and Government is not leading in a proactive way, so people put it in the “too difficult” box as well and they do not do their bit either in terms of planning for the likelihood of being old, which a generation or two ago was a rare likelihood. If they were
lucky they made it to 65 and probably only lived a few years later than that, especially if they were male.27

In terms of a vision, I am not sure there is an absolute vision. What there could be is a change in our state of mind on the issue. 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; and only when it is absolutely pertinent should we have separate things for older people as a group, because their diversity is just so massive.28

Q74 Baroness Tyler of Enfield: This is pursuing this point about how we can get a wider public debate and better understanding, particularly around this issue of what a “good” old age looks like, as Baroness Greengross was talking about. I would be really interested in your view about how we get that debate going and who the key players are. We have talked about the Government but there are obviously a lot of other people who need to be involved in that debate. Also, how will we get a good articulation of both the public policy choices and the choices for individuals?

Baroness Greengross: We have not as yet faced the huge need for much more expenditure if we go on as we are. In pensions alone we know that there is an enormous expenditure commitment and we have to do something about it. I think my main realisation is that we cannot cope with demographic change unless we bring in all sectors. In this country, we have to get over the feeling that public services can do their job alone. They have to bring in the private sector and the voluntary sector. We have to get over this reluctance. If we look at Scandinavia, they contract out. They have high taxation and a lot of public services—they expect them—but they contract with the private sector if they can provide the best results. We have to do that too.

I brought together an expert group recently. We had been looking at the Scandinavian model of hospital hotels, contracting care to the hotel sector. People are cared for in private rooms and enjoy family visiting when they like. Such facilities are marvellous for post-operative care and are linked to an acute hospital. The doctors and nurses can come in but people are cared for by carers; the family can be involved at all hours. This is just one example. We have to look more broadly across other countries to see what we can do to meet the huge needs coming up. Without the private sector in social care, as well, we cannot manage—even if the economic situation improves, which we hope it will. That is one aspect.

In social care, similarly, one of the reasons why Dilnot is good—it may be adapted; maybe the cap level is not right; and maybe there are some other adaptations that are needed—is that it does allow the possibility of bringing in the private insurance companies. We need them. We cannot manage without them. They could not come in; at present they cannot in any country other than where this is mandatory, because they do not know the risk involved. The Dilnot recommendations give a known risk because the catastrophic costs are taken up by the state. Therefore, they can come in. Therefore, my dream—that in the future we would save for our pension and save for our care—would be realised.

27 Additional comment from Professor Pat Thane: “It is often believed that it was rare to grow old until the very recent past. But even in the 17th and 18th centuries 10 per cent of the English population was aged over 60. By the 1940s average male life expectancy at birth was 70 and a man who made it to 65 could expect, on average, to live to 78.”

28 Additional comment from Professor Pat Thane: “I agree”.

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Age UK, International Longevity Centre, Joseph Rowntree Housing Trust and Professor Pat Thane, King's College London and Fellow of the British Academy – Oral evidence (QQ 72-93)

Realistically, we have to get to something like this. Otherwise, we are not going to manage this adequately because there are huge costs involved with the ageing of the population.

Q75 Baroness Tyler of Enfield: That is extremely helpful. I wonder if I could press you a little further on how we might translate this into the public debate, which so many people have told us—in evidence and in our own discussions—we need to be promoting in some way so that there is a wider understanding both amongst the general public and policy-makers.

Lord Bichard: Whilst we are challenging Baroness Greengross, not just in the public debate but in your two contributions so far you have not only identified issues for the elderly but also the flaws in our public services. I am going to try and turn this into a question. You have said we need more localism; we need more prevention and intervention; we need integration; and we need more services from the private and not-for-profit sectors. There are not many people who disagree with that, but making it happen is difficult. These are very high-level comments. What we are interested in is how we can get behind those concepts and really make them happen. Do you have any thoughts on why this has not happened? What is stopping this happen? What can we do to make those things happen?

Professor Thane: Do we need more regulation of the private sector? The private sector’s provision of care is often pretty inadequate—or perhaps on occasions is inadequate at the moment.

The Chairman: I will slightly hijack your question: do you want to answer the debate question?

Baroness Tyler of Enfield: The public debate issue is very interesting. Could we just finish on that point before we move on to the broader issues?

Professor Thane: I wonder if there is some way of drawing younger people into the debate. It does tend to be a debate amongst people already older. As to how you go about it, I really have not thought about it before. It could be made something that younger people know about—the idea that we do not fall over a cliff into decrepitude at the age of 65. I would like to think that through some more, but it would be good to get a wider age range actively involved in an informed debate about services for older people.

Caroline Abrahams: I think the idea that we live in an ageing society is quite well known now. It has almost become a cliché: people mention it as a phrase. What we have not done is unpack that for people so that people can understand, “That is not about them; that is about me.” That means that I am likely to be living longer,” which is a good thing, but there are all sorts of things that go along with that such as, obviously, that you need more money if you are going to be around for longer.

People usually think being old is five years older than whatever they happen to be, because, on the whole, attitudes to becoming old are ones of horror. There are all sorts of negative connotations to this. The most important initial thing on the public health side is to get the message across to people. Actually, there is a brilliant message: that getting chronologically older does not mean that you have to become terribly unwell. There are lots of things you and we can do to make sure that you have years of good health in later life. It is not true for everybody, but we know now that all those things are malleable. If people can do some simple things well—like look after their blood pressure and, if they have diabetes and things like that, learn how to manage those conditions—then there is no reason why they should not have many more years of health, fitness and activity, and happiness, hopefully, in later life.
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than people have traditionally thought. Getting that initial message across is probably the key, because then people can start to think rather differently about older age rather than assuming, “Old age hits you and then suddenly life is very different. You cannot do anything and there is no point thinking about it because it is all too horrible.”

**John Kennedy:** On the bigger point about how we get the message across and get the public and Government engaged, there is not one public health campaign but there is a carrot-and-stick type of thing. What people say is that they want a little bit of help and support; they want access to small amounts of services. The system we have at the moment is very acute and very inefficient. You do not get services unless you are practically on your last legs and it is picked up by the NHS. From the perspective of a social care provider—and I have that hat on at the moment—there does not seem to be any strategic management at the NHS in terms of the older population at all. There is huge wastage. Going back to the comment before, we are probably very over-hospitalised and we need a massive shift of resources from acute care, because in hospitals older people comprise 70% of bed nights and 50% of the people who are in at any one time. If you ask the hospital why they are there, it is, “Oh, they broke their hip. Oh, they have a urine infection.” If you actually follow it upstream as to how that occurred, you see that a lot of it is highly preventable. One of the sticks to the public, if you like, could be to give some more certainty to them—such as adopting Dilnot, maybe with different caps—so people know where they are and so that the private sector and other sectors can come in with products that do not exist at the moment. Financial advisers, bank managers and lawyers—when you are doing your will—and all of those people say, “Have you thought of your old age? What about this or that product? What about some equity release to pay for something?” People will not touch it at the moment because they have an uncapped liability. They are far too scared about doing anything. Government needs to provide certainty in some areas. It needs to adopt Dilnot, maybe with different sized caps. It needs to encourage housing for older people—not necessarily retirement villages, but the development of housing in people’s communities—to allow people to move from inappropriate housing to houses that they are not going to be evicted from in the future. Allow people to use things to buy a little bit of help, but also say, “Never mind the financial crisis.” If we were bubbling along with a nice growing economy, our NHS would still be utterly unaffordable. There are 1.5 million 85-year-olds today. When I am 85 there will be 4.5 million of us. That will not be sustainable within the NHS. We have to make that change and we keep putting it aside. We can do some small things on the ground, but we can also do some shock tactics and say, “You have to do something about this.” It is not just Government; it is people.

**The Chairman:** This touched on the question that Lord Bichard was wanting. Just staying with that particular focus, which is an argument that the NHS has to shift from being acute-focused towards being much more community- and preventative-focused, tell us how that should be made to happen.

**Q76 Baroness Morgan of Huyton:** May I just add something that picks up on Lord Bichard’s point as well? I think it is more than that, Chairman, because what you are saying is that the debate must happen and the provision has to shift to more personal responsibility as well.

**John Kennedy:** It is a bit of both.

**Baroness Morgan of Huyton:** You have identified for us—very clearly—where you think we should be on Dilnot and the development of financial measures that would help on that
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such as equity release. Do you think there is any way that we should be doing any of that within the health service? How do we not just talk about public health? Where is the stick on the health side, or should there be one?

**John Kennedy:** I do not quite get that. Do you mean for the health service?

**Baroness Morgan of Huyton:** Yes. We talk about people taking responsibility for their own health; how do we make that happen?

**Q77 The Chairman:** Sorry, there are two or three questions coming at you at once. I think you are being asked to stay with the question about the debate. One of the interesting points you were making, as I heard it, was that it would be great for Government to make it clearer what Government will and will not do. You would presumably hope for other political parties to sign up to that so it is not going to skid at every election.

**John Kennedy:** I am not a politician, but this is one of those issues that must be a societal contract or compact, if you like. It does not work on a five-year basis and that was why we had the Royal Commission 12 years ago, which was ignored.

**The Chairman:** Then, secondly, I think we were on the argument about how we make system-change to try to deal with it. Clearly, the King’s Fund and everybody else said that is how the NHS should change. Do you think it will?

**John Kennedy:** For a bit of context, I was on a review last year—appointed by the Department of Health—to look at the North Yorkshire patch of health, which is in dire financial straits. We looked at a lot of evidence. Hospitals know a lot about their patients but they live in their little islands. They get paid for people who come in. It is not in their interest not to treat people. Social care has people in care homes, and the hospitals complain that people go from care homes into hospitals. The care homes complain that people come back from hospitals in a terrible state. They work in different cultures; they do not work together. They do not have any respect for each other; again, I am talking as a provider. Nobody is working on the pathways; nobody is working on prevention. They are just bickering over where that person should be at any one time. That happens all the time.

If you are not in the eligibility criteria you basically get abandoned. For example, Mrs Smith is at home. She is perfectly okay, quite fit, and she hears the kids outside with their skateboards. She is a bit worried. She stops going out; she stops eating and drinking; she has a fall; she ends up in hospital. The services cannot respond quickly so she goes back to a care home to get better, and of course she never does. She stays there for the next three years. This is a bit trite but it is a pattern that happens.

**The Chairman:** That is very helpful. We have at least four sessions on this downstream, so I think we will come to that in more detail. Can we ask you to let us have anything that is written up on that description of system performance from North Yorkshire?

**John Kennedy:** Yes.

**Lord Bichard:** That was a really interesting intervention. I would like you to take it a bit further and say how you would deal with that. What you have just said seems to be absolutely critical.

**John Kennedy:** On a high level, we need somebody strategically managing the health and social care system. There is nobody doing that. You need to set up the balances so that hospitals provide care for people who are acutely ill and social care keeps people out of hospitals.
Lord Bichard: So you need some commissioning.

John Kennedy: Yes. When a GP who is often locum at night goes to see somebody at home on a Friday night and they just need a bit of hydration over the weekend, social services have all gone home apart from the emergency team. They cannot set up domiciliary support; there is nowhere for them to go. They send that person to hospital, because the risk-based thing is, “I’m not having them stay at home and then having their relatives send in a complaint on Monday. Send them into hospital.” There is nothing in the system to stop that, so the system needs to be redesigned. There needs to be political will because at the moment if anybody breathes about closing a hospital, nobody will do it.

The Chairman: Thank you. We will come to this in substantial detail.

Q78 Baroness Shephard of Northwold: You mentioned the “too difficult to do” box, that successive Governments have put the whole issue into the box and that all Governments have done this. Actually, what you have also described is something, in a sense, fairly simple. Somebody with that kind of experience of where it is not working—it would have to be at national Government level—could say, “Right, we are going to rethink,” but people are hampered at a political level by this fact: we had a written submission from Ipsos MORI saying that there is a common view amongst the public that the state will provide for them when they are older. That is just what people think. Such people, particularly younger age groups, really do not plan for their old age. I think that is an increasing problem because young people are facing possible unemployment or not many jobs at all. They shift jobs; it is immensely difficult to think beyond the next month or year. Similarly, people in their 50s think that it will not happen to them. They really do think they are not going to be elderly. That is what they think. How many people have you heard say, “They put me in the geriatric ward. I am only 75”?

There is a block in official thinking; there is a block in professional thinking. Would you agree that there is a block in personal thinking about the problem? It follows on from Baroness Tyler’s question: how do we get to that? How do we get there? It is not as though people do not have experience of elderly relatives; everybody has. You still think, “Poor old thing, but that will not happen to me.” Now, how do we get into that? How do we engage young people? What do we do?

Baroness Greengross: Can I answer one bit of that? We did it with AIDS. Publicity at a Government level can do a lot. We have to do this at a national level. We could do with David Beckham or somebody like that. We want really popular figures talking about these issues and changing attitudes. It is only with those sorts of people that we are going to make it happen. At a local level, now that we have health and welfare boards and the possibility of really good commissioning and so on, we could get this right if we do something about annual budgets.

Baroness Shephard of Northwold: They are not commissioners, though, Baroness Greengross; they are health and welfare boards.

Baroness Greengross: But a level where things can change, we do now have commissioning and we can change this if we get it right. Regarding local groups of primary practitioners, GPs, commissioning GPs and so on, one problem is that we cannot get this right unless they come together and stop having to work on Local Authority annual-budget systems that mean it is impossible to have any preventative work at all, as we have seen.
Lord Mawhinney: Baroness Greengross, can I just ask a question about something you said at the very beginning? You said we need to get a public change in personal views and that we did it with AIDS. I do not see the parallel. AIDS was going to kill people. Baroness Shephard has just told us that most people do not think they have a problem. Explain to me please, if you would, how you see a parallel between a set of people who do not think they have a problem—so there is nothing to worry about—and people who have AIDS and think they are going to die. How do you think the solving of one might read across to the other?

Baroness Shephard of Northwold: I do not think that is a fair analogy, entirely, Chairman. I think the problem with AIDS was that everybody thought that it would not apply to them and the campaign explained how it could—however unlikely you might have thought it was. You were probably there, though, in the Department at the time, so I ought not to argue with you.

Baroness Greengross: There is a stigma associated with old age and that is why we get discrimination. Even when the law changes, it takes attitudes a long time to catch up with legal changes. We know that. I do think that the stigmatising bit of this is similar. I do think that at a national level we need publicity and at a local level we need longer term budgetary systems so that you can invest and not have systems that just come in when there is a crisis.

The Chairman: Does anybody else want to comment on that question before we invite the rest of the Committee to have a go at it?

Professor Thane: There have been real shifts in attitude since the 1970s in gender discrimination, race discrimination and discrimination against disabled people. They are not complete, but it has been a huge transformation and that did owe a lot to Government leadership, changes in the law—plus publicity and campaigning by pressure groups on behalf of all those groups, which is increasingly being done by and on behalf of older people. Shifts can happen, though they are slow.

Caroline Abrahams: I think people's personal experience is really important. Certainly, as we get more older people, we do find that more younger people have personal experience themselves, because they know their parents are worrying about their elderly relatives or grandparents. All of that is really important. Will that necessarily make those young people think, “Ah, that means that I need to be thinking about my pension”? That is a rather different matter. I think, therefore, that things like the new Government policy of auto-enrolment are very important and are at least starting to nudge people in that general direction. I do not think it is enough on its own, but it is a very good start. A lot of people on the Panel have talked about the importance of certainty. I think that, too, would be hugely helpful to people in thinking a bit more about the future.

Q79 Lord Griffiths of Fforestfach: Mr Chairman, I would like to come back to the issue of personal responsibility and what Gillian and Baroness Morgan said, which was that we have a culture—or it seems that way from the evidence and statistics—at present where there is a lack of personal responsibility in planning for the future and so on. If you look at the amount of people in society who do not have any savings, no buffer against a rainy day, it is really frightening. You ask the question, “Well, how can we change this culture and move towards a society in which there is greater responsibility?” It seems to me that if you are going to develop the theme of personal responsibility, you have to encourage people to save. In the last few years we have had very low interest rates; savings are then taxed and the return on savings has frankly been very bad. If you then look at the mis-selling of pensions by banks and so on, you realise, when you think of it, that unless you have
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about ensuring real transparency, that it is not all buried in the small print, that people can understand what they are buying into and what the conditions are—all those sorts of things. There was a story on the front page of the Daily Telegraph today about this. All of those sorts of things are very important.

On the question of whether you can get people to save without a tax break, I suppose that is the whole point of pensions. They are a very good way of saving and, at the moment, they are treated generously. Pushing people more into understanding why pensions are a good idea seems to me a very good thing. On helping people see they need to take personal responsibility, I think telling people it is their job to do things is likely to be less successful than saying to people, “It is in your hands. You have the power to make things good for yourself and this is how you do it.” People need to be given some tools to know how to do it, as well, but it is possible to do that. If we want people to forgo some consumption earlier on in life in order to have a better later life, we have to start talking about that in ways that people can really engage with. A lot of people’s images of later life are so old-fashioned. Really, the question you want to be asking of 30- and 40-year-olds now is, “How are you going to afford your iPhone when you are 75?” We need to find ways of linking life as it is now and what it is really going to be like in later life for you as a person. We just need to be much more creative about that.

Q81 Lord Bichard: We have talked quite a lot about changing the culture of society. Let us come back to the people who are providing some of these services, because there is a huge cultural change that has to take place there. I was very impressed with what John Kennedy and Baroness Greengross were saying, but if you put social care workers, GPs, consultants, someone from the Department of Health and someone from the Local Government Association in a single room together, then you should buy tickets for the riot. The boundaries and professional jealousies are still there; I wonder if you have any thoughts. Right at the beginning you said there was no clarity of vision. Well, that is an issue because if there is no clarity of vision the ferrets will carry on fighting with each other in the bag. That is one important issue, but are there other ways in which you think we might do something to deal with these professional jealousies?

Caroline Abrahams: I think that is too negative. I am not disagreeing with what John is seeing locally, because I think when push comes to shove and there are very tight budgets locally, people do fight like rats in a sack. There are not enough measures in place to encourage them, for example, to put money together. At the moment, if you make a saving in one area of this on the NHS side, there is no easy way of transferring it so that the other side benefits. It is that sort of issue. It is the different lines of financial accountability and it is the fact we do not have joint commissioning; we do not have fully joint bits of money that everyone then sits down together and decides how to spend. That is the problem.

I think nationally, as a former LGA member of staff, there is much less scrapping; there is much more meeting of minds. There is much more acceptance that people are trying to make things work. There are some creative ideas locally that are trying to get over some of these barriers. I will just give you one example, which is that, in Cornwall, Age UK is piloting a social-impact-bond way of funding an early intervention scheme for older people, which works alongside local GPs, identifies older people at risk of exactly what John was talking about—those likely to go to hospital on an emergency basis in a year because they are falling apart at home—and intervenes, alongside GPs, to support them and keep them out of hospital, and then there is a wraparound service and it helps people, when they do go into hospital, to come out properly. Frankly, there are a number of schemes like that running
around the country, and they are working within a suboptimal set of local arrangements but they are making it work and showing interesting outcomes.

Lord Bichard: We need to learn why they are working. How have they managed to shift the culture, rather than just being interesting initiatives?

The Chairman: We would like the evidence of the social impact bonds; we are certainly going to have that at one of our sessions. We will send you through the schedule of future sessions so you have some visibility on what we are doing. I think witnesses need to see that; we have just agreed it. We were also thinking about having a local session whereby we talk to real-life people, so we would welcome ideas from any of you about where it might be good to go to, otherwise we will go to the wrong place and that would be a shame.

Q82 Lord Bichard: I will ask my question again—and we are not suggesting you are not real-life people. One or two of you have raised this issue about equity release. Most of us feel that people want to stay in their homes as long as they can and many people do want to contribute to their care or adapt their homes. However, I think, as you were saying, there are real problems with the financial markets at the moment in terms of equity release being an attractive option. We felt that this was something we wanted to explore. Do you have anything more to say about this? There is a lot of money out there that a lot of people have seen as a form of savings as they have got older and now find it very difficult to draw on. Do you have any advice on what we could do about that?

The Chairman: Could you also look at the broader question that we asked? We were keen to hear from Baroness Greengross. You essentially set out a template; you essentially set out a deal. You should draw down on your savings if you have got them; you should be expected to work longer, if I can put it so crudely; and you should be supported with independent life in your own home as far as you are able to and as far as you want to. We heard that almost as a template. Were you meaning that as a new deal? That is a dreadful phrase, but you know what I mean.

Baroness Morgan of Huyton: Can I add to that? How does that relate to home ownership and the built-in assumption now that the house will be passed on to the next generation? Somehow the state, therefore, is going to fund everything, but the house will be passed on.

Baroness Greengross: It would be a very bold Government that makes that disappear altogether from people’s aspirations. They want to be able to pass on their home to their children—at least partly or mostly—and I think the new safe home equity-release schemes are a very important way of dealing with that, if they become more accepted. They are not accepted because of the really bad practice and the sort of scams that went on within the memory of a lot of older people. It is time for that to go because the new schemes are okay and they do provide a way of enabling people to do both. I think we should be promoting those.

I would just query something that was said about housing. John, your scheme in York is exemplary, but I am the President of the Association of Retirement Housing Managers and they have great difficulties—partly with planning and partly because there are an awful lot of people who do not want the added burden of these services. They can develop flats; they can develop property; they do not have to look after older people. I have approached and spoken with so many developers and they say, “Why should I develop retirement housing

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when I can sell my flats without that?” We need to make planning take into account the demographic changes and, at the moment, the planning system does not help.

Lord Bichard: Are you saying that the current equity-release schemes are safe and of good quality?

Baroness Greengross: Yes, they are now. There are enough that are absolutely attractive and okay, in my view.

The Chairman: Can I take you back to the question in a rather tedious fashion? I want to hear from you. In your written evidence, you did imply that there was a deal: the state should try to support people to stay in their home; we should be expected to work longer; and we should be expected to use our equity assets. That is what you wrote; is it what you meant?

Baroness Greengross: Yes.

The Chairman: Would you make the case?

Baroness Greengross: We should expect to draw on the value of our home, which is obviously quite different if you are in the South East from if you are in the North East, but we should be expected to draw on it to pay towards some of our needs in later life. We have to make people much more realistic about what those needs are, which I think is about national advertising campaigns. We have not talked about dementia. I chair the All-Party Parliamentary Group on Dementia. I spend a lot of time on dementia. One in three of us is going to die with dementia. We have to be aware of this. It is perhaps the elephant in the room and we have not discussed it. We should do, because this will lead to a huge need for care. Talking about planning and housing is one thing, but housing with care is very important. It is only about 8% now, but more people need to know about moving from where they currently live to extra-care housing or housing of the sort that will take them through until the very late stages of their lives—if not totally. I do think that is very important. People should work for as long as they can. I think flexible work for everyone is important in enabling that. I am sorry, Lord Filkin; you asked me about that. I think people do need to work much longer. We need to facilitate that; we need flexible work patterns for everyone. We really have to encourage people to be part of the pensions system. Was there something else I wrote?

The Chairman: The last one was that the reverse side of that deal—if I am using rather crude language—was that it should be the expectation that we are supported more to live in our own homes.

Baroness Greengross: Yes, we should be. Our own homes might change.

The Chairman: These are your words, not mine.

Baroness Greengross: That is right. Our own homes may be very unsuitable. A lot of our very old homes, which are mostly populated by very elderly homeowners or dwellers, are often damp or difficult to live in if you have become disabled or somewhat frail. We need to encourage more knowledge, particularly of some form of extra-care retirement housing. This is very important because very few people really know about that or consider it, so I do think it is important.

The Chairman: Are you implying that, as part of what we were hearing previously—that the state ought to make clear what it will and will not do—these sorts of policy shifts ought to be part of that narrative?
Baroness Greengross: Yes, I do think so, and it is the Government’s role to encourage those changes.

The Chairman: Caroline, did you want to comment?

Caroline Abrahams: Yes. On equity release, I absolutely agree with colleagues that the modern equity-release products are a lot better than the other ones, their predecessors, and are really quite good. The problem with equity release is more about how much equity people really have in their homes. We are seeing more and more older people still trying to pay off their mortgages and finding it quite difficult. If you look at the average cost of a house—and John probably knows rather more about the details than I—there is not always that much equity still left. At the moment there is a lot of excited talk about equity release, particularly by policy-makers—I say that having been to the three party conferences—but people are all looking at the equity release. You can only use it once, as it were. You cannot keep on using it. It does not keep on paying out, so it is not going to pay for your pension and your social care and so forth.

There is a recent report you might be interested in seeing. I think it is from Just Retirement; their latest survey shows that the upcoming generation of older people are more prepared to use equity release, even if that means they will not be passing on as much money to further generations, so they have detected some signs of a shift that I think you might be interested in looking at. When you look at how people are currently using equity release, it is for a whole range of reasons. It is less for social care and paying out a bit more income—because you do not get very much that way. Some people are using it very sensibly to do structural repairs to their home to maintain the value so they know they will not be in a bit more trouble 10 years on. Of course, some people are using it for the trip of a lifetime, but I think that is becoming less frequent.

Q83 Baroness Finlay of Llandaff: There has been an underlying theme here that I think is taken as a given: that maintaining old people’s independence has to be a central policy goal. I wonder if I can split that down a bit, firstly into the health arena and then secondly into social care. You are talking about improvements in primary care and keeping people at home with the project that you were referring to. There is an interesting report out today, which I think Age UK have had a part of—with the Royal College of Surgeons—called Access All Ages, and there is pretty good evidence that, if you intervene early with conditions, people do much better. That works in completely the opposite direction to what you have been talking about, because that requires early referral to highly specialised services to get an intervention that would be relatively low cost compared with the costs stacked up by deferring that intervention until later. Yet that seems to fly in the face of the current policy direction, which is to shut down secondary-care services, which are already squeezed until the pips squeak. Primary care has not been asked to change over to seven-day working and provide full 24/7 cover, and yet, if you have people at home who are not well, Saturdays, Sundays and Bank Holidays are disasters for them because the health services are not there.

How do we, at a policy level, get a complete turnaround? How do we increase the number of home visits done by GPs? At the moment they are not visiting; people are expected to go down to the surgery, and to get somebody who is a little bit frail down to a doctor’s surgery can be just too big of an effort. How do we get drugs trials and the research agenda to refocus completely away from the criteria that had been used previously and to say, “Actually, we need to look at the health-economic outcomes of early intervention in what you could term ‘very old people’ to get better health outcomes,” and look at the whole
package in that group, rather than dividing it up into the silos of health budgeting to which you have already referred? I would slightly challenge the term “preventative” that has been used. I think it is used in terms of way back, about obesity and diabetes and so on, but actually early intervention—for example with breast cancer or with an early colon cancer—is not about prevention; it is about early intervention and this surgical report backs that up. It is quite different.

**Caroline Abrahams:** I think we need prevention and early intervention. That is the answer. We have another report that will be coming out quite soon, which has been done by the Peninsula College of Medicine and Dentistry. That is the first-ever profile of older people’s health in this country. It is a landmark and it is exciting because it shows it is possible to do some very simple things and to keep people fit and well much longer on the preventative side, which is about blood pressure, smoking and so on. That is a very exciting message.

The main message that comes out of the Royal College of Surgeons’s report, which you mentioned and which came out yesterday, is the merits of treating the conditions and not looking at someone’s age and assuming that it is right or wrong for them to do certain things. On early intervention, I could not agree with you more. That is very much the Cornish social-impact-bond type of model that I was talking about, and there are a number of other sorts of schemes going on around the country. I think most people would say that primary care needs to get a lot more flexible and responsive and be there for us so that we can get early care when we need it. I would not disagree with that at all, but I would point out that at the moment there are a lot of voluntary sector services—locally run by Age UK and many others—that are all about trying to make sure that older people can get to the GP. There are lots of social prescribing schemes and other things. It is not enough but it is a start. You may take a view that we need to change the way the statutory system works; I personally would not disagree with you.

**Baroness Finlay of Llandaff:** How are you going to do that?

**Caroline Abrahams:** That is a matter for the GP contract, probably. I defer to others who know more about this than I.

**Baroness Finlay of Llandaff:** But they now hold the budget; so, in fact, for them to change and incur increased expenditure would decrease—

**Caroline Abrahams:** One of the things that is helpful is the way that GPs are held to account in terms of performance. When I have talked to GPs, fairly recently, they have said that they totally get the message about early intervention and prevention but what is difficult for them in actually doing that is that they are required to meet financial targets on a very short-term basis. Of course, the problem with early intervention is that you do not necessarily get the payback immediately. You may have to wait a year or two, so the more that is allowed for within the way the financial systems work, probably the more likely it is that we will get more innovative early-intervention type approaches. Certainly, some of the things that the Department and the NHS Commissioning Board are saying at the moment are very supportive of moving to this kind of approach. I am quite optimistic—I have to say cautiously optimistic—that people have got the message at those levels of the importance of what ageing is going to do to the NHS and why it needs to change how it works.

**Baroness Greengross:** It is an absolute disgrace that we have very expensive machinery in our hospitals that is not used for 24 hours. We should be looking at other countries to see that this does not continue. The same is true for primary care: we must have the same standard of service delivery that many other countries do. We could do it, but it is a bold
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Government that does this. People complain about too many changes. There is also still huge age discrimination, even in the testing of drugs—as you know, Baroness Finlay—where they are tested on people under 65. The impact can be quite different.

We do need that but the integration of budgets is absolutely essential. I know in London it works extremely well, with some GPs coming together and forming very large consortia that should be able to manage change. You never close down a hospital; you transform it from secondary- to primary-led. Of course you work with the secondary sector, because early intervention in all the things you have talked about is not about long-term conditions. It is about acute conditions, which must be seen very early on. Of course we have to bring the services together; it is outrageous that at the moment they do not.

Q84 Baroness Finlay of Llandaff: Most of the pressure on social care comes from conditions that are chronic and linked to frailty. They are in roughly two groups: those that have been acute and developed into chronic and those that always were going to be chronic. We have a mismatch here. How are you going to get social care to link in across the piece instead of being viewed as the end point of an accumulation of frailty where the demand is very high and the need is very high? How are you going to get earlier intervention with social care to go to maintain your independence model?

Caroline Abrahams: Some hospital trusts are now commissioning social care. They have realised that it will help them manage their budgets and their beds to ensure they themselves have control of services that wrap around their provision. That is quite an interesting development, I think.

Baroness Greengross: Dementia is a terminal illness. It is quite ludicrous to label it and to only receive the benefits of social-care funding unless you go to hospital. They have to be brought together and that is not impossible to contemplate. It can be done.

Q85 Lord Mawhinney: Baroness Greengross, you stated what is absolutely true: that most of our hospitals work four-and-a-half days a week and Dr Finlay’s days are long gone. You said it would be a courageous Government that would take this on. Let us assume that there is a little bit of courage out there; would you like the Government to start with the Royal Colleges or the BMA?

Baroness Greengross: The Royal College of GPs, with whom I have had a lot of dealings over the years, are not easy to convince to change but they will eventually come round to it. I think we need to bring on board the medical colleges and the BMA, who, over the years, have been quite reluctant to accept change—but eventually it does come. We should all spend enough time being realistic about the fact that ageing is a good thing, but it is terrifying now with something like dementia. If we do not accept the huge challenges, we are going to be very cruel to people in our country. We are not going to be decent at all, so we have to take on these challenges. The one thing I would really like to discuss with my colleagues here is whether you get change by scaring people. If they actually face what is happening, maybe we will do better than if we are always positive.

Baroness Morgan of Huyton: That was the question I wanted to ask before. I thought the lesson of the AIDS advertising was not about discrimination; it was that we scared people to wake up. Is there a role for scaring people into preparing for the future?

The Chairman: Take that question away, would you? Work together and give us your view—even if there are two views.
Baroness Tyler of Enfield: I just wanted to pursue the very important point you made, Caroline, about GP contracts and how their performance is managed. I may be very lucky, but my personal experience of my mother, who has been housebound now for many years, is that her GP comes and sees her at home on a regular basis. She is an extremely good GP and helps with integrating care for my father—the social care aspects. It is a complicated package. I can tell it is rare, but the question is this: how do we spread some of that good practice? They are a busy surgery. If my mother’s GP can do it, why cannot other GPs do it? What is standing in the way of that good practice being spread? I do not think it needs changes in legislation for that sort of thing to happen. I think it needs changes in attitudes and culture amongst GPs.

Caroline Abrahams: My honest answer is I do not know the answer to that. I do not know enough about what influences change amongst GPs. Certainly, though, one of the things we have been doing is engaging with an online organisation called Pulse, which is accessed by GPs. As Age UK, we are now deliberately investing in trying to get messages directly to GPs about what works and what the issues are. I am sure that is one of very many examples of how you incentivise people to do it. I imagine, in the end, the conditions of the contract are key.

Baroness Finlay of Llandaff: Have you considered looking at the revalidation agenda as a route for change and the QIPP agenda in terms of the way that primary care is being reimbursed? Also, can you give us some data on how much health service research funding is specifically targeted at some of these innovative models that you are talking about? Also, in their evaluation, is there targeted funding on rolling them out and feeding them in to some of these processes. I do not know the percentage myself, but I have a feeling the percentage of research funding on health services research in this area is relatively low. Professor Thane, do you know?

Professor Thane: I know it is low. I do not know the statistics.

Baroness Finlay of Llandaff: Would you be able to get it for us?

Caroline Abrahams: We will have that data; we can send that to you.

The Chairman: To close the session, here is a specific question: is it a goal of Government policy to sustain independence and should it be? Has Government really made it clear that this is one of their overarching policy objectives? The reason for asking the questions is obvious: we know that, by and large, most people would prefer to be independent and supported in their own homes if they could be. Has Government said that is what it is trying to do or not?

John Kennedy: I do not think it has, explicitly. I think people say it but it is interpreted differently. The classic phrase is, “People want to stay in their own homes.” The point was made: they do not. They want to stay in the appropriate home. They do not want to be in a home or an institution. There is a huge diversity of people out there. People will choose and make decisions. As part of the strategic new deal, the compact that needs to be created, the Government needs to talk about the fact that people want to remain at home. Who would not want to remain independent for longer? The alternative is that you are either dead or dependent, and none of us wants to be either of those. We prefer to be independent, but none of us are absolutely 100% independent. We are all part of something at different stages in our lives. That has got to be the thing that wraps around. If Government does not start putting on the pressure, frightening the populace, to one extent, and doing its bit in terms of
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policy and making certainty, it will constantly be facing unsolvable crises and problems that will continue to dog us going forward if we do not address them.

The Chairman: Can I leave it with you, then? We as a Committee would want to start with what older people want rather than what we think they want. If we know that is one thing they want—nicely nuanced in the way that you did it—that ought to be, therefore, the challenge to us for how we construct policy interventions better to maximise that rather than to minimise it. If that is true, we would welcome your thoughts—just not now.

Q89 Baroness Morgan of Huyton: You gave us written evidence about pensions, Professor Thane, particularly about the need to move faster and the rise of pension age and an increased move towards flexible pension age, to which I think probably, in principle, we would all say, “Hear, hear; that sounds very sensible.” That has already come out partly from some of your contributions this morning. How on earth does that happen in practice? Have you done any policy work you can share with us, particularly on flexible pension age? How can we make that a realistic option?

Professor Thane: I have not; I raised it because it seems to be a policy option that is not discussed. I have not seen any analysis of it. I think it is important. We argued for raising the pension age because on average people are fit and active until later ages than in the past. 65 was the age fixed 60 or more years ago, when people did get old at earlier ages. Now, as we argued at the beginning, old age is even more diverse than it was. People age at different stages. I was very impressed by Sir Michael Marmot’s work, showing that about 20% of people cannot stay active and able to work even to the age of 65. If we raise the pension age to 67, to 70, there are going to be even more who cannot make it, through no fault of their own. They just physically cannot do it. Therefore, I do not see why we do not go back to Beveridge’s proposal in 1942 of having a default age, which maybe remains at 65, but people can stay on longer and accumulate, perhaps, a higher pension, but the people who really cannot make it past 65 keep their pension. Maybe there is some deep flaw in that some clever analysts in the DWP or the Institute for Fiscal Studies can work out, but I have not seen any analysis of that policy option, which does seem a desirable one if we are going to raise pension ages, which I strongly believe we should.

Q90 Baroness Finlay of Llandaff: In relation to the group you are talking about, who potentially cannot work until 65—assuming we still had a 65 pension age—how would you prevent more and more people entering a dependency culture of benefits, if you like, and the means testing associated with that?

Professor Thane: If they had an adequate pension, they would not need means-tested supplements. That has been a problem with our pension ever since it was founded—that it has never been enough to live on. Pensioners with no other income have always needed means-tested supplements. Obviously, people have to save as much as they can, but there are always going to be some people who cannot save enough to supplement their pension adequately. In a way, I think we need this in order to avoid too many people going on to means-tested benefits, because at the moment if the pension age goes up and more people become disabled, they go on to whatever disability benefit is called at the time. At the moment there are very stringent fit-for-work tests, which are problematic. They move off the benefit to which they have a right and on to one that is highly conditional. That does seem very hard on people whose health is poor. Again, I would just like to see the option explored.
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Q91 Baroness Finlay of Llandaff: Has anybody else on the Panel, such as Age UK, come across any real work on flexible pensions other than it being a well-meaning phrase?

Caroline Abrahams: I do not think there are any really worked-out policy ideas. We have thought about it a bit in the context of more flexible pension provision. You could do it another way: if you have people who are coming up to state pension age, you could actually have them receiving pension credit earlier rather than the lower level of working age out-of-work benefits. At the moment there is a growing concern about the number of people—particularly women—who are finding themselves out of the labour market in their late 50s and are crawling financially towards the salvation of state pension age and finding life very difficult indeed. I think that is a growing reality at the moment.

Professor Thane: And women have less access to non-state pensions.

Baroness Greengross: I do not know if you have asked for evidence from the Pensions Policy Institute. Declaring an interest, I am President of it. I think they are the people to do that for you, but it should definitely be done.

The Chairman: We will go to them.

Baroness Greengross: It depends on when you start in your job and the sort of job that it is as to whether you qualify for a pension. Because people who spend many years in university stop work at the same age, it is a bit unfair, so I think any flexibility should take into account those sorts of elements and be much more flexible.

Professor Thane: We should go on paying National Insurance contributions as long as we are working. It is crazy that it stops at state pension age.

Q92 The Chairman: Finally, could we ask you to give three snappy public policy recommendations to us?

Caroline Abrahams: If you nailed me to the wall and said, “What is the one?”, I think we would say, “Focus on promoting wellbeing and health right across people’s lifetimes. Get those messages across about the things you can do to make yourself fit and well in later life.” Secondly, we have not talked very much about inequality today but it is an absolutely huge issue amongst older people, so tackling poverty amongst older people and preventing future poverty through encouraging people to save and through pension policy we think is very important. Finally, reforming social care: we think that could make an absolutely huge difference to millions of older people.

Professor Thane: I also agree that reforming social care is absolutely essential—there is too much evidence that it is quite inadequate—and, also, health care, removing the discrimination that goes on and integrating health care and social care. But I have read Government reports ever since the 1950s saying that, and somehow it never happens. Maybe now that we have more older people, at last there will be enough pressure to make it happen, but it is an old story. Those were two issues. Preparing people throughout their lifetimes is obviously important and finding ways to do that. Thirdly, we should look at flexible pension ages.

Baroness Greengross: I really agree, but the integration of the services is an absolute priority because we are labelled at the moment quite unfairly. A lot of what is called social care is not and should not be. Pensions are important because we are going to have to do something about the benefits system—much more than we have discussed here. We cannot go on with the benefits system as it is at the moment, and so I think that is a priority.
Therefore, we need a better pension for everybody so that the benefits system can be rationed. We have a ridiculous system at the moment, I would say.

**John Kennedy:** Defining the deal is the biggest task of Government. All of these other things then slot in under that. If you define the deal and implement Dilnot—whatever the caps are—so that people know where they stand financially and where their eligibility is for health as against social care, etc, then people will know the products and the strategies they can use. They will be different for this diverse group of people: some people have houses with equity in nice parts of the South East; some people do not in the North East. Different solutions can then be defined when people know the terrain they are on. The point of health and social care integration is the difference between early intervention for medical provision and prevention. One of the biggest things that turns people into dependent people is not getting cancer; it is being lonely. These are the things that are the bigger killers, if you like. It is about defining that deal and the public service message with its carrots, its sticks, its fears and its positives. It is not about them anymore. It is not “these old folks”; it is actually all of us.

**Q93 The Chairman:** Thank you very much indeed. I think we found that a fascinating session. In a sense, this is a door-opening session for us. We will send you the schedule of our other evidence sessions so that you are sighted on what else is coming. Sometimes, some of you may be bullied or encouraged to come back for further sessions. At least three of your organisations are specialists in the field that we are looking at. As you track what we are doing, feel free to volunteer stuff to us; we do not mind that. I would like—if you are up for it—that our clerks and researchers are able to come to you for advice about sources and expertise, so that we can mine what you know to help us shape our sessions going forward. Would that be acceptable?

**Baroness Greengross:** Of course, yes.

**John Kennedy:** Yes.

**Caroline Abrahams:** Yes.

**Professor Thane:** Yes.

**The Chairman:** Thank you very much indeed.
The Chairman: Good morning and welcome. I am sorry about the rather tight bench you have there. You are slightly elbow-to-elbow, but I hope you will bear with it. First of all, thank you very much for coming, and especially coming for what is a particularly long session. You probably sense the structure of it. Initially, we want each of you to succinctly describe what you think of the quality and performance of the health and care system generally. We may do a bit of probing on that, but we want at least to get your views of it: essentially, what we ought to be thinking about improving and changing. The second session is asking you to think 10 years ahead; to think about not just the increased demand that we will have seen by then, but what, essentially, you think we should be aiming for as a society in terms of the values, standards and characteristics of a good health and care system. We want to get your views from your different perspectives of that, and we
So that is how this session starts. There will be a sequence of other sessions—I think you may have some sight on them—on integrated commissioning, prevention and intervention, social care, etc, where we will drill down into some of these issues in a little more detail. But this is a crucial one for us, because it sets the overall context for it and gets your perspective on where the challenges are to make the system work better.

What we will do is we will ask each of you the same question, which will be slightly tedious, but as ever the richness will be in the difference in the answers. We will share that between the Committee as we go around. I will not introduce us, because you can see who we are, but it might be useful if we just ran along the row and if you just said who you were and where you were from so that we all get the distinction between you absolutely clear, which should not be difficult.

Professor Ham: My name is Chris Ham. I am Chief Executive of the King’s Fund, and I also have a chair in Health Policy and Management at the University of Birmingham.

Professor Oliver: David Oliver. I am the National Clinical Director for Older People’s Services in England at the Department of Health, where I have been for about three years. But in common with all the other tsars, I spend half my time as a practising doctor, so I work in my day job at the Royal Berkshire Hospital in Reading.

Caroline Abrahams: Caroline Abrahams. I am Director of External Affairs at Age UK.

Dr McShane: I am Dr Martin McShane. I have recently been appointed to the newly formed NHS Commissioning Board, and I am the Director for Domain 2 of the NHS Commissioning Board, which is “Enhancing the Quality of Life for People with Long-Term Conditions”.

Philip King: I am Philip King. I am Director of Regulatory Development for the Care Quality Commission.

Steve McIntosh: I am Steve McIntosh. I am Policy and Public Affairs Manager for Carers UK. We represent the 6.4 million people who care unpaid for older or disabled relatives.

Q216 The Chairman: Excellent. Thank you very much indeed. We will start straight off. Could I ask for a succinct description of the assessment of the quality and performance of the current health and care system for older people? Chris Ham, would you care to open that? We read with interest your report recently, of course.

Professor Ham: I know you want us each to be relatively brief, so if I can give you the headlines from the King’s Fund’s point of view, the issue we would want to highlight is the huge variability in the current performance of health and social care services for older people. We have some examples of innovation and excellent practice. We have a lot of services that are pretty average, insofar as we can measure their performance—and we might come back to measurement, and what indicators we have to make these broad judgments—and, frankly, we have some services that are unacceptable. The broad point I would make in the context of that variation in performance and quality of care is, generally, we feel 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.

Quite frankly, public services for older people have not had the same priority in many parts of the country as other services in the NHS in particular, such as those concerned with cancer or cardiac care where we have seen huge investment and massive progress in improving outcomes of care for people with those two major clinical conditions. By comparison, services for older people have not benefited in the same way from the expansion and the investment we have seen. I could elaborate on that in many different ways. Perhaps the key point to emphasise here is that one of the reasons for that variation and the poor quality is the fragmentation that exists between GPs and hospitals; between health and social care; and between services for people with mental health needs and services for people with physical health needs.

We know that in a society where the population is ageing, which is a cause for celebration, we increasingly have a challenge around co-morbidity or multi-morbidity: people who have a number of long-term conditions—and that number increases with age—where we very much need a joined up and co-ordinated response where GPs need to work hand-in-hand with community nurses, with social care staff, and with specialist teams in hospitals, not to mention all the other contributors including carers and housing services. We may explore this later in the morning when we talk about the future system, but tackling the fundamental problem of fragmentation and getting services to work in a much more co-ordinated and joined-up way is something that we are arguing very strongly for. That is the key to unlocking a better quality of care and more consistent standards of care for growing numbers of older people who need that care.

Q217 The Chairman: That was very clear. Can I just put back to you what I recollect, probably imperfectly, from when I read the report, which was—almost in shorthand—that we have a health and care system that is probably designed for the population as it was, rather than the population as it is becoming, by which I crudely mean hospital-centric; focused on infectious diseases, or the chronic big historic killers; and with a culture, a staffing and a training system that had not really shifted towards recognising that the management of chronic long-term conditions of older people, best done in the community, was where we needed to be. Is that a pastiche of what you said?

Professor Ham: No, that is a very succinct summary. In some ways, we feel that we are victims of our own success: that the success we have had in improving outcomes, particularly in reducing premature deaths for people diagnosed with cancer, heart disease or stroke, means that many people with those conditions are now surviving into later life. Cancer and cardiac disease are now in many ways chronic conditions that people live with for many years, because they no longer die in the middle of their lives. They survive into a grand old age, but then they survive with issues around the quality of life they have, and increasingly they are affected by other long-term conditions. I am sure that we will talk about dementia and mental health issues in greater detail as the session goes on.

So we have built and invested in treatment services for what were previously life-threatening conditions. We have built up the capacity of our specialist services in hospital, and, by comparison, we have not recognised that the world is shifting and that the disease burden is moving in the direction we have been discussing. That requires, therefore, a
reinvestment in primary care services and community-based services to help people live those longer lives and live high-quality lives, as far as that is possible.

The Chairman: That was very clear. It will be interesting to see how much that critique is shared by the panel as we go along. I suspect in later sessions, more than today, we will be going into whether we think that the system is actually capable of changing towards that prescription you are implying.

Q218 Lord Griffiths of Fforestfach: Can I just ask one supplementary? You explained variability—that was the key thing—and you talked about one reason for variability, which was the response not being joined up. What about the difference, for example, between urban and rural communities, or between relatively middle-class areas and more low-income areas? Are there examples where the quality of medical staff is known to be first-class in some area, but in another area is known to not be so good? Could you just expand a little on variability, other than just saying that it is not joined up?

Professor Ham: First of all, there is no evidence that I am aware of—other witnesses may have better information—that suggests that rurality or being in an urban environment is a key factor that explains variability. Nor, indeed, is relative income per head in different areas. It is much more to do with the staff delivering the service, the quality of those staff, and the number of them. We know that there are shortages in some key areas of care for older people. We also know that many of the staff are relatively unqualified, and come in to act as care assistants and provide home care without the same degree of professional training and qualifications and support that we see in other areas of healthcare. So it is a really important, but quite complex, question.

Q219 Lord Bichard: Could I have a supplementary, and ask Chris just to reflect upon this issue of fragmentation too? You and I and others have been wittering on about the need for collaboration, joining-up or integration—whatever you call it—for the last 20 years. The fact is that it has not really happened. That is what you are saying. Do you want to reflect upon why? What are the main reasons why that is proving so difficult? When we come on to talk about what we want to do about the future, it would be quite interesting to know where you think the real issues are that are preventing that.

Professor Ham: First of all, there are some notable exceptions. There are a few places we might discuss later that have achieved a level of integration that is admirable, and which to some degree act as models for the rest of the health and social care system. I can talk in detail about a couple of those at the appropriate point in the discussion. Fundamentally—if I can respond in this way—we have a system that is not designed to promote integration, so we have organisational separation between local authorities and the NHS. Within the NHS in England, we have separation between mental health providers and acute hospital providers and primary care. Within medicine, we have the historical division that goes back 150 or 200 years between GPs in the community and specialists like David working in hospitals. We have different funding streams. If you were to design a health and social care system that was intended to produce fragmentation, it would look very similar to the one we have at the moment.
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Q220 Lord Bichard: Do you think professional boundaries have had that effect?

Professor Ham: Absolutely. Add that, too. There are many reasons.

Q221 The Chairman: There probably is not time now, but could I leave the question with you? Can we have evidence of where other countries do this successfully, and what are the characteristics of their system, particularly if it does not require a wholesale structural reorganisation again? You will understand why I say that.

Q222 Baroness Shephard of Northwold: Actually, you have answered my question. I was going to ask you: where there is good co-ordination and integration, is it based on systems or individual professionals? Clearly, it must be the latter, who are overcoming the system. Would that be right?

Professor Ham: Yes. The best example I know of is in the South West of England, in Torbay, where over 10 years now the local leaders in a community that has a very high proportion of the population aged over 65—it is a retirement area; the snowbirds, if I can use that language, migrate in the direction of the English Riviera for understandable reasons—the local leaders of the council and the NHS in Torbay said, a decade or more ago, "Does it not make sense to break down these barriers, to provide a much more co-ordinated set of services for Mrs Smith?", who was the guiding light: an 83-year-old who was increasingly frail and vulnerable, at risk of being admitted to hospital unless the service was focused around her and her needs. It is person-centred integrated care.

The Chairman: When Chris Ham was speaking, I think David Oliver and Martin McShane were nodding at certain points, so it will be interesting to see how much you share that critique and diagnosis. Leave that as a pause for now.

Q223 Baroness Shephard of Northwold: We have just talked about systems being patient-centred and being based around the needs of individuals. One of the things that concerns me, and I think most others, is that patients in care homes and people in long-term hospital care find it almost impossible to complain, because they are afraid of being intimidated and do not want their relatives to complain or point things out on their behalf. I know that you are representing Carers UK, but, of course, this must be a concern with the relatives who are caring. What do you think can possibly be done about this? I have personal experience—I think we all have—and it seems to me that this is a big area where the whole idea of a patient-centred system breaks down, because the patient is too nervous to make their concerns clear. That is appalling, but what can we do?

Steve McIntosh: First, I would absolutely agree. For us, it is not just about patient-centred care: it is about a wider family picture as well, whether it is treating families’ expertise in the condition of the person who they are supporting or have supported prior to their move to residential care, or whether it is ensuring that families feel able to give feedback or, indeed, make complaints in a way that is going to be treated seriously but not result in their fear that it is going to bring repercussions for the people who they care for. Actually, this crosses all different scenarios in terms of services. Whether you are receiving services from care workers in your own home, or in the home of an older parent or another older relative, very often people face the same challenges in worrying if they have a care worker
who is not doing things correctly, or fearing neglect or abuse in those circumstances. They do not feel that there is a system of redress, either to the care agency, or particularly if they have privately purchased that care from a care worker: hired them through a direct payment, or found them through other means. It is not clear where the mechanisms would be for making a complaint, or who to go to.

I think that the Government, particularly in the draft Care and Support Bill and through the recent White Paper, are looking more at a consumer voice. In many other aspects of life, we would expect that you can give reviews or make complaints in a way that makes those sorts of services more publicly accessible, so that if you are looking to hire a care worker or looking at a care home you would be able to access the views of users and families who have used those services. But I do not think that we can just rest on that sort of peer reviewing. One of the major concerns that we have had is that families do not feel they have access to quality ratings beyond basic standards. The Care Quality Commission provides those basic standard inspections, but we no longer have a star rating system that measures wider quality. So if you are looking for a care home for an older parent, you do not just want to know that it meets those basic standards: you want an idea of the quality of care and the quality of life that that parent might have using a care home or using care workers. Yet that sort of rating system simply does not exist any more on a national basis.

So families need that sort of information: a mix of peer reviews and consumer information, but also a quality standard so they can measure that quality. Part of that needs to be a clear way in which they can make complaints, whether it be anonymously or not, but also that they know that those complaints or concerns are going to be treated as areas for improvement, not seen as a complaint to which there needs to be an defensive response. That is also changing the culture of how you perceive complaints.

Q224 Baroness Shephard of Northwold: This has been achieved through other parts of public services. For example, in education, it is much easier to complain about a school’s performance or an individual teacher than it was 20 years ago. But 20 years is an awfully long time to wait for there to be an improvement in this part of the system for elderly people, for very obvious reasons. I would be very interested to know whether the panel feel that the combination of intimidation and helplessness is an important enough part of the system for there to be a pressure across the board for an improvement in that part of the system.

Q225 The Chairman: Steve, anything on Baroness Shephard’s question? Or any other high-level points from the perspective either of Carers UK or carers as to how the current system does not seem to be satisfactory?

Steve McIntosh: Perhaps I will leave the full answer to that specific question to the other panel members, but, broadly, I very much agree with Dr Ham’s points around fragmentation and integration. I will not go into those any further. I would want to make the point about funding of the social care system. At the moment we have a system that very much militates against investment in prevention, both by families and by local authorities and social care services. As we see a diminishing pool of people receiving social care services as a result of financial constraints, councils are focusing resources on an increasingly small pool of people with high-level needs who fall below the means test. As a result, we are not
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seeing the sorts of investment in both families and services that can prevent future need. But equally the payment system that families have in relation to the lack of model which caps costs, prevents families from investing in low-level support, because of a fear of long-term costs in the future, particularly residential care. The settlement that social care has really does not give us the confidence that the system is going to provide quality in the long term, or is in any way sustainable.

The issues that many families have around quality of services and trust in services very often have their root in the funding of how services are delivered, whether that be the training and support of care workers, their pay and conditions or in the reliability of care services, in terms of whether a care worker is going to turn up in the morning because they have such an incredibly high workload and they are dashing between different clients. We are also commissioning social care services for that pool of people. We are looking to meet the very high-level needs of those who qualify for social care support, and as a result we are not looking more widely at those people who are self-funders and need to buy their own services. Therefore, we are not looking at that market of services which the wider population needs; in which families would invest to enable them to juggle work and care; and which people with direct payments who are buying their own care would want to involve themselves in.

As a result, because of those funding pressures and because of the nature of commissioning, we are not looking at that wider spectrum of services, which is frankly a shift in how families are structured. We are now seeing people juggling care for older relatives and with childcare, sometimes simultaneously, and with work at the same time. Services are not being created to match those families’ needs, and as a result our members are falling out of work. Around a million have given up work or reduced working hours, and caring for them very often means their own health declining. It can mean debt and financial hardship. That is simply services not matching the shift we have seen in family care, and it is leaving many people in absolute crisis as a result of that lack of available support and good quality support.

Q226 The Chairman: I found that fascinating. If I heard it right, there are three things going on. There is evidence now that local authorities are applying higher thresholds, so there are more and more people not being able to get access to local authority-funded care; family structures are changing; and nobody is looking at the totality of the privately funded system, both in terms of the capabilities of families to provide care and in terms of market quality and market information. Was that what you were saying?

Steve McIntosh: Absolutely. Yes.

The Chairman: That was very helpful.

Q227 Lord Bichard: Before we move on, I am coming back to Baroness Shephard’s point. I do not know, frankly, what the governance arrangements are for care homes, by which I mean if you are a school, you have a set of governors. I hesitate to mention this in case the BBC is here, but if you are in prison you have visitors. Different parts of the public sector have got different ways of ensuring that institutions are not just inspected every now and then, but have some ongoing process of good governance. Now, I do not know what happens in care homes. Could someone just tell me?
Baroness Tyler of Enfield: I will just preface by saying that I also found what Steve said about changing family structures to be absolutely fundamental. I think it is one of those things that just has not been grasped sufficiently in some of these discussions. Caroline, I am very conscious, having spent quite a lot of time on the Health and Social Care Bill, that in a sense the current system is one that itself is going through very significant change. We are only seeing the very beginnings of that change. A lot of that new system is not yet in place, let alone bedded in. What is your assessment of the potential of the new system—if it is successfully implemented—to actually improve some of the quality issues we have been hearing about, and particularly the joining-up issues?

Caroline Abrahams: Nobody knows. Who knows, really? It is all up for grabs. I think it is possible, but it is definitely not certain. One of the reasons for that is that we have been talking about the care and health system, but it is not a system. I think that is part of the problem. It is not integrated within health. There are slightly different issues across health and care. Exactly as colleagues have said, the problem with health is that the change in the demographics and in life spans and so forth, and the development of many more people with long-term conditions, almost appears to have taken the NHS by surprise. It is as though there is still an image of Doctor in the House and lots of people with fractures, so there is a catch-up to be done in terms of adjustment. What is encouraging about where we are now is that, just within the last three months, you have had reports issued by the Royal College of Surgeons and the Royal College of Physicians that have both acknowledged that, in their own separate spheres, it is time to change. There is real pressure on their system, and they have got to work differently. It is tremendously important to get professional bodies acknowledging that.

Care is a different ballgame altogether. I very much agree with what Steve said, that we have a genuine crisis of funding and of enormous fragmentation, so that it is tremendously hard to know what is going on in care. It is easier to pinpoint the issues in residential care, but, frankly, we just do not know enough of what is going on in individual people’s homes. There could be all sorts of horrible things happening, and we just would not know them at the moment, because there are not the mechanisms to be able to flush those sorts of things out. Given that that is the state of play, when you then look at all the changes going on locally, in some areas the optimist would say that Health and Well-being Boards do potentially have an opportunity to bring people together, to set a positive vision, and to give sensible strategic advice about where resources should go to help move more towards a more preventive type of approach. But for every optimist, you can meet plenty of pessimists, who at the moment will tell you that Health and Well-being Boards are going to be talking shops: they will not have any money, and they will not have any clout. I suspect the truth is that they will be great in some places where you have got strong local leadership, for all the reasons that colleagues have explained, and they will not make much difference in others.
Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

Age UK’s perspective on the Bill and on the shift towards clinical commissioning groups has been quite positive, in the sense that if the true intentions behind the legislation could be realised, we would hopefully see the voice of patients and older people being very much more heard in this context, and much stronger mechanisms for ensuring that their views about what makes sense locally—both for them individually and collectively across an area—should have much more play. We also accept that it is good to have the people who are actually clinically qualified hopefully having a stronger say in what happens, because, after all, they should know. But obviously at the moment there is huge churn, there is huge turmoil, and there is lots going on locally. The question of whether any of that is going to be enough to tackle the issues on the care side, in particular, is a very good point.

In response to Baroness Shephard’s point, may I just say that an interesting and quite promising development is that you are seeing grass-roots lay assessor networks coming into being in some local areas, certainly in Essex and in Hampshire. These are people like a retired director of social services, in one case, who was definitely very worried about what he saw happening to his dad in a local care home. He has got together with some old mates, put together a network of people and made a formal agreement with a local authority, and they are now going in to care homes locally. They are not trying to be inspectors or trying to do what the regulator would do, but just asking care homes and residents in a very soft-touch kind of way about issues like kindness and the things that really make the most difference to individuals. As far as I can see, that is a grass-roots development. It is springing up from below. It is very positive, but it is not a system change, although it could be, if it were adopted and promoted.

The Chairman: That was exactly Lord Bichard’s idea, was it not?

Q229 Lord Bichard: So that is something that Age UK would support, is it?

Caroline Abrahams: Definitely. I think it is brilliant, yes. It would be great to see it happening everywhere, and not just down to a well-intentioned director of social services. On the issue of what happens in different areas, one of the curiosities about the social care system as it exists at the moment is: unless you are stonking rich, you cannot guarantee that you will be able to get good care. Whereas in most walks of life, if you have a relatively affluent standard of living you would expect to be able to purchase a good-quality product of any kind, that is not the case in care at the moment.

Q230 The Chairman: Why not?

Caroline Abrahams: The easy thing to say is that we have got a fundamental market failure, but that is just a description of the fact that the market has not responded and there is not a strong enough threshold basic level of what “good enough care” needs to look like, below which you cannot fall except in extremis. Obviously, that is the role of the Care Quality Commission and others.

Q231 The Chairman: There must be all sorts of normative statements that the LGA or the Department have issued on what good care looks like, are there not?

Caroline Abrahams: There may well be.
Baroness Tyler of Enfield: It is enforcement.

Q232 Baroness Shephard of Northwold: As you say, the market is not there, it is not developed, and therefore you cannot buy help in many areas of this country. It is not there.

Caroline Abrahams: Particularly it is not there in domiciliary care, rather than residential care: people coming into your own home to help you out.

Baroness Shephard of Northwold: Yes, exactly.

Caroline Abrahams: Some people are lucky, and there are some fantastic people with a strong vocation providing excellent care, but unfortunately they are probably more the exception than the rule.

Q233 Baroness Tyler of Enfield: I find that extremely helpful, so thank you very much for that. Can I just pursue on one point? You, I think, absolutely rightly indentified the absolutely key bit of the new architecture—the clinical commissioning groups—as the bits that have the potential to make a huge difference. We obviously hope that the Health and Well-being Boards make a difference as well, and we have got the National Commissioning Board. But is your current understanding that the importance of social care and some of the issues that we have been talking about this morning are going to be sufficiently represented around the clinical commissioning group tables, and that that patient voice will be being fed in? Certainly, during the passage of the Bill, there was a lot of talk such as, “This will only work if there is a real acceptance that there are going to be fundamental shifts of expenditure from primary care into community care, and from the NHS budget into the social care budget”. Can you see that actually happening through the CCGs?

Caroline Abrahams: I do not think we are seeing it happening at the moment.

Q234 Baroness Tyler of Enfield: Sorry, the potential.

Caroline Abrahams: That does not necessarily mean that it will not happen. At the moment, obviously, groups are working very hard to get themselves organised to start the work they have got to do, and at the moment the general sense in the voluntary sector is that it is quite hard to get into a discussion. Of course, it will vary hugely from one area to another, and I am happy to come back with a more evidenced response to that. I do not think that we could honestly say at the moment that we are confident that we, or others, are at the table where those discussions are being had.

Q235 The Chairman: How much would you agree with the diagnostic that Chris Ham gave?

Caroline Abrahams: Totally. Completely. Your description has absolutely hit the nail on the head, as well.

Q236 The Chairman: And do you share Steve’s view?

Caroline Abrahams: Yes, I always agree with Steve. Steve is absolutely right.
Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

The Chairman: This is either good or bad. I am not sure which. Good. Let us take it on, then.

Q237 Lord Griffiths of Fforestfach: Professor Oliver, I must say that I am very impressed with your curriculum vitae. I think you have five degrees, all of which are relevant to the issue, and secondly you are still a hands-on clinical consultant. So I must say, if I may, I give you very high marks for both of those things. The question I would like to ask—we are all asking the same question, basically—is about you being at the coalface, week in, week out. Instead of looking at it wearing an academic hat, would you now wear a practical hat? If I were to come to see you with ageing parents with broken bones or something like that, what, in your judgment, are the strengths and weaknesses at present?

Professor Oliver: I will just preface things by going back to Chris’s remarks, because I think one or two facts and figures are key. When the NHS was founded, life expectancy was 65 for men and 70 for women. This year, a 70-year-old man can expect to live a further 17 years, and a 70-year-old woman can expect to live a further 19 years, but the really compelling figure is that when the NHS was founded, 48 per cent of the population died before they got to 65. That figure has been constant at 18 per cent for the past two decades. We have had fantastic success in preventing common killers like infectious diseases, stroke, heart disease and cancer, but also in curative interventions. That is actually a cause for celebration, and I think we have to stop characterising ageing with all these words like “tsunami”, “burden”, “time bomb”, and “crisis”.29

Secondly, we must bear in mind that we need to stop characterising all older people as hapless victims who are ill. If you look at the figures from the big longitudinal surveys, most older people are happy or very happy with their health. In fact, life satisfaction peaks in the 70s. Most older people are not lonely, and most of them are not dependent on care. It is a story that is not well represented.30 If we are talking about quality, though, I do sit there in the front line as well as in the policy world, but you do not need to hear my opinions; you just need to look at the objective evidence. Lord Darzi used four headings for quality, and when I talk about this I put an extra two in, so I will just walk you through the evidence, really.31

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29 Additional comment from David Oliver: “The evidence for the facts I have stated around ageing can be found in a number of sources. Most recently, the Age UK and Peninsula Medical School Paper 2012 “healthcare quality for an active later life” which pulls together findings from several primary sources on population ageing and health, including regular ONS Social Trends and Life Tables Reports, English Longitudinal Study of Ageing, General Lifestyle Survey, Household Survey, Health Survey for England, OECD reports on comparative life expectancy all of which have tables and figures set out in Age UK/PCMD report. The Committee could usefully draw on this superb and recent report for many of the data. With regard to ageist attitudes and language around ageing there are a number of sources. A good overview can be found in Prof Christina Victor’s book “the social context of ageing.” Also in the 2010 Equality Act Consultation and in various publications from Age UK around ageism and ageist assumptions in wider society.”

30 Additional comment from David Oliver: “Once again, if you refer to the Age UK/PCMD report “healthcare quality for an active later life” these figures are clearly set out and the primary sources referenced.”

31 Additional comment from David Oliver: “Darzi in the Next Stage Review “high quality care for all” having famously said that “we can only improve what we can measure” set out quality in terms of Outcomes: Experience. Safety and Efficiency. I am adding my own personal view on these domains to say that in addition that 1. For “outcomes” we also need to include whether older people are receiving the evidence-based treatments that can deliver those outcomes, as some outcomes take a white to show effect – e.g. treatments for cancer, or stroke prevention or bone health 2. We need to look at whether care is ageist/age discriminatory or discrimination free 3. We need to see weather care is integrated (or as experienced by people using services, continuous and joined-up).”
The first one is outcomes. Part of delivering outcomes is “Are we delivering the evidence-based interventions that will deliver those outcomes?”, and we are palpably failing to do so for older people. We have big national audits on things like falls, bone health, incontinence, and nutritional and perioperative care; we are failing to do basic things for older people. It is the same in primary care. There is good objective evidence that, actually, common conditions of ageing are relatively neglected in primary care and that a person who is older with the same condition as someone in mid-life gets much worse access to treatment. I will give you the example of psychological therapies. If you are depressed, you are 10 times less likely to see a psychiatrist or a psychologist if you are over 65. They were not delivering the right evidence-based inputs. That is the first thing.

Additional comment from David Oliver: “For secondary care. Examples include. Royal College of Physicians Falls and Bone Health National Audit Report “falling standards, broken promises” 2011. Royal College of Physicians National Audit Report “Struggle for Quality” 2010. Royal College of Physicians National Audit on the Care of Older People with Dementias in General Hospitals 2010 and 2012. National Hip Fracture Database Annual Reports. National Confidential Enquiry into Patient Outcomes and Deaths 2010 report on perioperative care for older people. The Alzheimer’s Society Report “counting the cost of care” which surveyed a large sample of nurses, ward managers, patients and carers also highlighted some deficiencies in basic training and awareness around the care of older hospital inpatients with dementia. All have showed major care gaps and failures to provide basic assessments and interventions recommended in good practice guidance. A recent publication 2012 from the Royal College of Surgeons “Access all Ages” showed that older patients were often being denied surgery from which they could benefit and the National Cancer Registry Report 2011 showed also that older patients with cancer were often not being referred for specialist assessment and treatment from which they would benefit and that the outcomes of older patients with cancer were worse than most European nations even though we do well enough on international comparisons for patients in mid-life. The RCP Pilot audit of nutritional assessment and support for older people as well as the Age UK “still hungry to be heard” report of 2010 also highlighted deficiencies in basic assessment of nutritional status and provision of nutritional support for older people in care settings.

For primary care, there are a number of graphs and figures in the Age UK/PCMD Report Healthcare Quality for an Active Later Life setting out from various primary sources the lack of basics assessments and interventions. The paper by Steele N et al BMJ 2008 on “self reported quality of care indicators” for common conditions shows clearly that older people in a big sample received less good care than young for the same conditions and that common conditions of ageing were relatively neglected when compared to younger patients. The Dementia Strategy and work of the Dementia Action Alliance has also shown that many cases of dementia are being diagnosed late (often only when patients present to the acute hospital in crisis). Both the Dr Foster 2012 Hospital Guide and the CCQ State of Care Report and the King’s Fund Papers “emergency bed occupancy in older people” and “care of older people with complex needs” make the point that many patients are admitted to hospital for avoidable reasons and stay too long, because of insufficient access to proactive and reactive primary care services and care outside hospital.

We also know from long term care settings that older people are often failing to receive a range of healthcare reviews and interventions despite often being among the sickest and most complex patients on practice lists. [See BGS Report “Quest for Quality” 2011 and BGS Report “failing the frail” 2011. The first set out the range of health care needs of long term care residents. The second – using CQC data highlighted major deficiencies and variation in the provision of basic primary and community care inputs into long-term care settings, including adequate end of life care and advance care planning (also highlighted in the DH national end of life care programme bereavement survey VOICES – which in addition highlighted problems in care and communication for older patients who were dying in all settings) There is also a very specific issue of medication prescribing and review for older people in care homes who are on a median of nine medications per resident with considerable error rates in prescribing, administration and follow up – described in Barber N et al Care Home Use of Medication Study (CHUMS) 2010 and in the 2011 Health Foundation and Age UK Report “making care safer” . Even in Community Health Service Provision, there is evidence from the NHS Benchmarking and British Geriatrics Society “National Audit of Intermediate Care” 2012 of very variable provision of the full range of medical and healthcare inputs into step up and step down home based and bed based intermediate care facilities. Finally, we know from extensive reviews of the evidence commissioned by the government as part of the national consultation on the Equality Act that older people are often denied treatment or assessment that is more routinely available to younger people with the same conditions and that common conditions of old age are often neglected in service prioritisation and funding. This evidence is clearly set out in the four reviews (2010) by on ageism and age discrimination by the Centre for Policy on Ageing commissioned and sponsored by government in Primary Care, Social Care, Mental Health and Secondary Care Services.”

The Chairman: This is fundamentally important to us. Can you send us chapter and verse, please?

Professor Oliver: I can send you chapter and verse. I have all the reports on my desktop, as Martin knows, because I am bombarding him with things. The second thing, beyond outcomes, is safety. If we look at the story of patient safety in the NHS, a brain-damaged baby through maternity malpractice may get you a £2 million payout, but the reality is that the story of patient safety is a story of older people. There are 300,000 falls per annum in NHS hospitals alone; that is one-third of all the safety incidents. Drug errors, preventable deaths in hospital, pressure sores, DVTs and hospital-acquired infections are all largely problems that affect older people. Even the stuff that got Mid Staffordshire Foundation Trust on the radar, which is hospital standardised mortality, is largely about old people dying. That is safety.

The third thing is experience. We will come back to talk about dignity in care, I am sure, but on the story about experience—about care being not person-centred, not dignified, about poor communication and disrespectful attitudes—in fact, this House led the all-Parliamentary inquiry into the human rights of older people in health and social care about five years ago, and it said an “entire culture change is needed.”


36 Additional comment from David Oliver: “There are numerous sources of evidence on this issue. For instance the Report of the Parliamentary Ombudsman Care and Compassion 2010, the reports from the CQC of the Dignity and Nutrition Inspections, the Patients’ Association ongoing CARE Campaign and Patient Stories, the DH-funded PANICOA report of Tadd and Colleagues Dignity in Practice 2010, the Alzheimer’s Society Counting the Cost report, the WHICH magazine survey on discharge from hospital and the Age UK report on patients’ experience of readmission to hospital, the Annual CQC State of Care report and the national bereavement survey VOICES project – sponsored by DH. In addition the Age UK, NHS Confederation, LGG enquiry Delivering Dignity presented large amounts of evidence and recommendations around undignified care for older people as did the Kings Fund 2011 report The care of older people with complex needs."

37 Additional comment from David Oliver: “The report of the 2007 all parliamentary enquiry into human rights of older people in healthcare Found evidence of discrimination, care gaps, poor access to care for older people in nursing and residential care settings and said that the following infringements of rights were commonplace before going onto say that an entire culture change is needed."

Abuse and rough treatment (Articles 3 and 8)
Malnutrition and dehydration (Articles 2, 3 and 8 ECHR)
Lack of privacy in mixed sex wards (Article 8)
Lack of dignity especially for personal care needs (Article 8)
Insufficient attention paid to confidentiality (Article 8)
Neglect, carelessness and poor hygiene (Articles 3 and 8)
Inappropriate medication and use of physical restraint (Article 8)
Inadequate assessment of a person’s needs (Articles 2, 3 and 8)
Too hasty discharge from hospital (Article 8)
Bullying, patronising, and infantilising attitudes towards older people (Articles 3 and 8)
Discriminatory treatment of patients and care home residents on grounds of age, disability and race (Article 14)
Communication difficulties, particularly for people with dementia or people who cannot speak English (Articles 8 and 14)
Q239 Lord Griffiths of Fforestfach: Sorry, are you talking about the experience of providers?

Professor Oliver: The experience of older people and their carers who are using services, not being treated with enough respect, and having undignified care. The fourth dimension under the Darzi terms of reference comes back to what Chris is saying, which is efficiency. In broad terms, inefficiency comes in two guises. One is huge, unwarranted variation, and I will give you a couple of examples. There is a sixfold variation in your chance of going straight from hospital to a nursing home, do not pass “Go”, depending on where you live. There is a fourfold variation in your chance of being admitted to hospital if you are over 65 depending on where you live, even if you adjust for other factors. So there is big variation.

The second inefficiency, which comes into the integration story, is what happens at the interfaces between the different agencies. We have a big problem with delayed transfers of care from hospital for all reasons, and with readmissions to hospital. If you ask people—because this is about people—what it is like to use the system, they repeatedly tell a story of having to repeat the same information to different professionals; about falling down the gaps between the different systems; about poor join-up; about poor continuity.

There are two dimensions I would add to Darzi’s four. One is integration and continuity, which I have touched on already, but the other one is about age discrimination and person-centred care. As part of the Equality Act consultation of 2009 and 2010, we commissioned the Centre for Policy on Ageing to review all of the evidence for ageism and age-based discrimination across mental health, primary care, secondary care, and social care. 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.

Back to your question about what it is like on the front line, I get around the country a lot, and I see lots of fantastic services that we should be celebrating and lots of satisfied customers. I resent the doom and gloom approach of certain mid-range newspapers.
Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

portraying everything as scandal and neglect. But there is an issue, from my angle as a front-end hospital doctor, where we have too many older people drifting into hospital avoidably because of a lack of prevention, crisis response and support for carers, and staying too long because we have a lack of step-down services and we have a social care funding crisis.

Stephen Dorrell had a great quote in the Health Service Journal, which I have used so often I know it verbatim: “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”. This is the problem. We have not caught up with the reality that the core business of health and social care is older people with complex needs. A quarter of bed days in hospital, for instance, are for people over 80 now. We have not really caught up with that reality sufficiently.42

Q240 Lord Griffiths of Fforestfach: My parents are both deceased, but they were part of the care system in Swansea. I thought the system was remarkably joined-up. There was a meeting initially: my mother had a stroke, and so on. You are a practical man. If a client comes to see you, can you not just pick up a phone and get people together? I am in a totally different field, but if a company came to us and said they wanted to raise capital for something, you would phone somebody in debt or equity or something and say “Let us get together and have a meeting”. What prevents that from happening?

Professor Oliver: That is a big question. Within one organisation, like an acute hospital where I work, we do have very multidisciplinary meetings where we have social workers, therapists, doctors and nurses, and patients’ relatives trying to plan the discharge. Although the King’s Fund did produce a report about continuity of care within hospital, [cited above] what we are talking about is what happens between the different agencies. For someone drifting into hospital late on a Friday night, or on the long weekend, you simply do not generally have enough information about their community service provision or about previous care. We have never really systematised a person-held record in a single assessment document so we can share the information.

Something to reflect on, though, is that if you look at the Nuffield Trust evaluation of what happened in the devolved nations, they scrapped the purchaser-provider split in commissioning and contracting.43 Many of the same issues about different cultures between primary care, secondary care, social care and so on still persisted, and they had the same issues of avoidable admissions to hospital, delays, readmissions, etc. Just having a more integrated system to build around services does not seem to solve the problem entirely, but that is another discussion, probably.44


43 Additional comment from David Oliver: “Nuffield Trust Report 2010 Funding and Performance of the Health Systems in the UK before and after devolution.”

44 Additional comment from David Oliver: “See also NHS Futures Forum Report 2011 on integration and Nuffield Trust/King’s Fund Report on Clinical and Service Integration 2011.”
Lord Bichard: Sorry, we do seem to be asking supplementaries. This is something that we have never talked about, but what you said struck me. Some of the things you have said about the way in which older people are treated: it may be worse for older people, but many would say that the health service generally suffers from a failure to centre on the patient. It has been alleged—I was interested in your views—that some of that goes back to the basic training that people get. It is actually about disease and about the hardwired issues of health, rather than—and I can see Dr McShane smiling, so I have probably got something totally wrong—about the patients and how you deal with them. It is just that it gets more difficult when the patient gets old and difficult like me.

Professor Oliver: I am sure Martin will echo what you said. You are exactly right: even for, say, a mid-life person with a long-term medical condition, we have not designed the system to be sufficiently person-centred and got into more shared care and self-care. That is quite right. However, objectively, we know that older people—especially older people with complex needs or frailty—are systematically getting a worse deal than younger people. They are getting worse levels of treatment and assessment than younger people. I will just give you one example from audits: there are over 200,000 people with fractures every year in this country. That is twice as many fractures as there are strokes. Only one in five women who has a fracture, at the moment, is receiving any treatment to prevent the next fracture or any assessment of their falls and bone health risks. Now, if that was a 45-year-old with a heart attack, you would not have only one in five of them leaving hospital with aspirin or cholesterol-lowering drugs with them.

You are exactly right: we are not sufficiently person-centred across the age spectrum, but older people are not a minority. They are now accounting for the biggest proportion of spending in the NHS, so the idea that they should be disadvantaged is perplexing.

The Chairman: I found that, again, fascinating evidence. It would be very helpful if you would send to us chapter and verse, but also anything else that would enrich the critique that you have so clearly put across. I am closing your little session. To what extent do you share the analysis that Chris Ham gave? Did you share the view of Steve? Are you on a similar page to them? Clearly you were saying additional things, but do you think their critique was also correct?

Professor Oliver: I think Chris’s three main points—multi-morbidity, multiple long-term conditions and complex need—are where we are at. We are not sufficiently integrated at the moment. We have disintegration, and there is an awful lot of unwarranted variation. Now, I do not think any part of the country that I have been to—and I visit a lot of sites—has got every part of the care pathway right, but I would say, with this big variation in admission rates, in bed days and in readmission rates, if we got every part of the health economy and every part of the pathway performing as well as the top quartile, we would go a long way to solve the efficiency challenge. What I worry about is this focus on innovation all of the time, when we have very good practice models. Just one, for instance: better advance care planning and shared care in nursing homes means that people do not

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45 Additional comment from David Oliver: “Reference, the four Centre for Policy on Ageing Reviews, the Age UK/PCMD report “healthcare quality for an active later life.”

46 Additional comment from David Oliver: “Source RCP Falls and Bone Health Audit – “falling standards, broken promises” 2011.”

47 Additional comment from David Oliver: “See my earlier references on the data on unwarranted variation.”
Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

have to come into hospital in a blue-light ambulance to die, completely avoidably. Yet most parts of the country are not doing it, even though we know it works. There is something about mainstreaming the good practice that we already know about.

Q243 The Chairman: Can I just make sure that I have understood that? I am putting it crudely again, so bear with me, but if we were effective at stopping unnecessary, unplanned admissions into hospital of people with acute conditions, we would have made an enormous improvement in terms of the quality of life of those people, and we would have gone a very long way towards meeting the budget crisis of the NHS. Was that essentially it, or is that too crude?

Professor Oliver: Yes, with two small caveats. Number one: older people should never be denied the full facilities of a general hospital when they need one. We are not going to fix people’s hip fractures on the kitchen table, so we cannot represent all older people as a problem. They should be there when they need to be. The second thing is that community alternatives will not save money if they are not cheaper than being in an acute hospital bed, and if it is not accompanied by some kind of deliberate shift of resource out of acute. If we look at the period of plenty during the last two Labour Governments when there was record year-on-year investment in the NHS, nearly all the extra spend went into acute care activity. Now, that was not a political decision in the centre: that is just how things panned out in the localities. We missed a trick, because we failed to invest in prevention and community services during that time.

Q244 The Chairman: The political difficulty of making the big shift of funding from acute into community is the elephant in the room, is it not? Ministers and the system are frightened of either making that case or supporting that massive structural shift of services.

Professor Oliver: Well, I am a proud Mancunian, and every time I phone my mother up she tells me how maternity services in Manchester have been decimated and people have to go a long way to have their babies. I explain to her every time we need lots of births to have a viable special care baby unit and intensive care unit, but she will not have it. The local hospital, maternity services should be open. So it is a hard argument to make, even in my own family.

Q245 The Chairman: But you are ducking my question.

Professor Oliver: Well, of course, I am a Government official, so I do not want to be drawn in.

Q246 The Chairman: No, I am not trying to make you say rude things about Ministers, but I am asking you to give a professional assessment about the difficulties of making those structural shifts.

48 Additional comment from David Oliver: “Reference NHS Confederation 2009 “dealing with the downturn.”

49 Additional comment from David Oliver: “King’s Fund Transforming Health and Social Care Report 2012; Nuffield Trust NHS and Social Care Funding Report 2012.”
Professor Oliver: We need to have an honest discussion about reconfiguration of services. We do not want people hanging on to small units that are not providing high quality care. The difficulties of the structural shift are the cycle that was described by the Audit Commission 10 years ago: rising admissions, a smaller number of beds, more people coming in, and all the money being consumed in acute. Unless somebody had made a very deliberate decision to shift resource in a step change way, the problem would not be cracked, and basically hospital admissions have been on the rise for the past 10 or 12 years. It is not an easy thing to accomplish. It is the Holy Grail.

The Chairman: Okay, but Martin may have more to say about that.

Q247 Lord Bichard: I was going to try to seamlessly move from Professor Oliver to Martin. When we sat around the table across the way the first time we met, one of the things that everyone here said was, “We have got an example of really good practice in our area”. It is not just Torbay, it is elsewhere, and I remember Baroness Shephard saying, “Why on earth do I not see it happening elsewhere?” which is actually what you have been saying from the beginning. It is not just about structures and systems and all the rest of it, because these things have happened in spite of what we all agree may be a less than adequate system. As I understand it, we have got a National Institute for Health and Clinical Excellence, which is trying to ensure that clinical standards are maintained. Do we have a national institute of operational excellence that could pick up some of these great ideas, and make sure that they do not just stay in Torbay or Norfolk?

Professor Oliver: I think I will defer to Martin, because he is in the Commissioning Board and also works for the NHS Institute for Innovation and Improvement.

Q248 Lord Bichard: I said I was hoping it was a seamless move! Let me ask you that question, as well as asking the same question everyone else has asked. I am not going to put it to you, other than to ask what your assessment of the quality and performance of the current services for older people is, and whether you think we are well-placed for rising demand in the future. You might pick that up as part of your answer.

Dr McShane: Yes, I will. I would like to echo some of what David said, in that the first thing I learned about training and improving someone’s performance when I went into general practice was that, you start with what they are doing well, and then you ask where they could do better. The OECD highlights that we do relatively well on healthy life expectancy in comparison with other countries: for instance, you can expect to have a healthier life after 65 in the UK than in the Netherlands, France, Spain, Poland, Italy, or Germany. I think that is important. We have very, very solid foundations in primary care, which is incredibly important, and we have an information system that collects a wealth of information about people and about long-term conditions. There are many other countries that are now actually looking to the NHS for how we are delivering on some of these issues.

However, there is a whole raft of areas where we could do a lot better. The demographic inversion that we have experienced, now that we have more people in the country over the

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Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

age of 65 than under the age of 16, is going to have a massive impact. The problem is that our biomedical model—as has been alluded to—is now outdated. When I worked previously in Lincolnshire, GPs would come to me and say, “The trouble with our patients, Martin, is that they do not have diabetes; they do not have respiratory problems; they do not have arthritis; and they do not have depression. They have got diabetes, arthritis, respiratory problems and depression”. Most of the guidelines that they are often asked to implement for general practice are predicated on single condition research that excludes any other conditions in its evaluation, and is ageist.

There was a recent paper: the BMJ has recently been running a series on co-morbidity, which has been alluded to. If you take five common guidelines, they contradict each other and they create a drug regime that is hugely complicated and difficult to manage. Towards the end of my mother’s life, I used to go in at the end of every week and check the pills that she had not taken. One could just open the tray that she had been given, which was a very good system, and knock those all out. We have a huge problem, in that what we have is a biomedical model that drives the system around conditions, not around individuals. We need a shift so that the locus of control is around individuals and their carers. We need to use the information and technology to shape care processes around goals and outcomes that are defined by the individual, not by professions or the professional mindset and view about what is good for you.

Over the last decade, for good reasons, we have focused on process. And the trouble is, somewhere along the way, we disconnected process from purpose. One of the things that David has alluded to is that the Darzi definition of quality brought back into focus the importance of the patient experience, and that we need to use a system that starts to look at outcomes and reconnects process properly to delivering those outcomes, to create something that will create that person-centred care. We have—as has been alluded to—focused on hospitals, and we have not engendered the same degree of attention to care outside of the hospital walls. We have not understood the ask that is being laid at the door of social care, primary care and community and mental health care, and we have not managed the interface.

Let me just give you some examples. Between 1995 and 2008, the average number of consultations per head of population in general practice rose from 3.9 to 5.5. In the over-75s, it rose from 7.9 a year to 12.3 a year in 2008. The number of GP consultations rose by 11 per cent; the number of nurse consultations rose by 150 per cent. As Atul Gawande—who is a Boston surgeon and a great writer—points out, medicine is now a team game. It needs to be about collaborative working between professionals to address the complexity of care in the 21st century, focused around an individual. In my domain, which is mainly focused on this, I have taken a paper to the executive team in the NHS Commissioning Board. Central to that was a description of a model of a house of care.

The foundation of the house of care—and we have all the components to do this in the health system at the moment—is commissioning, which should be about quality improvement. It is not, as people think, purely a contracting process. It is about planning; it is about making change happen, and doing; it is about studying the impact of that, acting, and then doing it again. We talk about having an evidence-led system: sometimes we also need to create the evidence. We need to lead, not follow. That is the foundation, and the roof of the house of care is the organisational and system processes that we focused on. The problem is that we have not really put the pillars up in the system to create space for person-centred integrated care, and those two pillars are putting individuals and their carers in control; giving them information; shifting the locus of the control service to focus around
Everything you have heard already I would echo and reinforce. I have experience of this, and in my career—both as a surgeon and GP and as a commissioner—I acknowledge this. One of the most important things we need to move on to is to understand how to track value across a system. At the end of the day, it is how we use our resources—taxpayers’ money—and demonstrate their effective uses to best effect that will persuade people that we are doing the right thing. The problem is that we do not link the investments we are making in primary care, community care, mental health, the acute sector and tertiary, highly specialised commissioning in a way that tracks back to the population and the outcomes that we are delivering for that population at a national, regional, local, and even individual practice unit level. If you do, and if you demonstrate that, that makes very clear and apparent to people the unexplained variation—although there is unwarranted variation in it—in the use of resources across the system.

There are two things that have changed my behaviour as a professional and an individual over my career. One has been information: I knew that I was one of the best doctors in Derbyshire until someone kept showing me that I was not. That was hugely motivating, because I want to be the best doctor, but you do not know that you are not until someone shows it to you. The second was peer review and challenge. It is very difficult to maintain behaviours, attitudes and a culture if your peers challenge you. These are some of the opportunities presented by the current reforms, and are why I have invested the next stage of my career in trying to support the potential that could arise to address the biggest challenge of the 21st century: to enhance the quality of life for people with long-term conditions. It accounts for approximately 70 per cent of the cost of the system. It accounts for a huge amount of activity across the system: 50 per cent of all GP consultations, 60 per cent of all outpatient consultations, and 70 per cent of all inpatient bed occupancy. In Lincolnshire, where I worked recently, 15 per cent of all hospital beds were occupied by people above the age of 85, and they accounted for 25 per cent of all bed days.

Now, I know that an acute medical ward is probably not the best place for any 85-year-old to spend a long time. We have a big job to do. I think we recognise the job, but I do not think there is a magic bullet. As I say to people, you do not pick a jelly up with one finger. You use both hands and ten fingers. We need to adopt a number of interventions if we are to move this without it falling apart in our hands, and move the system from where it is now to where it needs to be.

Q249 Lord Bichard: I am beginning to feel like I did when I was a Permanent Secretary. When you are a Permanent Secretary, you say, “I am not very happy about what is going on on the ground”. You get presented with the two most enlightened officials in the whole of the department, and they will come and sit in front of you and say, “It is not quite as bad as you say. There is some really good practice out there, and we have plans to make it better. You should not be worried about it, so leave us alone”. So you will not mind if I just probe some of the things you said, in a friendly kind of way. The main aim of the NHS Commissioning Board is to improve health outcomes.

Dr McShane: Yes.
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Q250 Lord Bichard: Actually, I had to read through quite a long way before I got beyond “to improve health outcomes”. You have not actually been talking just about health outcomes: you have been talking about care and individuals, yes? Should I be reassured that, actually, it is not once again going to be about health outcomes, because that is what has too often happened by your own admission? Should I be reassured about that? You will say this is really unfair, but I am still often hearing talk about “patients” from health colleagues, and you have done it again this morning. I do not want to be a patient. Well, I am going to be a patient shortly, so I do not want to be too rude to you, but I do not want to be seen as a patient. I want to be seen as an older person who wants a really good quality of life. The health service tends still to see me as a patient. Can we be as confident as you are suggesting that these basic cultural issues—these training issues, as I have said—are going to change? We have not got 20 years for them to change. We need to change them faster than that.

Dr McShane: I am sorry if I gave you the impression that I was confident. I think that this is a huge challenge, and really, really difficult. If I could show you the slide, it talks about individuals and carers: it does not talk about patients. I agree with you. One of the phrases that someone once said to me was, “We need to get patients off their knees and the professions off their pedestals”. Put it this way: in the 20th century, as a professional, I was a repository of knowledge. I had, in my head, a huge amount of training, knowledge and experience that the person in front of me would not have. As an individual now, I can go on to Google and I can find out as much as a specialist or a GP would know.

There is a change in the relationship between professions and individuals. It needs to be an equal partnership, and it needs to be about, “How can we support you with this condition that cannot be cured? You will have it 365 days of the year. I will see you for an average of five hours a year. How do I give you as much control as you want?”—again, respecting that some people have different attitudes to how much they want to take control themselves and how much to give away. We create a new dynamic in the system. I am under no illusions about the difficulty and the challenge of this, and that is why we are trying to look at how we can use commissioning to support that and how we can support clinical leadership. Tim Kelsey, for instance, who is the new National Director for Patients and Information in the Commissioning Board, is working to bring patient voices to bear on the system and to feed back, so that we are listening to what people are saying, experiencing and hearing, rather than pre-determining what we think is best for them. I am under no illusions about the difficulty of this.

Q251 Lord Bichard: Good. We have heard this point that there is good practice around—which there is—several times. One of the things that you would expect a commissioning board, a commissioner, or someone who is procuring services to do would be to commission and procure the best practice. Is that something that the Commissioning Board is aiming to do?

Dr McShane: The Commissioning Board works with clinical commissioning groups, who are also commissioners in the system. We would say that our job is to move away from a command and control, top-down system that disenfranchises, disempowers and demotivates people, and promote clarity about the vision, clarity about the “what”, and clarity about the measures and metrics that we hold up as a mirror to people, and can ask compelling questions about how they are delivering the best possible outcomes for local communities in partnership with local government and social care. What it can do, for instance, is
Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288) promote the utilisation of good innovation, pace David’s earlier reference. I agree with him: let us get the good done first.

For instance, there is an electronic palliative care co-ordination system that has been developed over the last two to three years. In London, it is called “Co-ordinate My Care”. It now means that anyone in an ambulance, in an accident and emergency department, or in a GP out-of-hours service or GP practice community service can see the patient’s care record. As a result, the number of people dying in hospital who have used the electronic palliative care co-ordination system is 25 per cent, compared with 50 per cent across the rest of London: so 50 per cent of people, on average, currently die in hospital. I know, again as a doctor and as a son, that a good death—one with dignity and respect—is a marker of a good healthcare system. To be able to deliver that in someone’s home according to their wishes is a great achievement.

As people are using this, they are starting to see that this could be used to co-ordinate care more widely. In my role, I will certainly be promoting that to clinical commissioning groups as something that they should be looking to commission and implement. We need to pick up the best practice and spread it, but also to recognise that there are differences between areas, and it is up to local people to work out the “how”. We can set out the “what”, but they need the freedom to design services locally to meet local needs.

Q252 The Chairman: David, you wanted to come in on the same point?

Professor Oliver: Yes, because it is such a vital point that you have made. I want to avoid straying too much into political territory, but when I first spoke to the previous Secretary of State, I remember him saying to the national clinical directors that we will define the high-level outcomes in the centre, and then the form and function of the services will be a matter for them, to deliver those outcomes. There is a tension between that and making sure that, where there is a proven way of delivering good outcomes, it is made mainstream.

I will give you two quick examples.51 We know that stroke units save lives. If you have a stroke and you are admitted directly there, and you spend most of your stay there—which could include early supported discharge—it works. You do not want a free-for-all where people design their own stroke pathway, ignoring what the evidence suggests. Another example of this is the work that has come out around hip fracture management.52 Hip fracture is a prime example of services not being designed around the needs of older people, because the average person is 84 and will have lots of co-morbidity. What was going on four or five years ago is that these very old, very frail people were being starved and cancelled and starved and cancelled, and not having any senior supervision. Because the National Hip Fracture Database and the Best Practice Tariff said, “You must go to the operating theatre within 36 hours. You must have a dedicated slot. You must be seen by a specialist in the care of older people before and after your operation”, mortality has gone down, length of stay has gone down, and time to theatre has gone down, through having a “do it once and do it well” mainstreaming of what good practice looks like.

51 Additional comment from David Oliver: “Reference Langhorne and Williams Lancet 1993 “do stroke units save lives?””

Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board ("Improving the Quality of Life for People with Long-Term Conditions") and Professor David Oliver – Oral evidence (QQ 215-288)

We have things like NICE quality standards and NICE guidelines, but around the edges of stuff like integrated service provision for older people, Cumbria is nothing like a London borough. They have their own historical provision of services and their own local challenges, and you could not just impose one model of integration, although Chris may disagree with me there.

The Chairman: Very helpful. We must get Lord Bichard to bring the Care Quality Commission in now, because you have been patiently silent on a fundamental part of what we hope is the solution.

Q253  Lord Bichard: Again, it is a question about what is your assessment of the current system and how well equipped it is to cope with future pressures. I would preface what I have to say by making the point that I think the Care Quality Commission have taken a hell of a lot of stick, and have improved their performance and are having an impact. In no way am I being hostile to the Care Quality Commission: I am an admirer of what you have done. But the fact remains that most of us are not satisfied—I am sure you are not—with many of the things that are happening in care settings around the country. In the sort of discussion you must have in the Care Quality Commission, one of the questions must be, “Have we got it right? Is this the right way of ensuring quality?”. Because we do not want quality just in a few places, we want consistent quality. Are ideas like having younger or older people involved in the visiting situation, allied with what you are doing, going to raise the quality of care? What is your take on all of this?

Philip King: I think it is important. Obviously, we look at inspecting services and quality in a number of ways. It might just be helpful to run through that. We inspect most health and social care—certainly NHS hospitals, independent health care and care homes—on an annual basis. Other than that, we also run a series of themed inspections, which are quite important to talk about. Particularly, we have run three programmes in recent times. One is about dignity and nutrition, which has had particular purchase in terms of older people’s experience, and we have done that in both NHS hospitals and adult social care. We are now in the middle of doing that work. We also chose—and this will tie into Baroness Shephard’s point earlier—to look at domiciliary care services, because the nature of the care that people receive in their homes is more intimate. It is quite difficult to regulate. It is not like turning up to a hospital ward: it is actually looking at the interaction on a one-to-one basis, and what people tell us or do not tell us about those services on occasions. We have also done a thematic inspection into learning disabilities as well.

If we look at those as being some barometers and proxies—because dignity and nutrition is very helpful—when we first looked at hospitals, we were finding that 15 per cent of hospitals were not ensuring adequate nutrition. That is quite a concern for us. We found the themes coming out of that were about the culture around staffing, and particularly around some of the training and support needs of staff, which has been something that we found consistently and we reported in our last quarterly State of Care report. It resonates not just in hospitals, but also in adult social care and domiciliary care as well, as being a key theme. When we have looked at dignity and nutrition in adult social care, there is a phenomenon that we call the “bow wave effect”. Basically, if we announce we are going to do an inspection in a certain area, then people brush up their act in that particular area. There is real use there, because you can inspect 500, but 5,000 may be looking to step up their game.
What we found there was that there were a lot of residential care homes and domiciliary care agencies that had done a lot to look at respect and dignity, but we also looked at the general standards around care and welfare. What we found, particularly in adult social care, was there were problems, particularly in nursing homes. Only 72 per cent of homes met the general standards of care and welfare, so we have a growing position there across health and social care. As part of that work on adult social care, we did an adult social care survey, and that was particularly around people in care homes. Now, you have to bear in mind that over half of people in care homes have dementia and may not actually be able to respond to that kind of thing, but we did ask people’s carers, for example, to participate in that as well. We found that about a quarter of people felt that they did not have enough control over their own care and lives, and that 5 per cent of that 25 per cent said they had no say in the way they lived their lives.

I absolutely take David’s point: there are some really good examples of care out there, and indeed we are publishing some of them in our annual State of Care report. But there are also significant concerns as well. We do certainly have concerns about the fact that our inspectors overall are seeing—very helpfully—more people being looked after at home, where they may have been looked after in care and nursing homes before. This is on the adult social care side. We have certainly found the same thing that colleagues have mentioned about the number of people in hospital, when that is not necessarily the best place for them to be. Of course, it is very helpful for people to be at home—it is a good principle—but you have to balance that against the need to make sure that the staff working with them have the right training and support from their employers, be it domiciliary care or the more complex care that we are now finding in nursing and care homes.

Just one more point. I agree with Steve’s view. It is important to say that we do not, at the moment, issue a quality rating. The former social care regulator did. We are actually in the middle of a strategy review, which is out to public consultation and concludes on 6 December, and obviously quality and how we regulate more effectively are things with which we are concerned. So we are taking your point, Lord Bichard. We think we have made significant improvements, but there are potentially other ways that we can do this potentially more effectively, whether that is taking a differential approach in certain areas or working more with strategic partner organisations while still maintaining our independence of regulatory decisions. We will certainly take those comments on board and look at how we do that.

Q254 The Chairman: So the outcome of that quality review, the strategy review that you are talking about, will be before Christmas.

Philip King: The closing date is 6 December. I understand there is a decision around the end of the year. I do not know the exact time.

Q255 The Chairman: Can you send that to us?

Philip King: We certainly will do, yes.

Q256 The Chairman: And we will be interested to see whether Lord Bichard’s suggestion is incorporated.
Lord Bichard: That is all very helpful. In a way, the Care Quality Commission is a kind of independent observer. From where you sit, are you seeing signs of better co-operation or better respect between health and local authorities? I am getting a mixed picture, and that is so important as we move forward with Dr McShane’s hope for things changing dramatically. They are going to change dramatically if there is a real respect between local authorities and health. Are you beginning to see that happening?

Philip King: I would agree with the fact that it is a variable picture across the country. We are seeing progress in that area. People have different views about the coming online of clinical commissioning groups and the work of the NHS Commissioning Board and health and well-being boards, but there is certainly more of an intention to go in that way, and that is why we are working particularly hard with the Commissioning Board. Obviously, we need to be independent in our view, but equally we want to make sure that where we regulate we are aligning issues around quality and sharing information if possible.

Lord Griffiths of Fforestfach: I was very impressed with a figure you mentioned in relation to care homes. You said 72 per cent meet standards, which means 28 per cent do not.

Philip King: 75 per cent, yes.

Lord Griffiths of Fforestfach: 75 per cent. What do you then do?

Philip King: We have got a range of options that we can do as a regulator. You can not meet a standard, but the services can still be of a reasonably safe level, or it can be of far greater magnitude to that. It could be something where we regard the care as being unsafe. We have a ladder of enforcement powers that we can use. One of our most useful regulatory levers is that all of our reports are made public, and very often we find that a well-motivated provider of services will take our comments on board and seek to improve them. We will go back and look at that improvement. There are occasions when we can take regulatory action, and that is everything right the way through to suspending their registration, which is effectively their licence to operate.

Baroness Tyler of Enfield: I just wanted to come in with a supplementary, which is really about enforcement of standards in care homes. I do not know whether you saw the very helpful supplementary evidence that Age UK submitted; there are four case studies. You can read them, and you can only but be appalled. It would be helpful for me to know if this is the very extreme tip, or whether the prevalence of this—as I suspect—is actually far wider than is frankly acceptable in any civilised society. We have heard all the issues about low-paid staff with very little training and perhaps not really much feel for the vocation that they are in, but who are doing it just to earn some, and frankly not very much, money. What concerns me—and it is a point that Lord Bichard has made—is that, in the worst
cases in some care homes, there seems to be a lack of corporate governance and any real sense of responsibility at the senior management level and at the level of people who own those homes. There has been talk about introducing something like “corporate neglect and abuse” as a criminal offence, like we have issues of corporate manslaughter. In your view, would that provide some of the teeth or bite in the system that does not seem to exist at the moment?

Philip King: If I try and take some of those points in turn, forgive me if I cross them over a little. There are clearly examples of poor care, and one will always see that in a system. There are also examples of very good care, and the way that we are going—just to say something to Steve—we do not just look at essential standards. We do also look at examples of good care as well, although we do not give an Ofsted-style rating. It is certainly the case that there are, as we have seen, significant concerns and high-profile cases. What we find most are concerns around the ability of staff to work in these areas, and it is not just about the shortage of staff. Thinking particularly about adult social care, it is not necessarily about the numbers; often it is about their training, their supervision, and their support.

Regarding people with incredibly complex needs, I will give an example of this. I have been working with colleagues from a variety of agencies on the domiciliary care work that we have been doing. As I say, the reason that we wanted to look at that was because we were not hearing as much as we thought we should, because it is a high risk area. We deliberately decided that we would not just inspect ourselves, but that we would take in an expert by experience—who might be a carer, or someone who works with Age UK or similar organisations—and a professional expert in some of these areas as well. That very much bore out that there are some broader concerns within the system. I am just trying to think to the second part of your question, Baroness Tyler.

Q261 Baroness Tyler of Enfield: It was about whether there should be a much greater obligation on owners of care homes to take personal responsibility when there is neglect and abuse going on in homes.

Philip King: Obviously, there are discussions going on about that at the moment, and we have heard some of that talked about in the press. The difference in the governance between social care and the NHS is quite significant, as Lord Bichard was hinting at. We are not responsible for the governance of those organisations, but we do take a view of that in how we regulate and expect. In adult social care—although we do not do this for the NHS—the provider has to identify a registered manager, somebody who will take overall responsibility for quality in the specific home. When we register those services, we look at whether they are a fit person to do that. They have a responsibility, backed up by the regulations, to ensure the quality and safety of services within that location. But, as you say, it could be one care home in a larger organisation, so it is certainly something that we would be looking at in terms of our strategy review as well.

Q262 Lord Bichard: Risking the Chairman’s wrath, if I may—because I think this is a very important point—I think we have all been appalled by what we have seen, and it may only be the tip of the iceberg. The thing that appals me most is that no-one knew it was
going on. I never felt in the school system, for example, that you could drive quality up just from inspections. You actually need more than that. One of the things that I am asking you whether you might need is greater transparency, because many of the care homes are quite closed. There are a lot of people there with dementia. Maybe we are all a bit less willing than we should be to visit or to get involved. Families are very reluctant to complain, because they fear that their relative is going to be badly treated as a result, so these places can become very closed institutions subject to your annual inspection. Okay, I am being provocative. Should we be looking for ways of opening up these institutions, so that they are more part of the community and so that there is more involvement by people in their day-to-day activity?

The Chairman: I sense that there are about four people who want to respond to that. Why do you not have first bash, and then we will run along the row?

Philip King: Thank you. The answer is yes.

Lord Bichard: That will do, yes.

Philip King: To add a little more to that, you are absolutely right. If we look at where there have been significant failures in care, then lack of transparency and being able to see what is going on in the organisation can absolutely be a factor. Conversely, we have a very good example of really good practice that we have just looked at, which is a care home in London that has deliberately taken the decision to locate themselves in that community, so they have open doors, they work with schools, and they work with local community groups to very much make sure that the care home is part of that. Of course, there is a greater amount of transparency. I mentioned the domiciliary care work that we did: it is very interesting that what people told our inspectors was different to what they told experts by experience, these people who work with Age UK or who have been carers. For us, often people would say to us, “The carer I had in this morning was absolutely fine. They were lovely; they were really helpful”. When they spoke to somebody who was a peer, what they were saying was, “It was very good, but I have got concerns because I am not getting the same person coming to see me”.

Q263 The Chairman: That must worry the hell out of you as a regulator, because it says, basically, that your inspection and regulation system is flawed.

Philip King: Well, no. That is why we decided that we were going to work with peers of people and also professional experts, to try and make sure that if we are missing something as inspectors then we make sure that we get that view from other people in the community. I think that is a really helpful thing. In response to Baroness Shephard’s question, it is absolutely the case that it is a concern, thinking about the number of people who very often cannot speak for themselves in these circumstances. Our attempt to deal with that is to try and involve more people in the breadth of inspection and understanding of services. There are other examples of things that are going on in terms of the use of patient-led inspections in the NHS, which will soon come online, and local HealthWatch. But the point is: does more inspection deal with that, or is it a different style of inspection? I would argue that it is possibly the latter. Certainly where there are positive efforts to ensure there is transparency within an institution, then we should be sharing that best practice, in my view.
The Chairman: Can we just run along the row and get some quick comments? Then, because we are running just a tad behind time, we must ask the question that was down for Baroness Tyler. That, obviously, is a critical question. Quick comments on that.

Dr McShane: For the sake of time, I will shift along.

Caroline Abrahams: I just agree. That is all. I think they should be more open, and some of the more progressive care home operators are. There is an interesting conversation going on amongst people who are talking about turning some care homes into hubs. I suppose the risk is, as ever, that the really good ones could be hubs, but an awful lot of them—the ones you really want to open up—are not remotely in a position to be hubs. As ever, it is the variation across the system.

Q264 Lord Bichard: So has Age UK run a campaign on this? Have you made your position clear?

Caroline Abrahams: About opening up care homes?

Lord Bichard: Yes.

Caroline Abrahams: Well, we have run a Dignity Commission. I am sure we will talk about that a bit later. We have run a commission recently with the NHS Confederation and the LGA, which is all about the quality of care in care homes and in hospitals, and what needs to happen to improve that. Opening up services is part of the answer around that.

Professor Oliver: This applies to hospitals as well as care homes: we must stop this false dichotomy between, “Over there, we have the relational aspects of care, about choice, privacy, dignity and nice compassionate staff, and over there we have the technical, medical things”. The usual dialogue is, “Oh, the technical medical things are much better, but the care is undignified”. There is a real issue with care homes about healthcare inputs that I just want to raise. First of all, why are people going into care homes, and why is there so much variation? Partly it is to do with capacity locally, but many people who have perfectly reversible, treatable problems like immobility or confusion are not having proper investigation of those syndromes, and sometimes end up going straight from hospital beds into care homes because they have not been properly assessed and we have not done everything we can to try and get them better.

But worse than that—and this came out in the all-Parliamentary inquiry into the human rights of older people in healthcare in 2007—there is very significant under-provision of healthcare inputs into care homes. There is a report from the British Geriatric Society based on CQC data that is called Failing the Frail, showing that we are really failing to deliver adequate things like medication review, GP input, rehabilitation, and access to chiropody or dietetics in the care home sector. It is probably worse access than you might get in prison, for instance, and that is something that we have to sort out. When we look at

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whether the quality in the care home is good, it is not just about the personalisation and the environment. It is also about the healthcare inputs, because these are very ill people, on the whole.

**Dr McShane:** Can I just quickly come back on that? That was a point that I was going to make earlier. As a GP in the 1990s, all the long-stay geriatric beds were closed in our area. Two nursing homes were opened. Suddenly we had 70 beds to look after; 70 frail, elderly people to look after as a practice. We had to provide quality of care, and they could choose which practices to use. We felt that the only way we could cope with that, to provide the quality of care that we wanted to see being delivered, was to ask the care homes to register everyone with us and set up regular ward rounds as general practitioners. There was no resource for that. There was no specialist support for that. So I totally echo what David has just said. There has been a shift of care, but it has been hidden, and it has grown topsy-turvy without any system to support it and make sure that both health and social care are working in a collaborative way. It is a really important issue.

**Q265 The Chairman:** You must be as irritated as we are, because there is so much to cover, and it is impossible in just a short session. I do want to ask Claire to ask the question that she has got, because it is a fundamental one. Then I will invite you as we close this session to say whether there are any pointers we have missed, in terms of a high-level diagnostic of what is wrong with the system.

**Q266 Baroness Tyler of Enfield:** It is essentially the question I put to Caroline. It is really about the potential of the new commissioning framework to provide the sort of substantial changes in health and social care that we have been talking about this morning, to meet the needs of an ageing population. I would be interested in the views of other people on that point. Caroline has already answered on that.

**Professor Ham:** CCGs are going through this quite complicated authorisation process at the moment. Sadly, it is totally unrealistic to expect CCGs to make a big impact around patient care and quality of services for the next year or two, until they have appointed their key staff, gone through the authorisation and are at a point where they can begin to be effective as commissioners. For the time being, we ought to be looking at the other levers out there, particularly relating to that last bit of the conversation; I was going to bring in a slightly contrary voice to those that have been expressed. Not to disagree with opening up inspection in the way that has been discussed, but the first line of defence in ensuring the right standards and quality of patient and user care has to be the staff delivering that care. If we put too much emphasis on the inspectors, the visits and what the CQC does—important as that is—we are frankly missing the point. If we do not have the right number of staff with the right skills in care homes, nursing homes and hospitals, then inspectors are not going to solve that problem for us. So, yes, let us have a debate about the right kind of inspection, but let us really turn our attention to those who are providing care and the work that people like Jill Maben at King’s College London have done, showing that the key variable around good quality care—particularly for older people—is the ward manager or the team leader in the care home or nursing home, and the tone and style that that frontline clinical leader sets for all the other members of team, including the care assistants and
Philip King: I agree with Chris’s point. I was at an event recently where Sir Bruce Keogh made exactly the same point, which is that you do not solve a whole problem across a whole health and social care system simply by looking at regulation. It is necessary, but it is just one part down this end of a broader picture.

Professor Oliver: The report that was mentioned—which is an excellent report, if you have not seen it—is from the Delivering Dignity Commission, which was Age UK, the NHS Confederation and the local government group. They took evidence from many people, myself and the King’s Fund included. The King’s Fund also produced a report last year called The Care of Frail Older People with Complex Needs, and what was good with both of those reports is that they said, “What do we need to do in terms of the public; the frontline professionals, people like ward sisters or care home managers; organisational leaders; professional leaders; and policy makers? For every level, what is the critical and sufficient role?” If you have not looked at the evidence from those, then they are worth looking at, actually. There tends to be a focus on knee-jerk, simplistic solutions like, “Stop sending nurses to university” or, “Bring back Matron”, which are particularly unhelpful.

Steve McIntosh: On a slightly different tack—on commissioning around social care, rather than around clinical commissioning groups—very often, social care commissioning is done on a lack of information. The majority of social care purchasing is done by self-funders: people buying their own care, rather than local authority care. Local authorities are looking at the map of social care through the prism of the services they are going to commission themselves, so they gather information based on the people that they are likely to deliver services to: those who do not exceed the means test. As a result, they are not taking—as I mentioned earlier—that wider view of the care services that need to be available in their area. That is a flaw in that mapping exercise, because people look across their population; they are not looking at a population-wide basis. There are several devices: there are joint strategic needs assessments where local authorities are supposed to get together with other statutory bodies and look at needs in their area. More recently, there are market position statements. This is a recent and potentially groundbreaking advent, which is where local authorities look at the care market, are supposed to look more widely at population need, and consider how they fill in the gaps in the care market. There was actually a recent Private Member’s Bill brought forward by Barbara Keeley MP and a group of other MPs, which was looking to shift the way in which local authorities look at those needs in their local area. Unless they have that full range of information, unless we start to gather information on what self-funders are purchasing and what their needs are, then there is no way of structuring commissioning arrangements. This means that local authorities either commission statutory services, or work with providers in their area to generate services to plug the gaps, whether it is specialist services or that range of services that fall between a cleaner to help an older people clean their home and full-on residential care homes: that gap of care services in-between those lifestyle services. Unless they have that information on need, they are not going to be able to work with the providers who will commission to meet that need.

55 Additional comment from David Oliver: “I have referenced the report earlier on.”

56 Additional comment from David Oliver: “I have cited these reports earlier.”
Baroness Tyler of Enfield: My final question to you, then, is: is that sort of shortcoming in how some of the local authority commissioning takes place that you have described to do with lack of training and expertise, or, frankly, is there a lack of political will?

Steve McIntosh: We are beginning to see the structures where it should take place. Those market position statements should be a vehicle through which councils should assess that, but again, a message throughout has been the variation in those, in the joint strategic needs assessments, for example. Some local authorities will see no mentions of carers and employment—the ability of services to help carers juggle work and care—whereas other local authorities have a joint strategic needs assessment specifically on carers, which mentions employment. There is a real gap between what needs are assessed and the extent to which those involve a wider look at what services can deliver for families.

It is, again, driven by funding. If, as a local authority, you are desperately trying to fulfil those substantial and critical needs categories on a shrinking pot of funding, then that is going to be the entire focus of your commissioning arrangements and you are not going to be looking more widely. I imagine for many local authorities, it would seem like a luxury to look at services for people with lower-level but incredibly significant needs, and also those people with means who are not likely to ever qualify for social care services as a result, when you are looking at development of future need.

The Chairman: It is pretty explicit from the recent audit by ADASS and LGA, is it not, that the budget pressures on local authorities are inevitably squeezing out what is probably of crucial import to any form of preventive work? Only significant needs are being dealt with, and therefore the costs will circle back onto the hospital sector and the NHS in its traditional form.

Let me just try and conclude, and then give you a break for a couple of minutes. As a layman, I have heard a remarkable consensus across you from your different positions about the fact that, whilst there is much excellence in our NHS and our care services, there are some pretty serious structural, performance, attitudinal and training problems in the system as it is currently performing, which means that we are less able to get the quality of outcomes and of relationships that our older people currently expect. That is crudely what I have heard from all of you, in different forms. Secondly, if that is true now, as the demand progressively hits the system in 10 years’ time, and it will—you know the numbers as well as I do; the numbers of more frail people, 85-plus or whatever—then it is obviously going to be a system that is going to be in even greater crisis as more demand hits it. Is that a fair summary? Yes, okay. Then we will address the question about what is to be done on another day.

Perhaps I may thank you very much for a fascinating initial session. Do you want to take a comfort break? Some of our staff will show you where the gents’ and the ladies’ are, if you need them. Then we will come back to what, in a sense, I suspect, may be an easier session: what does good look like, have we already defined what good looks like, and have we got clear standards for that?

Sitting suspended between 11.37 am and 11.45 am.
TUESDAY 6 NOVEMBER 2012

Members present

Lord Filkin (Chairman)
Lord Bichard
Lord Griffiths of Fforestfach
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Witnesses: Caroline Abrahams, Director of External Affairs, Age UK, Professor Chris Ham CBE, Chief Executive, The King’s Fund, Philip King, Director of Regulatory Development, Care Quality Commission, Steve McIntosh, Policy and Public Affairs Manager, Carers UK, Dr Martin McShane, Director, Domain 2, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”), NHS Commissioning Board, and Professor David Oliver, Consultant Physician, The Royal Berkshire NHS Foundation Trust, Department of Health National Clinical Director for Older People Services (England), and Professor of Medicine for Older People, City University London, gave evidence.

Q269 The Chairman: To repeat what I signalled previously, you have seen the questions, so you know where we are shifting our focus. We are trying to take a view of what we should be aiming for in 10 years’ time, in terms of the values, the qualities, the style of our health and care services and systems, whether public or private sector. In a sense it is to try to see to what extent there is a consensus about what we should be moving towards, even though we cannot achieve it now, and therefore that gives us some understanding to take into later sessions. If that is where we should be going, how do we get there?

Does that make sense to you? I have not put that very clearly. You will no doubt tell us what current standards are, and obviously we are not meeting all of those, but where would you speculate or, alternatively, hope for, that we would be raising standards and shifting the system’s values? Is that clear enough as a question? Yes? Then let us do it a bit like we did last time. Chris, do you want to start off with that one?

Professor Ham: To make the obvious point first, if we take a 10 year perspective, this is going to be a decade of austerity for our public services. It is about doing more with the same—in fact, more with less if we think about social care—rather than planning for expansion and growth. Therefore, it is incredibly challenging if our starting point is huge
variability and, in some respects, we are not providing an acceptable standard and quality of care for older people: there are going to be far more of them.

The constrained resources that are available, especially in social care, are targeted more and more at people with substantial or critical needs. Potential investment in prevention, upstream interventions that might help people requiring expensive social care support, is inevitably being cut back, because the funding is not there. These are very, very tough times indeed. I am sure we all want to paint a positive picture of what might be in future, but we have to ground it against that reality of effectively 10 years of no growth and, in fact, real cuts in some areas of the care we are talking about.

Q270 The Chairman: I really hear that as a plea for realism, which basically says: if we have got the system up to the standard of the best now in 10 years’ time, and able to cope with the volume, we would be doing pretty well.

Professor Ham: We would be doing incredibly well. Adding a more positive point—David made this point earlier on—if you think about the variability, if every part of the country came up to the level of the top quartile, or, more ambitiously, the top decile of current performance, we could release resources that are currently probably misspent, for part of the time, on the more expensive acute hospital services, nursing home, care home sector. Those funds could be reinvested in other services that are genuinely much more to do with prevention and the crisis response early intervention services that we have all been talking about in different ways.

I have just spent two weeks in India and had a look at some of their current challenges and problems, and I came back reminded that we live in a very wealthy country with huge investment in our public services. We talk about tough times that lie ahead, but they pale by comparison with what you see in other parts of the world, and we need to keep on reminding ourselves of that.

We could do a lot better with the funds we currently commit to health and social care, and we are going to have to find ways of using those funds ever more efficiently, with the growing numbers of older people in future. What does good look like? We know much of that from the work of the British Geriatrics Society, ADASS, other organisations including the King’s Fund, that have begun to paint a picture of the desirable pattern of care and services in the future.

In some ways, it is a mirror image of what we have been talking about so far. The services we need in future, in our view, need to be person-centred around individual patients, service users and people; the language is very important. The services need to be integrated, joined up and co-ordinated, rather than fragmented. To use a catch phrase, it needs to be about the right care, in the right place, at the right time, for growing numbers of older people, and it needs to be care much closer to home. That involves the home becoming, if you like, the hub of care and support in future, and more of the intensive support provided in the community and home care setting, to avoid that inappropriate use of the more expensive acute hospitals and care home sector.

Supporting that, we have not talked very much about information and IT. If you look at how other countries and other systems operate, they have invested hugely in the electronic patient care record.
Professor Ham: I am not suggesting Connecting for Health Mark II; do not get too anxious here. Health and social care are way behind what we have seen in many other sectors, in terms of the adoption of IT, and therefore the benefits you get from accessibility to patient user records in many different settings. IT is a fundamental building block of an integrated health and social care system: it is not about organisational integration; it is all the things that support that.

Q272 Lord Bichard: I am assuming that Chris is including telecare and telemedicine in that IT, because you talked about information.

Professor Ham: Yes.

Q273 Lord Bichard: I do not want to put words in your mouth, but just in case you were intending to, you have not mentioned much about prevention. The model I have heard you talk about before would have included prevention.

Professor Ham: Yes, absolutely. We know from some of the work that Age UK and the British Red Cross have done that preventive services in social care in particular have suffered, because of the cuts in local authority and social care budgets. There is so much evidence that it is never too late—David can talk about this in much more detail than I can—to invest in prevention. Even at the age of 65, 70 or 75, people who are regularly taking exercise, looking after their diet, doing other things, will benefit from that in their later years. Prevention must be a fundamental building block in all of this too.

Q274 The Chairman: You mentioned the British Geriatrics Society, ADASS and King’s Fund all having documents, which I assume are rooted in the public’s wishes, that made some normative statements about what good looks like.

Professor Oliver: Yes.

Q275 The Chairman: Is that all captured by the Department of Health into one over-arching, clear enough, set of values and principles, and statements that span health to social care? I would expect that it would be. David you are saying, “No”.

Professor Oliver: Well, not out loud.

Q276 The Chairman: Should there not be? Would you not expect that there ought to be such a statement by the Department of Health, which said, “This is what we think good looks like across the system”?

Professor Ham: I think so. It goes back to the debate you were having earlier with Martin, if I can make some connections to the earlier part of our discussion, because there is a really important set of issues around how we move from where we are to the good system that we will be describing in the next part of our discussion. The huge challenges we face are not around diagnosing what is wrong, or describing a better future; it is finding the
means and the will to move from one to the other. I would be much less hesitant than Martin was, in relation to your question, about the need, where we know what good looks like, to be pretty prescriptive about that.

**The Chairman:** As you know, we will be asking you to come back with the answer to “How do we fix it?” later on, in two months’ time.

**Q277 Lord Bichard:** We were quite impressed—it was good to hear other people’s comments—when we looked at the Australian stuff a couple of weeks ago. The Australians have got a vision. They have got a Minister for Ageing; they have got a strategy. We thought, this is interesting, because we do not think that we have. I am not suggesting a dedicated Minister changes the world, but it seemed to be a co-ordinated cross-cutting approach that we have not yet achieved. Is that true?

**Professor Ham:** We are far too sensitive about this argument that we have a command and control system, and it is all about devolving more responsibility to CCGs. That has to be part of the answer, but if the consequence of that is unacceptable variation, which we have all been arguing, then it cannot be the whole answer.

**The Chairman:** Absolutely.

**Steve McIntosh:** We are looking in the next 10 years; we know that already the number of carers is rising rapidly. In 2001 the census showed us there were 5.8 million; we estimate that in 2011 there were 6.4 million; by 2037, around 9 million people will be caring for an older or disabled loved one. This is a rapidly expanding group within the population. The pressure on those carers is growing rapidly; in the last 10 years the proportion of carers caring for over 50 hours a week has doubled. We are seeing not only an increase in numbers, but an increase in the intensity of the caring that they are providing to older or disabled loved ones.

For us, that means more and more families are going to be brought in to what is part and parcel of life: that there will be different moments in which our lives will be providing care. That may be when you have young children and you look after them; you may also be caring for disabled children; it may be your partner has a long-term condition, perhaps cancer, or has an accident, and you provide some care then. For many of us, there will also be the inevitability of supporting parents, whether they need care itself or just ongoing support when they are older; then support for ourselves and our partners when we need care later.

The vision for us is a system that recognises that care is an inevitable part of all our lives, but that services and support fits around that. For us, we are already doing the work with employers; we set up an employer forum, Employers for Carers, around the importance of work and care, the workplace support, advice, information, flexibility, but also the way in which services match up with workplaces. Through several of the case study examples that we submitted as part of our additional evidence, the issue of work comes up time and time again: that services simply do not match working patterns.

We have seen a real shift in perceptions and support related to parents of young children and childcare. The vision for us in the future needs to be a similar revolution in how we understand care for older and disabled people. Given that we have 1 million people who have given up work, or have reduced working hours, to care for older or disabled loved ones, around 3 million people who are juggling work and care, we must see that infrastructure behind people as a key part of shifting how we see social care. We have done
employers’ surveys, and surveys of their employees, for those top employers, who do provide some support and see this as a big issue. Distance caring is increasingly becoming a phenomenon, where you are looking after or supporting a parent at the end of the motorway, spending all your time on the phone at work, at lunch breaks, arranging care, speaking to GPs.

That is a serious productivity issue for employers as well; they are increasingly seeing it in exit interviews with people who have simply not been able to juggle family responsibilities with work. Therefore, it has contributed to their leaving work and that loss of skills and expertise from the workplace, as well as inevitably the loss of income and earnings for the individual, who may then have to receive benefits. For us, it is reimagining care as that similar to the childcare debate; it is ensuring there is that infrastructure to enable families, as they move in and out of different carer responsibilities, to get that support.

Currently, services do not knit up with employment. One example in the evidence we submitted is someone who has given up work to care for her husband, who has early onset dementia. Having not received information on her entitlements for a couple of years, she now receives some support from a day centre. That day centre provides care from 9.00 until 2.00. That simply does not meet her working patterns, and, not only that, but there is no transport to and from the day centre. She would love to maintain work; her employers can be flexible, but the pattern of care, which you would not get in childcare, simply does not match working hours, cannot deliver the integration of people’s working lives, particularly at a time when we are asking people to work longer, particularly into their older age. It does not match those two requirements and responsibilities in people’s lives.

The Chairman: Very helpful; very important.

Caroline Abrahams: In terms of values and principles, being optimistic, it would be quite nice in 10 years’ time for people to more routinely talk about “people” in the system, rather than “patients”. That itself would be a helpful shift. It would be great to get to a point where issues around dignity and respect for older people who are receiving services are not viewed as either soft and fluffy, or nice-to-haves, but are both viewed as essentials and as just as important professional attributes as the commitment to excellence in healthcare that David was talking about earlier. It is important that those things become seen as on a par with each other, and that everything about how people are recruited, retained, trained, supported and managed, emphasises the centrality of both alongside each other.

In terms of what the system would look like to be better, the Richmond Group is another report, apart from the others you have already heard about today. The Richmond Group of charities produced a report earlier this year about what a good system would look like. We are a member of that; it is 12 of the biggest charities that work around health conditions and older people. We came up with five attributes of what a good system would look like. They were as follows: firstly, co-ordinated care; secondly, patients engaged in decisions about their care; thirdly, supported self-management; fourthly, an appropriate emphasis on prevention, early diagnosis and intervention; and finally, really good provision of emotional, psychological, and practical support, increasingly at home, as Chris was saying.

We have not talked about the local home environment very much today, but increasingly when people are talking about integration and what good care is going to look like in the future, they are also starting to think about, “What does home look like? Where do practical adaptations fit in to be able to support people in staying there longer?”. I think all these kinds of people sitting on this panel are going to be thinking a bit more about housing in future than they are currently.
In terms of other characteristics of what a better system would look like, data and the intelligent use of data would be a significant shift from where we are now. We were hearing earlier about how much data is collected, which may be the case, but a lot of people would say we do not use it as intelligently as we could do. Therefore the system we have as a whole is not very purposeful, because it is not a managed system; it is not full of analysts who are interrogating the data and helping to support good decision-making by managers and planners. One would expect to see more of a shift to that over time.

A very good test of whether we have got a good system or not would be what the people working in it say about what it is like to work in it, particularly people on the front line, who, frankly, must be having as miserable a time, quite often, as that of the people who are on the receiving end of poor services. We must ensure that it is a place where people want to be; that we have managed to make the shift to understanding in health that the bulk of the clientele are going to be older people; that people are electing to be there, wanting to be there, and are being really well supported to do a good job. One thing that has not come out too much today, and was implicit in some of the other questions you did not get to, is that it is quite a hard job.

It is not an easy or straightforward job, particularly for older people who have dementia, or have other problems of that kind. It is really, really tough, you need to be very well supported, and a lot of people cannot do it. It is not the sort of job anyone can walk into; it is quite a special job requiring special skills, and currently we are miles away from recognising that in any meaningful sort of way.

Q278 The Chairman: You did not mention, as I thought you might do, supporting independence as a goal. I would have thought that for many people they would prefer—both the words are crucial—the support to be as independent as possible to avoid institutionalisation when that is not really necessary.

Caroline Abrahams: Absolutely. I am sorry I did not say that; you asked that last time, I remember. Yes, absolutely; that, as part of an overarching vision for what we are trying to achieve for people, would be very important. The final thing to add is that, I hope, in 10 years' time, we will have cracked the challenge about where the improvement function is across the whole of the system. It has emerged today, for example, in this conversation that it may be there in the health system, but it is not there in the social care system, which is highly fragmented. You have regulation, you might have grass-roots initiatives, but what you do not have is a sense, or a process or a system for helping people to learn from each other, and get better across the board.

Q279 Lord Bichard: You did mention the issue of information and data, which we have not talked about a great deal, but is certainly something that I worry about, and which I had a meeting with the Information Commissioner two weeks ago to talk about. It worries me that we have become so concerned about the privacy of individual data that we are not now very good at sharing it. A lot of what we have all been talking about today will only happen—the co-ordination, integration and the rest of it—if we become better at sharing data. Therefore, I was trying to suggest to the Information Commissioner that he should do a lot more to get out advice and support on how you share data. I have even suggested,
Caroline Abrahams: When I worked in Government, I looked at all this stuff in a slightly different bit of the sector. It becomes clear when you start to interrogate it that it should not be a problem. The myth that it is still a problem seems extremely powerful; it has a powerful hold over frontline practitioners quite often, even though when you read the guidance, and all the rest of it, in many cases you can share data.

I would like to say that my points about data were at the level of the individual, so that people are able to make intelligent decisions, having understood the trajectory that a person might be on through their later life. But there is also the point Steve was making about the capacity to gather data and interrogate it properly locally, to understand overall patterns of change and what that means for you, for example, as a local authority, in terms of the kind of care you are going to need in five or 10 years’ time.

Lord Bichard: Dr McShane, you are wincing or looking quizzical.

Dr McShane: I agree with your point about information. To get the electronic palliative care co-ordination system off the ground, there are 144 different bits of regulation sign-off to go through. However, there was legislation passed, and there is an information strategy, which was published earlier this year, and the work that is being led by Tim Kelsey of the NHS Commissioning Board on—a phrase I have to use—interoperability means that we can move forward on that. There is also a cultural attitude, especially when it comes to carers, about using common sense.

Q280 Lord Bichard: That is the issue though, is it not? When I did the Soham work, the problem was cultural. The problem was that it did not need to be a barrier, but people thought it was a barrier, because you did not share information, because you were scared someone was going to hit you around the head for having done it. Therefore, it is a big step from saying, “We now have a theory” to “We are going to change the culture”.

The Chairman: We will come to that.

Professor Oliver: I should say, before I go on, the living manifestation of what you have just described, Lord Bichard, is nurses refusing to tell people’s relatives on the phone what is wrong with them, because of so-called confidentiality. The OTs are quite happy to talk to them; the doctors are quite happy to talk to them. We have got to the stage now that we are not allowed to have people’s names above the bed in hospitals; you have to sidle up and read their drug charts to find out who they are, because of false concerns about confidentiality.

Two things: one is systems, and the other is what happens to people within services. With systems, I am going to quote you a report by The Economist magazine Intelligence Unit 2012, which took evidence from over 1,000 European experts, including me. The reason I am going to quote it is because 1,000 brains are better than one, and I agree with everything they have said. They ask people: given current standards of care, do you worry about care

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57 Information governance.

Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

for you when you are older? Are older people less likely to receive the same standards of treatment as younger people? Do you regard ageing as a threat to the viability of our systems? Interestingly, although I digress, only Germany, Holland and Sweden said, “No, we are quite relaxed about ageing; we have got the right things in place”.

Across Europe, there is consensus about what might help this. The first thing was more focus on preventative health strategies and long-term conditions management; I will come back to prevention in a second. The second was more use of technology; of every country in Europe, including Eastern Europe, the UK was the least confident about its ability to use telecare, telehealth, new technologies. The third thing was training and support for volunteer caregivers. In my experience as a jobbing hospital doctor, it is often carer stress that precipitates admissions, because people do not know where else to go. The fourth thing was integration, which we have discussed. Another thing was more specialists in geriatric medicine; we are blessed in this country, because we have got more geriatricians than most places have. Then there was more training for staff in core skills looking after older people.

We have a situation at the moment, whether it is nursing, social work or medicine, where we have not equipped the workforce with the skills that are required to care for the people who come through the door. For instance, one in four people in hospital beds has dementia and very few places have any mandatory dementia training.59 We have not caught up with that reality of who is coming in. If you think about it, you would not ever let someone be a consultant nurse in a special care bed unit or intensive care unless they had spent years in that speciality, but we are quite happy to give people charge of a nursing home who have got no bespoke qualification in the care of older people. It needs to be recognised as a skill every bit as exacting as the care of a child. I am fed up of this tired narrative: it is just compassion; it is just common sense; it is just empathy. That should be a basic entry requirement: you require a lot of skill.

So, there was training for staff, statutory requirements around age discrimination, and the final thing was long-term social care funding—I was at a European conference in Strasbourg last year where every system in Europe was up against this—but, crucially, including the healthcare inputs into social care.60 I think that report is about right.

In terms of prevention, there is a tricky thing here, because on the one hand everyone is signed up to the idea that prevention matters, but if you want to get quick gains, you deal with the people who have already got the high intensity needs now. If I manage people with broken hips better I will save money quickly; if I focus on bone health, falls prevention and healthy communities, it may take years to see the gains.61 There is a trick, but in terms of prevention we are talking about primary prevention—things like healthy ageing over the life course, obesity, activity, alcohol, smoking; housing, which has been mentioned, is very important. But we are also talking about secondary prevention: when you do have a long-term condition how do you remain well and stay independent, and prevent deterioration? Then there is tertiary prevention, which is, when you do have a catastrophic


60 Additional comment from David Oliver: “Write up of all Strasbourg conference proceedings “l’automne de la vie” in “Ethical Challenges of Ageing” editor M-J Thiel, 2012 RSM Press.”

In terms of what happens in services, if you start with the person and their carers, they need to be far more involved in educating staff, in designing services, in feeding back on services. Even the best-intentioned health professional does not see what it is like through the eyes of the carer of the person with dementia bouncing in and out of systems. As Martin said, services should be designed around their goals.

Staff: someone has already mentioned the issue of who cares for the carers. It is a tough job sometimes; we need adequate numbers of staff. The Royal College of Nursing report on staffing levels on wards for older people showed if you are on a ward for school age children there are three times as many nurses per patient as there are on a ward for older people. There is no logic behind that; we need the numbers. The staff must have the appropriate skills and supervision. If you are going to be a ward sister it is a big job: lots of people to manage, a big budget. We are throwing people into those roles without support.

Leadership: in the best places I have seen around dignity and care, it is because from board to ward, the chief nurse, the medical director, the non-executives, all buy into this being absolutely critical. For instance, Salford Royal starts every board meeting with a patient story, not talking about the money; it is that important to them.

Professional leadership: colleges and specialist societies need to value this stuff. If you look at the Royal College of Physicians work now on future hospitals they are getting with the programme. I was heartened to see the Royal College of Surgeons themselves saying that there were ageist decisions being made about operations.

Advocacy from charities and campaigning groups is important. The politicians and the policymakers need to set down a marker; law matters in terms of things like the Equality Act or the Human Rights Act. Getting the right policy levers to ensure that there is enough focus on the needs of older people is important. So are effective regulation and inspection.

The final thing is, almost back to the public really, what role does a public conversation have? Currently either we have got elite older people running marathons and skydiving, or we have got victims of abuse and neglect. There is no representation in the lay press of people living with a couple of long-term conditions, having a walking stick, having a hearing aid and having a perfectly good and worthwhile quality of life. We have ageist attitudes in society that colour everything else.

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62 Additional comment from David Oliver: “Source Allen and Glasby 2010, WHO Europe Report 2011, Department of Health Partnerships for Older People (POPS) project 2010.”

63 Additional comment from David Oliver: “Royal College of Nursing Report 2011. Staffing on Wards for Older People.”

64 Additional comment from David Oliver: “Source Tadd W et al “dignity in practice” report for PANICOA 2011; Kings Fund Report “care of older people with complex needs” 2012; NHS Confed/Age UK “delivering dignity” commission 2012.”

65 Additional comment from David Oliver: “This is the Royal College of Physicians Future Hospitals Commission – all on www.rcplondon.ac.uk and also the RCP report “hospitals on the edge” of 2012.”

66 Additional comment from David Oliver: “This is the Royal College of Surgeons 2012 Access All Ages Report.”

67 Additional comment from David Oliver: “See Oliver D Journal of Holistic Healthcare 2012 and Oliver D chapter in “ethical challenges of ageing” 2012.”
If you think it is all pie in the sky, think about what has happened about dementia care or hip fracture care. We have had a social movement generated by Alzheimer’s Society, Dementia UK, let us say. It has got before a Public Accounts Committee; it has got on the radar of the politicians; they have created further momentum; and gradually there is a step-change, which is now being reinforced by the right policy levers. The same thing has happened around stroke care, so it can be done; it is not just platitudeous gobbledygook I am talking; we have got living examples of how this can work.68

Certainly, when older people are in health services, primary care or secondary care, they need a proper diagnosis, they need proper assessment, and currently we are failing to address reasons why they are becoming immobile, or becoming dependent, and writing them off.69 People use phrases like social admission or acopia, when people have got perfectly treatable pathology. We are normalising disability and frailty in older people when often it is reversible; that is a real cultural challenge for the professionals.

Q281 The Chairman: That is fascinating, again. Martin, in a sense, this is an invitation to say what either the Department or the Commissioning Board has got as its normative standards about what it is trying to aim for and to achieve.

Dr McShane: One of the things that I would state is that we are going to have the mandate, the constitution and the outcomes framework as a triple high-level driver in the system, which should comprehensively support the sorts of issues that people have been articulating here. This is not a vision that needs reinventing or redesigning; one of the reasons I got passionate about long-term condition care was reading Crossing the Quality Chasm over 12 years ago, which defined many of the things we have been talking about here and people have continued to talk about.

One of the things that we need, which would support this, is to make population diagnostics as important as individual diagnostics, so that local communities, local people, can see the quality of the care that is being delivered for them as a population, as well as experiencing what is being delivered to them as individuals, and placing that in front of Health and Well-being Boards, clinical commissioning groups and individual practices, which, after all, have a registered population that they are responsible for.

We need to build on the foundations we have, the potential we have in this country with primary care, which has a comprehensive electronic medical record; many people are quite envious of our disease register and the things that we could do with it. It needs to be mined. We need to create a far more coherent and consistent offer from primary care, with a common purpose. We need to listen to what people are saying: going to a national voices workshop, people are not bothered about the word “integrated”; what they want is co-ordination.

I saw a definition of continuity recently, which is quite helpful. The first is information continuity: that no matter where someone goes people can access the information about them, whether they carry that themselves, or it is available, because it is electronically shared. The second is management, and that is about co-ordination and collaboration

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68 Additional comment from David Oliver: “Reference from DO National Dementia Strategy 2009, PM Dementia Challenge, Dementia Action Alliance.”

Age UK, Care Quality Commission, Carers UK, The King’s Fund, NHS Commissioning Board (“Improving the Quality of Life for People with Long-Term Conditions”) and Professor David Oliver – Oral evidence (QQ 215-288)

between organisations focused on delivering what is best for the individual. Again, it is the sorts of evidence that David has described. The third is relational; it is very difficult to navigate a complex care system, and people in the future should know that they have someone who is a trusted advisor—it might be your GP; it might be a nurse; it might even be a consultant—and that they have that relational continuity, which may change at different aspects of their lifespan, but that happens.

I will go back, because I think I have been misinterpreted, and say that the NHS Commissioning Board needs to clearly define the “what”—making the “what” happen. We need to empower local professionals and communities to do that. If there is a “what” that is a no-brainer, it will be hard for local commissioners to argue against it; they have to show that their alternative proposition is better than that.

Q282 The Chairman: This is aligned to what Chris Ham was saying: “We know what works; for God’s sake, do it”.

Dr McShane: Yes. It is about defining the “what”, and the challenge will be: if you think you have a better “what”, if you think you have a better way of delivering that, given the evidence, then tell us, show us, because then maybe we could learn from that and share it with other people. Otherwise, here is the best evidence. I go back to this fact that one of the greatest transparencies we need to make clear is the value across the system. We do not understand the value of primary care; we do not really understand the value of mental health services; and we have focused all of our attention on measuring stuff in the acute sector. Neither do we understand the value between health and social care. One of the pleas I would make on an operational basis is that, if we could get local authorities to adopt the NHS number, we could track value right through the system. What happens in social care, we could see the impact in health as well.

Q283 The Chairman: That sounds as if it is a research job for economists for about 10 years.

Dr McShane: It is not really.

Q284 The Chairman: We know where there are inefficiencies in the value chain between social care and the NHS—do we not?—very clearly; we have talked about it previously. Why do we not focus on a few things like that rather than build an enormously complex model?

Dr McShane: I am not asking for an enormously complex model, but if you are going to a director of finance and saying that investing in assistance going in to do medication reviews will reduce costs, we can track the cost of that, who they visited, and can see the impact on prescribing and the outcomes. One of the most difficult barriers to overcome is convincing a director of finance that this is the right thing to do.

Q285 The Chairman: That is going to drag you into the Care and Support Bill; that is going to lead you relatively fast into whether some NHS funding should be going into social care interventions, because it is in your interests for it to do so. Is that not correct? That is the logic of your argument.

Dr McShane: That is an interpretation, yes.
Philip King: I agree with many of the points that have been made, particularly those made by Caroline and Chris. I would pick out two points. The first is the need to address the current concerns, because we have heard about significant concerns that exist. It is picking up Caroline’s point about the skills and experience needed to look after, particularly, people with dementia. I say this with the benefit of not just being a regulator, but having had a career as a clinical nurse specialist and a director of nursing in this area. I think it is absolutely right; if one wants to talk about the values, then the values are around person-centred, personalised care. You can look at a task-orientated system, and bring people in to do that, but they may not do it very well, and there is a significant amount of technical skill and interpersonal work that makes good care. That can only be within a person-centred system.

Second, it has to be properly led. At the end of the last session we had a discussion about leadership in this area. That gains resonance with us as a regulator. If I could put my finger on one determinative factor of improvement, it is where the leadership of an organisation, whatever organisation that is in health and social care, takes on the challenge of improvement, rather than arguing about it or talking about being a high-performing organisation when the evidence of that is not there. I would talk about the need for leadership.

Q286 The Chairman: We all know that, do we not? We know that good leaders change systems; the problem is that they are not universal. You have to go beyond, “Let us have some good leaders”, as an argument for change.

Philip King: We have seen some examples of really good leadership and some examples of where the leadership is not there.

Q287 The Chairman: I totally agree; we want more good leaders, but that is a rhetoric we have used on every single service we have strived to improve for the last 50 years.

Philip King: Specifically you need people who can ensure, within the organisations and within the professions, that the people who are delivering the care on the ground—and I take David’s point that good care and good technical standards of medicine should go hand-in-hand—can ensure that that is delivered, and ensure that in the governance of the organisations that is relevant.

If I could move on to the second point, in effect the question here is: how do you do more with less? There is a point here about innovation, and I am sure that that will be encouraged by all of us on this panel. Lord Bichard talked about the use of technology; certainly with dementia, the use of assistive technology in terms of helping people stay at home is something we have seen very good examples of, but it is not necessarily widespread. Possibly there is something about potentially scaling that up.

In terms of international examples, we have contact with various international regulators. It is true to say that in developed and western countries, we are facing very similar concerns. There are some examples of very good practice internationally. They tend to describe and cluster around the examples that Caroline and Steve have talked about, which is taking the care of older people, not just in the health and social care system, but thinking about housing and communities. Some of the examples we have seen in Holland, particularly, give some resonance to that. We would be happy to share those examples with the Committee.
Baroness Tyler of Enfield: Certainly those international examples would be very helpful, and we have heard two or three of them this morning. If we had had more time for questioning, we would have asked more on that point. My final point is, a lot of you have talked very correctly about the wish for far more people to be looked after at home, and then the impact on families and carers, and all of that. I was rather surprised that no one made any reference to the growing number of people who are going to become old without having dependents, childless people, people whose families might be at the other end of the country or might just not exist. Could you point us to any sort of thinking that you are aware of about how that aspect of an ageing population might be addressed? It seems quite a big issue to me.

The Chairman: Your silence is an eloquent answer.

Caroline Abrahams: It is a very fair point. I was talking to someone from the Family and Parenting Institute last week about the fact we are heading towards a world in which you have got four generation families for the first time. You have got two squeezed middles, if you like, alongside people with no family. I do not think we have worked out what that means for either; the four generation family could become very introverted and cut-off. The obvious answer to that dilemma in policy terms is about the more mutual type of approach and more reciprocity. There are some pros and cons to it, but the Southwark Circle scheme tries to find a systematic way of enabling people to help each other around a community, and local currencies are used to buy care in different sorts of ways.

There might be something in that, but they will not happen on their own; they will need quite a lot of infrastructure to support them. It is hard to think of other ways really, particularly for people with less money. For people with more money there are always other options: friends deciding to share a house in later life together, and jointly pool money to buy care. You can imagine that happening. But for people without those financial resources something else is going to be needed.

Dr McShane: We have got the three aspects of this: there is the political, the professional and then the social change. How do we create the conversation and the understanding in communities of this level of problem? Health and Wellbeing Boards, which we have touched upon from time-to-time in our conversations, again, have a potential to play a significant role in this, by bringing together the key partners in local communities, to take action on this agenda.

The Chairman: We sincerely hope so.

Steve McIntosh: I have two very quick points. First, in terms of the supply of support to families, I would like to draw the Committee’s attention to welfare reform, and the impact
that may have as a knock-on effect to social care services. We are seeing huge reductions in the financial support available to disabled people and their families. They are switching to a Personal Independence Payment; we will see a reduction by 500,000 of the number of people eligible for disability benefits, as they are moved from Disability Living Allowance to Personal Independence Payment, and also the time limiting of the Employment and Support Allowance and other benefits.

It is really the extent to which Government are looking across these two policy areas. We have talked about integrating outcomes and possibilities, but it is the integration of impact assessment; looking at our social care spending as benefits are restricted to families. We could see, at a time where we are asking people to work for longer, the pressures on those families increasing through a reduction in support from several different directions. The cumulative impact would be quite disastrous for some families who are providing round-the-clock care, but also families who are just managing to cope with limited support from social care, and from welfare benefits. They see a reduction in support from one or both of those things, and we are going to see considerable additional pressures put on social care services from people losing welfare benefit support.

Finally, on international examples, we touched upon something in our evidence around growth in care services. We are very keen, in terms of carers juggling work and care, for social care to be seen through an economic prism: that you understand and you are valuing the impact of social care; that you understand, if a family member is able to stay in work as the result of a social care intervention, that is a benefit that should be seen more widely and valued, rather than just being seen through a value of social care and health services. Equally, in France and Belgium, the generation of a vibrant care market has been seen as part of a wider growth strategy. It is surely the growth market: with such spiralling demand, and people who are buying their own care services, but cannot access that support, the gap between statutory provision and the availability within the market present huge opportunities for the generation of those sorts of services.

In France a single agency has brought these together, looking through an economic aspect at whether this can be part of the growth agenda. It has seen sustained economic growth and job creation, but also a raising of standards and a professionalisation of the workforce, through the wider economic strategy and seeing care through that prism. We would love to send you a note on that.

The Chairman: We would very much welcome that. Geoff Mulgan was making the point as well, this week. We would really like to see that, particularly the evidence from other countries having done it.

Lord Bichard: In a way, that is what we did—“we” being the country—with very young children: we developed caring for young people as part of an economic agenda, quite successfully.

The Chairman: There we go. I can feel another recommendation coming on.

Thank you very much indeed. I found that a fascinating session. A complex view with the span, but nevertheless, from our point of view, it worked very well to get people from very different parts of the system speaking to it. Do interact with us: you know where I am; you know where Susannah is. If you have got further thoughts, or further things you think we should be thinking about, we would welcome that. Thank you very much indeed.
Age UK Cornwall Social Impact Bond project

The committee asked for some more information about this ambitious early intervention programme to improve health outcomes and reduce unnecessary emergency admissions to hospital among frail older people, intended to be funded using a Social Impact Bond (SIB).

Working with our delivery partner, Age UK Cornwall, Age UK has established a pathfinder service which integrates voluntary sector led maintenance, early intervention and preventative approaches with NHS clinical and specialist responses to create new opportunities for older people to self care, be supported at home rather than in a clinical setting and to offer improved outcomes at a reduced cost.

The pathfinder service became operational in two GP practices in June 2012 and will provide and test new interventions for 100 frail older people over the next 9 months. The ambition is to scale up the project in 2013 to 1000-2500 older people in Cornwall.

The support for the SIB programme and the development and delivery of the pathfinder in Cornwall from key senior leaders and practitioners has been overwhelming. It has been contained within the authorisation plans for the Clinical Commissioning Group and robust local governance arrangements have been established with the full range of partners, all of whom are committed to improving outcomes and preventing unnecessary admissions for older people into hospital. The local partners have worked together to reshape local approaches and delivery models to be able to demonstrate what works to achieve and sustain reduced demand for hospital services.

Our aim is to leverage funding from social investors to set up the programme, rather than having to call on hard-pressed NHS or council budgets. Our hope is that over the coming months we will be in a position to expand the pathfinder using a SIB as a viable financial cash-flow tool in improving health outcomes for older people, and testing whether using the rigour of an external investor can result in better outcomes than traditional commissioned services.

The SIB model works on the basis that if we deliver each element of the programme well, not only should it pay for itself it should also release sufficient savings as a result of fewer emergency hospital admissions, to pay a dividend to the local health economy which can be reinvested in community-based preventive services and provide social investors with a modest return.

A SIB for frail older people programme is genuinely ground-breaking – it has never been tried before – and if it works it could transform the health outcomes and the wellbeing of older people in every community. Age UK is taking the initiative because far too many frail older people are going in and out of hospital, often on an emergency basis, because they don’t get the treatment and support they need at home to keep them fit and well.

November 2012
Alliance Boots—Written evidence

Alliance Boots welcomes this inquiry and hopes it will provide concrete recommendations on how public services should evolve over the coming years to prepare for the consequences of demographic change.

Conventional narratives have framed population ageing as a negative development which will burden society. This is understandable given that an increase in life expectancy hasn’t resulted in a significant extension in healthy life years of the population. While there has been a degree of progress in recent years there is still a huge scope for improvement. Average life expectancy for a male born 2008-2010 in the UK was 78.1 years while average disease free life expectancy was 63.9 years.70

Inequality within the UK remains problematic. For males born between 2006 and 2009 life expectancy in the least deprived areas in England was 81.4 years, while disease free life expectancy was 69.4 years.71 For males born in the most deprived areas of England over the same period life expectancy was 73.3 years and disease free life expectancy 54.6 years.72

Ageing should not be seen simply as a cost. Current evidence suggests that people aged over 65 make a net positive contribution to the UK economy. In 2010 this was estimated at £40bn and is projected to rise to £80bn by 2030.73

However if left unchecked funding of health and social care will consume a larger and larger proportion of public spending as the population ages. While this could most likely be funded through existing means of public taxation it is likely to be at the expense of investment in other services. Public services therefore need to be assessed over the coming years to ensure they remain sustainable and can contribute positively to alleviating the potential burden of demographic change.

A major challenge facing health and social care is the treatment of chronic illnesses and disability. More than 15 million people – 30% of the population - in the UK have one or more long term conditions; by 2025 it is projected that more than 18 million people will have at least one long term condition.74 The Department of Health estimate that 70% of the total health and social care budget is spent on long term conditions.75

Improving public health is therefore essential in managing costs and several key steps should be taken. Firstly recognising the value of disease prevention by addressing key health determinants contributing to illness and disease. Secondly by managing long term conditions

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74 Kings Fund and Centre for mental Health “Long-term conditions and mental health: The cost of co-morbidities” (2012)
75 Department of Health “Improving the health and well-being of people with long term Conditions” (2010)
more effectively through earlier diagnosis and timely intervention. Thirdly by ensuring services are accessible and convenient and are built around the public need. Supporting patients in their community and avoiding hospitalisation is a well recognised way of avoiding unnecessary costs.

These steps will not require significant new investment or services but the better use of what already exists. The 10,900 community pharmacies in England are uniquely placed to deliver a large scale, long term public health programme. Pharmacists are highly qualified healthcare professionals trained in medicines management and advising on health issues. They already provide a number of public health services albeit on a smaller scale to what could be achieved.

The Government needs to establish a long term vision and strategy that recognises and responds now to the challenges and opportunities of demographic change. Facing the challenges of tomorrow today, and setting public services on a suitable trajectory of reform over the next decade and beyond, is more likely to create services that are robust and responsive to public need and avoid short term upheaval that can often result in lost productivity and higher costs.

To accompany such a long term vision, and reforms of public health and community based services, it is essential that a credible narrative is created to inform and empower the general public about ageing. This is important for ‘normalising’ ageing and removing negative perceptions and prejudices that exist. It is also central in preparing the public for later life and empowering them to make important health and wellbeing choices earlier to reduce the risk from life limiting conditions and keep them healthier for longer.

**About Alliance Boots**

Alliance Boots is a leading international pharmacy-led health and beauty group, employing over 70,000 people in the UK. The group’s businesses in the UK include the Boots pharmacy chain, Boots Opticians, our full-line wholesaler Alliance Healthcare Distribution Ltd and our clinical homecare specialist division, Central Homecare.

Boots UK operates the largest chain of community pharmacies in the United Kingdom. It is synonymous with pharmacy in the public mind and Boots is one of the country’s most trusted brands.

There are approximately 2,400 pharmacies trading under the Boots brand in the UK and these are well distributed across the country. The chain encompasses those which serve small local communities, including some of the most deprived locations in the country, and health centres through to high streets and those which are part of the largest retail and destination shopping centres.

**I. Demographic change: what is happening?**

1.1. Current projections, from the Office of Budget Responsibility, estimate that without service redesign NHS and social care costs will increase dramatically as our population ages. The OBR estimates that health spending will rise from 6.8% of
GDP in 2016-2017 to 9.1% of GDP in 2061-2062. At the same time social care costs will increase from 1% to over 2% in the same period.\textsuperscript{76}

1.2. One major challenge is that people are living longer but are not necessarily living healthier lives. Currently co-morbidity is more likely to lead to prolonged periods of time spent in hospital and the use of multiple medicines treatment.

1.3. Long term conditions currently account for 70% of the total health and social care spending in England and over 50% of the health budget is spent on secondary care (some estimates place this figure between 60-70% - see Reform, (2010) ‘Fewer Hospitals, More Competition’ or Policy Exchange, (2010) ‘Controlling Public Spending: The NHS in a tight period of public funding 2011-2017’).

1.4. Long term conditions affect both people of working age and those who are retired. Dame Carol Black, former government Director of Health and Work, estimated that dealing with sickness of working age people costs the Government in the region of £60bn per annum, and that this potentially costs the economy almost £130bn every year.\textsuperscript{77}

1.5. However ageing should not be seen entirely as a cost to society. Current evidence suggests that people aged over 65 have a net positive contribution to the UK economy. In 2010 this was estimated at £40bn and is projected to be close to £80bn by 2030. Effective policy interventions now could increase this figure\textsuperscript{78}. This figure includes the contribution made in caring for elderly partners and family members, informal child care support and community based volunteering.

2. Community Pharmacy

2.1. Community pharmacies, including those operated or supplied by Alliance Boots, will have a key role in helping the NHS meet the challenges of demographic change over the coming years.

2.2. Nearly 99% of the population can access a community pharmacy within 20 minutes\textsuperscript{79}. They operate where people live, work and shop and are a mainstay on high streets across the country including in deprived areas or rural communities where accessibility to other primary care services are often limited.

2.3. Pharmacies currently provide a range of services including, but not limited to, smoking cessation, NHS health checks, medicines use reviews, alcohol and drug user services, sexual health screening and treatment, weight management services, vaccinations, minor ailment schemes and medicines management and adherence support.

2.4. Community Pharmacy provides healthcare that is accessible and convenient. Many operate extended opening hours including weekends when other primary care services are often not available. The convenient and universal access to highly

\textsuperscript{76} Office for Budget Responsibility “Fiscal Sustainability Report” (2012)

\textsuperscript{77} Dame Carol Black “Working for a healthier tomorrow” (2008)

\textsuperscript{78} WRVS “Gold Age Pensioners: Valuing in the Socio-Economic Contribution of Older People in the UK” (2011) cited in Bazalgette, Louise, Phillida Cheetham and Matt Grist “Ageing Sociably” Demos (2012)

\textsuperscript{79} Department of Health “Pharmacy in England: building on strengths, delivering in the future” (2008)
trained pharmacists providing ready advice and help alleviates the need to visit a GP in the first instance and provides the major point of access to healthcare to those not registered with a doctor.

**NHS Health Checks**

The NHS is not meeting its targets for offering NHS Health Checks to people aged 40-74 years, with only 1.4m of the required 2.4m-a-year offers being made at the end of 2010. Many people in full-time employment would find our longer opening hours and high street locations more convenient. Boots estimates that it could deliver up to 100,000 Health Checks a year, helping to meet the NHS target for achieving long-term savings through early diagnosis of health issues. This equates to saving the NHS £2.5bn over next 20 years.

2.5. With NHS spending essentially flat for the foreseeable future, the NHS must focus on removing duplication and inefficiency. Community pharmacy already contributes strongly to the efficiency of the NHS. The National Audit Office found that between 2005 and 2009 pharmacies became 8% more efficient (delivering 17% more volume for only an 8% real-terms increase in funding). In addition, purchasing efficiencies driven by pharmacies had saved the NHS over £1.8bn. These savings continue to be made, with prescription volumes having risen 70% in the past decade.

**Minor Ailments Scheme and fewer visits to A&E – a more efficient healthcare service**

Around 18% of GP appointments are taken up with minor ailments that could be dealt with in pharmacies through advice or OTC products. Based on current progress with the national Minor Ailments Service in Scotland, we estimate that Boots pharmacies could save £100m by treating 7.8m people in our pharmacies, freeing GPs to undertake specialist or commissioning work, set against costs of £25m.

Visits to A&E have risen by 12% in five years, but of the 15.5m visits a year, 38% result in patients receiving only advice or guidance, similar to what they could get in pharmacies alongside OTC products. Each assessment costs £59. We estimate that Boots could release £35m through reducing pressure on A&E and GP services in conjunction with a minor ailments scheme at a cost of £5m.

3. **Does our culture about age and its onset need to change, and if so, how?**

3.1. Population ageing is often seen as a negative development which will result in a society which is poorer, where people work harder for less and where public services are few and under-resourced. It is clear that an older, larger population

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80 NAO “The community pharmacy contractual framework” (March 2010)
Alliance Boots—Written evidence

will create challenges but any notion of the inevitability of a collapse in public services is not accurate. There is time and opportunity to avoid a ‘doomsday’ scenario if challenges are recognised and changes made.

3.2. How people approach and respond to ageing is an important indicator of their behaviour. Ageing well and continuing to live independently as an engaged member of society depends on physical wellbeing, social engagement and cognitive ability.

3.3. Research shows that socio-economic status also influences a person’s perception of their health and wellbeing. If you are from a lower social class, unemployed or financially poorer you are more likely to feel that you are not in control of your health compared to those from more affluent backgrounds. Unfortunately this same socio-economic group is more at risk from long term chronic illnesses and premature death.

3.4. This is further supported by ONS data of life expectancy at birth by neighbourhood. A male child born between 2008-10 in Kensington and Chelsea had a life expectancy of 85.1 years, compared with 71.6 years for male child born in Glasgow.82 This difference of 13.5 years highlights the magnitude of the challenge. The report suggests the variance is due to “various individual area factors, including socio-economic status, health behaviour (for example, alcohol consumption and smoking), environmental conditions, the proportion of people living in deprivation, and the availability of local services and resources.”83 Community pharmacy can play a huge role in promoting healthier lifestyles in all communities.

3.5. While extending average life expectancy should remain a goal the Government strategy should focus on reducing the gap between average life expectancy and Disease Free Life Years. Successfully addressing this challenge will have a positive impact on all areas of public service.

3.6. A credible narrative is essential to inform and empower the general public about ageing. This is important for ‘normalising’ ageing and removing negative perceptions and prejudices that exist. It is also central in preparing the public for later life and empowering them to make important health and wellbeing choices earlier to reduce the risk from life limiting conditions and keep them healthier for longer.

81 McKinsey & Co “Achieving world-class productivity in the NHS 2009-14: detailing the size of the opportunity” (March 2009)
82 Office of National Statistics “Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2004–06 to 2008–10” (October 2011)
83 Office of National Statistics “Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2004–06 to 2008–10” (October 2011)
Empowering individuals to live healthier lives

In Scotland, prescribing of nicotine replacement therapies (NRT) as part of smoking cessation attempts almost doubled between 2008 and 2010 following the introduction of a national service through community pharmacies. By the end of 2010, nearly two-thirds (63%) of all quit attempts were being made through pharmacies, and over three-quarters in some Health Board areas.

In the year to March 2011, Boots helped over 81,000 customers with their attempts to stop smoking, of which over 36,000 were successful (45%).

4. Do the extent and nature of public services need to change? If so, how, and how should they be paid for? Do we need to redesign and transform public services for these challenges? If so, how?

4.1. Public services will have to adapt to changing circumstances. They will likely need to do ‘more-for-less’ as public funds remain squeezed as a consequence of the current economic crisis and increased demand for services. Specific challenges will exist within particular communities with public transport, housing and access to healthcare services potentially problematic in rural or deprived areas.

4.2. There does need to be a healthcare redesign with a greater emphasis on community based care that can deliver accessible, available and affordable services. Accessibility to services is essential for empowering the patient in making decisions about their own health and wellbeing; and empowerment is key to introducing an effective public health service with a focus on prevention and earlier diagnosis.

4.3. At the same time a more ‘personalised’ approach to health and social care could bring cost savings to the NHS and Local Government if services can be successfully joined-up and coordinated. To ensure the quality and standards of care continue to rise, national frameworks and standards should be introduced to allow services to be benchmarked and best practice identified and adopted.

4.4. Service redesign shouldn’t cost more. Better use of existing healthcare provision such as community pharmacy would go a long way in re-orientating how services are designed and delivered. The previous Government engaged McKinsey & Co84 to examine the key areas of NHS expenditure in terms of potential efficiency savings. McKinsey found that around a quarter of the potential savings it identified (£2.7bn-£4.1bn) would come from “shifting care into more cost-efficient settings”. This includes moving services from secondary into primary and community care.

4.5. Looked at in more detail, a major challenge remains the better management of patients with long-term conditions (where medicines are the mainstay of treatment), and in promoting self-care (where pharmacies are frequently the first

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84 McKinsey & Co “Achieving world-class productivity in the NHS 2009-14: detailing the size of the opportunity” (March 2009)
4.6. All government departments should be required to consider how their current services and emerging policies will effect or be affected by demographic change. Departments should benchmark services provided or commissioned against the need to retain accessibility, availability and affordability for the general public. Failure to ensure these ‘three-As’ is more likely to result in ongoing inequality and social exclusion.

5. What should be done now and what practical applications are needed?

Recommendations

1. The Coalition Agreement 2010 states, “The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health.” We believe that the Government should hold firm to this commitment.

2. The Government needs to establish a long term vision and strategy that recognises and responds now to the challenges and opportunities of demographic change. Facing the challenges of tomorrow today, and setting public services on a suitable trajectory of reform over the next decade and beyond, is more likely to create services that are robust and responsive to public need and avoid short term upheaval that can often result in lost productivity and higher costs.

3. All government departments should be required to consider how their current services and emerging policies will effect or be affected by demographic change. Departments should benchmark services provided or commissioned against the need to retain accessibility, availability and affordability for the general public. Failure to ensure these ‘three-As’ is more likely to result in ongoing inequality and social exclusion.

4. While extending average life expectancy should remain a goal the Government strategy should focus on reducing the gap between average life expectancy and disease free life years. Successfully addressing this challenge will have a positive impact on all areas of public service.

5. A targeted approach to addressing health inequalities within ‘at risk’ communities is imperative to improving the overall health of the nation and reducing a reliance on public services. Particular focus on key health determinants such as smoking, alcohol use and diet could have a significant impact on morbidity and mortality rates amongst at risk groups.

6. Greater use of existing community based services such as community pharmacy is essential for reducing a reliance on secondary care and supporting a disease prevention agenda. Community pharmacy embodies accessibility and availability of public services and can be better utilised in delivering a public health agenda including services and support, and supporting patients with long term chronic conditions.
7. Finally, a credible narrative is essential to inform and empower the general public about ageing. This is important for ‘normalising’ ageing and removing negative perceptions and prejudices that exist. It is also central in preparing the public for later life and empowering them to make important health and wellbeing choices earlier to reduce the risk from life limiting conditions and keep them healthier for longer.

31 August 2012
Andrew Bonser, Director of Public Policy, Alliance Boots, Professor Martin Knapp, London School of Economics and Political Science and Personal Social Services Research Unit (PSSRU), Professor Les Mayhew, Cass Business School and Social Finance, gave evidence.

Q327 The Chairman: Good morning and welcome. I am sorry that we have kept you waiting a while: it is a problem of dealing with too much complexity. Are you good until 12.30? Can I just check that? Excellent. So we have a good hour and 10 minutes plus. You know why we are interested in this. Clearly in the evidence we have, written evidence and the oral evidence we took last week, everybody says we have clearly got to make both health and social care systems better at preventing problems, have fewer crisis interventions and clearly better able to intervene earlier. It is what we all say when we get out of bed in the morning. Clearly we want to focus on some more specifics about where, how and when, and does it really work? Also, Ben, a signal to you as well: we realised we did not have a specific question on Social Finance, so we have rectified that. We are going to have one, which I will call 4A, and we will have a specific question on Social Finance, and you can guess what we will ask on that one. So, would you like to run along the row before we kick off, just to introduce yourselves?

Professor Knapp: I am Martin Knapp. I am Professor of Social Policy at the London School of Economics. I am also Professor of Health Economics at King’s College, London.

The Chairman: Welcome.
Professor Mayhew: I think I can say two things. I can just quickly run through four areas where I think there is some quite good evidence on the economics side and make a general comment as well. The general comment, just quickly, is that there is lots of emphasis now on saving money; most of the things that get done in the health care sector and the social care sector do not save money, but they do maybe generate good value for money. So getting that balance right is quite important.

But then looking at the evidence, there are four areas that I would just quickly highlight, and I am happy to go into more detail, if you want to, later on. One would be dementia, where I think we are getting some good evidence coming through now of the benefits of screening, early diagnosis and intervention. There is some evidence on exercise programmes, which seem to be quite promising. There is lots of evidence now on carer support and looking after the health and wellbeing of carers, because we know it has a major impact on the health and wellbeing of people with dementia and the costs later on. So that is one.

The second one would be falls prevention, where the research I did in preparation for the meeting suggested that there is lots of evidence around now. Most of the strong evidence seems to be behind tai chi as the most cost effective solution, surprisingly perhaps, but everybody seems to think that is the way to go.

The third area is befriending, where I think there is a lot that communities can do: low-cost, easily organised services to engage with isolated people to reduce loneliness, reduce the risk of falls and so on.

The final one would be in the social care field, where I think there is good evidence about intensive home care and day care and keeping people out of care homes and out of hospital, which is better for them and better for the public purse.

Professor Mayhew: Shall I go next? I would like to step back a little bit and just put on record that prevention starts early in the life course, and instilling good habits at an early age helps enormously later on, so you prevent a crisis occurring. There are all sorts of ways in which society has done that over the last century, from clean water to better housing and so on. But then there are secondary and tertiary interventions, secondary being things like flu jabs and hard hats on building sites, safety belts and pendants and things like that. They apply to individuals. Then there are tertiary interventions that are appropriate once the crisis has manifested; the person has had a fall or whatever it happens to be.

My work on this suggests that for prevention services to be effective you need very clearly defined goals. You need to be able to select people into the programme who are going to...
benefit, and it is important to avoid duplication of effort. There may be some other service out there that purports to do the same thing, but in a slightly different way. You need a very good referral or case-finding system, because a lot of the need for intervention is hidden from view. People do not present to GPs, they do not phone up social services and they tend to come from fairly selective groups. You can imagine the types of people that I am talking about, I suppose, so you need a good case-finding and referral system.

I think we are at the stage now where we have cohorts of people coming through to this tertiary stage some of whom were probably smokers, worked in coal mines or hazardous industries and all that sort of thing, and so they have very specific needs. They tend to have long-term conditions: COPD, heart disease, hypertension, diabetes and so on. We looked at the lifecycle costs and health care costs of a delayed diagnosis. So if you can defer somebody getting diabetes or hypertension by 10 or 15 years, it turns out that has benefits over the lifecycle. I will give you a particular example, and this is based on some research we did. People diagnosed with COPD at 75 had a median life expectancy of just under six years. If they were diagnosed at age 65, 10 years earlier, because they had smoked more heavily, for example, they had a median life expectancy of 11 years. So whilst the person diagnosed at 65 did not live as long as the person diagnosed at 75, they had more years of life in which they needed health care, and so the lifecycle costs to the health service of that individual were substantially higher—five years longer, I think.

The point I am making is that we do not measure the right things very often in this area. We are more interested in how many cases we push through a hospital rather than how many cases we did not push through a hospital, and so we may be measuring and looking at the wrong things.

Andrew Bonser: Just to add to what Professor Mayhew was saying. In regards to the service provision, in some of the pharmacy and healthcare programmes we have run supporting early intervention and ongoing care we have found that involving the patient in the service design has been important. Particularly when looking at ways of improving compliance such as through the use of new technologies like, text message reminders. So I think as well as identifying the right people who can benefit from certain interventions, it is also important to provide the right support service for the patient.

Q330 The Chairman: I should say do not feel that you have to answer every question; it is not like that. Just come in when you feel that you are moved to.

Ben Jupp: I suppose, just by way of introduction, I would say that clearly the big task is to try to extend years of healthy and active life and compress years of morbidity, which is what Professor Mayhew was talking about. I think there are a couple of really interesting areas of action around extending active life. The first is around enabling people to work longer and better and, if you do that, start to bring in a whole lot of benefits. You have benefits, probably, for most people, in terms of their health and wellbeing. You have benefits in terms of reductions in expenditure, but you also have benefits in terms of contributing to the economy. I think that is the only way in which a ageing society is going to really add up as a sustainable system.

The second area, picking up on what Martin was talking about, is around social isolation, which is probably a theme that has already come up in your Committee, I think there are double benefits from that as well, because you keep people healthier but you also provide the networks that will be important to people when they inevitably become unhealthy and then allow lower cost forms of support and care in that environment as well.
I think those two big themes of working longer and reducing isolation are areas for further work and exploration.

**The Chairman:** We are hearing quite a lot on the employment and retirement age, as you can well imagine.

**Q331 Lord Bichard:** I worry that prevention is becoming a bit like joined-up Government. We all agree that it is really, really important and we all talk about it, and it is always part of the rhetoric but hardly ever part of the reality. So is there a major cultural issue that we need to tackle, which I know makes it very difficult? My own sense is that public services have always been responsive—that is why they were set up—and not preventative. Somehow we have to switch that, and the only public service I have seen make a decent fist of that so far has been the Fire Service, which everyone dismisses as being rather inconsequential. But is there a major cultural issue and how could we do something about that? Sorry, while you are thinking, maybe one of the problems has been that you are asking someone sometimes to invest in prevention who will not get the financial benefit from their investment. It is all very well saying, “We need these services,” but there is not much of an incentive sometimes for parts of the sector to invest in prevention.

**Professor Mayhew:** I agree and disagree. I think prevention is going on around us all the time; it is just not visible and we do not measure it, and it is not necessarily delivered by the NHS or social services. It can be all sorts of things, like putting extra taxes on tobacco and that sort of thing. So these things are going on in the background, but you do not necessarily associate them with prevention.

But I do think you have put your finger on a very big issue, which is that the people who do the preventing do not see the financial benefits of that; they fall on other services. So one of my hobby horses is the split between health and social care, where you get situations in which a service is set up that prevents a hospital admission but the costs fall on the social services, and of course their budget is capped and they cannot do anything about it. What you need is a kind of simultaneity, a synchronicity of services, so that when a GP sees a patient, he or she has the option to either refer them to hospital, prescribe a social care package or whatever else happens to be needed at that point in time. What happens instead is that there may be a referral to social services, but that person does not get assessed for maybe two months unless it is an emergency. By the time that two months is up, the older person has had a fall or whatever it is, and so she ends up in hospital, and then social care will step in, because it has reached the right threshold and so on. So, somehow you need to bring all these different interventions together at one point in time in a much cleverer way, but you also need to have mechanisms so that the funding or the savings are somehow spread between the people who are putting in the effort, and you get a virtuous circle arising.

**Lord Bichard:** It is very complicated to achieve that. I agree with you.

**Ben Jupp:** I had a public service strategy brief in the Civil Service for a few years, and this was an issue that we wrestled with quite a lot. I think it is not helped by the fact that there are some organisations out there claiming, for example, that if they undertake this little preventative programme, commissioners are going to save £500 million over the next however many years. It is not that people in the public services are stupid. They are scratching their heads and saying, “I have not seen this saving come through from what we did five years ago.” The system that Les is talking about will only work if we are also
introducing greater rigour in the delivery of prevention. My hypothesis is that, if you are a terrible heart surgeon with lots of people dying on your operating theatre these days, you probably will not get away with it for many weeks, and certainly not a year. However, if you are very poor at prevention, probably the best that will happen is that Les or Martin or somebody will come along and do an evaluation in three years and say, “It is not working very well,” but you might get away with it for ever, as it were. I think there is a twin track needed of looking at some of the financials, but also introducing rigour into the delivery.

Professor Knapp: There is this need to co-ordinate the flows of funding and so on. I think there is a need for better co-ordination at both a national level and at local level. We see a reorganisation of the Health Service every five years, and the new one is Health and Wellbeing Boards. Many people are seeing them as maybe an opportunity to do better than we have done in the past, because they are bringing together a whole range of different stakeholders. Hopefully, that will give some local opportunity for that proper discussion of what the benefits might be and the flows across different budgets. At national level, however, one still hears stories from central Government Departments of the huge difficulty in persuading other Government Departments or persuading Treasury to see the benefits of those flows across.

I think back five or six years ago to the initiative to roll out psychological therapies for people with common mental disorders, where there was this high level of discussion between DWP and the Department of Health, or whatever the Departments were at the time, because most of the benefits from doing something about depression flow in terms of benefit receipt and people getting back into work or being absent less. They do not flow very quickly in terms of reductions in health spending. It is getting those people together and recognising that. That is difficult enough when the evidence base is good. I think the evidence base is good in some of the areas, and perhaps it is not helped by the fact that there is a lot of smoke from areas where the evidence base is not very good, and people get distracted by that.

Q332 The Chairman: Do you want to come in on this, Les?

Professor Mayhew: Yes, I think I do, because there are other things going on here as well. When I evaluated this care-co-ordination service in the London Borough of Brent, it was quite clear that it was very effective. It was saving between 14 and 28 bed days in hospital a year for this particular client group, and it was reducing the number of days in hospital at the end of life by about 15 or 16 days per person, which was very good. But when we came to look at admissions to hospital—what it was supposed to deter or avoid—we found that had remained level, and what was happening was the Health Service was just admitting people into the beds that were vacated by the people that were looked after by this particular service. You have to take capacity out of one system to realise savings in another part of the system.

Q333 The Chairman: That implies you have to start closing hospitals, by the sound of it.

Professor Mayhew: I do not necessarily think so. I do not like big hospitals for older people. I prefer small community facilities, where you can keep them in overnight and do a medical assessment rather than a big complicated intervention. There are lots of hospitals that work like that, and their benefits are not proclaimed as much as they might be.

The other thing that really annoys me about the system—and this is one of Lord Bichard’s hobby horses—is the lack of joined-up information. One of the things we did with this
Alliance Boots, Professor Martin Knapp, London School of Economics and Personal Social Services Research Unit (PSSRU), Professor Les Mayhew, Cass Business School and Social Finance – Oral evidence (QQ 327-372)

study that we evaluated was join up health and social care data using an NHS number. It turns out that, in social services, they have some other number, depending on what computer system they have; in the Health Service, they have an NHS number. If you just joined them together, a GP could look at the health record and the social care record simultaneously on his computer, but because we have this silly boundary, we cannot do that. The consequence of that is that one bit does not know what the other bits are doing. It creates all sorts of complications, handover delays, inefficiencies, and meetings that do not need to happen, and the person who suffers in the end is the client. It is a really big issue.

Baroness Blackstone: I want to ask a rather basic question—an infill question, in a way. I am not absolutely clear what it is we are trying to prevent, and I think it would be very helpful if we had a list of what they are. We cannot prevent people becoming older—the march of time continues.

The Chairman: That takes us on Lord Hutton’s question, so let us leave the steerage of that question to him at this point, shall we?

Baroness Blackstone: Yes, okay, but what is it we are trying to prevent?

Q334 Lord Hutton of Furness: That is exactly the question I was going to ask myself. All four of you have described a system that, if it was working rationally, could potentially save the taxpayer a lot of money and improve the quality of care, but in your evidence you have each described a system that does not deliver those outcomes. Professor Mayhew, you said—and I think you used the word “somehow”—“Somehow we need to get everyone working together.” How do you think we can do that?

Professor Mayhew: Going back to what I said earlier, I think it is something to do with the points of contact. In this referral system and case-finding system for this care-co-ordination service, the referrals could have come from any source, but about 50% came from GPs. A small tool was developed to show who would benefit from this service, so that they could spot the profile in the patients they saw. Then they made the referral and other things clicked into action. The care-co-ordination service visited the person in their home and they assessed them. That assessment was wide ranging. It was not just a social care assessment; it included whether they needed things done around the house—gardening jobs, replacing light bulbs—or a visit from the Pension Service to put their finances in order. All those things, collectively, had the impact, and they were all sourced and organised at one point in time by this service. Everybody who worked with it thought it was a very valuable thing. Ultimately, it was preventing unnecessary hospital admissions.

Q335 Lord Hutton of Furness: The evidence, therefore, is there, but not enough people are acting upon it.

Professor Mayhew: In terms of the corporate memory of the Health Service, with turnover and everything else that goes on like that, the expertise is not spread widely enough and, if it is not invented here, it does not necessarily happen. It is a very bespoke kind of activity, if you see what I mean.

Q336 Lord Hutton of Furness: Is the challenge that we face one of how we spread best practice, or is it a different challenge?
Professor Mayhew: That is one of the challenges, yes. I think there are other ones besides, but it may need more steering from the centre to ensure that it happens, which may mean fundamental enabling changes to allow these things to develop.

Q337 Lord Hutton of Furness: Baroness Blackstone was asking the question about what it is we are trying to prevent here. Presumably, all of you would answer that question by saying—and I do not want to put words into your mouth—something to the effect of “We are trying to avoid unnecessary care being delivered in inappropriate settings.”

Professor Knapp: I would not say that. I think that is a by-product of what we are trying to prevent. What we are trying to prevent is unnecessary suffering, poor health and poor quality of life. We do not always have the evidence to prove that we have achieved that, so we often, from the research point of view, have to have these intermediate measures such as preventing admission into a care home or into a hospital, because most people do not want to go into a care home or hospital. Those are often inappropriate settings. So we do want to prevent those things, but the ultimate objective is to improve the health and wellbeing of individuals.

I think there are areas where the evidence base is pretty good, but we have not yet found the lever to persuade organisations to invest more in those areas. There are other areas where the evidence base is not that great. Every time I go to see my GP—not very often—because I am an asthma patient I have to have a go on the peak-flow meter, and that is because she gets paid a little bit extra every time I do that, or every six months or something. There is something that works. There is an incentive mechanism that works in that context to click something to happen. Maybe we ought to be doing more of that with other interventions that have a sound evidence base.

The Chairman: Tell us.

Q338 Baroness Blackstone: Could you tell us what they are?

Professor Knapp: I mentioned dementia earlier on. There is a very nice little piece of work by Professor Sube Banerjee, who used to be the national director for dementia services and runs the Croydon dementia service. There is the Memory Service, which are new things that are being rolled out across the country, which are co-ordinated, integrated services to get people into contact with specialist staff of various kinds. He, with an analyst at the Department of Health, showed very strong economic evidence, as well as effectiveness evidence, that these things are good things. You are getting people, in the early stages of their dementia, in contact with services. You are getting carers in particular in contact with support, and that seems to be quite powerful, but you have to find a way of routing those people into those services and, in addition, with the dementia area, you have to find a way of overcoming the stigma, because many GPs are very reluctant to give people a diagnosis of dementia. They would rather not do that, because it is such a negative label. I am wandering around now, but I think there a number of things we need to try to tackle here in terms of improving the motivations of key professionals to engage people in the right pathways of care.

Q339 The Chairman: That is very helpful. Is there a fuller note on that setting out where you think there is good evidence?

Professor Knapp: I am happy to put something together for a note on those points.
Alliance Boots, Professor Martin Knapp, London School of Economics and Personal Social Services Research Unit (PSSRU), Professor Les Mayhew, Cass Business School and Social Finance – Oral evidence (QQ 327-372)

The Chairman: That would be excellent. Thank you.

Q340 The Earl of Dundee: If we really do get better at prevention, and let us suppose, even, that we get very much better at it quite soon, how, then, as a result, will current services have to adapt?

Professor Mayhew: If we maybe step back to the primary-prevention area and all the benefits that we have had over the last century, ranging from clean water and so on, we are now, as I said earlier, at the end of a period where tobacco is taking its toll, and still taking its toll, and people are dying and having all sorts of long-term conditions around that. After the war, 80% of men smoked, for example, and the life-expectancy gap between males and females was something like six years by 1970. What is happening now is it is converging very rapidly, as the old smokers gradually die out, so the profile of people who will be coming forward may be different. Life expectancy is going up, so the frontier of prevention may be moving as a result to an older age, and if we are successful in eliminating or removing some of those conditions that were associated with tobacco, we may be on much more of a dementia track or some other track, where some other killer replaces the previous killer, if you see what I mean. Years ago, infectious diseases were the problem, so we built infectious-diseases hospitals everywhere; then we had vaccinations and that helped a lot, so people lived longer; and then we hit the next barrier and the next barrier. That barrier may be shifting today. Did I explain that very well? That will require shifts in what you mean by “prevention”, what you are trying to prevent next and what you do to prevent it, but ultimately we all die, and there is a lot of debate about whether we will live indefinitely. The oldest person who ever lived was 120, but we may now be hitting a barrier around the 100- to 105-year-old mark, which means that you are going to get lots of people coming through who live to an older age, but they will die in their 80s or 90s, rather than their 100s.

Q341 The Earl of Dundee: Following from that, we take prevention as being a sine qua non. We then think of a methodology of being proactive about it and we begin from top down. With the growing evidence in favour of prevention, it is the case more that governments all over the place, including our one, will be supportive towards it and will adapt their health services in this direction. If you take, as complementary to that, a methodology that is bottom up, I wonder, in your current experience, how you find that works. For example, in our last set of interviews, I was rather uncomplimentary in health terms about Bulgaria, so I am now going to do the opposite of being, on purpose, complimentary about them. Let us suppose that, in the regions and towns of Bulgaria, there is unequivocal evidence that prevention works in a variety of fields—dementia and everything else. At the moment, in Britain, knowing the form as you do, would our reaction on the cross-fertilisation of information be a rather supercilious, dismissive one to say, “Good for the Bulgarians. We are delighted they are doing something or other,” or is it a nicely grown-up, intellectual, engagé one to say, “They are doing this. We jolly well should be taking note of what they are doing and adapting ourselves”?

Professor Mayhew: Certainly, we should be. The problem in the former Eastern Bloc countries—Bulgaria and so on—is that the males are all heavy smokers and drinkers, and their life expectancy is far lower than it is here, so you might argue that we do not have much to learn.
Q342 The Earl of Dundee: Perhaps I should have said Holland.

The Chairman: Do not take him literally.

Professor Mayhew: No, okay. Well, in Holland, they do not elect to die in hospital. In the United States, there is concern among demographers that, for the first time ever, the children of the current generation will have a lower life expectancy, because of the obesity crisis, which has all sorts of implications for health and social care, and intergenerational support. You might like to think that one through and whether we have a similar kind of issue here. I think obesity is something that needs to be tackled, because somebody with a waist-to-height ratio of 0.5 lives a normal life but, if they have a waist-to-height ratio—and I know you are all calculating your own now—of 0.7, they might lose seven years of their life at age 30 if they stay that shape.

The Earl of Dundee: What is your forecast, in five years’ time, in the United Kingdom, taking all the areas that can benefit from prevention, of where we will be, which may be in a better position than now?

Q343 The Chairman: Could I just stop that question, Alexander? If we go back to your affordability question, clearly we got from Martin a pretty clear agenda of: “This is where I would go first.” What we got from Les Mayhew was an extremely depressing picture from the Brent experience, which was essentially that, if you do not do something about the supply, then the demand will just fill up. Therefore, the commissioners will argue they do not have the money for the scale of the shift towards preventative programmes that common sense would say that we need. I am being a bit glum, perhaps, but is that not the dilemma: if, using common sense, we have to put more effort into prevention, where the evidence looks as though it works, the money has to be found from somewhere? It will not be self-funding—see previous comment; therefore, we have to do something to other inefficient bits of the system. If that is right as a critique, how do we make those changes?

Ben Jupp: We are working in one health and social care economy at the moment, where I think we are probably taking the right approach. Rather than simply putting in a whole lot of additional services and then saying ‘we will wait for nobody to walk through the door in A&E’, we are asking how commissioners could reconfigure the way in which acute services are operating, if they had confidence that the sorts of interventions that Martin was talking about were going to work. Then they are seeking to introduce these relatively simultaneously to avoid that filling-up problem.

One of the things that they are looking at is whether commissioners could use what we sometimes talk about as a Social Impact Bond mechanism to do that, saying that they will only pay the providers of those preventative services if they are having an impact. They are therefore avoiding the situation where they reduce some hospital capacity and increase preventative services, but those preventative services do not work and they get a queue at the A&E door. The worst that could happen is that the preventative services do not work out and patients start forming a queue, but commissioners still have the money so they can open up some wards again. That is the sort of approach that I think is maybe necessary.

Q344 The Chairman: Thank you. A comment from others on that? Andrew, it is about time you had a chance.

Andrew Bonser: Yes—thank you. I believe there is a great opportunity to better use other health professions in delivering health services in the community. Community pharmacy is
an example where by emphasising the delivery of healthcare services as part of their contract to the NHS, more could potentially be done, even within existing budget constraints.

**Q345** The Chairman: It happens in France; why does it not happen here?

Andrew Bonser: It is starting to change, and you are now seeing community pharmacy delivering, for example, medicines-use reviews and a new medicine services. Health services are an emerging opportunity for Community and Pharmacy and, there is definitely a long way to go to maximise their full potential.

**Q346** The Chairman: We will come, in a second, through Lord Bichard, on to social finance, but, Les or Martin, any comment on the problem of putting the money into prevention when you still have, to put it crudely, smokestack delivery models, which we really want to shrink?

Professor Mayhew: I think that smokestack analogy is very good, because you get smokestacks within professions as well. We have so many different specialists. We did some work on intermediate care at one point and we found that there were, potentially, 22 different health services alone—this is ignoring social care—that could theoretically be aimed at an older person needing care at home. I do wonder: these specialisms have grown up in a hospital type of environment, not in a home environment. One of the things I see is, for example, care workers going round to people’s houses. They spend 10 minutes with the client and then move on to the next client, but they then spend 20 minutes sitting in a traffic jam before they get to the next one. If they could stay at the same person’s address for longer, they could undertake more tasks—care tasks, cleaning or whatever—but also, crucially, do simple, basic health tasks, like taking bloods, blood pressure and the like. We do not really have that type of person—a generic kind of older-person care worker—who could do all those things. That would improve, in my view, the efficiency of delivering care to people’s homes enormously.

The Chairman: Interesting.

Professor Knapp: The only comment I would make is that I think we went through a period when the emphasis on performance measurement and performance targets made it much harder for people to move outside their smokestacks. They were very concerned with their performance, so organisations were less enthusiastic about spending their own money to improve somebody else’s performance. I cannot substantiate this with evidence, but the anecdotes one hears are that, in the current financial pressures that people are under, that has become even more of a problem. I think people are less willing to engage in activities that will have spill-over benefits elsewhere. They do not want to not engage in that area, but they just find themselves under terrible pressure to manage what they do within their own budgets.

**Q347** The Chairman: You could postulate that the next five years’ of NHS funding, or social care funding, is going to accelerate that parochialism and drive it away from prevention, could you not?

Professor Knapp: Yes, you could do, but I think it is both within and outside. I was just looking at a review of falls prevention. The most cost-effective intervention that the researchers who did this review in Australia identified for preventing falls in older people was expedited cataract surgery. If you go down the list, you get to about number seven and
hip protectors come in. There is cataract surgery, psychotropic-medication withdrawal, Tai Chi and exercise. There is a whole range of other things before you get to something that is quintessentially orthopaedic per se. You have to then find ways of engaging across the different medical specialties and across the different agencies and budgets to get this co-ordinated action, and I think it is absolutely essential. I always joke that a Nobel Prize in joint-working has never been awarded.

The Chairman: We spent two hours on it earlier this morning. I wish that I could say we have cracked it.

Q348 Baroness Morgan of Huyton: Can I just add to something Professor Mayhew just mentioned? You were describing what makes sense, I am sure, to all of us, which is the notion of somebody in the home who does more than the basic narrow care, but is there not a yawning gap between what you are describing in terms of highly specialised health interventions, which most people do not get access to, and then much more routine care-worker attendance, which is incredibly unskilled and poorly paid, and is very unlikely to pick up any of the things you are talking about? Have you got any suggestions on how we could incentivise the up-skilling of care work in the home?

Professor Mayhew: You touch on a huge area: what are the economic benefits of all these different appliances? When you are evaluating that, there is always the danger of double-counting the benefits and everything else. In a lot of cases, it is “suck it and see”. Can I give you a little anecdote? I have a mother-in-law who is Austrian, and she goes through the Viennese care system. She was in a care home. She could pay for it herself because she got a better pension and they had better disability allowances and more levels, so, socially, it was better. She also got tax relief on her care-home costs. Then, however, it got too expensive even for her. Her needs went up a level, so we brought her back to her home and we have employed two 24-hour Slovakian care workers, who alternate every two weeks—two weeks on, two weeks off—and she has two visits a week from her GP. That seems to be working out incredibly well, and it has virtually halved the costs of care in her case—not halved it but reduced it by about a third. There are other routes that you can take. I like technology, I suppose—I would, would I not? My mother had a pendant that she refused to wear because she did not want to be a bother. With all those sorts of things, you are dealing with people.

Q349 The Chairman: That describes the Italian system, whereby Italians get people from further east in Europe to come and live with them.

Professor Mayhew: Yes, that is right.

Q350 The Chairman: It is cheap and cheerful, and it seems to work.

Professor Mayhew: They are very nice people. They are very capable.

The Chairman: There we go. Lord Bichard.

Lord Bichard: I'm just hoping the BBC aren't here at the moment!

The Chairman: As you well know, nobody is listening to this conversation!

Q351 Lord Bichard: I just want to focus for a little while on social finance, and get Ben maybe just to elaborate on some of the things he has already said. There are several
reasons why I am interested in social finance. Although most people see it as a source of new investment, I think it also could play a part in dealing with some of the issues we have been talking about today, because, if it works properly, it focuses on outcomes, it encourages people to work across bureaucratic boundaries, and it puts an emphasis upon service design and prevention, because, in order to get the outcomes, you have to be good at all of those things. You may want to say more about all of that, but the issue, I think, for us is whether this is ever going to be anything other than marginal in the foreseeable future, or whether it is genuinely scalable. In order to make it more prevalent, could the Government be doing more, or could anyone be doing more? Big Lottery Fund, for example—I think to their eternal credit—have just invested £40 million in enhanced outcome payments, and the Cabinet Office have stumped up £20 million, bless them, but is there more that Government could be doing to make this scalable more quickly? Thirdly, as I understand it, at the moment, Social Finance itself is both developing the product and also offering advice to potential users. Should one of the things the Government looks at be setting up some kind of independent advice resource, so that state and non-state individuals who are interested in social investment could get some proper, reliable advice on when it is appropriate and how to go about it? Sorry, it was a long question, but I am mostly interested in just hearing you say a little bit about social finance.

Ben Jupp: I will try to be fairly brief, but I have just a little bit of background for Committee Members. The drive for social finance really came initially from charities who started to question both their traditional grant-making strategies and their traditional investment-making strategies using their charitable endowments: the grants because these were always there for three years and then gone, and the investments, because these were not always achieving social value. At its heart, social investment is trying to ask, “Can you blend those two elements to achieve a social impact and a financial impact and return as well?” That ranges, from traditional investments in innovative forms of care homes and Extra-care, through to backing social enterprises and trying to bring a different way of looking at a problem. Investment in prevention is one of the areas that we and others have been working in.

The project that has rightly attracted most interest is the Peterborough Social Impact Bond. For many years, groups such as ourselves here have been saying, “If only somebody could meet a short-term prisoner at the gate and help provide accommodation and deal with the drug issues, etc, we would not have such re-offending.” The number of times probably many of us around this table have written that in White Papers, etc, is countless. It took a group of social investors to say, “We will fund this approach with £5 million to catalyse a change.” The deal back to the Ministry of Justice and the Big Lottery was, “And you only pay us if reoffending among those cohorts falls.” I think that the value here, as you were saying, Lord Bichard, is almost not just in the finance itself; as Mike Farrar says—who I know you met this morning, and who chairs our advisory group—it is the positive strings attached. It is the fact that, because investors are doing that deal, it forces them to be rigorous in their analysis of where they are going to put the money. It liberates social enterprises to step outside of traditional smokestacks and it encourages an ongoing emphasis on performance rather than getting in a good business case and then moving away.

I think that there are some really exciting areas around health and social care, for example. We are just working with SharedLives Plus. I am not sure if people are aware of SharedLives’ programmes, but the approach is where a carer, within their own home, looks after somebody needing care. The drive for this was around those with learning disabilities, rather than being in small institutions, being cared for within a family home; the drive was a
Alliance Boots, Professor Martin Knapp, London School of Economics and Personal Social Services Research Unit (PSSRU), Professor Les Mayhew, Cass Business School and Social Finance – Oral evidence (QQ 327-372)

social one, but it typically also saves £10,000 a year. ShareLives is just moving into dementia care and respite care. There are about 8,000 carers around the country, so it is not a tiny approach, and we are looking at how you scale that with social investment. The interesting thing is that social investment is bringing that combination of investment and support to enable that scaling. We are looking at capitalising a national incubator for lots of local schemes that could then move out. Again, the deal back to the local authority is, “Only start paying when you are able to transfer people from residential care and see improvements in outcomes,” rather than just hand over a block contract and hope that it all works.

Q352 Lord Bichard: The fascinating thing in what you have just said is that, whereas all of our existing funding arrangements encourage silo-based activity, with a few add-ons to say, “Here is £50 million; go and work together,” what social investment does is start from exactly the opposite end. It is rewarding based upon co-operation and prevention.

Ben Jupp: Yes, and I think, if you get the outcome measures right—and they are not easy to get right—you can start to catalyse some really interesting coalitions. Going back to the Peterborough example, yes, there is a core organisation, St Giles Trust, but then a number of other organisations are coming together to help address that outcome, such as YMCA family support and a variety of others.

What could the Government do around this? I think the Department of Health, in the Social Care White Paper, has indicated that, at least in the social care area, they are going to be looking to provide some support for feasibility analysis, designing what the metrics would look like, which is really positive. I think that the good thing about health and social care is there is quite a lot of expertise in these areas, and it needs a careful market nurturing, for example. I am a little bit nervous about thinking that the Government itself will necessarily have all of the expertise in this area, even as an ex-civil servant myself, but I think it does require a strategy for thinking about how the different components of market development need to come together in this area, and we can talk about that.

Q353 Lord Bichard: Is this scalable or is it something to which we should say, “That is really rather interesting and we think it is great, but—”.

Ben Jupp: If you look at the whole health and social care economy, we are talking of 12% to 13% of GDP, so I do not think it is sensible to think that the entire financing of that will come from socially motivated investors. I think it is at that point, where services want to move something from R and D to scale, or where commissioners have a problem that is stuck in a certain smokestack at the moment, that bringing in social investment can really help. I think, if we can then prove a new approach, it may be that you can then change mainstream funding arrangements. The most successful thing at Peterborough for us would not be that the contract just gets renewed after five years; it is that, after that, the concept is proven and it is then taken into the mainstream.

Q354 The Chairman: How does it differ from Government contracting on a payment-by-results basis for the same outcomes?

Ben Jupp: At the heart of these sorts of mechanisms is a payment-by-results contract. What we have found really useful is trying to structure that contract as a dialogue between social investors, commissioners and providers, so that they can all bring their insights. When we have got it right, what that has led to is a much richer service, more focussed on outcomes than some of those traditional contracts.
Q355 Baroness Blackstone: I just want to know what the size of your budget is at Social Finance, and whether you can really make a difference in terms of the amount you have to spend.

Ben Jupp: We are an organisation of 30 people or so, so we cannot cover every social area. We have raised about £10 million or so into these approaches over the last couple of years.

Q356 Baroness Blackstone: That is very small.

Ben Jupp: It is quite small but certainly Big Society Capital, which now has £600 million to put in to support the social-investment market, estimates that the health/social care/ageing/social-investment demand will be about an extra £150 million over the next couple of years.

The Chairman: Good.

Q357 Baroness Tyler of Enfield: We have talked quite a lot, both in this session and, indeed, in many of our earlier sessions, about whether the new commissioning frameworks, which have only just come in, are likely to encourage this shift of expenditure from acute services into community and preventive services. Frankly, most people think it might nudge in the right direction but is unlikely to be anything like sufficient. I wonder if, in answering this question, you could say what additional incentives you think need to be in the system. I am thinking particularly about financial incentives of one type or another, not least from the conversation we have just been having.

Professor Mayhew: One thing we have not talked about is what you may write into contracts with commissioners, GPs and so on. There may be certain incentives to not only find other ways of sourcing care that are cheaper, better and so on, but you could also give them a responsibility to improve the health status of their caseload: stopping smoking and all the usual things that we know about. I do not know the status of that in these contracts and whether they have been evaluated or work, but that seems to me to be an obvious thing.

Q358 Baroness Tyler of Enfield: One thing I am particularly interested in is how outcomes are framed in the new commissioning framework. We have heard quite a lot this morning around wellbeing. I wonder whether you think there is enough emphasis on things like wellbeing indicators, particularly for older people, as a way of commissioning and measuring outputs, and how effective services are, or whether there is more scope for that sort of thing.

Professor Mayhew: Ideally, you would like to draw a link between an action here and an outcome there, but what you get is an attribution problem. There are multiple different actions and one outcome, and you do not even know which one that relates back to, if it relates back to any of them, so you are fundamentally stuck like that. But I do think there is a lack of intellectual understanding of how all these things work, and it may be that you need to re-orientate the analytical firepower of the civil service departments to think about not only how many people you have put through hospital but how many people you have prevented from going into hospital, so that we have some rules of thumb that would enable—their role is enabling—providers to say, “This looks a promising area. If we do this, we might have this effect,” and then, rather like you were saying, you test it out. At the moment, however, we are working in a fairly data-less environment, which is getting worse, because the commissioning framework has resulted in fragmentation of evidence and data,
and commercial boundaries and data Iron Curtains that have come down, which might be making things worse. The saving grace—and it may or may not work out—is the Health and Wellbeing Boards: provided they are given the support and the information, and they do have a local focus, they may be able to do something about this and spot prevention gaps and other things, which they can then encourage commissioners to step in and fill. It is, however, so early in this process that we just do not know whether or not that will be the outcome. But I am terribly worried about the fragmentation of information that we are seeing.

Andrew Bonser: I would like to add to what Les was saying. I believe Health and Wellbeing Boards, together with the development of the Joint Strategic Needs Assessments and an enhanced, role for local government should provide balanced and qualitative approach to how care and services are delivered. However I think a real challenge is going to be the number of Health and Wellbeing Boards. There are going to be 211 or however many as there may be fewer in the end—and the potential variation in their performance and development we are going to see across the country. There are also other factors at play, such as how politically motivated some of them may become because of their membership, and who will control and influence the Health and Wellbeing Board agenda. I think there is a great potential here, but it has yet to be seen whether it will work in the way that it has been designed.

Q359 Baroness Tyler of Enfield: Thank you very much. I wonder if I could just specifically ask Professor Knapp: you talked about four areas at the beginning, where you were talking about preventive work, around dementia, falls, befriending and intensive home care. Could I just ask how confident or otherwise you feel that the new commissioning arrangements we are moving into are going to incentivise a greater focus on those sorts of issues?

Professor Knapp: Two things, I think: one would be a slightly more optimistic view on information than Les, which is that I look back over 15 or more years and just look at the influence of evidence and, in particular, the influence of bodies such as NICE. I am a great fan of NICE, and I think they have done a lot to help local commissioners make comparisons across different clinical areas, for example. The health economists with their QALY concepts, and it has lots of faults but it has some benefits, one of which is it allows you to compare across different clinical areas. NICE invested whatever it was five years ago in public health, so some of the interventions we are seeing and some of the preventive strategies that are out there are now being evaluated on that same perform, and it is possible, then, for commissioners to begin to compare the consequences of preventive strategies alongside responsive or curative strategies, with similar metrics.

I think that means that at least the local commissioners, who will always vary in their priorities and so on—and that is very good, in lots of ways—will have more information to hand if they want to use it. I think that, firstly, the information is there. In terms of how we incentivise them to get into that area, the key to me is how we incentivise, in some sense, the system to get money out of acute wards or out of acute hospitals. It is the acute sector that is stopping things happening, so you have to find ways of getting that money out of the acute sector.

Q360 The Chairman: To be beastly, that does mean, in some sense, nationally, does it not, that is partly what we have to do?

Professor Knapp: Absolutely.
Professor Knapp: No. 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. It is finding ways of getting money.

Q362 The Chairman: That is what we are getting crystal clear from evidence from The King’s Fund and others: if we want to have more prevention and more community interventions, which the population is going to need, then, God bless them, the hospitals that we have are not the right ones that we need for the future, and that means a shift of funding, which means closures, but nobody dares make that argument, do they?

Professor Knapp: I was hearing a presentation last week from Professor Peter Tyrer, who is Professor of Psychiatry at Imperial College London and Editor of the British Journal of Psychiatry. One of his areas of expertise is health anxiety: people who feel they have all sorts of health problems but do not have those health problems. They have an intervention that works well. It works very well in dealing with that anxiety and then reducing the use that people make of health services. In one of the areas where they were doing the evaluation, in one of the acute hospitals, the hospital did not want the evaluation to continue, because it was taking money away from them.

Q363 The Chairman: They are a trading organisation. Why I am pushing in on Claire’s question is because—and I am putting it too crudely—this is a bit of the elephant in the room, is it not? You know why Ministers are not going to say it, because why would you? It is tied up with the fact that the public are not convinced that they will get decent out-of-hours or emergency care if you close a hospital. They see hospitals as the solution, so we have neither addressed that problem nor have we made the case as to why we have too many acute hospitals. Unless we do, we will starve prevention and we will starve community care. Is that analysis right or am I being just grossly too naïve and simple? Tell me if I am right or wrong.

Professor Knapp: No, I think you are right. I think the difficulty is that people compartmentalise their views. Sorry, going back 15 years, most of the people in my street were out campaigning against the planned closure of their local hospital in Canterbury. These were your typical Guardian-reading intellectuals who, taking the broader picture, would have seen that closing the hospital was a very good thing to do and a much better way to use public money. However, when it was their hospital, they did not want to see it close.

Q364 The Chairman: For clarification, then, you are saying, yes, I am right, but it is difficult.

Professor Knapp: Yes.

Professor Mayhew: I think it also depends on what you mean by a hospital. We have this image of a massive, hi-tech thing that costs hundreds of millions a year to run, and it has not always been like that. If you go back to the 1930s, London had over 500 hospitals, but they were all tiny little six-bed affairs that did far fewer things. I think you have to say what you mean by closing hospitals. I favour small community hospitals that look after older people for short periods until their condition is stabilised and they go back. Somehow, we take our cue on this a lot from the United States, but maybe, to your point, we ought to look at some other places. In Japan, for example, I do not think they have the concept of an acute hospital. To them, hospitals may be incubation places where you keep older people warm.
in winter. Sorry, I am simplifying it somewhat, but the concept of having short lengths of stay, turning people through and maximising the occupancy of the beds and so on is not something that they tend to operate. Of course, they have reached the stage where they do have the oldest population in the world and they have transformed their way of looking after older people in a way that we have not, so I think it is worth looking at that.

The Chairman: Fascinating.

Baroness Tyler of Enfield: Thank you very much.

Q365 The Chairman: Andrew, anything about community pharmacies as a way of reducing unnecessary demand on A&Es or in terms of out-of-hours services?

Andrew Bonser: Yes, absolutely. I think there are some excellent case studies that show community pharmacy providing some excellent services, such as out-of-hours or the provision of minor ailments services and medicines-use reviews. There is a common element which community pharmacy does really well, and that is providing accessibility to these services. I do not think that has really been mentioned yet today. What we certainly find, when we look at early or secondary prevention, is that accessibility and convenience for patients is key. To give you an example, we reviewed data of a private flu service we provided in Wales last year and found it attracted a high proportion of older people who would be entitled to, a free vaccination on the NHS. In fact, 20% of all those who paid for a flu vaccine in Boots were entitled to receive one at their GP for free.

Q366 The Chairman: Because it was accessible.

Andrew Bonser: Because it was accessible, and they had difficulty in getting an appointment at their GP or they were faced with inconvenient opening times—all of these things. Accessibility, then, when looking at prevention, is essential.

The Chairman: That is very helpful.

Q367 Baroness Morgan of Huyton: In a sense, this is something, I am sure, Andrew will want to comment on anyway. Do you have any practical examples or particularly evidence to help us understand whether there are examples of things that work in terms of keeping older people in their homes and particularly preventing hospital admissions. I guess it is about the management of long-term conditions, but also, thinking back to the early stuff on good prevention that Professor Knapp was talking about, are there any specific examples?

This is not in the question and may be unfair to throw at you, but earlier on we were talking about social isolation as being one of the key issues in terms of prevention. Are there any examples of relatively small amounts of glue in the system that free up voluntary input? It seems to me we have quite a big divide between professional help and then what we talk loosely about as voluntary help, but with no real mechanism of freeing that up and making that happen. I just wondered if you have any examples—or could send us later any examples—of where just a bit of resource frees up quite a lot of additional help.

Professor Knapp: Just very quickly on that last question, Exhibit A is a piece of work that we did, which I will happily send you—sorry, it has not been circulated. We were looking at what we call building community capital. It is looking at the capacity of the community, with low levels of funding from local authorities, in most cases, to set up things like
There are also befriending schemes. These are things that do not take very much in the way of resources to get going, so what you are seeing in some councils—Leeds, for example—is a number of people in certain neighbourhoods who are getting personal budgets and direct payments for their social care, and they are trying to bring these people together to use their personal budgets collectively, in combination with various community neighbourhood networks and so on, to address a whole wide range of needs. I think there are some interesting things going on. The evidence around them is local or anecdotal and tentative, perhaps, but I think that the evidence, I would say, is pretty encouraging that these things are effective and they are cost-effective.

Q368 The Chairman: We would welcome any thoughts on how their use should be rolled out or accelerated.

Professor Knapp: I have been working in the economics of health and social care for a long time. I have never, ever had as much demand now from people saying, “Can you help us make an economic case for…”—fill in the blank. These are often organisations that have had many years of funding from their local council but who are now facing the threat of that funding being withdrawn, because it is very easy to cut that funding. It is not losing local-authority staff, etc, but these are often very effective and probably very cost-effective things. There is a problem that maybe the savings do not come to the council. Maybe there are savings but they do not apply for two or three years. There are lots of difficulties in that mechanism.

The Chairman: That is in some way stimulating more volunteering schemes, whereby you harness the local neighbourhood’s ownership of caring for other older people in practical ways.

Q369 Baroness Morgan of Huyton: I am really interested in any hard examples of where a bit releases a lot of additional support that, otherwise, it misses.

Professor Mayhew: We sort of had that, exactly as Martin described, in Brent, with this care-co-ordination service, because of their role to locate, assess and connect older people in need with providers. These could be from the private sector—they could be dentists or opticians—but they could also be from the voluntary sector, so they could be the Brent Energy Network, warm homes, befriending services and so on. The value that they got from what we were doing was that we could put them in contact with people who could benefit from their services. One was a toenail-cutting service, for example. There were lots of little things like that. If they had not had that care-co-ordination service to feed off and feed into, they would not have had the same level and quality of case-finding information that would have enhanced their effectiveness. Bringing those together in a very simple way had an impact that was many times greater than the component parts.

Q370 Lord Bichard: I do not yet feel that we have got full value out of Andrew here, not through any fault of his. I am just sitting here wondering: we are all in the business, in the public sector and as Government, of improved services at less cost, whatever the client group, and we are looking particularly at ageing people. Do you feel that you are sufficiently
involved as a private-sector organisation in the debate about public value, whether it is with GPs, local authorities or Government more generally, or is there, as one sometimes suspects, a bit of a standoff in the sense of, “They are the private sector and we are the public sector”? Could we do more or should we do more to encourage this kind of discussion/conversation, and do you have things to bring to that table?

Andrew Bonser: I would generally agree with your comments. I think it does vary though depending on where we may be operating and, quite often, how willing commissioners, for example, would be in engaging community pharmacists and other providers as well. I think there is that variation, which is still sometimes problematic. Can the providers such as community pharmacy do more? Absolutely. Is it difficult to engage more broadly in such a dialogue? I think it has been.

In fact, community pharmacy did make what I thought was a strong case, when the Health and Social Care Bill was going through Parliament, that community pharmacy and other allied health professionals should have more of a role in the Health and Wellbeing Boards, at least to be able to feed in in a more co-ordinated and agreed fashion. Unfortunately, that has not happened, so community pharmacies will be represented but more on an ad-hoc basis rather than having a seat around the table. I feel that is a missed opportunity, because, coming back to the points that I have mentioned already accessibility to, community pharmacy and other providers providing a broader base of access to health services – avoiding, if you like, the choke point of GP surgeries, because everything seems to go through the doctor and then back out again into other services – there are a number of community-based services that can provide that, including community pharmacy and other private-sector providers. I think there is sometimes a sense of a standoff, which is unfortunate, because I think working together as we have in many cases, can demonstrate real value.

Q371 Baroness Morgan of Huyton: Is there a particular problem there with GPs? Certainly, I had some experience a few years ago of community pharmacies doing some quite interesting work that GPs then actively stopped because, bluntly, they wanted the cash themselves, even though you, as a group, were more accessible. They would redo the tests that you had been doing, because they wanted to make sure that you did not start to get the NHS contracts. Is that still a pattern? It is fine you doing flu jabs and having to charge for it but, arguably, you should be able to give NHS flu jabs.

Andrew Bonser: Interestingly, in Wales, this year flu jabs are being provided through community pharmacy, so I think that, as an example, should hopefully shed some light on how successful community pharmacy can be.

Q372 Lord Bichard: You are being funded, are you, by NHS Wales to deliver that?

Andrew Bonser: Yes. There is a slight variation in the specific service, depending on the Health-Board areas, so some are looking at community pharmacy providing more out-of-hours flu service, or community pharmacy providing them in their entirety, seven days a week. It does vary, then, depending on the Health-Board area, but, yes, we are doing that.

The Chairman: Very helpful. I think you are being encouraged to keep pushing and probably encouraged also to drop us a note of where else you would like to see this moving. Thank you very much indeed. I am sorry we kept you waiting at the end. It has been, again, a very interesting session. We are ploughing our way through the fascinating publications by both Les and Martin, so there is lots of stuff we are engaging with. I think
Susannah set you a few questions at the end, just in case you had an idle moment, but do feel free to tell us things that you think we should hear and we should be thinking about that the questioning did not bring out. You can see what we are trying to do: we are trying to get a very holistic, rapid overview of whether we are ready as a society for ageing and what needs to change in our policies. Anything in that turf that is big and that you think we have missed, we would be really grateful for. Thank you all.
Alliance Boots – Supplementary written evidence

Can you provide any examples of effective prevention and/or early intervention programmes? How were these evaluated, and were they cost-effective?

Alliance Boots welcomes the opportunity to provide supplementary evidence to the committee. This document provides details of effective clinical interventions delivered by community pharmacy. We maintain that the accessibility and availability of healthcare services is integral to improving public health. Community pharmacy is perfectly placed to deliver effective interventions and tackle key health problems.

1. Anticoagulation Service in Brighton and Hove

Service overview

1. The Boots UK developed Community Pharmacy Anticoagulation Monitoring Service in Brighton and Hove is an innovative, patient-centred scheme, which demonstrates how the NHS’s ambitions of quality, efficiency and value can go hand in hand with outstanding patient care. It has significantly improved the care of 2,500 warfarin patients in the city who previously were tested in hospital and has achieved its success through collaboration and multidisciplinary working across primary and secondary care. The service has consistently delivered clinical outcomes that exceed national targets, and has received positive feedback from all patients, commissioners and professionals involved. It is excellent example of the wider role community pharmacy can play in supporting the NHS and providing high quality, clinical interventions in accessible locations.

Background

In response to a competitive tender Boots developed and established an innovative pharmacy-led anti-coagulation monitoring service for 2,500 patients across NHS Brighton and Hove. The service has been running since 2009, originally for 3 years and has been extended to March 2013. The work required redesign of patient pathways through multidisciplinary working, resulting in a service with improved patient outcomes, from a number of pharmacies geographically located near to where patients live and work. Boots holds the Contract for the service and is responsible for the service design and operating processes. Local pharmacies are subcontracted to provide the service to the same standards defined in the Contract.

Historically patients on warfarin attended hospital for a blood test. Waiting times on average were 45 minutes per appointment and patients experienced hospital parking restrictions. Test results were received three days later by post, with no opportunity for the patients to discuss them or potential change in Warfarin dose, with a healthcare professional. The computer decision software that the hospital, used made it difficult for the PCT to understand, the numbers of patients accessing the service and the associated patient outcomes.

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85 Boots UK 2012
Drivers for change included increased visibility of patient outcomes, cost saving (circa £500k), improved patient and healthcare professional feedback, and better use of skills and expertise. The Contract for this service is provided through the Standard NHS Contract (bilateral) for Community Health Services.

Boots developed the new service offer by redesigning patient pathways and developing policies and protocols aligned to National Patient Safety Agency guidelines. To support the pharmacists provide the service in a consistent way we also implemented an IT platform and protocols for the transition of patients to and from the hospital and community service. In order to ensure access to the service Boots worked collaboratively with local pharmacies to invite them to participate in the service which is now offered through 17 pharmacies across the city.

Patients choose the most convenient pharmacy to visit and the service provides a point of care test and dosing service, which is completed within 10 minutes. The patients are managed through a web based clinical software system, which also provides key performance indicator management information, as well as providing GPs with the results of their patients tested. The service is also visible to the hospital service, so if patients are admitted, there is visibility of their anti-coagulation history.

**Service outcomes**

Improved access to anticoagulation service by offering patient appointments at 17 different pharmacies geographically spread across NHS Brighton and Hove, with clinic availability on weekdays, early mornings, late nights and also on a Saturday. Clinic capacity is regularly reviewed to ensure that sufficient appointments are available where patients want them with two new pharmacies added in Hove due to high demand in this locality. Follow up appointments are booked at the time of the previous appointment and are tailored to the condition of the patient and previous results, as defined within the policies. The service introduced point of care finger prick testing, instead of venous sampling, which is less painful for patients.

Patients are provided with instant access to INR results (blood test used to monitor warfarin therapy) giving them an opportunity to discuss results and any dosage changes with the pharmacist on a one to one basis at the time of testing. Also patients usually see the same pharmacist, which has built great relationships, and trust and confidence in the service. The traveling and waiting times for patients is reduced through individual appointment times.

The service achieved an overall patient satisfaction of 98% as measured by a survey in 2011. Clinical outcomes were delivered which are exceeding national targets. Patient time within target INR range is 79% compared to national target of 70%, the number of patients within INR range at point of test is 67% compared to national target of 60%. There is also a reduction in numbers of patients not attending appointments and a robust follow up process for patients who do not attend an appointment is in place, thereby ensuring that they are contacted straight away. The number of patients not attending is 3% throughout the service, which is below the national target of 5%.

A domiciliary service is available for those patients assessed as housebound, who are also provided with instant access to results and pharmacist consultation. The service was the Winner of the Clinical Service of the Year Chemist and Druggist Awards 2012.
2. Community pharmacy influenza vaccination services

There are numerous examples across the UK of community pharmacies successfully providing influenza vaccination services to NHS and private patients. All pharmacists delivering ‘flu vaccinations are provided with additional training and all ‘flu vaccinations are administered in a consultation room or appropriate premises.

There are several consistent messages across the case studies:

a) Accessibility of services can have a significant impact on the uptake of clinical interventions. In Hackney vaccination rates in over 65’s rose 17% in 3 years.

b) Patients will pay for convenience, In Wales 18% of patients paid for flu vaccination through a Boots store even though they could receive one for free on the NHS.

c) Ensuring that treatments are available for patients is essential. In Sheffield people aged over 65’s were actively turned away from pharmacies as they were ineligible for the service. Reaching into under doctored groups and communities to provide clinical interventions can have significant impact on health inequalities and in treating key health determinants.

City and Hackney PCT 2005-200886

The importance of accessibility is further supported by City and Hackney PCT findings. To improve uptake of influenza vaccination, City & Hackney PCT in London introduced an enhanced pharmacy service allowing pharmacists to administer the ‘flu vaccine. Following provision of this service through pharmacies, the uptake increased from 59% in 2005 to 76% in 2008, for patients over 65 years. The over 65 age group is an essential target for ‘flu vaccination and national designed service delivered to nationally agreed frameworks and training could be administered through community pharmacy with relative ease in time for the 2013-2014 ‘flu season.

Wales 201187

In 2011 nine Boots pharmacies carrying out a private ‘flu vaccination service in Wales were asked to collect additional data from the patient at the time of their vaccination. The purpose of the data collection was to understand how many patients coming through pharmacy for their ‘flu vaccination were eligible for it through the NHS.

In total 18% of patients paid out of their own pocket to receive a ‘flu vaccination at a Boots pharmacy rather than attend the NHS where they were eligible for a free vaccination. The majority of these patients cited the convenience and accessibility of community pharmacy as the main reasons for their decision. This underlines how much importance patients place on the accessibility of healthcare services, and in many cases would go without the service otherwise.

86 City and Hackney Teaching PCT “Annual report and accounts 2008-09 (2009)”
87 Boots UK (2012)
Sheffield 2011-2012 service

The Sheffield LPC published an evaluation of the 2011-12 ‘flu vaccination programme for hard to reach at risk groups aged 18-65, delivered by 12 accredited pharmacies in the Sheffield PCT. These were located in a variety of settings including high streets, supermarkets, health centres, close to GP surgeries and in town and city centres. The catch-up service launched in Nov 2011, 2 months after the GP service commenced. 170 vaccinations were administered, with 159 patients (94%) completing a survey.

The findings of which are:

- 61% cited convenience as the reason for choosing community pharmacy as a location for receiving the seasonal ‘flu vaccination. No appointment needed, easy access or no waiting queue also featured as fairly strong opinions, potentially indicative of comparisons with other providers. 98% considered the service provision excellent.
- The pharmacy service did not impact on uptake of vaccines from practices, given that there was no decrease in GP vaccination rate. Anecdotal evidence actually suggests there was the beginning of a collaborative approach amongst practices, as a small number of pharmacies facilitated further supplies of vaccine to practices that had run out. A small number of patient referrals from practices to pharmacies were reported.
- Pharmacies located in superstore environments were actively turning away patients over 65 who wished to have the vaccination whilst shopping but were ineligible. During November, one pharmacy cited turning away an average of 5 patients per day on this basis.
- Vaccination rates for the under 65 in a clinical risk group and pregnant women increased by 1.6% vs the previous year. In practice sites located close to participating pharmacies, GP vaccination rates increased as much as 20% year on year.

Isle of Wight 2011-2012 service

In 2009 the Isle of Wight PCT was eager to improve seasonal influenza vaccination rates with the threat of pandemic influenza and declining vaccination rates in both under and over 65 age groups. They have commissioned community pharmacy to deliver a varying flu vaccination services since that point.

In 2011/12 a total 4192 people were vaccinated through community pharmacies across the island with 98% of patients rating the service as good or excellent. 71% of patients indicated choosing pharmacy as a provider for its convenient accessibility and a further 16% stated that they simply preferred pharmacy.

7 Boots pharmacies on the Isle of Wight delivered ‘flu vaccinations for both NHS and private patients during the 2011 season. On average, 76% of vaccinations were for NHS patients, from a total of 927 administered. In addition, 2 of the top 3 pharmacies delivered a

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88 Sheffield Local Pharmaceutical Committee & Sheffield PCT “NHS Sheffield Community Pharmacy Catch Up Seasonal ‘flu Vaccination Programme for hard to reach at risk groups 2011-12: service evaluation” 2012
89 Pinnacle Health Partnership “Seasonal Influenza Vaccination: Isle of Wight community pharmacy end of vaccination report” (2012)
3. Health Check Service in Norwich\(^{90}\)

### Service background

The service is for adults between the ages of 40 – 74 years old, once every 5 years. Customers under the age of 40 years old are able to access the service privately.

The service model is specified by the Department of Health; however local PCTs develop the service to reflect local health priorities. A number of software solutions are also used as part of the service specification, enabling data transfer between healthcare professionals and provision of management information. Some of these systems require integration with pharmacy provider systems, which has resultant cost and information governance issues for the pharmacy provider.

One service that operates successfully as a paper based service, enabling it to be provided within the pharmacy setting and as an outreach service to local businesses is the service that is commissioned by NHS Norfolk.

### Service overview

Customers are referred into the service by local healthcare professions, as well as referral in the pharmacy. Local businesses are also approached for an ‘off site’ service. Once recruited the service takes approximately 20 minutes and includes personal details, family history as well as lifestyle information. Biometric measurements are taken including body mass index, blood pressure, total cholesterol and the high-density lipoprotein, random and where necessary fasting blood glucose.

The information is captured and fed into the QRISK2 risk assessment tool, which captures the percentage risk of a cardiovascular event in the next ten years. An action plan is then developed with the customer aiming to reduce their risk score. The QRISK2 tool can also be used for this to create scenarios which can help the customer understand the impact of modifying behaviour on their risk score. GP referral and signposting to other services for example weight management will also take place if necessary.

### Service outcomes

One of our stores providing the service saw 108 patients over 6 month period. 25% of these patients were found to have a risk of between 10% to 20% of developing cardiovascular disease in the next ten years and 8% were calculated to be at high risk (over 20%). All of these patients had been previously undiagnosed. The feedback for the Norwich pilot has been very positive from the customers who have used it with many compliments about the professionalism of the service and the quality of advice given.

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\(^{90}\) Boots UK (2012)
Recommendations

1. There needs to be a long term vision and strategy that recognises and responds now to the challenges and opportunities of demographic change. Setting public services on an evidence-based trajectory of reform over the next decade and beyond, is more likely to create services that are robust and responsive to public need and avoid short term upheaval that can often result in lost productivity and higher costs.

2. Changes to public service do not necessarily require significant investment or large scale service reorganisation. Instead better use of what already exists such as community pharmacy can yield considerable efficiencies.

3. Accessibility and convenience are essential for effective public health delivery. Community pharmacy has the opportunity to make significant advances in addressing key health determinants and preventing ill health, managing those people with long term illness better and promoting self care. The case studies presented in this paper show that patients are more likely to access health services, including early interventions, if the services are convenient for them.

4. For clinical interventions to be truly cost effective they must be designed with patients’ best interests at heart. Where there is national need for public health service or clinical intervention, such as with weight management services, there should be national standards and specifications established which inform the design and implementation of that service. This can drive up the quality of interventions providing certainty for patients, allow commissioners and regulators to effectively monitor and evaluate services and incentivise providers to innovate.

12 December 2012
TUESDAY 13 NOVEMBER 2012

Members present:

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
The Earl of Dundee
Lord Griffiths of Fforestfach
Lord Hutton of Furness
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope
Baroness Tyler of Enfield

Examination of Witnesses

Mike Farrar CBE, Chief Executive, NHS Confederation, Phil Pegler, Chief Executive, Carewatch Care Services, Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent, and Geoff Alltimes, former Chief Executive of Hammersmith and Fulham Council and NHS Future Forum joint lead, gave evidence.

Q289 The Chairman: Good morning and welcome, and thank you for coming to help us. You know essentially what we are looking at. We are looking at the fact that our society is ageing, as we all know, and in many ways we are asking key questions about whether we are ready, as a society and in service terms, to handle that positive change positively. I will ask you just to run along the row and say who you are, so we are all absolutely clear, and then we will go into the questions. Would you like to start Professor Julien Forder?

Professor Forder: Yes. Julien Forder; I work at the Personal Social Services Research Unit, mostly at the University of Kent, but also at the London School of Economics.

Phil Pegler: Hi, good morning, it is Phil Pegler, Chief Executive of Carewatch Care Services. Carewatch are the UK’s second largest provider of home care. We do about 200,000 hours of care every week through about 10,000 care workers up and down the country. Prior to that, I was with BMI Healthcare as MD for their operations and business development team, so I have some acute care experience, albeit in the private setting, too.
Geoff Alltimes: Good morning, everybody. I am Geoff Alltimes. I was Chief Executive of Hammersmith and Fulham Council and the PCT for a while, but I am here largely, I think, as one of the co-leads of the integration work stream of the Future Forum. I now chair a task group at the LGA and am a member of the Commissioning Board’s executive management team as an associate.

Mike Farrar: Good morning. My name is Mike Farrar; I am the Chief Executive of the NHS Confederation, which is essentially the trade body for the National Health Service.

Q290 The Chairman: Good. I will not introduce us all; you can see who we all are, and you probably have a good idea of who we are without going into detail. Last week, we had a fascinating session with six people from both inside and outside the NHS and care systems. What was surprising to us was they by and large agreed that the structure and performance of the current health system was not well placed for coping with our ageing population as it is, let alone as what it is going to become. To put it crudely, that was due to an excessive focus on hospital care rather than community care and services not joined up around the needs of individuals as human beings. I am giving a very crude summary, but they all, I think, by and large agreed with that diagnostic, and the extent of it was surprising. So, in a sense, we are looking to you to see to what extent integrated care and commissioning might be the solution to some of those problems. I do not want to put you too much on the spot, but that is where our header is from that last session, and so we are particularly interested to see whether this is a crucial piece of the solution going forward. So, let me start off in Chairman’s fashion, if I could, by asking—and you do not all have to answer every question, so seize the ones that attract you—effectively what is it and why does it matter? By “it” I mean NHS and social care integration. Who would like to have a go? Julien, you look as if the spirit has moved you.

Professor Forder: Well, I do not think at this stage I want to try to define what health and social care integration is; however, broadly speaking, health services and social care services are organised, funded and delivered in separate ways, but their effects, especially on older people, tend to be interdependent. So that means that the provision of social care services, for example, home care services, is likely to have impacts in terms of costs and benefits on people that are affected by the amount of health care that is being provided, and also you see that process going in the other direction. So if you have these two systems that are interdependent in their effects but are not organised in a way or run in a way that is in partnership or collaborates, largely, then there is the potential for inefficiencies, inappropriate services, and inappropriate balance between the services, as you mention. I think those are all considerable issues.

Q291 The Chairman: I suppose a key question, which is not fully for this session, is: can you solve it by joining up at the bottom or do you also have to do something at the top?

Professor Forder: I think you need to do both. I definitely think the way to approach the problem is bottom up. We have seen over the years quite a few attempts to introduce legislation that facilitates joint working at the strategic level. For example, the 1999 Health Act introduced pooled budgets or the ability for councils to pool budgets with the Health Service. So there have been these facilitating mechanisms and yet we do not see that much integrated or partnership working, so we would have to think quite strongly about a solution that is driven from individuals. After all, that is where the focus should be. It should be around the individual person, from their perspective. They do not always make a distinction anyway between what we call social care services and what other people call health services. For them, it is about seeing the services as a whole, and I think that is a
Geoff Alltimes, NHS Future Forum joint lead, Carewatch Care Services, Professor Julien Forder, University of Kent and NHS Confederation—Oral evidence (QQ 289-326)

good point at which to do it, and mechanisms like personal budgets might help to facilitate that.

**The Chairman:** Excellent.

**Mike Farrar:** I agree with the diagnosis, in that the system does not work properly at the moment, and one of the reasons why I do not think it does is the balance between care and, indeed, a medical intervention is not right. So when you ask whether you start with integrated care bottom up, if you start with the needs of the family as well as the individual, the needs predominantly are ones of care and support, which require a medical adjunct on occasion, usually a specific medical adjunct. So it is not just the balance around our use of hospitals. I believe that we have over-medicalised our primary care intervention, and what we really need to do is have a care service with a medical adjunct rather than a medical service with a care adjunct. If you put it that way, you start to see it builds from the kind of support that families need, and then you bring in the medical elements as and when it is appropriate. Far too often, because much of our resource has gone into the medical element of care, the basic needs of people are not being dealt with and, consequently, people are over-reliant on some of the bits of the Health Service, which is sometimes the most expensive and the most unsuitable. So people with dementia really should not be being cared for in physical hospital settings. We have talked a lot about integration as though you are bringing together two equal bits of the system. Fundamentally to achieve integration I think you have to start with changing the balance, so it fundamentally is a care service to which the medical elements come and contribute. I think if we did that, it would be much easier to achieve a seamless care service built on what the needs of families are.

**Q292 The Chairman:** Well, we may have a chance to go into more detail on that, because we clearly would need to, to understand it. My apologies, it is Mike, is it not, rather than Mark, despite your name badge?

**Mike Farrar:** It is Mike, yes. It is fine. I will answer to anything. I am just grateful to be here, thank you very much!

**Geoff Alltimes:** If I just go back to the essence of the first question as to what it is, from that work we did in the Future Forum it was clear that our ambition was around integrated care. We are persuaded by the patient advocates to refer to that as “connected care” now, but it is integrated care for the individual. That is definitely working from the bottom up, but I think it is important to focus on the people with what is referred to as “comorbidities”, i.e. people with multiple long-term conditions and at the sharp end of needing support and services from both the health service and from social care.

We are not trying to, in my view, talk about integration in relation to everything that we need to do, and I think from the Future Forum work the key point was that there were lots of examples of integrated service provision—lots of small-scale models—that demonstrated that you could, through them, achieve a better experience and outcome for the patient. So that bit of it was there. It was not happening at scale, and our argument is that in the financial circumstances we are all in and given the demographic pressures, we need to be achieving this at scale, but our focus needs to be starting from where the patient is. There is quite a bit of evidence that if you do that you can achieve efficiency savings in the transactional sense. Certainly that was my experience in Hammersmith and Fulham, i.e. saving the cost of assessment, saving the cost of joint visits from different agencies to support, etc.
Geoff Alltimes, NHS Future Forum joint lead, Carewatch Care Services, Professor Julien Forder, University of Kent and NHS Confederation—Oral evidence (QQ 289-326)

The key question for us is: can we achieve the transformational changes? Can we reduce the number of people, up to 30% in a lot of studies, who are unnecessarily going into hospitals? That is the bit that is going to be the money-saving point. Hopefully, we will get a chance to explore that a bit more in the discussion that follows.

Q293 The Chairman: It is critical, so if you find we do not, remind us. Lord Mawhinney wants to come in, but let us just finish off. Phil Pegler, did you want to come in on this question or not?

Phil Pegler: Yes. I believe you need to start at the top level, which is the budget. One of the fundamental things that we have to confront is that the NHS is free and social care is not; it is means assessed. Therefore, until you fundamentally address that at a top level and understand where the budgets sit, you are, just on a practical, local level, always going to have an issue, in my experience.

Q294 The Chairman: What do you mean by that?

Phil Pegler: There are many hospitals that we go into, and I will give you a live example of a respiratory patient who needs intravenous antibiotics and goes into hospital for a five-day period. That patient is surrounded by people with similar lung diseases or problems, and that is the worst place for that individual to be long-term. They have had their course of antibiotics; they need to get out of the hospital and go back home with the right support. So I am saying that until you then agree who is going to pick up the funding of that individual leaving the hospital, you have a challenge and a fight—an internal fight—that we are seeing on the ground.

Q295 The Chairman: That is understood, but what were you specifically recommending should happen?

Phil Pegler: Where I was going to come in was in terms of the intervention. I believe that if we look at the elderly patients, one can stratify them and understand who is at risk and who is not. In fact, for our 25,000 clients, I can tell you those who are most likely to go into hospital, because of their environment or their vulnerability, and intervention at that level when they are at home in their safe environment strikes me as the best way in which we can save the health budget, because there are a number of people coming into the NHS hospitals who really should not be there.

Q296 The Chairman: That is an extremely important point, but it is a different one from the one you were making previously. The one you were making previously was we need to address the integration of funding. We all wave our hands at that and say, “Rather,” but what specifically are you recommending?

Phil Pegler: Either you pool the budgets in certain areas, whereby you end up with three budgets: a health budget; acute care settings that need to stay that way; and, equally, social care. But at the moment they are seen as two separate ones. I think, particularly for the elderly, there is a case to have a joined-up budget, where you end up with three separate budgets, as I have described.

The Chairman: Okay, we will probably come back to that.

Q297 Lord Mawhinney: Unlike in England, in Northern Ireland health and social services were not separated and it is still, in Belfast, the DHSS. In what practical ways, not
theoretical ways, do people in Northern Ireland get a better service than they do in England as a consequence of that?

**Phil Pegler**: I am sorry, I cannot answer that.

**Lord Mawhinney**: I am asking anybody.

**Mike Farrar**: I will try to pick that up. The understanding I have of Northern Ireland is that, although there is a single entity in respect of the management of services, there are still significant issues in terms of delivering joined-up care, in part because we still have the tribal instincts of different bits of care being made available to try to organise things in line with families' and patients' needs. So I think that Northern Ireland has an advantage in the sense that it has taken out some of the bureaucracy, but I do not think it has fundamentally got to the issue of starting with the patient. We still have professional responses coming down different lines to try to get the patients and their families what they need.

**Professor Forder**: There have been a few studies looking at the experience, because it would seem to provide a slightly natural experiment in respect of whether integration of health and social care service or management and organisation would have an impact. But those studies still show that, for example, there are problems with delayed discharge in Northern Ireland as a manifestation of health and social care systems not working very well together. Although that is one aspect of the barriers that we see to having a joined-up experience for an individual, the funding and the culture issues are still pretty strong barriers to effective joint working.

**Mike Farrar**: One thing I should have mentioned, of course, is that primary care in Northern Ireland is exactly the same as it is in England, and it is not part of the system. So when people talk about health and social care being integrated, they are talking about community health and community social care organisations. Primary care, in its own separate bubble, contracted separately, is still distinct from those services and run separately. I think that is one of the big problems when you start bottom up, because most people's experience is of primary responses and primary care first and foremost. That is, in part, why I think Northern Ireland does not have quite the maximum benefits of having integrated health and social care around community services.

**Q298 The Chairman**: If not Northern Ireland, to stay with Lord Mawhinney’s question, are there other states or countries where it is evidentially better when they do integrate the funding stream at a national or regional level?

**Mike Farrar**: When we were thinking about the evidence session, we were looking worldwide for examples of where they have cracked this. I think there is some hope for Finland, but in terms of an evidential base we have not got the data at the moment. There is Alzira in Valencia, where they have a completely capitated budget around secondary and primary care, and of course there is this huge experiment going on in America at the moment with accountable care organisations. $10 billion has gone into the evaluation of that over the next 10 years, and it remains to be seen whether or not having a single capitated budget in that way does deliver. I am sorry; I did want to bring you evidence of systems that have got this right, but unfortunately there does not seem to be that much, and I have probably researched badly.

**Q299 Lord Mawhinney**: You have talked about culture and you have talked about budget as being the two problems, and even the Government overhang does not address culture and budget. What I am not clear about, and I would be grateful if you could help
me, is: is the difficulty with budget because there is a fundamental difference in the culture, or is there a fundamental difference around the budgets and that is what drives the culture? In other words, if you go out of here leaving us with culture and budget, on which should we focus?

**Professor Forder:** Again the evidence base is not massive around this issue, but the normal answer around culture is that health care operates essentially to a biomedical model and that social care colleagues are operating to a social work personalisation model. That means, for example, in the health system you tend to focus on conditions, and in the social care system there is maybe more focus on the individual and their families. Clearly, these things, in respect of integration or partnership working, will rub up against each other quite considerably. So that is an issue. I am not sure that is necessarily related to funding.

On the funding side, there is clearly this issue that if you are a person using services, then the health services you receive, generally speaking, are free at the point of use, whereas if you have to come out and go into a care home and you have assets of more than £23,250, for example, you will pretty much end up paying the full cost of that. So that is obviously an incentive for individuals to think about where their care is being provided and the amount they have to pay. So I think those two issues are pretty stark. To a certain extent they might be interrelated, but also they have their own underlying effects.

**Phil Pegler:** That is the nub of it, though, is it not? I do not know what you would put as the cost for an elderly patient in a bed—£250 or £400 without any medical intervention. The fact remains that if you manage to get that patient back out for a sum of £25 a day, compared with £250 a day, the overall budget is saved. The indications are that when you get somebody back in their own home with the right support, they get better more quickly, and if you ask the relatives of that particular client, that is where they want to be as well. That applies to dementia or somebody who has had a fall or somebody who has had a respiratory condition. People want to be in their own surroundings and that is where they can get better, but they need the right support, and the right support is not just somebody going in; it is nutrition, physio, wellbeing, and company. There is a whole range of things that people need particularly as they are getting older, which I think was today’s focus.

**Q300 Lord Hutton of Furness:** I have only been a Member of this Committee for about 35 minutes, but I have already had my déjà vu moment, because I have heard this so many times. Any of us who have ever had any responsibility in Government will have heard exactly the same analysis, exactly the same examples, exactly the same description of the problem, but we really do not seem to be materially any further forward. We have spent the last 20 or 30 years looking at organisational integration, and that does not seem to have addressed the problem. Lord Mawhinney has talked, I think quite rightly, about the problem of the culture within organisations. Is it right to assume, however, from what you are all saying today, that there is no quick fix? If the problem is fundamentally a cultural problem about medical models or social care models, it will take a long time to physically turn those models of care around to develop social care predominance over a medical model. The problem is urgent and compelling if you look at the facts about demographic change. You seem to be saying to us, “Well, you can forget about anything happening for 20 years or so.”

**Phil Pegler:** I am not sure that I agree. It is slightly more than 35 minutes, but I have been in social care or home care only for about 14 months, the acute care setting before that and hospitality before that, so I bring a range of experiences to the party. My observations are about how you commission that care. Let me give you an example—a real practical example that I think could change the way in which we commission. If you look at the local
community care nurse, they go around on their round; it is a very tight geography, and they get particularly well known by the clients who are frequent fliers to the GP surgeries. They can determine where they spend their time: how much here; one client might need more care one day rather than the next. I think there is great merit in moving the commissioning to change the way we support people in their own homes. Rather than minute by minute, which is what we are experiencing at the moment, we could commission a cohort of clients within a very tight geography and allow the provider to determine how much care one needs to deliver this day compared with the following day, and what type of intervention or technology could assist with that. But at the moment, social care at least is commissioned purely on framework agreements, and a framework agreement, in my experience in the last 14 months, is purely an invitation to play. There is no guarantee of volume. There is no planning that as a provider I can do around that, knowing that I am going to get a sum of money that I can choose then to reinvest to make my processes and my delivery much more efficient.

Q301 The Chairman: What outcomes would you nominate for such a funding system? Because you cannot just say, “Here is some money. Go and play.”

Phil Pegler: Well, no, I am saying more than that, because we are already doing some re-ablement programmes, where we are measured on taking a client from hospital and if, after a period of either six or eight weeks, they show some marked improvement, we get rewarded for that, but they are few and far between. The way it is commissioned is essentially minute by minute, hour by hour, because that outcome of six or eight weeks gets translated in terms of the number of hours that you are being commissioned to provide.

Q302 Lord Hutton of Furness: What is stopping us doing that?

Phil Pegler: What is stopping us doing that is, at the moment, it is configured in my experience so we have a health budget over here and we have a social budget. To my earlier point, if we find a way of merging the two, you are able to commission in a different way and bring in technology and other business partnerships that I might be able to provide as a provider. But culturally, my experience is if you have been in social care, it is most likely you have been in social care most of your working career. The people I am dealing with have been in it for 15 or 20 years, and their experience and exposure to different ways of commissioning or different areas of how you might deliver care is very limited. I know that because I have seen that from different businesses and different sectors. Until we move from a framework agreement, where you are just invited to play, and put some serious money in to even trial it in certain geographies, it is very difficult, because most of this technology does cost some money, and without the funding behind that, it is difficult to play in that arena. I think it can be done.

Q303 The Chairman: Geoff, do you agree with that or not?

Geoff Alltimes: Can I come at it by going back to the question about the fact that we have been having these discussions for some time and nothing has changed and so on? I think there is a potential change for us, which I think goes some way to connecting with the things Phil was saying. We have now agreed that we will have these Health and Wellbeing Boards, and they are going to be the place where local government and the new NHS CCGs are required to come together. It is local government, not just social care, i.e. it is encapsulating those wider determinants of health. I think that the signs are, from those people who are making up those health and wellbeing boards to come, in shadow form at the moment, that people recognise on both sides that the only way they are going to solve their financial
problems and achieve the improvements in care is to do it together, so that there is a win-win element even though the scale of win may be different on one side from the other. So I see that as the place where there will be the discussions about where to jointly commission, which I think is then the key to being able to commission the sort of joined up services that Phil is referring to.

You used the example, Phil, of the community nurse. Well, it needs to include the social care too and the home help service. It needs to be one provision of service that we are talking about. It needs to be one where there is a single model of assessment, not separate assessments by separate commissioners and separate providers. I do see some reasons for optimism that the Health and Wellbeing Boards are beginning to think about how that may be. We may get on to talk about some of the work that is going on in relation to community budgets, where again in North West London—where I come from—Manchester, Essex and so on there is attention paid to how we might put together at scale those things that deliver the sorts of benefits that Phil is talking about.

Mike Farrar: I think there are improvements that you can make in the system, but fundamentally the cultural change remains elusive. Let me talk about some of the improvements. Indeed, the current set of reforms gives us a problem: 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. So, effectively, if you are a family with an ageing relative who needs specialised care on occasions, all those organisations have to come into it. So integrated commissioning remains a challenge. However, I think there are opportunities through Health and Wellbeing Boards, if they have primacy, to try to pull and brigade some of that money through, and the commissioning support unit could, perhaps, be the technical place to do it. But they will all help improve on the current system.

You could also argue that if we change the funding mechanisms—so, Lord Bichard’s work on community budgets, bringing some of the budgets together, building on pooled budgets—you would make improvements. But the cultural change is not just about the relationship between social care and health care. It is the cultural change about where you start with the families and addressing the needs of the families and changing the balance of care. We might be able to make improvements that get us five or, if we are lucky, 10 years’ worth of efficiency savings coming out of the system, but for a 50-year horizon we have to fundamentally change the whole basis on which we are pulling our resources through. You can just see how difficult that is in that successive governments have had problems over the question that Andrew Dilnot raised about the contribution of the public to that care. That is in the territory of: what is your responsibility as a family, and what does the state provide for you? So I am not disagreeing with the fact that we could do some of the things that colleagues here have described, and I think we need to, but they will make improvements to a system that fundamentally has not made that cultural shift into a sustainable position in the longer term, and that is my fear.

Phil Pegler: If you were looking at it as a business, though, it is hugely inefficient to get five or six different individuals pitching up to the same house in an environment where, with technology, you can multi-skill individuals or even have small teams in very tight geographies. The great benefit that gives you is familiarity. It brings us back into community life and a degree of support. So, Lord Hutton, I think there are some really practical, good examples
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that can be implemented, and I do not think there are big battles in terms of cultural issues. I think I have described there a very practical example that could be implemented, but it does require a small geography to be looked at in its entirety, and I think therein lies the issue, because you cross over GPs and community care nurses and physios and nutritionists within a very tight geography. The big solution is bringing those all together and having a multi-skilled team of two or three individuals to deliver the care that we need.

Q304 The Chairman: You focus, if I heard you correctly, on those with multiple problems rather than the generality.

Phil Pegler: No, I would not say that at all. I think technology can help you stratify various patient groups and those that are more vulnerable, but you have a team that is in a very tight geography and can call and move around with great flexibility. That is the point.

Q305 Lord Bichard: I have been tasked to ask you later about international experience, but since Mike has now made it clear that is a waste of time, I will ask a supplementary at this point. We may have already touched on this, but I am interested in hearing a bit from Geoff Alltimes, because I think you are still unique in all sorts of ways, of course, but you are unique in one way in that you chaired a local authority and health joint management team. Now, I am not going to suggest that all the answers are in structural change, but I am interested in giving you an opportunity to download your experience from that—what it taught you. You are sounding quite optimistic about the changes that are now in train: Health and Wellbeing Boards and the rest. Is that because of your experience? I would just be interested in hearing you talk a bit about what that experience was like.

Geoff Alltimes: Very briefly, the most important thing about that experience was it was not predicated on a lengthy legal process of reorganisation. Quite straightforwardly, I was appointed to be the Chief Executive of the PCT. I was already the Chief Executive of the Council, and that therefore meant I was the ultimate manager of both staff groups, and we worked to bring those staff groups together. I did that for a relatively short period of time, but made some very quick changes by saying, “We will not have two lots of people commissioning children’s services. We will have one team doing that. We will do the same for adults,” which was much more complicated—a wider span. The important point was that it did change the culture in the organisation. It stopped people blaming the other part of the organisation for things not working and, most importantly, it meant that both aspects of the team took credit for successes. So it was a very positive experience and, as I was referring to earlier, it meant that we made quite significant transactional savings, i.e. we needed fewer people to do the same things. We improved the sorts of contracts that we had, and I think the one in relation to provision for families with children with disabilities was a good example of that, where the families themselves thought the better of it, but it was not that complicated organisationally to do.

The issue I then faced was the changes in Government—the changes in the approach that we are now in the implementation phase of—meant that did not work. That got me into working with colleagues in the neighbouring two boroughs, Kensington and Chelsea and Westminster, about how those boroughs might work together. Some of you will know that we now have a single director of adult social care for the three boroughs, and a single director of children’s services. That matches the single organisation within the then PCT grouping and means that we have the three boroughs coterminous, mostly, with the three CCG leads. In taking forward that work I was describing in Hammersmith and Fulham and the community budgets proposal, they are there looking at how together, through their Health and Wellbeing Boards, the CCG leads and the councils can put forward a model that
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will be about joining commissioning and about commissioning integrated services. It will be focussed on those people with long-term conditions, i.e. not the population as a whole, but with the aim of providing that single multi-disciplinary team, with hybrid workers providing the service. I am optimistic that can achieve the sorts of improvements in the patient experience that we are talking about and contribute to the reduction in the number of people unnecessarily going into hospital. I could talk further about it, but I am sure that you have limited time.

The Chairman: If there is a note you could send us that encapsulates what you think are the key learning points for us, that would be really helpful. Liaise with us and with Mike, and we will get that sharp.

Q306 Baroness Blackstone: Like John Hutton, I have a bit of a problem about some of this with déjà vu. I worked on a joint approach to social policy in the 1970s when I was a member of the CPRS in the Cabinet Office, and we talked about all of these issues. That is more than 30 years ago, so one does have to start asking why we cannot make this happen. I do not think it is about cultural differences between professional groups. There are plenty of people in the health service who work on community provision of one kind or another. They are not all full of the biomedical model. There are plenty of people on the social services side who understand that people have physical needs as well as psychological needs and financial needs. I think it is much more of a huge organisational problem. Part of the organisational problem, I believe—and you can criticise me or counter it if I am completely wrong—is that in some ways it is easier to keep an elderly person who has quite a lot of different problems in hospital than it is to have them living in their own home. You have talked about the multiple skills needed to care for this person in their own home: they need nutrition; they need physiotherapy; they need people to get them out of bed and back into bed—all these sorts of things. It is very, very complex. One of the problems about the provision that is often made available for people at home is it is low-quality people, they do not have a lot of skills, and it is a different person every day, and it is often a different person twice a day and they are very often low-paid people who have poor-quality English. So, for families, sometimes, they are longing for their elderly relative to be back in hospital.

Lord Bichard: Where it is free.

Baroness Blackstone: So we have to think very deeply about the organisational aspects of all of this. In some ways, there is an interim place for people to be, which we have not talked about, between a hospital and their own homes, and that is really good residential care for elderly people. I think that has to feature in all of this, because it may often be the most suitable, although it is of course desirable for people to stay in their own home if they can do so. But coming back to this organisational problem, we have directors of children’s services now, and this follows up on what Geoff Alltimes was saying: should we perhaps think about having directors of services for the elderly? I do not believe they exist anywhere, and it seems to me, in a context where we are going to have huge numbers of people over the age of 80 in the future, this is just as apposite as having directors of children’s services for people under 20.

The Chairman: There is quite a lot to go at there. I think perhaps start at the end.

Professor Forder: Yes, okay. I will pick up on a few points there. I think it is interesting, is it not? You talk about this issue having been discussed for a long time, and I think that is absolutely right. There has been a lot of focus on ways to bring health and social care together on a strategic level. Councillors and PCTs have had the opportunity to pool
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budgets for a long time. There have been care trusts, as Geoff has talked about, where PCTs and social care are together, but they have not made a huge impact. We are still talking about this. What joint working we have seen is pretty marginal, pretty peripheral. So although we do not have a great evidence base on this, it does surely suggest that a purely strategic solution is not going to work. If it has not worked so far, why do we think that it continues to offer some potential? So my view is that perhaps we should change the focus. Perhaps we should try to really take the focus much further down on the individual and work from that basis.

I mentioned personal budgets before. We have had evaluations of personal budgets in social care. There is some evaluation happening about personal budgets in health care. They do offer the opportunity to bring money together and pool resources around the individual. There is some limited evidence elsewhere in the world, for example in the Netherlands, where they did this, and where people do have personal budgets you see quite a change in the balance of services that they use, i.e. the balance between social care services, community health services and so on. So if that is happening, perhaps we should make it a focus on trying to look at the solutions to some of these problems at that point. Then, hopefully, you will get the integrated provider services following from that demand for integrated solutions.

The Chairman: We will come back to personal budgets if there is time, we hope.

Q307 Baroness Morgan of Huyton: Can I just pick up on that point? Are you saying that there would be a shift in the funding basis of health care? This is picking up on something that Mike Farrar said. I do not want to put words in your mouth, Mike, but it seemed to me that what you were saying was that anything beyond fairly short-term fixes demands clarity about the deal, in a sense, between the state and the citizen. In a sense, until we have that, the whole thing is going to continue to be pretty shambolic on the basis that, bluntly, health care is free, social care is not, and there is a crucial cut-off point. In a sense, certainly my experience and that of others I talk to is the priority of local authorities that are somewhat stretched is dealing with the ones they know they have to deal with, who are under the 23,000 mark. In a sense, beyond that, people kind of make the thing work for themselves to a greater extent. But until we sort out the deal between what is going to be offered, then both the private sector and the public sector are going to find it hard to develop the appropriate services to meet the needs of the individual.

Mike Farrar: Can I make a practical point on the back of that quite high-level point, which in some ways challenges Baroness Blackstone’s point? If you were thinking about the most strategic use of the resources available to help care for older people, I think we would be spending not a lot of money but spending it very effectively supporting partners and carers to have a higher level of skill to be able to look after the person who eventually becomes ill. I think you can see it in other areas: I saw some research in Holland that looked at the carers of partners who were HIV-positive and with AIDS, and the ability for the individuals to care at a higher level for longer would take some of the burden off the state.

Why I disagree slightly with Baroness Blackstone is that for a lot of people the worst day of their lives is the day that their partner has to go into a care home or residential care. They want to have the skills to look after people at home. Now, that starts with training them. This is very personal, and I do not want to bring a personal story in other than to demonstrate this point. I lost my mum just before Easter. My father lost the ability to keep her at home in November, and they had been together for 60 years and had one night apart, so it was a terrible day for us. But what would have kept my mum at home for even two
weeks longer, to get us to the other side of Christmas, was my dad being taught, when he was able, better lifting skills, some more basics around continence support and, indeed, about aids and adaptations, and we are a health-literate family. That was our experience. There are families for whom I think it is a godsend sometimes when they have just run out of their ability to look after someone.

Now, that relies on people believing that it is the right thing to do, and so 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. That six months of avoiding the state having to care for them is very low cost compared with the fact that a lot of those people are now ending up in hospitals, which are the most expensive bits of our system, not in residential care, often at two and three times the cost. So I think that is why that deal is so important. You start to get at: what is the basis of looking after people, and what would you expect to pay, and what would you expect to contribute, not always in cash, but in your own ability to look after your own? I think that is a very profound thing that we just need to pay some attention to.

Q308 Baroness Shephard of Northwold: What has happened with the excellent answers that we have had from our panel is that many of the questions many of us were listed to ask have been answered. Mine are: how can we commission an effective bundle of care and are the current service structures able to provide this? Well, you have really answered a lot of that, but I just wanted to probe a bit more. I think that Geoff Alltimes indicated that he thought that the health and wellbeing structures do have the potential to deliver more integration. I think that you also said that we could make much more streamlined and effective use of what we have in place, as things stand. I was most interested in what Baroness Blackstone said about the high policy of working together in the late 1970s. In the late 1970s I was putting all this into action as a councillor. I was the Chairman of social services, where, in Norfolk, we provided, first of all, integrated care based on two GPs’ practices. We provided a continuum of care for people with learning difficulties and a continuum of care model for elderly people. So it could be done then, and the magic thing we had at that time—and I am really talking history here—was something called joint funding—joint financing between social services and health—which was a Labour Party initiative, no doubt, coming from Baroness Blackstone. It is funny how things turn out, is it not? It was really tremendously effective, because it was used absolutely at local level.

Now I come to Phil Pegler, who has used several times the phrase “tight geography”. Now, I would like to ask him what he means by that. At what level would these decisions about the care package be made? Is he talking about a local authority? Is he talking about a district council? Is he talking, for example, about the catchment area of a GP’s surgery? At what level should these mechanisms of bringing together sources of finance be made easier? At what level would this most effectively be done? I have to confess I have my own strong view here and I am not telling you what it is. I would love to have it corroborated.

Phil Pegler: It is the latter: the GP.

Baroness Shephard of Northwold: Great.

Phil Pegler: What do we mean by package of care? Can I just talk about that to see whether we have commonality, first of all? It is a degree of home care, telecare and telemedicine. There is technology in the home in terms of fall prevention. There is health and safety in terms of fire alarms and stuff like that. There are movement sensors that one
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can place in the house just to see the pattern—rather than Big Brother—of somebody getting up in the morning, going to the toilet, going to the kitchen. All of this technology is around at the moment. There is equipment at home to help people stay at home longer. There are day-care services, medical intervention or medication administration, nutrition and physio. That is what I am describing as a bundle of pretty much full support to allow people in the community to stay in their homes as long as possible.

I can see that might be different for one client living in their own home compared with another. The reliance is working in partnership with the GP to determine what the right care is for that individual and having the flexibility in the way it is commissioned that gives the provider flexibility to change the degree of provision as, sadly, an elderly client deteriorates. So that is what I am talking about—very, very local.

Q309 Baroness Shephard of Northwold: May I just ask three supplementaries? Firstly, all of the panel have tended to speak as if the needs of the client, the patient, remain static. Of course, they do not. They do deteriorate over time, but sometimes there are good times and worse times even on that steady path, and I do think we have rather been given the impression that there is a condition and you deal with that, and that is it; well, it is not. Of course, the carers also have changes in circumstances.

Phil Pegler: If I may, Molly might have been very good this morning, got up and dressed herself, but she has no hope of getting out of bed by lunchtime the following day. It changes day by day rather than in longer time periods. In the way you described it, one might have thought they were slightly longer than that.

Q310 Baroness Shephard of Northwold: No. What I also said was there are changes within the steady deterioration, so people do indeed have good and bad days. That is one point.

Phil Pegler: I agree.

Q311 Baroness Shephard of Northwold: Secondly, I would like to know if you see differences in the challenges of providing such care between urban areas and rural areas and, thirdly, how easy or difficult would this be to do if you really did adopt a GP’s surgery as the kernel of providing this care? Sort of briefly. I am asking everybody.

The Chairman: Let us ask Geoff Alltimes to kick off, shall we, because in a sense you are sitting on this spot, are you not?

Geoff Alltimes: Just very briefly, I have a slight difference with Phil. My view of the scale of operation, the geography, would be you would really need to work on groups of practices. So I think a population of 50,000 and those practices covering that population would work, but when it comes to the commissioning, I think you need to be at varying scales upward of that. So in that North West London model, we are talking about the CCG level, the borough model, the 200,000 population, but also some pan-commissioning across the three.

Q312 Baroness Shephard of Northwold: Would your point about 50,000 apply equally to urban and rural areas?

Geoff Alltimes: To be honest, I am less familiar with rural.

Baroness Shephard of Northwold: I thought so.

Geoff Alltimes: But I think the same principle would apply.
Baroness Shephard of Northwold: You could still have groups.

Geoff Alltimes: Can I just connect that with Baroness Blackstone’s comments earlier? We have talked about and acknowledged the fact that there have been lots of attempts over a number of years—I have certainly been involved in them myself for many years—that have not achieved this holy grail of integration. The experience at the moment is more optimistic than at previous times, from both the health side and the local authority side, and I see that as being evidenced through the commitment I was describing in the Health and Wellbeing boards. But I absolutely believe that it will only work locally where the people who understand their locality are coming together, and GPs and local councillors are the most local people I know, and have a long-term commitment to an area. It will only work where those people come together to work out how to do that on that local basis.

You talked about the way in which in the past we have had joint financing and so on. We have obviously had some money recently transferred from the NHS to local government. Well, that sort of money helps, but I am talking about the integration of the totality of the money, the main programme money. That is what we need to achieve to deal with the present situation.

Lastly, to pick up your specific point about changing circumstances, if you have those practices covering a 50,000 population, I see a particular focus on the people within that geography with long-term conditions. As we said in the Future Forum report, there needs to be a model where those individuals and their families have a named key worker—someone who is able to respond to their changing needs. We must have a system that responds when somebody has an urgent need at the weekend, which at the moment will often mean that they end up being taken into hospital, because that is the only place that you can get contact with a service at that time. We have to have a model that can be as responsive in the community as those emergency services in hospitals.

Baroness Shephard of Northwold: Thank you.

Q313 The Chairman: You might give us a note on what you meant by the integration of the funding, because I am not sure I understood it and there is not time. Could you do us a note on that, so that we at least know clearly what it was you were saying?

Mike Farrar: Just three very quick points. In all the experience I have had of the health service, it has been easier to get joint working in urban areas, largely because of the one-to-one relationship between unitary authorities and PCTs. Clearly, that is why the Health and Wellbeing Boards establishing themselves as that kind of new footprint is going to be really important.

The second thing is that rural health care generally across the country is more under pressure. Many Committees in this House have sat and looked at the allocations formula, but I do not think it is an accident that places like Cumbria, North Yorkshire, Cornwall, and Lincolnshire all have financial problems that are long-standing in the health service. So I think there is an issue about rural health care.

Lastly, if we are going to say GP populations are the right ones, then it would be wonderful if we also said that part of the integrated funding is that money that goes for primary care through the GP practice. Now, I know they are independent practitioners and they need elements of that, but that is the key bit that needs to be joined in. If you just take a GP practice population and integrate their community social care spend and their community health care spend, you will not get the true integration that we need.
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Baroness Shephard of Northwold: No, I agree.

Q314 The Chairman: Do you agree with that or not?

Professor Forder: I think I largely do, yes. I think part of the problem is that it is not fundamentally about the mechanisms to bring the money together. As I have said on a number of occasions, those things have existed. It seems to be the will of separate parts of this whole structure of this health and social care economy, with their own particular sets of values and also lines of accountability. These are not brought together, so it is not surprising 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. So I think unless you can bring those lines of accountability together in some way, there are always going to be these problems. You can facilitate this 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.

A potential way of doing this is bottom up, as I have mentioned as well, but also to combine that with an outcomes framework that recognises the person in the sense of the whole of their care needs, so health and social care. So do not have these separate structures where the performance mechanism for the health service is this, the performance mechanism for the social care service is that, because people are going to work, quite naturally, towards achieving those targets and performance goals, but they are not joined together, so that is going to have an implication for the services that the individual receives.

Q315 Lord Griffiths of Fforestfach: On the issue of funding, as Mr Pegler spoke right at the beginning it suddenly hit me that what we are talking about here is a product that is growing, which is care for the elderly, and as the demand is growing, the supply will respond to it. In terms of integrated funding, there is taxpayers’ money, which can fund it; there are people paying out of their private pocket, which can fund it; and there is people giving their time, which is an important resource, in order to fund it. If you were planning, say, on a five-year time horizon as to what you think your business would be like, what would you see as the role of the taxpayer and the role of private individuals, whether putting their hands in their pocket or giving up time? How do you put that together, and do you go out, in selling a service, because people are paying you, to say, “Here is a market,” and so on, “And we can see tremendous potential,” much as people might say, if a child wants to go to university, “I am going to make an effort,” and so on; “I am going to save.” Do you see that as something that also influences your whole view going forward?

Phil Pegler: I have a couple of observations. Firstly, what we are planning is thinking about what products we are selling. My thinking increasingly is moving away from just selling an hour of care, because one can package that in the way I have described: using a bit of technology and movement sensors and whatever it might be. That appeals more and, I have to be honest, it is easier to sell that vision to the private sector or to private individuals self-funding rather than the local authority. In fact, I am meeting people on Thursday just to scope that out.

As to my vision for five years, I want to become less reliant on local authorities, I have to say, because the funding that is coming through to local authorities is reducing the charge-out rate—the amount of money I get per hour—and yet my costs are going up, because I am having to pay my carers more through national minimum wage increases. So I have to get out of this market, and I do not want to, because I want to form a different type of
offering that I know will suit the local community and provide a better provision and be more cost effective. But it is incredibly difficult to do that.

**Q316 Lord Griffiths of Fforestfach:** Who pays for that?

*Phil Pegler:* Because I am chasing the private paying individual, I am seeking the private market, because it is easier to engage with. That is based on facts; that is where we are. Many times I have called on local authorities and said to deaf ears, “Please engage with me. I am meeting with some technology partners. I really want to talk through and scope out what the offering might be.” That is really frustrating. To be honest, I could, as a private organisation, invest our money, our capital, and our people in those areas, but I need a payback in the next 12 months, not the next five or 10 years or 30 years, for what we talked about earlier.

I also have a couple of side observations, if I may. Firstly, in terms of the personal budget, it is not my experience, Julien, that people are welcoming this. If you are over 80 years of age, the last thing you want to be worried about when you are worried about your own wellbeing is the finances associated with that. I think there is some fudge going around with local authorities at the moment, where they essentially are still pulling the strings but they are calling it personal budgets. So I do not buy the fact that this is a direction of travel. Common sense gets you there, but the practicalities on the ground are quite different.

**The Chairman:** Could I just ask Geoff Alltimes to comment on your point about the inability of getting local authorities to buy what you thought would be sensible for them to buy? I am putting it crudely, but that was essentially what you were saying.

**Baroness Morgan of Huyton:** Sorry, Chairman, could I just pick up on something, on the back of Baroness Shephard, back to Phil, around personal budgets?

**The Chairman:** We have a question on that.

**Q317 Baroness Morgan of Huyton:** I know, but it is relevant now and it saves asking it later. If you went back to the notion of the GP, are you saying that personal budgets are wrong or the individual owning the personal budget is wrong? In other words, if the individual has somebody in the system to manage their account or their budget, i.e. the GP practice, potentially, is that a way through the conundrum that you are describing?

*Phil Pegler:* I think it is, and we have not spoken about the Dilnot recommendation as well, because just as a provider I think that is absolutely the solution and would open up an insurance product as well that would allow people the peace of mind of not being exposed to whatever that means. I can see a way of that capital budget or the insurance market working together whereby, irrespective, it takes away the means testing, essentially, or there is an opportunity to do that, I think, if structured correctly.

**The Chairman:** Geoff, we will probably park the question I was putting to you. If you are moved, you can give us a note on it. We should move on to Baroness Tyler.

**Q318 Baroness Tyler of Enfield:** Firstly, my initial supplementary was precisely the one that Lord Bichard asked of Geoff about the impact of the arrangements that you have overseen, bringing together three boroughs in both health and social care. I was very encouraged by your answers as, indeed, with another hat, as Chair of Cafcass I have been by seeing the improvements in children’s services in those three boroughs, integrated services...
Geoff Alltimes, NHS Future Forum joint lead, Carewatch Care Services, Professor Julien Forder, University of Kent and NHS Confederation—Oral evidence (QQ 289-326)

and the family justice reform. So my personal view is, in terms of transposing that to the world of older people, that there is really some very fertile territory for us.

My precise questions we have covered to a large extent. They were about whether the new structures brought in by the new Health and Social Care Act are really going to achieve this integration of health and social care through the joint planning and commissioning arrangements. On top of structures, if that is not enough, what other sort of policy levers might there be? For example, would there be financial incentives, public involvement or regulatory change?

That was my broad area of questioning, but given the discussion we have already had, I want to focus on something else. Some of you, I think, have been a bit more enthusiastic than others about the new arrangements with the Health and Wellbeing Boards, the CCGs. Mike, I think you made the point, which I know is right but I find quite concerning, that within these new arrangements we have four different bits of commissioning going on when you bring in the National Commissioning Board as well. So I guess my question is: how do you see these new arrangements sort of panning out, particularly the relationship between the Health and Wellbeing Boards doing the strategic needs assessment and the CCGs doing the commissioning—hopefully much more integrated commissioning? I am particularly conscious that they are not all coterminous. That is my first point.

Mike Farrar: I think they have been made slightly more difficult in the short term, but there is a great hope I have that the technical support for CCGs, on their commissioning, is largely going to be provided by commissioning support units—commissioning support services. They are not statutory bodies as such. At the moment, they are part of the National Commissioning Board, but they operate typically with around 10 to 12 CCGs worth of business. I think it has now become clear that local authorities can ask them to do the technical support on social care commissioning. Because the commissioning support units are part of the National Commissioning Board, I see no reason at all why the National Commissioning Board could not use them rather than their local area teams to commission primary and specialised care. So, having said that technically the statutory accountabilities are scattered to the four winds, which they are—we cannot do anything about that because it is in primary legislation—the technical support to all of those could be done by the same organisation. I think if we were able to support them to pull that together, they may well, because of that kind of helicopter vision, be able to secure integrated care. But they should be driven by the needs assessment that is done between Health and Wellbeing Boards and Clinical Commissioning Groups. I think that the mandate that is being published today will help with that, because it is less numeric and it gives much more flexibility, perhaps, than it might have done at one point.

So I do think you can see how the new system can emerge, but I also think colleagues are right when they talk about some of the best places being really good because of the people. There is a lot of attraction to Geoff. Geoff was probably one of four or five colleagues up and down the country who were in that situation. So whatever the structures were, it was the people. I think inevitably, because of the change, we have lost some of those contacts between health and local government. GPs and local government have never been easy bedfellows, and I think we are going to have to work hard at the people side.

Q319 Baroness Tyler of Enfield: Do you know of any practical example of where that technical support—and I know it is very early days—to all parts of the system is being provided by the same technical support unit?
There are certainly ones emerging, which we can let you have a note on, where they are doing some social care exploration. The primary care and specialist care bit at the moment is not really being done, because the Commissioning Board is using its local area teams. I make the point that all they are doing there really with primary care commissioning is paying GPs. They are not really commissioning primary care. But we can encourage them in that direction, and you might want to think about that from your perspective.

Baroness Tyler of Enfield: Thank you.

Geoff Alltimes: I have two quick comments. On that structural point, I think the main point echoes what I said earlier in relation to Health and Wellbeing Boards being able to get on with it. We definitely do not need any new structural changes. Mike was saying where it has worked has largely been because people have got together. We have to have a mechanism that supports people getting together, and I do think the recent agreement between the Commissioning Board, Local Government Association, Monitor and Department of Health is an important point. We are going to have one place that supports the work that is going on in relation to integration rather than lots of places doing it separately, and we are trying to ensure that the taking forward of integration, the ownership of it at the national level, is through the organisations that are responsible for delivering it locally rather than some sort of separate mechanism.

Just in relation to your point about finance incentives, obviously we have not talked about the changes in the tariff model. The Year of Care type model for commissioning budgets is an important step forward, and I think that has largely been accepted, and we are out to testing in relation to that. I think that connects with Phil’s point about the commissioning contracts for service provision. We need to be working to models that achieve an outcome focus for providers rather than a by-the-minute service delivery model.

The Chairman: Thank you very much indeed. Just to keep score, the Earl of Dundee wanted to ask a further question on cultures. We then have Graham Tope to go into personal budgets, which we do want to spend a bit more time on, but we do not have a lot. I think we would like to get Lord Richard to ask a bit more on the question of international examples. I thought there were some interesting examples from the States that we should learn from. As you can sense, we are already out of time, but I think we will have another 10 minutes on this session and put back the other one a little bit, and I will make some closing remarks about further information.

Q320 The Earl of Dundee: I wonder if I can pick up the themes, as it happens, introduced by each of my neighbours. Lord Mawhinney talked about the relationship between culture and structures and, as he did so, I felt he talked as an optimist. Lord Hutton talked about how, in his experience—and he was speaking very much as a realist, because it is a fact—when one looks back politically here and elsewhere over the last 20 or 30 years, very little has changed. But what I would quite like to suggest is that now it might be that one can speak perhaps as a pragmatist, neither as an optimist nor realist, by saying that there is a sufficiency of change in the mixture of whatever may be culture to look ahead to the next five or 10 years and to say, in terms of a football match, where on one side of the pitch you have culture and on the other you have structures, that culture will possibly win. You can think of three ingredients of culture: firstly, what we call British common sense. It is very much, surely, which we believe in, the view of the British citizen that there should be joined-up writing. It would seem ridiculous to him that there should not be joined-up writing, and the more facts and figures showing that there are better...
results when this happens, the more we would feel, maybe, that it is within the culture of the British citizen to approve of that. Secondly, there is health literacy, and I do not know but I would suspect that the Netherlands would probably be top of the league. We would be not too bad, but not too good either, and probably better than Bulgaria. That is health literacy. Then we have maybe a political resolve and will, and I think we might all possibly agree in this room that over the next five or 10 years there will be an increasing consensus internationally, in Europe and all democratic countries, to achieve joined-up writing with health. If you lump that under the heading of culture, all these things—political will, health literacy and the culture of common sense—and just call it “culture” for convenience, just looking ahead not too long, no longer than 10 years, assuming that culture gets the better of the stick in the mud structures, what stages would you highlight, simple ones, over a five or 10-year period, where we could achieve the purpose of having much better, pragmatic, joined-up writing?

The Chairman: Nice and crisp, if you could.

Mike Farrar: I would like to phone a friend. What stages? Well, necessity is the mother of invention, and I think I would be optimistic, despite the fact I think that there is some restriction, because we have a great belief that we want to have a caring society. You just have to see the Olympics and the commitment to the NHS that was part of that, and we all feel proud of it. I think there is a risk that it will fall over, and I think that we will not let it. So I do believe that there will be a desire to find a settlement that we talked about before. The talks around Dilnot, if they can be maintained in an all-party way, which I think is fairly fragile, I think are the opportunity to have a settlement with the public about this.

In terms of the structures, this is going to take another three years to bed down. I think everybody has now come to the conclusion that it is not a good idea to have further top-down reorganisation of the service, so I would hope that they are in place for 10 years, which will allow you to have that kind of thing. So, being realistic, I think that we are going to have some difficult days in the next couple of years, but we might start to emerge with those structures really working and a positive commitment from the public to desire to make them work.

Professor Forder: Slightly to plug the research, I would hope a good way to change the culture is to demonstrate some of the evidence that we are seeing that integration does work. So bring people out of their silos and say, “If you adopt a slightly different mindset, if you view the problem in a different way, here are some of the advantages that we are seeing.” If we can do that and keep feeding back the messages, then, hopefully, that will change some of the more focussed thinking that some people in those organisations have.

Q321 Lord Tope: We have mentioned personalised budgets rather tantalisingly several times and not explored it, and I think Phil said just now he did not really buy into them. So, in the few minutes that are left to us, can I ask you what evidence there is on how far personalised budgets enable integrated care? What are the limits on the extent to which people are able to use them and, indeed, the limits on their delivery?

The Chairman: Julien, this is your special subject.

Professor Forder: Yes. In some respects I agree with Phil that if you are talking about direct payment, i.e. giving people money, then that does not always work in a number of cases. The evidence suggests that it seems to work much better for younger adults with disabilities, but maybe not so much for older adults. But as Baroness Morgan said, it is not necessarily so much about the personal budget; it is about care navigation. It is about having
Geoff Alltimes, NHS Future Forum joint lead, Carewatch Care Services, Professor Julien Forder, University of Kent and NHS Confederation—Oral evidence (QQ 289-326)

a care manager or, if you like, a case manager there who can bring together funding streams, who knows the system, who can help a person navigate through it, and who does it very much from the perspective of the individual and not from the system.

If you look at some of the international evidence about integration and what works, people talk about single-point-of-entry systems. They talk about care management, care planning, and integrated-assessment systems. They talk about identification and targeting of people with complex needs, because those people are more likely to use a range of services. They also do talk about pooling of resources, but it is only as a part of that gamut of potential solutions. I think personal budgets help because they do facilitate that care manager pulling resources from different parts of the system.

Q322 The Chairman: Very helpful. Any other comments?

Geoff Alltimes: I have just a brief comment in connection with that, and it just goes back to the point about users being at the heart of their own service plan, and I think personalised budgets are just an example of that. I would connect it with the culture question. These reforms are going to work if we get to a point where it is much more the case that the patients and carers, and the families, are talking positively about their care experience. All of the contacts with the Future Forum and subsequently with the patient advocacy organisations can give you vivid stories of what has not worked in terms of the integration for them and also vivid stories of examples that have worked, some of which have included the personalised budgets. But I think if we can achieve that change over the first few years, other things will follow from it.

Mike Farrar: The great, interesting feature of introducing personalised budgets has been that people very often buy things at substantial variation from what the state used to provide. I think that tells you everything about how engaged people have been around their own care.

Phil Pegler: Holidays, for example.

Q323 The Chairman: What is wrong with that?

Phil Pegler: Because it is not for them, and it is an abuse, and then they still need some care and they do not have the money to pay for it, because they have already spent it or their family members have.

Q324 Lord Bichard: As you know, I am going to ask a question about international experience, which you dismissed earlier, but as we have gone on you have tantalisingly pulled in stuff from the Netherlands and the States. So this is really an opportunity just to focus on that at the end. Are there things we can learn? Are there interesting things happening that we should keep abreast of around the world? We have seen recently the Australian vision for an ageing society: Living Longer, Living Better, a Minister for Ageing and all of that. Is that worth looking at?

Phil Pegler: I have seen some experiments, I think in Holland, where the GP became quite a central point for determining the care and the medication of their cohort of patients in their catchment area. We have seen some of that in the UK as well, in fairness, because GPs are splintering out and doing their own pathology and imaging. We are just on the way; that model is a really positive direction of travel for us. We are already implementing some of the learnings from other countries, from what I have seen.
Professor Forder: It is patchy and this is an inherently difficult thing to do well—evaluate different systems rather than, say, different drug interventions—but there is some evidence from the US. The Program of All-Inclusive Care for the Elderly is an example. Care and Counselling I think Mike has already mentioned. Some of these programmes have shown some benefits. I think it is fair to say that these do not show overwhelmingly good results. They are clearly not a panacea and there are underlying problems and difficulties, which are not going to be solved with these simple reorganisations. But there is evidence to suggest that there are some benefits, and it is certainly worth pursuing that direction, I would say. In Australia, you mentioned the Co-ordinated Care Trials also showed some benefits. They are sometimes slightly counterintuitive. For example, on hospital admissions, sometimes these things have resulted in increased hospital admissions, because what they have done is identify unmet need, and so people who were inappropriately avoiding hospital, for example, were going in. So it is a complex picture, unfortunately, and I cannot see a very clear solution through this, but more experimentation, more trialling, more piloting I am sure will help.

Q325 The Chairman: Other comments?

Mike Farrar: Across the world there are different forms of a single capitation solution: the idea of a single budget with a population in mind. There seem to be variations across that theme, and in the States it is the accountable care organisations, but you can see it in other places where that kind of joint working speaks to the idea of bringing a budget together. But I was just going to make a simple point, which is that I think the mature democracies may find themselves lagging behind, because some of the areas that are having to create new health systems from scratch—and I think about a place like South Africa, which is going to go for a universal health system that is going to bring together the very poor service in black communities with what looks like an Afrikaner general medical services—will have to find new ways and they will not over-medicalise; they will find other ways of engaging. So if I was looking for international experience, I would probably be looking at places like South Africa, and I would also look at those countries that will hit the rocks sooner than we do, which are simply going to have to find different solutions.

Q326 The Chairman: Such as?

Mike Farrar: I am thinking of Greece or Southern Ireland, where they have taken a third out of their health care budget. Southern Ireland has just decided that it is going from 42 hospitals to 13 hospital and health care groups overnight. They will have to do it in haste and that is not always the best basis, but in terms of radical options to help us we might want to look at what is going on in some of those places as well.

The Chairman: Fascinating.

Geoff Alltimes: Obviously, I think you have Chris Ham from the King’s Fund and Jennifer Dixon from Nuffield at future sessions. Their work looking at various international examples informed a lot of what we did at the Future Forum, and I know it has been helpful to that community budgets development in North West London. We always have to keep our minds open to lessons from elsewhere. Mostly, the international lessons seem to show that there is not one size fits all. That is definitely the case. It also shows, though, that you can, with determined leadership, make a big difference, and that includes a big difference in terms of the cost of the service, which is important to us right now.

The Chairman: Thank you. Thank you all very much indeed. It is utterly fascinating and extremely difficult. You know what we are about. We are essentially taking a panoptic
view, looking 10, 20 years ahead maximum, and asking ourselves the question: is our society prepared for ageing, both at a governmental policy level and individually? In the light of that, we really would welcome a note from you on anything that you think has not come out in the evidence that you really think we ought to pay serious attention to in terms of what we ought to consider in terms of our recommendations. Would that be all right? Thank you very much.
Anchor—Written evidence

About Anchor

1. Anchor is England’s largest not-for-profit provider of care and housing, with almost 40,000 customers.
2. Since we began life in 1968, providing sheltered housing as Help the Aged (Oxford) Housing Association, we have been innovating and driving up standards in order to help older people to get the best out of life.
3. Today, Anchor provides housing for rent to older people at 700 locations across England, as well as homes for leaseholders in managed estates. Anchor also runs almost 100 care homes.

Does our culture about age and its onset need to change, and if so, how?

4. Demographic change, coupled with today’s economic realities and slow progress by successive governments on social care funding reform has combined to create a “perfect storm”.
5. This has powered intergenerational tensions in a variety of areas from employment to welfare to housing.
6. While just one example, it is perhaps most stark in housing where the media has fuelled tensions resulting from older people "under-occupying" homes they own while many younger people are unable to get onto the property ladder. For some, this indicates a breakdown in the contract between the generations – baby boomers hoarding at the expense of the young.
7. Of course, this view is an oversimplification. A significant proportion of older people are not home owners and those who are are not necessarily well-housed. Perhaps more significantly though, it ignores the real contract that has been damaged; that between the individual and the state. With blurred definitions of social care, tighter state funding and rising incidences of dementia (largely deemed a social care issue) the concept of "cradle to grave" NHS healthcare is being eroded.
8. While Prime Minister David Cameron said back in 2007 that demographic change was one of the most important challenges faced by this country, real progress on dealing with it is sorely lacking.
9. The policy issues that affect older people are wide-ranging and complex; and being made more so by demographic change. As things currently stand, they span almost all government departments and several Ministers’ portfolios, yet individuals are being let down by a collective failure to address the needs of our growing older population.
10. At Anchor, we have campaigned for the appointment of a Minister for Older People at Cabinet level, who would ensure that demographic change is considered in the policies of different Departments. For example, the Minister would contribute to Cabinet discussions around issues such as local authority cuts, care funding, pension
reform, welfare support, discrimination, health & social care, planning and elements of transport.

11. The Parliamentary Advisory Council for Transport Safety (PACTS) called for the government to appoint a Minister for Older People in their It's my choice report, which looks at aspects of public and private transport. Recognising the many benefits that independent mobility can bring to quality of life, PACTS argue that we need to promote greater and safer mobility for an ageing society.

12. The Grey Pride campaign is not simply calling for more money for older people’s services. We appreciate that national budgets are already stretched. However a dedicated minister would have a role in increasing efficiency, by better joining up services. We believe that an existing Minister should be given responsibility for overseeing issues affecting older people in the same way that Home Secretary Rt Hon Theresa May MP is also Minister for Women.

13. In June 2012, MPs voted in favour of a motion calling on the Government to consider making such an appointment. As Margot James MP told the Commons during the debate: "One of the toughest jobs of the minister for older people would be to manage the expectations of our older population now and of the general population as they approach old age."

Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

Savings, retirement and independence

14. The same transformation which has taken place in the public consciousness around pensions is also needed around saving for social care. However, while recognition of the need for saving for retirement is increasing, there remain significant issues which prevent that transformation in social care. These include:

- Sluggish progress on state reform of social care funding which has increased confusion and uncertainty. This has meant people are less likely to save and financial services products have been slow to develop.
- Ignorance that social care is means-tested. According to Anchor research published in 2012, over 11 million Britons risk poverty in old age as they are unaware they may have to pay for their own social care. Almost one in four (24%) Britons are unaware that the Government does not fully fund social care for older people - and as a result don’t have any savings in place for this purpose.
- Just six per cent have begun to set money aside to fund their future care needs.
- Taboos: While saving for retirement is seen as a positive thing to do, too many people assume that they will not need social care in old age.

Equity release

15. Older people are far more likely to be outright home owners than other groups, with almost three quarters of retired households in England owning their home.

16. Raising money against the value of a property can enable older people to fund repairs, adaptations or home care, allowing them to stay in that home longer.
17. But equity release has failed to expand in the way many had anticipated. Tarnished by a reputation built on cheap daytime TV advertising, it is mistrusted, misunderstood and, in some instances, mis-sold.

18. There are other significant barriers too. Around a million older home owners have at least £100,000 in equity, yet their incomes are so small that they qualify for means-tested benefits. Access to that equity could provide them with practical help to improve their quality of life and enable them to continue living in their own home. But many are concerned about the effect it would have on their entitlement to pension credit, leaving them no better off.

Workforce issues

19. Ageism remains a significant issue in the workplace and is likely to increase as demographic change and the challenging economy increases competition for jobs.

20. Anchor research published in 2011 found ageist attitudes are endemic in the workplace, with two fifths (41 per cent) of young Britons aged 18-24 years saying there aren’t enough jobs for older people to be in work and 14 per cent claiming older people should retire to make way for younger people.

21. One fifth (21 per cent) believe the over 60s are slower and are less productive than their junior counterparts with one in 20 claiming they should be paid less because they work at a slower pace.

Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

22. Essentially there are two options for health, housing and social care. Either public services become simply the safety net for the least well-off after a crisis or preventative services are prioritised because of the benefits to individuals and the public purse of the resulting reduction in costly NHS care.

23. While there is a growing evidence base to support the latter option and positive noises from Government, the reality on the ground is that preventative services are increasingly losing out on funding. Housing providers continue to have robust conversations with local authorities about funding for housing-related support following the end of the ringfence around Supporting People funds.

24. On social care, there is strong sector-wide support for the proposals of the Dilnot report, both in terms of the specific recommendations on capping care costs and wider recommendations around housing.

Do we need to redesign and transform public services for these challenges? If so, how?

25. A more holistic approach is needed. On health and social care local decision-making should better reflect the national rhetoric on prevention. However, the national message must also widen to include planning and transport among other issues.
Planning policy

26. The National Planning Policy Framework, announced by Government in March this year, is an opportunity to make it easier for housing providers to build more housing suitable for older people without being hindered by restrictive planning laws.

27. Until now almost two-thirds of planning applications for new retirement housing schemes have been refused first time round, according to research by the University of Reading, because of a lack of understanding of the need for such developments and the merits of this form of housing.

28. The NPPF could open the door to the new developments with one of if its core objectives being to provide "an increased supply of housing to meet the needs of present and future generations" and create a built environment that reflects the community’s needs and "supports its health and well-being".

29. Indeed, the Department for Communities and Local Government has revealed that government spending on housing-related support results in savings to the public purse, primarily in health and social care costs.

30. At Anchor, we believe that new housing for older people should be exempt from the planning restrictions that apply to mainstream housing. At present, care home developments are exempt from some section 106 requirements, but other accommodation for older people is not.

31. This is based on an outdated understanding of the nature of housing and care for older people. It fails to acknowledge that many people in retirement housing receive support or care, discourages the development of suitable housing and works against efforts to enable people to stay independent for longer.

32. With extra-care and new models of integrated housing and care blurring the boundaries between what is a care home and what is retirement housing, such a planning distinction seems increasingly archaic. Extra-care developments are also subject to an increasingly costly regulatory regime, which makes it more difficult for specialist housing to stack up financially than mainstream housing. Couple that with the extra costs of regularly having to go to appeal in order to develop in the first place and it's clear that developing older people's housing can be an uphill battle.

What should be done now, what practical actions are needed and how can we stimulate national debate about these issues?

33. The recommendations of the Dilnot Commission should be acted on to begin to resolve the issues surrounding social care funding, most notably around fairness. It must be recognised however that while the recommendations are a significant step forward, lack of funding will continue to be an issue.

34. Anchor is part of the Housing and Ageing Alliance which has called for a number of practical improvements, including the delivery of more and better housing options for those in later life. As the alliance points out, nearly a third of all homes are already lived in by people over retirement age and older people will account for nearly half of new household growth by 2026. More and better accommodation suitable for older people is urgently needed.

35. Local authorities can help by developing housing related policies and practical initiatives that enable older and disabled people to live independently in their own
homes for as long as they wish. But most importantly they should plan for and build a range of retirement and supported housing options across all tenures. All new homes should be “future proof”, having features which enable people to live independently across their lifespan.

36. Local authorities should develop housing and neighbourhoods that foster community involvement and improved well-being. They should also provide good advice on housing options and practical help.

37. The provision of independent, impartial information and advice about later life housing and care options, alongside help with home adaptations, is key.

38. On demographic change more widely, Anchor’s view is that the issue is one of accountability. No single individual in the Cabinet is responsible for thinking holistically about the range of areas affected by demographic change. Identifying one individual who is accountable and who is responsible for ensuring the various government departments act in a co-ordinated way would give greater focus to the issue and enable greater scrutiny.

31 August 2012
TUESDAY 4 DECEMBER 2012

Members present
Baroness Blackstone
Lord Filkin (Chairman)
Baroness Finlay of Llandaff
Lord Hutton of Furness
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Professor Sara Arber, Centre for Research on Ageing and Gender (CRAG), Surrey University, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, General Secretary, Fabian Society, Professor John Hills, London School of Economics.

Q537 The Chairman: Hello. Thank you very much for coming. I am sorry that we have kept you waiting; it is a bit of a habit of ours, as you can probably guess. You know essentially what the committee is about. It is asking a relatively simple question: are we as individuals, as a society, in terms of our policies and services, ready for the ageing changes that are coming? That is our focus. We are particularly interested in hearing your evidence today on the subject of inequalities around this agenda. If you would introduce yourselves, we will move straight into the questions.

Andrew Harrop: I am Andrew Harrop. I am General-Secretary of the Fabian Society and, a former director of policy at Age UK, which is also relevant today.

Professor Peter Goldblatt: I am Peter Goldblatt from the Institute of Health Equity at University College London.

Professor Sara Arber: I am Sara Arber from Surrey University and I am co-director of the Centre for Research on Ageing and Gender.
Professor John Hills: I am John Hills. I am the director of the Centre for Analysis of Social Exclusion at the London School of Economics. It may be relevant that I was Chair of the National Equality Panel, which reported a couple of years ago.

Q538 The Chairman: Thank you very much indeed, and welcome. You can see who we are and you probably know a number of us as well, so I will not go around the table.

Effectively, we are breaking the subject up into questions about gender, health, income and wealth and intergenerational issues and then about social care funding. Those are some of the blocks of topics. Let me start off on gender, if it is not too inappropriate for me to do so, and ask Professor Arber initially, and then other witnesses as they wish: how does the experience of ageing differ for women as compared to men?

Professor Sara Arber: There are four critical differences. One is that the life course differences between men and women are fundamental. Women enter old age having had key roles in caregiving for both children and older people, which have reduced their role in paid employment—more part-time work, more fragmented careers, lower pay and so forth. That clearly leads to gender inequalities in pensions and income. That is a fundamental difference. The second difference relates to marital status. Nearly half of women aged over 65 are widowed. When you get to those aged over 85—the oldest, who need the most care—more than 80 per cent of women are widowed. That contrasts very much with men, where a minority are widowed. Even over the age of 85, about half of men are married. So women can expect to be widowed; men can expect to die married. This has a major impact on caregiving, support and so forth.

Another change that we are seeing in marital status is in the number of divorced older people. This obviously reflects the cohort of people who have been divorced in their 30s and 40s, who are now in their 70s and 80s. Older women who are divorced are particularly disadvantaged because they do not have shared pensions, and so forth. Older men who are divorced are also disadvantaged, because they often have very bad social networks, and so on. We need to take seriously issues about gender difference in marital status among the older population.

The third critical factor is living arrangements. Older women are much more likely to live alone. Nearly half of women over 65 live alone, and that proportion increases over the ages of 80 and 85; compared with men, who are much more likely to be married and not living alone. Obviously, if you are living alone, you have not got access to caregivers living in the household. If you need care when you come out of hospital, who do you rely on? So there is a greater need for family caregiving from outside as well as state support, and so forth.

The fourth difference, which I think we will be talking about later, is that older women have higher levels of disability and functional impairment than men. There is the old adage, “Men die, women get disabled”. Women are much more likely than men to have musculoskeletal problems, and so forth, and therefore need more care and support.

Crosscutting all these factors are class and ethnic differences. There is increasing ethnic difference among older people, which was not an issue in years gone by; but class differences are fundamental.

The final thing is that when we are talking about older people, we are primarily talking about older women, because of mortality differences. 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 we talk about the care needs of the oldest old, we are primarily talking about older women who are living alone, widowed, vulnerable, and so on.

**The Chairman:** Any additions from others on that before we turn the question to the policy implications?

**Andrew Harrop:** I totally agree with all that. It is worth noting that the trend is moving slightly away from what Professor Arber just said. There are more men in late old age and therefore more couples in late old age than was previously the case, which obviously has positive implications. Also, there are specific issues for older men who are on their own, partly because [late old age] is such a feminised world—there are few other men and social networks and services are oriented around women—and partly because they often do not have the life skills that they need to cope well or to care for a partner in late old age.

**The Chairman:** But it is an adjustment; the big picture is still largely true.

**Professor Peter Goldblatt:** One of the other trends is what is happening among people in their 50s and 60s just before they retire, where you are getting more divorce and cohabiting at that age, which slightly complicates the picture but does not undermine Professor Arber’s basic message.

**Professor John Hills:** I would not disagree with anything that Professor Arber said. I only stress that the issue of caring sets in earlier in pre-retirement—often daughters caring for parents. That obviously has an effect on their labour market participation and transition into retirement. The process starts earlier, not just at pension age.

**The Chairman:** Let us hear from Lord Mawhinney, and then we shall start to look at some of the policy implications, although we may pick that point up under the specific themes of income, wealth and health.

**Q539 Lord Mawhinney:** Professor Arber, you gave us four reasons why the gender disadvantage is towards women. Can you give us one example of where gender differentiation is in favour of women?

**Professor Sara Arber:** Yes, and that is that older women often have stronger friendship networks and may have stronger family support networks than men. This comes back to Andrew’s point about men who are alone, who often have less good friendship networks because their wife has been the one who organises the friendships, and so on. Women often cope better with widowhood than men do. Men often remarry quite quickly. Divorced men are often disadvantaged because they do not have very good relationships with their children. Whereas widowed men have very good support from their children, divorced men have often had fractured relationships after the divorce. They are a minority, but they have less good support networks.

**Lord Mawhinney:** So why did you think that it was not worth mentioning that when you made your original presentation?

**Professor Sara Arber:** I had it down originally but I did not know how much time we would have. You are right; some groups of men are disadvantaged; that is important and the social support is important; but that does not detract from the fact that the majority of men are married and have very good support from family and everything else.

**The Chairman:** Can we touch on the policy implications of what you have described? We will come on to health and income in a minute so let us pick those questions up then. Are
Professor Sara Arber, University of Surrey, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, Fabian Society and Professor John Hills, London School of Economics (LSE)—Oral Evidence (QQ 537-553)

there any other particular policy implications you would like to draw our attention to in terms of gender differentiation?

Professor Sara Arber: The gender differences come out when we look at financial security and caregiving.

The Chairman: That is much tidier. On to health. Baroness Finlay.

Q540 Baroness Finlay of Llandaff: You have already mentioned health inequalities as a differentiator. What could be done to tackle them? We are talking across a broad range, but are there particular geographical differences in health inequalities that are putting that into even sharper focus? The question is initially addressed to Professor Goldblatt but then it is for others to come in.

Professor Peter Goldblatt: In understanding health inequalities in the elderly, you need to understand that there are two processes. One is linked to birth; the other essentially to death. The way that that operates is that there is the effect of the life course and the socio-economic inequalities, which mean that people arrive in old age lacking wealth, in particular, but also with poorer pensions and having accumulated health disadvantage throughout their lives. That strand operates. The broad message on that is that poorer people live shorter lives and spend more of those short lives with an illness or disability. Those who arrive at pensionable age—many do not—are more likely already to have an illness or disability. Broadly, that is the life course effect.

Then a second effect operates, which is the ageing process. The simplest way to think of that is to look retrospectively from death. We know, for example, that about half of acute spending on an individual is concentrated on the year before death. As we approach death, at whatever age it is, our health needs increase and those people who are approaching death—over a process of years—have an inequality compared to people who have many more years to live. A lot of the inequalities we see in older people are related to the process of developing ill health. As we have heard from other evidence, that process can lead to impoverishment, both social impoverishment in terms of social isolation and the need to afford care, using up what resources people have.

Those two processes are operating. For any individual at a particular age, it will rather depend on the balance between those processes, but 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. A particular issue there is dementia. There is a lot of evidence for what is called salutogenesis, which is that, even in disadvantaged circumstances, people who can make sense of their environment are more likely to be healthy, survive longer and report better health. Obviously, if your mental capacity goes, you can make less sense of your environment, so there is a much more rapid decline in health. People with those sorts of mental health problems are disadvantaged compared to other older people.

Baroness Finlay of Llandaff: And is a differential driver now emerging between those areas which are economically doing better, so that people’s capital resources, which may be tied up in property, are going up in value; versus parts of the UK where they are dropping in value and may even be heading a few people towards negative equity?

Professor Peter Goldblatt: The regional differences in health are quite long-standing, so the life course that people typically lead in those regions, if they are socially disadvantaged, is worse than the life course of those who live in the most advantaged areas. In terms of the
It is debatable what property prices mean. Other forms of wealth which you have accumulated over life—John can probably answer better on that—have a bigger effect on the elderly. If you can use your property to buy care later in life, then it is an advantage.

Baroness Finlay of Llandaff: Turning to Professor Hills, then, taking that evidence, is there anything that we can do in a policy direction to tackle those inequalities and remove some of the bigger problems as people get older?

Professor John Hills: One thing I would point to is what happens much earlier on your life course. To think that we can pick up health inequalities when people are into their 60s and 70s without having thought of it when they were in their 30s and 40s is probably a mistake, although I think that Peter and his colleagues will know much more about that. I am thinking of two things in particular. The obvious ones that are familiar to everybody are lifestyle, diet, smoking, drinking, “five a day”, and all that stuff. I am not sure that there has been as much emphasis on working conditions in the middle of people's working lives and the long-term effects of job strain, of people who are in jobs where they are simultaneously under pressure but have very low control over their work. The group that Peter is a part of has done a lot of work on that. Perhaps we should realise that there are very long-term consequences of working conditions.

Baroness Finlay of Llandaff: Could you steer us to a seminal paper on that?

Professor John Hills: There have been a lot of studies on that. I could point to an excellent PhD thesis by Doctor Ben Baumberg, who is at Kent University these days, but there are many studies using the Whitehall II study by Peter's colleagues.

Professor Peter Goldblatt: We commissioned a summary when we produced a publication for the Department of Health called Fair Society, Healthy Lives. One piece of work we commissioned was on work and employment by Professor Johannes Siegrist. That contains a good summary of the evidence. We have asked him to update that, and that will be published early next year, looking right across Europe at what John describes as work stress and effort-reward imbalance in work. Those are the two factors: the control you have over the work you are doing and, indeed, over your life more broadly; and the balance between the effort that you put in the work and the rewards, which may not be financial rewards. They both have a huge effect on things like cerebrovascular disease, which not causes not early death but dementia in old age, so it is a double whammy. He has published a paper which shows the same pattern across 11 countries in Europe; it is not special to this country.

Q541 The Chairman: Anything from others on health inequalities and what we ought to be thinking about as big issues or big shifts in policy or service?

Professor Sara Arber: Can I just add two points relating to the point that Peter and John have already made? When we are talking about extending working lives and people working longer, there are all sorts of issues about whether people can get jobs, but those jobs are very class-differentiated. If you are a university professor, it is wonderful to work into your late 60s. You have autonomy and control. If you are working in a supermarket and have lack of control and you are in your late 60s, that will have much greater adverse health consequences. We also know from research that, with ageing, you need longer recovery
times to recuperate the body, and so on. \(^9\) We need to be very careful about the class-differentiated health impact on people who are working longer in jobs which are stressful where they do not have that autonomy.

My other point on class inequality is that another double whammy is that, if you are working-class, you are more likely to have ill health, but you have less resources to cope with that ill health. If you are an older person and you have not got a car, you cannot afford taxis to hospital and all these other things, coping with health problems is a much greater burden and stress on both the older person and the other family members. We need to look at class inequalities in resources to provide care and support to people with ill health [and disability], which are very strong; and they are obviously gendered as well, because women living alone have less access to cars.

**Andrew Harrop:** The main point that I want to add is that the evidence suggests that inequalities are widening, so it is not a static situation—not widening by very much but obviously, if this continues indefinitely, it has big implications for the whole texture of later life in retirement. You will have more people alive from the more affluent groups and big issues around the transition between work and retirement.

I have a couple of points to make about late-life specific issues—which, I totally agree, are not determinative but which we should not neglect either. Transitions into retirement can be important—how well you make the transition. There is evidence that some men make the transition less well than women because work is such an important part of their identity.

Echoing the point that Sara just made, it is really important to focus on how people cope with and progress through ill health, rather than seeing it as an inevitable decline. Most people in late life have periods of good and bad health. They cope or they do not cope; they recuperate or they do not. Partly that is about the quality of services but it is also about their own internal resources and networks. You do not want to be defeatist by saying that health trajectories are set in stone; the quality of rehabilitation and the emotional and mental support that people have can make a huge difference.

**Q542 Baroness Blackstone:** Are there the same patterns of social class inequalities in mental health among elderly people as there are in physical health? Is there any evidence on the subject of people retiring and then becoming mentally insecure or depressed, partly because of high levels of inactivity and being cut off from the social life and employment life that they are familiar with?

**Professor Peter Goldblatt:** Again, it depends on the type of mental health problem you are thinking about. In terms of the predominant one with ageing of dementia and related illnesses, yes, those are socially graded, for the reasons I outlined earlier. Another key factor which we have not mentioned is the process of leaving employment. Long-term unemployment in your 50s or being labelled as moving into permanent sickness in your 50s is a very bad transition into retirement.

What you said at the end is particularly relevant: the issue of social isolation. Whether the individual becomes socially isolated because of social disadvantage or because of increasing health problems, irrespective of their social background, there is a lot of evidence that social

\(^9\) “Subsequent comment by Professor Sara Arber: “Older workers have been found to have a significantly higher need for recovery from work after performing psychologically and physically demanding work compared to younger workers. See J J Devereux and L W Rydstedt (2009) ‘Does the older workforce with high work demands need more recovery from work’, in P D Bust (ed) Contemporary Ergonomics, Taylor & Francis.””
isolation leads to worse health. In terms of policy initiatives among the elderly, focusing on social isolation is the key entry point—John said this—you need to deal with things earlier in life if you are going to do it well, but if you are going to look among the elderly population, addressing the issue of social isolation is important. That relates to housing, social care support and integrated transport for older people. So there is a range of things that you can do to mitigate—

**Baroness Blackstone:** You did not mention work, unpaid or paid, as a mitigating factor.

**Professor Peter Goldblatt:** I would absolutely agree that the ability to get work, as Sara mentioned, when you are retired depends on having good health and your skill levels. Based on educational attainment, we see that there are huge gradients in health, social isolation and social exclusion in older age. Your ability to get work is socially determined.

**The Chairman:** To conclude on this, what needs to change? I know that that is a silly question, because it is all of Marmot, but focusing on older people and health inequalities. What two or three things do you think that we should focus on?

**Professor Peter Goldblatt:** As you say, aside from the whole life course, if we then focus on the lead-in to retirement, people in their 50s and 60s, the factors that will make that retirement more or less successful. Long-term unemployment in your 50s can severely damage your retirement both in losing assets quickly and the psychosocial impact of long-term unemployment. The second thing, as I said, is focusing on an entry point, the factors that lead to old people being socially isolated, whatever their health conditions. That means focusing on elderly services, trying to reduce isolation but also looking at transport and housing policies, which is the start of a wider agenda, but among the elderly rather than for everyone.

**The Chairman:** Any other comments on the question I posited about what needs to change, before I call Lord Mawhinney?

**Andrew Harrop:** My comment is more to highlight a risk then identify what needs to change. There is a big risk relating to health inequalities in increasing the state pension age, raising questions about how you manage social security in people’s 60s. In principle, everyone can support the idea that with rising longevity, you increase the state pension age. There is not a problem there. But if you have a great many people who are unable to work even in their 50s, you are expecting them to be on social security for a very long time. Of course, you can support an active welfare policy and help as many people as possible back into work, but, particularly with the state pension age due to rise to 68, there are big issues, which I am sure that Lord Hutton grappled with when he was Secretary of State. Are there some people who you just cannot reasonably expect to have the full regime of welfare-to-work placed on them all the way through their late 60s? That is a tricky issue that widening health inequalities will make much harder.

**Q543 Lord Mawhinney:** I should like to set aside the economic discussion for a moment and focus on the social, particularly what you were saying, Professor Goldblatt. If the social environs affect health, I am slightly surprised—not at the principle, because that is fairly obvious—but because today, probably more than at any time in our history there are more charities, more opportunities for voluntary work and to contribute. There is more social involvement potential than perhaps in recent history. Is there a danger that we will be led to think too much of what can be done for old people rather than focusing on ways to galvanise older people to take advantage of all the increasing social possibilities that there are? Is that a danger? Are we likely to fall into thinking, “What can we do for them?” rather...
than, “How can we stimulate them to go out to solve, at least in part, their own social problems?”?

**Professor Peter Goldblatt:** We go back to the question of control. It is about giving older people control over their lives to be able to go out and have active social lives. That is the simple answer. The slightly deeper answer is that the countervailing force to greater charities, et cetera, is the ability of families to care for older people when they are geographically disparate. There has been more mobility, so you will find more isolated older people. I think you have discussed what you could do to ensure that families were able to care. One of the key areas that has been put forward is for the young elderly to support the older elderly, which is mutually beneficial, because it is a spectrum as you move into older age. You are then part of a network of people; you are not socially isolated. It is a win-win situation if we can create those conditions. It is, as you say, creating the conditions in which people can help themselves.

**Lord Mawhinney:** Forgive me, but I do not think that that is what I am saying, so let me try again. Let us pick a city at random. Let us pick Peterborough. If you go to Peterborough today, you will find more charitable activities, social activities, community groups than, probably, ever in the history of the city. It does not matter whether the family lives in Bournemouth. Those all exist within walking distance or a short bus ride of anybody who lives in the city of Peterborough. Setting aside all the other things which you moved into in your answer, what is the explanation for why people do not avail themselves of those social opportunities? It is not really a question of control, is it?

Take somebody who works in a supermarket or a factory in Peterborough. They have time which is their own, day by day and at weekends. Is there something that we ought to be doing to say to the Government: “You need to find ways to mobilise people to take more responsibility for their own social activities, because that has a health-giving effect”?

**Professor Peter Goldblatt:** I think that when individuals start becoming older and less able to be self-reliant, it is probably too late for them to then participate in those activities, as their ways are set. They are then more concerned about their physical disabilities. That is why I suggest that we engage earlier in their trajectory to old age, not when they are still working 24/7, as many more people are these days, but as they are moving into retirement or have moved into early retirement, and look at ways to get people who could be doing full-time jobs but are doing part-time jobs to be more engaged in their community.

**Professor Sara Arber:** There is quite a lot of work on the extent to which older people, and other people, engage in voluntary activity, which shows that areas with the greatest social capital and affluence have the greatest proportion of people who volunteer.\(^92\) That is great, but it means that—I know that Peterborough is in the middle—if you go to some really disadvantaged inner-city areas, you have not got that. You need the health capital to be a volunteer. You need to be healthy. You probably need some resources—a car or some money to go wherever you are going—and the energy to do it. Yes, volunteering is great, but 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.

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\(^92\) “Subsequent comment by Professor Sara Arber: “For example, the Pathways through Participation ‘Briefing Paper no. 3 – Who participates? The actors of participation’ showed that volunteers were more likely to have a higher educational level, be in more managerial occupations, be more affluent, employed, and white. [http://pathwaysthroughparticipation.org.uk/wp-content/uploads/2009/09/Briefing-paper-3-Who-participates.pdf]”"
Baroness Tyler of Enfield: I want to pursue the issue of income and wealth inequalities. My question is initially directed to Professor Hills. We have already heard in this session about some of the potential drivers about health: geography, socio-economic inequalities in earlier life, employment, skills history, family size and structure and whether people have inherited or not. Can you give us any sense of how those all interact as people enter older age and what are the most critical drivers of income and wealth?

Professor John Hills: I will try my best. First, there is evidence on age differences across a range of economic indicators, including income, wealth and earnings, in the report of the National Equality Panel, which is available online, which you may find helpful for precise numbers, because we tried to cut everything by everything, and age was one of the things that we looked at.

One thing that leapt out of all that analysis is that it is often easy to think about differences between groups—we often think about gender differences in pay, for instance—without concentrating so much on differences within groups. Age is very important in that respect. People talk a great deal about the differences in wealth and income between the baby-boomers and the young without thinking about the considerable wealth differences within the older population. If you look at the wealth that people have as they head towards retirement, the cohort aged 55 to 64, there is a difference of 50:1 in wealth between the people near the top, the 90th percentile, and the people near the bottom, the 10th percentile.

Sometimes people think that wealth differences are about the life cycle: people build up their assets and then spend them down in retirement. Actually, there are considerable differences within each age group. Looking back to the discussion that we just had, the piece of evidence that I was most struck by in the whole National Equality Panel exercise was the research done on the English Longitudinal Survey of Ageing. We are very familiar with mortality differences when we cut by social class or education, but actually, as a single indicator, 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.

Having made that point, where are these things coming from? Starting with income, we have talked about a lot of this, but a lot of income differences at older ages are about pension rights, and pension rights are hugely skewed. Lord Hutton will be very familiar with the differences between men and women and the particular differences between people who were higher paid and people who were lower paid in terms of whether people have taken up occupational pensions, the level of occupational pension they get and the extent to which the state has assisted through usually generous tax reliefs in the accumulation of those pension rights. Wealth difference is also clearly related a great deal to tenure—whether people are owner-occupiers and, if so, precisely where they live.

One of the biggest drivers in a lot of this is simply luck. If you happen to have been able to buy a flat in 1982 with part of the deposit coming from an inheritance from your grandmother—I am speaking personally here—you see the effect of entering the housing market at a critical moment as opposed to people who are entering it after the huge increase in house prices, which has subsided only slightly. That creates very big differences; only some people were beneficiaries of that. It varies hugely across the country but also within age groups. There will have been luck as to what kind of employer you worked for:
whether it was a large employer or a small employer. That will have fed through. There will have been luck in terms of inheritance, probably coming through to people in their 50s, and whether that cascaded down to grandchildren to allow them to enter the housing market. A very large proportion of young first-time buyers are now getting assistance effectively from older relatives one way or another, either from inheritance or from parents who have paid off their mortgages and are able to take that on.

So we have those two different things happening. One is a process that is relatively predictable through the life course, the advantage reinforcing itself as you go through in terms of what people enter older age with. There are also these very big random factors, such as—we will come on to this later—whether an older relative had care needs and therefore needed to sell the house or whether they were one of the lucky ones whose older relatives did not. Some will pay very little by way of inheritance tax. That kind of gamble will affect what people end up with in their 50s and what they take into their older age.

Q545 Baroness Tyler of Enfield: One quick supplementary just to check that I understand what you are saying. I found that extremely helpful and we will certainly want to look at the age analysis of the National Equality Panel. That will be a very helpful source of information for us. I sense that what you are saying is that if the question is what can the Government do about some of these huge social and economic issues, the biggest single thing they could do about the amount of money that people enter older age with is around pensions. Am I putting words into your mouth there?

Professor John Hills: I have a bias there, but I do not think that it is the only thing that is important. Pensions are clearly important. The good news is that the pension reforms that are working their way through from the two Pensions Acts are very important in at least beginning to stabilise the situation. There is the reform to the state pension system by making it easier for women to qualify for a full state pension over a shorter length of time; the move back to linking pensions to earnings, or indeed to be triple-locked, rather than to prices; and the automatic enrolment, which started rolling out in October.

All of those will help, set against the background that they are measures that are designed partly to offset the decline in pension accumulation over the past 20 years. We have a generation that has retired with the best rights from the state second pension—what was SERPS—and with the most generous private sector pensions, where half of the working population were getting them. Their successors will to a large extent have less good rights in both respects. Some of the measures on the basic pension and automatic enrolment will help with that but, by themselves, they will get only part of the way to what people would regard as being an adequate income in later life.

Baroness Tyler of Enfield: We explored some of that in our session last week.

The Chairman: Any comments from others on income and wealth inequalities and what, in a world of fiscal realism, can be done?

Professor Sara Arber: I just reinforce John's point. I think that the state pension is critical for women and gender equality. To increase the level of the state pension has the greatest equalisation between the genders and is the most important. The new auto-enrolment pension is good, but women will still be disadvantaged because, to the extent that women are interrupting their careers to have children, working part time, ending up in low paid jobs, and so on, they will end up with small amounts of the new pension as well.
Professor Sara Arber, University of Surrey, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, Fabian Society and Professor John Hills, London School of Economics (LSE)—Oral Evidence (QQ 537-553)

We have also to see the interconnection between elder care policies and childcare policies. We are talking about older people, but childcare makes a difference. What we have at the moment is that because childcare in Britain is so incredibly expensive, either it is not worth women working because the cost of childcare is so high that they leave the labour market and that has knock-on consequences for their own pensions, and so on, or they say, “I’ve got to keep working to pay the mortgage”, and the grandmother stops working to look after the grandchildren. We have a fundamental issue here. Women in their 50s and 60s are often leaving work to look after their grandchildren because of the expense of childcare.

Those women are then disadvantaging their own income and pensions.

We need to look at the interconnections between our care policies—childcare as well as elder care—and our labour market policies, because it may not be possible for women to work, given the current arrangements, because of their need to provide caregiving.

**The Chairman**: Well argued, but I hear you almost hinting that we need to increase state subsidy for childcare. Is that what you are arguing?

**Professor Sara Arber**: Yes. That will have a major impact on well-being in later life both for the current generation of women who are working who do not have to interrupt their work, can carry on working full time, carry on in their careers and not have the pension penalty caused by interrupting their careers and for older women who are not leaving the labour market to care for their grandchildren.

**Baroness Finlay of Llandaff**: Might the flexible working policies contribute to solving some of that problem?

**Professor Sara Arber**: Yes, but if you are working 80 per cent, that is okay, you can carry on in your job, but if you flexibly go to part time work you may still be losing quite a lot.

**Q546 The Chairman**: Are there other comments on income and wealth before we move on, in a rather frustrating fashion?

**Andrew Harrop**: I take a very different view on the prognosis for income inequality and for wealth inequality. On income inequality, I am quite bullish. If we look over the past 30 years, we have made incredible progress in the incomes of older people, particularly low-income and middle-income older people. If we exclude the top 2 per cent, who have done very well, just as they have in working age, and look at everyone else, inequalities in old age for income have not increased. If we look at the future reforms, which John was obviously involved in recommending, if you believe the modelling of both the state reforms and the private pension reforms, we should do pretty well over the next 30 to 50 years in terms of the level of income of older people and replacement rates when they retire—certainly if you compare that to the very gloomy outlook for working-age lower and middle-income groups at the moment. On incomes, I do not want to be complacent, but we have a set of

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94 “Subsequent comment by Professor Sara Arber: “A large number of research studies have demonstrated the substantial penalties in the UK of women moving from full-time to part-time employment after they have children. These include financial disadvantages, reduced promotion prospects, and much poorer pensions. For example, see research by Jay Ginn, including J. Ginn (2003) Gender, Pensions and the Life Course, Policy Press.””
reforms in train. We need to keep them under review, but in terms of preventing income inequality from rising we should be at least there or thereabouts.

On wealth, I am incredibly concerned that we will see increasing wealth disparities. You can think about that simply as an effect of longer lives. People have longer to save, but saving rates are higher for richer groups than for poorer groups. Over the past 50 years, asset inflation has outstripped earnings inflation so again, if you have longer to save, those disparities will widen. Put on top of that what we have seen with regard to house prices and other equity bubbles and, assuming that that pattern continues, wealth inequality will widen and widen. That is a very pessimistic scenario not just for individual well-being but for our broader social fabric.

The Chairman: That is very helpful. John, do you want to qualify the first point about income disparities?

Professor John Hills: No I don’t. Income disparities are lower than in working life and much lower than wealth inequalities in older age groups. I wanted to say something about the sheer incoherence of policy towards wealth accumulation. This affects both sides of the public accounts. You can contrast somebody who does things that professionals would expect to do, that is, build up tax-privileged pension rights as much as they can, with a lot of advice to do that, invest in an effectively tax-free house, apart from a very small amount of not very progressive council tax, with the ability as a couple now to pass on £650,000 tax-free to their children. If you look over a lifetime, I suspect that for many of us the state will have added to our lifetime saving. You can contrast that with people in a different situation, with much lower incomes, who may not have been members of pension schemes, who may latterly have their money in an ISA but in the past, perhaps still, have money in a savings account with a very low return because it is taxed on the nominal return. They might still reach retirement with a little nest egg, but they then find themselves 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.

On the one hand, there is one group of people who are having their assets added to by the state—that sometimes includes people who have benefited from things like the right to buy, and there will be a cohort coming through with child trust funds, and so on—but by and large, the better off you are in your working life, the more the state is likely to have done. Then there is another group where we will use wealth as a means test, an asset test, and people find themselves penalised for having saved. It seems to me very strange that we have that mix.

The Chairman: Very clear and very interesting. Let us turn to intergenerational inequalities.

Q547 Lord Hutton of Furness: As you would expect, the committee is focused on the issue of ageing, but we are also very interested in the question of intergenerational equity. It has been suggested to the committee in earlier evidence that there is already a serious generational unfairness in public policy today, in that older people are already generously treated in terms of both public spending and taxation, whereas younger people tend to be the net losers in that overall equation. I ask each of you for your respective views on this issue.

Professor John Hills: I think you need to divide the question into two parts. One is about the way in which successive generations have been treated across their whole lifetimes. The
Sometimes there is rather loose talk about whole generations that were the big gainers from the growth of the welfare state and did not pay anything in and younger people who are getting nothing out. By and large, a huge amount of the welfare state part of public spending comes to people in later life. Education comes earlier, by and large, but pensions and the bulk of social security spending and healthcare come in later life. Younger people will always be paying in more as a group and older people will be, as it were, net gainers from the situation at that time.

However, as policy has developed and as society has aged, different cohorts have been treated in different ways. A few years ago, we attempted to put numbers to that and look, five-year age group by five-year age group, how much people had put in and how much they had got out. We found a surprisingly balanced picture. There was a group born between 1900 and 1920 whom you could identify as being the people who benefited from the welfare state, growing up without having had to pay very much tax for it. There is also a group, possibly including my own cohort, now in their 50s, who may well be gaining from the slow adjustment of state pension ages to increased longevity. We may get a bit more out than we put in. But we are talking, depending on how you measure it, about different cohorts getting out between 100 per cent and 110 per cent of what they put in, which is not a big difference. Such differences can be exaggerated.

What is much starker is what is happening at the moment in the extent to which the pattern of state spending on the welfare state is becoming more age-related. If you look at the list of things that have been most subject to cuts and the things that are most likely to have been protected, you see an age difference. Although it is still under pressure, the health service is protected, state pensions have actually improved, council tax benefit for pensioners has been protected, winter fuel payments, free TV licences and all those things have been protected. Against that, of course, older people are losing local authority care services, and so on, and a higher state pension age is coming in for women who are in their 60s at the moment, and there has been a reduction in the value and then abolition of the age allowance, but interestingly, all hell broke loose when the abolition of the age allowance was accelerated in the Budget earlier this year. Contrast that with what is happening to working-age benefits: linking to the CPI or possibly not even that, benefit limits, possible caps on numbers of children, housing benefit restrictions. We are now likely to see 20 per cent minimum council tax benefit payments for working-age people, whatever their income, however poor they are and of course, at younger ages, cuts in education maintenance allowances, youth provision, child benefit frozen, and so on.

Although in a cohort intergenerational sense, it is hard to substantiate some of the talk that the baby boomers got all the money and young people haven’t got it, when you look at the balance of fiscal adjustment at the moment, it seems to be quite strongly age-related.

**Professor Sara Arber:** Can I link this by looking at intergenerational transfers? Now, because the younger generation has to pay for education, cannot afford housing, et cetera, there are a massive amount of intergenerational transfers from the older generation to the younger generation, but that is hugely class-related. My three middle-class children received money to buy their first house, they have not got any student debt because I helped them. I went to university and had a grant, so I decided that it was fair to them to give them the money to pay for their education and not have a debt. [Reference to individual removed] comes from a more working-class family. He has still, at the age of [removed], got £20,000...
Professor Sara Arber, University of Surrey, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, Fabian Society and Professor John Hills, London School of Economics (LSE)—Oral Evidence (QQ 537-553)

of debt. Fortunately, they were able to buy a house because I could give them the money; his family could not; and that was fine. Many of my daughter’s friends have bought houses now because their parents have enough money to pay. Others have not. They are exactly the same educationally. They have degrees, but they cannot afford to get on the housing ladder because they come from a divorced family, or whatever. They do not have those resources. When we are talking about the younger generation being disadvantaged, it is because their parents do not have the financial resources to support them.

What we are seeing now is that, because of house prices, the cuts to education funding, and so on, intergenerational transfers are now incredibly important for supporting the middle generation and the younger generation, but they are entirely class-related.95 Similarly with issues of co-residence. If you are middle-class and have a big house, that is okay; if you do not, it is difficult for your 20-something or 30-something children to live with you. I come back to childcare and grandchild care. It is the working class who are doing the regular grandchild care and pauperising themselves96; whereas in the middle-class either the parents can help with the grandchild care or the young people have been supported [by their own parents] to have a good enough employment and education situation to pay for their own childcare.

So yes, the older generation may be benefiting in many ways, in the ways that John said, but a lot of that income does not stay with the older generation, it passes down to the middle generation [adult children] because they [parents] want to support them in whatever way they can. It is not a level situation; it is entirely class-linked.

Andrew Harrop: I strongly agree with both the previous comments. The issues that Professor Arber just talked about all go back to the housing market. The cost of housing in large parts of the country is far higher compared to average earnings than it has been historically, although prices came down a little after the financial crisis. That drives all the inequalities: between different generations; different classes; north and south; homeowners, tenants and landlords. Perhaps intergenerational distribution is the wrong prism through which to focus on an issue that I think is mainly driven by our housing market being totally dysfunctional.

I very much agree with what John said. The two phrases to think about are intergenerational fairness and intertemporal fairness—in other words, have we got the right balance over each of our lifetimes? As John said, I think that, broadly speaking, intergenerationally, the long view looks alright, as long as you believe that the future taxpayer can honour the obligations implicit to young people today, as they fund older people’s consumption of welfare and the NHS. If you believe the numbers from the Office for Budget Responsibility, the long-term public finances are broadly stable and manageable. That means that young

95 “Subsequent comment by Professor Sara Arber: ‘A range of research studies have shown the class divided nature of transitions to adulthood, for example, see Gill Jones (2002) The Youth Divide: Diverging paths to adulthood, Joseph Rowntree Trust - http://www.jrf.org.uk/publications/youth-divide-diverging-paths-adulthood””

96 “Subsequent comment by Professor Sara Arber: “Lack of affordable childcare means that working class parents in particular turn to grandparents for daily childcare (or a regular commitment of childcare on 2-3 days per week). Research has shown that employed mothers have a heavy reliance on grandparent care and that some grandparents give up paid work in order to provide regular childcare. For example, see: Dench, G. and Ogg, J. (2002) Grandparenting in Britain: A baseline study, London: Institute of Community Studies; Wheelock, J. and Jones, K. (2002) "Grandparents are the next best thing": Informal childcare for working parents in urban Britain’, Journal of Social Policy, 31 (3): pp 441-463; and Glaser, K, Montserrat, E.R, Waginger, U, Price, D, Stuchbury, R, and Tinker, A. (2010) Grandparenting in Europe, London: King’s College London and Grandparents Plus.”
people today can feel fairly confident that they will receive something like what they have paid in.

Turning to intertemporal issues, the issue is basically whether we have the right balance about when in our lives we pay in and take out from the Exchequer. There is a sensible debate to be had about the balance. Looking first at paying in, older people are undertaxed relative to their ability to pay, relative to their incomes. Notwithstanding that they tend to have more assets, on average, an older person on the same income as a younger person will pay less tax. Whether this should remain the case is a legitimate debate. As John alluded to, politically that debate is very difficult, but we need to accept that in terms of both wealth and, to some extent, income, older people are undertaxed. That does not mean necessarily having age-specific policies, but it does mean designing your tax system with these issues in mind.

On consumption public spending, others have made points about the short-term profile of spending cuts: is it 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? For example the government is not making sure that in-work tax credits are sufficiently generous to incentivise work, which the universal credit will not. The point has already been made about childcare. We need to ensure that we have a state that incentivises work and invests in people early in their lives as well as all the valuable things that the state needs to do to help people have a good quality of retirement.

That is not necessarily an issue about unfairness between generations; it is whether the allocation to each of us over our lifetime is right. The short-term cuts have not been focused on those important strategic issues.

**Professor Peter Goldblatt:** There is a medium to long-term issue, which is the demographic pressure of an ageing population, particularly because the years of healthy life are not keeping up with the gains in life expectancy. That in itself creates pressure on the NHS and care services to focus funding at the end of life versus focusing on younger people. As long as that trend continues, it will create some intergenerational inequity.

In terms of younger people, I just add to the point that Andrew made: we are not investing in younger people in active labour market programmes, which are one of the few employment initiatives for younger people which are shown to be cost-effective. It is not only the benefit side of things but how we get younger people into work, which allows them to build up wealth for future generations.

**The Chairman:** Thank you much for those answers. Again, we should spend a week on this rather than 10 minutes. Baroness Morgan: social care.

**Q548 Baroness Morgan of Huyton:** Yes, just a little issue. Obviously, we have heard a lot of evidence in previous sessions on social care. I think I was supposed to ask you: is the system unfair? In a sense, we have had sufficient evidence that says that it is not working at the moment and that there is real uncertainty about future funding—a significant problem in itself for people planning for the future. Bluntly, to what extent do you think that the system is unfair? To what extent do you think that Dilnot is an answer? Let us not bother too much about the figure that he suggests, but to what extent do you support the approach of Dilnot; how quickly would you like to see it implemented; and do you have any other feedback on the issue of social care funding?
Professor John Hills: I think that Dilnot helps to solve one issue, which is what he describes as being the greatest uninsured risk that people face: the scale of formal, paid-for care that a minority of people will end up needing. It does seem bizarre, given how much, as a society and as individuals, we are prepared to pay for insurance in other circumstances, that we have left this as a gamble. Often the gamble is for the inheritors as to what happens: whether full costs of two years of nursing care may have come out of someone’s estate or whether people are expected to spend down their assets to £23,000 or below.

Dilnot's proposals are aimed at that problem. They have a net cost, because you end up with people who have some assets being charged less. The interesting question then becomes: who pays for that? Going back to what Andrew said about older people in general paying a lower overall rate of tax than younger people, one might think that one might look at the way national insurance works or other measures. If you like, the people who have the most visible gain from changing the system are the people who contribute, when they can afford to, but there is a much bigger issue, which I am not at all an expert on, which is the sheer scale of unmet care needs. Dilnot is focused on one particular issue and puts forward a sensible way through, but there is the whole issue of growing care needs, the strain that local authority budgets are under, and so on, where others will have a lot more to say than I do.

Andrew Harrop: This is linked to some of the inequality and distributional issues that we are discussing today. The Dilnot proposal is to bring mid and high-income or asset groups into the public system. Therefore, distributionally, you need to think about where that money should come from. It should probably come from mid and high-income older people themselves rather than either from younger age cohorts or poor older people.

If you look at the broader problems of the social care system, I would argue that the Dilnot report addresses only one out of three. The other two are the incredibly tight needs-testing for people who are already eligible in terms of means, because their income is low enough; and not having sufficient quality or large enough quantum of care for those being told that they are passing both the means test and the needs test.

So you have three big overlapping issues, and the latter two—to increase resources there—would be very redistributive because they involve people who already meet a means test but are not getting a fair allocation of resources, particularly when you compare the situation to other public services. The obvious comparison is with the NHS. As a society, we have chosen to value medical healthcare at a much higher level than social care, relative to the quality of life improvements it can deliver. It is not a rational allocation of resources; it is because of political decisions.

What do you do about it? It all comes down to money, unfortunately. Although family care is incredibly important, I do not think that it is realistic to expect a sudden upsurge in the amount of family care available; if anything, we should expect the opposite.

Let us use very round numbers. Let us say that there are three lots of £2 billion to think about for English social care. There is around £2 billion that is being cut at the moment from whatever baseline you want to choose in the mid-2000s. There is around £2 billion of unmet need over that baseline. So already you have a £4 billion gap opening up over time.

The Chairman: This is on social care?

Andrew Harrop: This is on English social care. On top of that, there is about £2 billion to pay for the Dilnot proposals—in other words, to get rid of the means test and have the
Professor Sara Arber, University of Surrey, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, Fabian Society and Professor John Hills, London School of Economics (LSE)—Oral Evidence (QQ 537-553)

lifetime cap on liability for care. You can see immediately that you have huge resource pressures from three different directions: cuts, unmet need at the beginning of the cuts programme, and Dilnot. I would argue strongly that you need to address all three at the same time rather than to prioritise one or another—and for that we need to have a significant debate about resources first. Clearly, that is where the cross-party talks and the Department of Health’s thinking has got stuck, because Dilnot was a solution without revenue attached. I think that that is the problem at the moment.

The Chairman: If it is not prying too much into cross-party talks, is that the nature of what is happening in those discussions: that they are trying not just to get agreement on Dilnot but, recognising the argument that you have put, to address the funding and thresholds for social care support for those who will not be touched by the Dilnot changes—which, you have argued, are desperately needed?

Andrew Harrop: The Dilnot commission deliberately decided to focus on a single issue. That was partly a tactical decision because the commissioners knew that the whole price tag was so terrifying, so they tried to present a price tag under £2 billion that they hoped might be accepted as a discrete measure. But they did say that more money was needed for the whole system as well. In particular, the Labour Party has wanted to bundle those issues together, but the biggest faultline is probably between the Treasury and the Department of Health rather than across the parties.

Professor Peter Goldblatt: The first thing I want to say on the inequity of the system as it works at the moment is twofold. First, there is a social gradient in health expectancy and health, which means that the requirement for social care is socially graded. Having a means test is then inequitable because it always excludes some groups who are disadvantaged, but not as disadvantaged as those who receive the means test. That is why the Dilnot proposals are fundamentally a move to equity.

The other key point, taking up the point that John raised, is that as people get closer to death, in that last year or two of life, a large proportion of them will need some intensive social care for their last part of life. It may be a minority of their life, but it does affect a substantial number of people at that point in their lives, which is why the insurance point is so important—that we should be funding so as not to create insecurity and risk in people’s last year or two of life.

Linked to that is the issue about the spend between acute healthcare and social care, and having integrated care, because there is a lot of resource built into the NHS around that final year of life. The question is: are we using that money in the most efficient way? With greater integrated care, many elderly people could be diverted from acute hospitals. That raises a lot of issues about our capital investment in acute hospitals, but in terms of policy, integrated care, which we have failed to achieve up to now.

Q549 The Chairman: I want to stay with this for a bit, because it is obviously an issue which we have dealt with in other evidence sessions and is clearly one of the most important issues for us to get our heads around. The evidence is pretty clear even now, let alone given what is going to hit us in 10 or 20 years’ time, that there is a need for a substantial increase of expenditure, both private and public, on social care. There are also equality issues, and there is certainly the issue of integrated commissioning, which we have struggled with. My question is about the policy choices around that.
People like Chai Patel say that you can only ever address that if you renationalise social care, such that you join up at the top. Clearly, the Government are not going to do that for all sorts of reasons, because it contradicts the direction of travel of local commissioning. You have signalled that there is a big issue in the Treasury, as there would be. We sometimes naively say, if we only reshape the health service over 10 years, so we close down the acute smokestacks—you know what I mean, lots of fainting—and shift the funding into community and primary care, we would get the sort of healthcare we want. That in itself, even if you could do it, would take 10 years. So I have two questions. What is your recipe for addressing that social care funding dilemma, as opposed to the social care commissioning dilemma and the social care quality and funding dilemma?

Andrew Harrop: Ultimately, it goes back to the sources of revenue. I said earlier that under the Dilnot proposals, older people need to pay for themselves. John mentioned some possible ways to do that—national insurance or you could look at the current set of entitlements older people receive and say that if the overall amount stays the same, would older people choose for that money to be spent differently, including on social care?

The Chairman: You mean free travel, et cetera?

Andrew Harrop: When you look into the detail of those entitlements, it is questionable how much money cuts would save, given the administrative complexities, but in principle you should look at these distributions in the round rather than budget by budget. That is an issue. The second issue that I think you are driving at is: how do you make a system work where you have National Health Service national funding allocations plus a local social care system which—I am sure you have heard evidence on this—the Government tried to put a bit of a ring-fence around care funding but this has totally failed because local government funding is under such huge pressure. Although a little bit of earmarked money was available, social care has had to take the brunt of cuts, alongside other areas of local government spending.

The radical view, which is I guess your “This would take 10 years” position, is to ask: is it sensible for local government to have discretion solely over social care, given that it affects quite a small proportion of local taxpayers. It is becoming the lion’s share of local government spending particularly with education and housing being basically ring-fenced budgets.

You would not start from here. You would start by having social care and NHS services commissioned together or go to a Total Place scenario where all local public spending was given to a powerful, autonomous decision-maker to allocate as it saw fit. I think that is attractive, but it is not something to do in the middle of a major cuts programme.

Professor John Hills: Can I say something that I think is rather unfashionable, although it echoes what Andrew was just saying? A lot of what we are grappling with is about both needs and inequalities in old age. An automatic response to that is to say that the implication is that we need more means-testing, so that, rather than shelling out on winter fuel payments or whatever, willy-nilly, we should in some way restrict them to people on lower incomes because they have greater needs; and that, similarly, if we have scarce resources for social care, we need to keep tight means tests in place.

That is a mistake in not looking in the round at the way in which the system reacts to people’s resources, including the tax side of the equation. After all, you can think of the tax system as being the most effective and best functioning means test around. If you can somehow put those two things together: the expanding need for care spending and the way
Professor Sara Arber, University of Surrey, Professor Peter Goldblatt, University College London (UCL), Andrew Harrop, Fabian Society and Professor John Hills, London School of Economics (LSE)—Oral Evidence (QQ 537-553) in which it is financed through some form of taxation, there might in the long run—I am sure not at the moment—be some way forward.

We know the history of national insurance contributions, the fiction of the national insurance fund and the lack of real relation between anybody’s entitlement to a pension and what they have paid in. Yet that national insurance system does convey a deeper truth, which is that we pay in through our working lives and we get something out later on. If we had a system, as I think some other countries have, where you explicitly pay in a way that relates to your economic resources and you can see what you are getting out, you may make some of those changes more acceptable. They are clearly unbelievably difficult, but to restrict ourselves to thinking, “How do we pay for things by making more things more means-tested?” may be a mistake.

After all, we have just been through major pension reforms to reduce the spread of means-testing in old age because we want to give people a clear signal that they should be saving for their retirement. We want to avoid recreating that through a lot of other mini-means-tests. That may mean that you have to look rather further and think about both the tax side and the spending side together.

The Chairman: Very interesting. I think it is very clear, but if you read Hansard and it is not, do drop us a note to articulate it, because it is a critical issue for us.

Andrew Harrop: Just to add to what John said, the OECD has found that the UK actually has a very redistributive set of public services, even though they are basically universal. Because of what John said about tax funding and also the greater demand arising from groups who need services more, you can have open access to entitlements and still have the effect of good redistributive outcomes.

Q550 The Chairman: Thank you. Peter, and then Sara, and then we must go to the last issue.

Professor Peter Goldblatt: On the issue of funding, the term we used was proportionate universalism: that you have universal funding but the amount you provide is proportionate to social need. The second thing is that some of the changes to integrated care are not really about overall costs; they are about how you use existing staff in the NHS and social care system. The Chief Nurse today took a step towards recognising that we should not be quite as focused on acute clinical care, medically driven, and that the social needs of patients are as important as their medical needs.

Professor Sara Arber: Just to add, I think that what we are talking about is fundamentally class inequalities in later life. At the moment, if you are wealthy, it does not matter; you can pay for good care. That is happening. Similarly, if you need care in the home, there are increasing numbers of live-in carers, often coming from overseas to live in, and you pay for your own care. It is a middle-income and lower middle-income problem. They are burdened by providing care support. People say, “I’ve got to care for my mother at home for as long as possible because we will lose so much by them going into a care home”. Broadly, I support Dilnot, but the issue is how you actually fund it.

The Chairman: We are dreadfully beyond our time. Have the panel and others got a few more minutes?

Baroness Tyler of Enfield: I have got a visitor who has just arrived upstairs so obviously I have to go.
The Chairman: We will still be quorate, won’t we, because there are three of us. Ilora, do you mind if I slightly broaden the way in which we articulate the last question?

Baroness Finlay of Llandaff: You go ahead then, because I want to follow up a bit on some of this stuff too.

Q551 The Chairman: The last question was going to be about the geographical differentials in equity, but the question that came to me—the evidence we received on this from local authorities has been surprisingly light—is that, if you take what you have said about the main drivers for inequality in older age, they are clearly linked to income, social class, employment and life history. Those are dreadfully correlated in health inequalities. Geographical areas in the country where you have high unemployment and low social class will have, as we know from Marmot and others, very poor health outcomes. They will probably have a disproportion of elderly, because some of the younger will move away, to put it crudely.

You have a description there of a collection of pathologies which sound dreadful. Clearly, both local government funding and, I think, health funding, to some extent, takes account of some of that. Nevertheless, you have a description of geographical social structures where, if it is not putting it too negatively, you would worry about the sustainability, health and welfare of those local societies 10 or 20 years down the line. That is a very crude description. Does it make any sense, or am I being foolish?

Professor Peter Goldblatt: Up to a point. There is just one point where it is slightly different, but it actually exacerbates the resource allocation issue. That is the migration of healthy older people to the south coast, and that creates a distortion in the demands for services, because the middle-class, healthier old people on the south coast are very demanding. What you get in current resource allocation is something called the age-cost curve dominating resource allocation. There is evidence that the people left behind in these poorer areas have multiple health problems. Those multiple health problems are much more costly to deal with in both social and NHS terms. At the moment we are seeing resources being shifted from those areas to the south coast through the latest changes in resource allocation. That is creating an inequity that perhaps did not exist before, or existed to a lesser extent.

The second element of that is that we have also shown that there are huge differences in health according to the affluence of neighbourhoods. Our headline figure 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. In those neighbourhoods, demand on services is hugely greater than in middle or high-income areas.

Q552 The Chairman: Thank you. Any comments from others on the local concentration issue that I was positing?

Professor John Hills: Only to reinforce the point that if one looks at the geographical distribution of the reduction in local authority support where, effectively, the mechanisms that the previous Government used to give more resources to more disadvantaged areas are being unwound. Then you see really quite stark differences in the percentage reductions, which reinforce all the problems that we have been talking about. The areas that appear to be losing most are the ones where the older population probably has the least resources to cope.
The Chairman: Did you agree with my rather crude premise that the concentration of poverty, ill health and ageing populations will make the local management of some of those issues more challenging, or do you think that the funding equalisation—apart from your point—is meant to address that?

Professor John Hills: I do not think I know enough about that particular area.

Andrew Harrop: Practice varies very widely. There are good and bad examples of local government practice in very deprived areas.

The Chairman: This is a needs point, not a response point. What is surprising is that we have heard nothing from local government about either the Eastbourne issue or, how shall I put it, little pockets of the north.

Professor Peter Goldblatt: Blackpool.

The Chairman: Blackpool, exactly. If they are looking at what is going to happen to their population in 10 years’ time, they should start to worry very seriously; or am I wrong?

Professor Sara Arber: I agree with your analysis entirely. We need to look at these local areas, and the resource allocations from the health side and the local authority side need to address them. The fact that some of the policies to support disadvantaged areas have been reversed over recent years needs to be looked at and changed.

The Chairman: I am sorry; that was the worst hijack ever.

Baroness Finlay of Llandaff: It was a bit of a hijack. One issue that I was really interested in is your comment about health and social care needing to be totally integrated. I am anxious that there is a perception that you have either acute care services or chronic care services. In that, there is a lack of recognition that people who are chronically ill have acute-or-chronic episodes in which, if they are properly diagnosed and intervention is rapid, their deterioration is less than if it is neglected. An absolutely classic example is urinary tract infections in people who become confused and the stack-up of healthcare costs if they are not adequately diagnosed.

I have a real concern that in all the models of social care funding that separate it from healthcare, you lock people into being away from the diagnostics that would keep them more independent and keep social care costs down. Then you stack them up later, because they have a fall, they get a fracture, they then deteriorate, they are then stuck in hospital with all kinds of complications, when the whole thing was avoidable earlier down the road.

I wanted in the closing seconds to get a comment from you on that and the whole economics, because I have never seen an economic model that has analysed that properly.

Professor Peter Goldblatt: I think that there are some analyses. That is one of the things that integrated care should be achieving, because it is the carers of an elderly person who will identify a potential urinary tract problem initially.

Baroness Finlay of Llandaff: Or any deterioration.

Professor Peter Goldblatt: Then to have the ability to get GP-related services, and primary care, to treat that an early stage, is far better than waiting until you have a problem that needs acute hospital care and there is the difficulty of extricating an elderly, confused...
Baroness Finlay of Llandaff: You need seven-day services and you need continuity of care.

The Chairman: We have kept you a long time. Thank you very much indeed. That was an extremely interesting and valuable session. If, when you reflect on it, there are things that you felt that you either did not have enough time to say that you think that we should think about, or that we did not ask and we ought to have, please feel free to drop us a note, because this is an extremely important focus to us.
Audit Commission—Written evidence

The Audit Commission welcomes the opportunity to respond to the Committee on Public Service and Demographic Change’s call for evidence on the impact of the ageing population on public services.

The ageing population is a topic of major importance for government and local public bodies. The Commission has looked previously at the scale of the challenge and how local services might respond to it. Our work focused on the locally-controlled services within the Audit Commission’s remit, particularly primary care trusts, councils, and their partners. As such they are relevant to your question about how public services might be redesigned and transformed.

There is a need for operational changes to provide services at lower cost but also more transformational change, such as prevention, personalisation, building community capacity and a shift to independent living in the community. Our research showed that such transformational change is difficult to achieve and the pace of change so far has been slow. A particular challenge in the current financial climate is that savings from such strategies are at best uncertain and are unlikely to be cash releasing.

Our work has also considered joint working across the boundary between health and social care. We believe this offers clear potential for both efficiency gains and improving outcomes for people, even if progress remains uneven. Our research, and that of other organisations, highlights only a few examples of where it is possible to demonstrate that such partnership working has achieved efficiencies and positive impacts on people’s lives.

Looking beyond adult social care to other council services, we believe that councils should age-proof mainstream services (which can incur little or no costs) by tailoring them to older age groups. Councils can also provide well-planned, targeted services to support independent later life. These are especially beneficial for those who have not yet become dependent, but who have started to develop early signs of isolation or ill health. Involving older people in the design of services and communities more fully, is also important. They can also be a potential source of volunteers in their local communities.

The detail of our work in these areas can be found in the following publications:

- Improving value for money in adult social care, Audit Commission (2011).
- Don’t stop me now: preparing for an ageing population, Audit Commission (2008).
Our work does not provide a comprehensive response to the Committee’s questions. However, I trust that these publications, which are all available on our website at http://www.audit-commission.gov.uk/nationalstudies/pages/default.aspx, will be of interest.

28 August 2012
B & Q – Written Evidence

Overview

• B&Q is the largest home improvement and garden centre retailer in the UK with 361 stores employing around 33,000 people nationwide,
• Nearly half the retailer’s workforce is female and nearly 30% are over the age of 50, with some 21% under the age of 25.
• Our apprenticeship scheme is unique as it is open to all employees regardless of age. Most company apprenticeship schemes are only open to those under 25. Our eldest apprentice this year is David Holbrook, aged 66, at our Halifax store.
• Our oldest employee is Albert Billington aged 89
• B&Q is a founding member of the Employers Forum on Age, (now known as ENEI – Employers Network for Equality and Inclusion) a network created by employers to remove barriers to an age-balanced workforce
• B&Q is part of Kingfisher plc, Europe’s leading home improvement retail group and the third largest in the world.

1. B&Q’s Age Neutral Policy

• We’re proud of the diversity within our workforce and nearly 30% (29.5%) of our store employees are over 50
• B&Q’s workforce spans a huge age range from 16-89
• We led with a progressive older worker employment policy, derived from a project at our Macclesfield store in 1989, which was staffed entirely with employees aged over 50 for a trial period.
• B&Q has an age neutral working policy and removed the retirement age over 15 years ago along with any age criteria in relation to recruitment or benefits.
• B&Q offers a flexible retirement option enabling employees to draw their pension whilst continuing to work.
• Having a diverse workforce works for our staff and has led to great engagement scores – we are world class in engagement as we offer flexible working and training solutions – even apprenticeships which are open to all ages
• We really don’t believe that our staff should have an age related cut off date for their employment with us
• We are constantly working to remove any age barriers to work and negative stereotypes people may hold of employing older workers.

2. B&Q’s Flexible Working Policy available to all ages includes:

• Term-time contracts – available to parents and grandparents with children/grandchildren up to the age of 16 years (18 if child is disabled).
• Job share – for employees who do not want - or are unable - to work full-time.
• Staggered start/finish times – allowing for personal commitments/interests.
• Part-time hours.
• Split shifts – fits in with employees’ personal commitments.
• Dual location contracts – allowing employees to work at more than one location.
• One employee/two roles – allowing employees to develop new and different skills, benefit from multi-skilling, and work in more than one area of the business.
• Home/remote working – allows employees to work from home or away from their normal workplace on an occasional basis.
• Career breaks – three to 12 months offered, can be taken for any reason.
• Paid compassionate or carers' leave - one-week off per year.
• Adoption policy aligned to our maternity policy therefore over and above statutory minimum.
• Prior to the introduction of the statutory additional paternity leave, B&Q allowed for partners to share the mothers maternity leave if they both worked for B&Q
• KIT - Keep in Touch Days – offered to employees on maternity, adoption and additional paternity leave to encourage them to keep in touch with their colleagues and the business during their leave and enable a more
• Approx 75% of those taking maternity/adoption leave return to B&Q and remain for a minimum of 12 months thereafter.

Our flexible working arrangements can either be permanent or on a short term temporary basis to suit the needs of the individual and the business.

3. Commercial Benefits of Employing Older People

We believe our customers, colleagues and business benefit from a mix of ages working together, to provide the best in new ideas and experience.

Older workers specifically fit with B&Q’s core objectives because they:
• are more likely to be Home Owners
• have experience of DIY
• reflect our customer base (our Diamond Card Club gives exclusive discounts to our over 60’s customers when shopping on Wednesdays and has a membership of 6 million)
• understand what makes great customer service and help improve customer perception of service
• have knowledge and skills which they pass on to younger employees, as well as customers

At our Macclesfield store trial in 1989, where we employed a staff of over 50's only for a trial period, we measured the benefits and found that:
• profits were 18% higher
• staff turnover was six times lower
• absenteeism was 39% lower
• shrinkage was 59% lower
4. Benefits of Working for Older Employees

Many older employees often express the wider social benefits of working at B&Q including the ability to build their circle of friends and spend time in a lively atmosphere, alongside the financial benefits of being able to plan their retirement better.

5. The Roles Of Older Employees at B&Q, and Hours Worked

All roles are open to any one of any age and this is reflected in spread of roles undertaken by older employees. There are some roles where older employees significantly over index (i.e. above 28.4%) - these are:

- greeters/farewells and telephonists: 75% and over 55% (respectively) are over 50. These are often the first members of staff a customer has contact with
- over 40% of our night crew are over 50, so they’re not just in customer facing roles
- Expert roles – more than half are filled with employees over 50 including Plumbers, Electricians, TradePoint, Joiners, and Horticulturalists

There is no discernable difference between the average hours worked by the over 50s (26.73 hours per week) when compared with the average for all employees (27.01 hours per week).

6. Meet Our Oldest Employee - Albert Billington, Aged 89, Greeter at Longwell Green store, Bristol

- Albert started working at the age of 14. He completed a 7 year apprenticeship in the general print trade until he was the age of 21.
- He worked on a number of Sunday newspapers as a type setter and then went on to work on Fleet Street at the Guardian Newspaper.
- Albert started his career with B&Q in 1990 at the Sutton Store looking after the car park in the early morning getting ready for trading. Whilst he was shopping in the store he was asked if he would be interested in working at the store and his wife quickly said he would!
- He moved across to the Mitcham Store in Surrey whilst the new Sutton store was built and then moved back to Sutton store as a car park assistant.
- Albert then left B&Q for one month in 2003 as he moved down to Bristol and rejoined our store on 14 September 2003.
- Albert is currently a greeter and enjoys the social side of the job. He likes meeting different people and has met several friends through B&Q. He likes DIY and has completed numerous Home Improvements through the years.

November 2012
Barchester Healthcare is the 4th largest independent provider of health and social care in the UK, with more than 200 homes providing nursing care, residential care and close care (assisted living linked to residential schemes). In our homes and independent hospitals we look after people with long term and rehabilitative needs, including older people, people living with dementia, people with learning disabilities and people with long term mental health needs. Answers to the consultation questions below are written from the perspective of an independent care provider principally offering services to older people.

Consultation questions:
1. Does our culture about age and its onset need to change, and if so, how?
1.1 This consultation’s call for evidence is based on recognition of changing demographics, with a predicted continuing rise in numbers of older people to 2050 and beyond (particularly people over 85, the group in which frailty and dementia are highest, putting most demand on health and social care) and a concurrent decrease in the numbers and proportion of working age tax payers. This raises questions about the sustainability of current models of health and social care, ageing and taxation.

1.2 Though hard evidence is not abundant, there is a general consensus that older people are healthier than they used to be as a result of better diets and healthier lifestyles, that periods of morbidity in older age are shorter, and that this trend will continue for the foreseeable future. If this analysis is correct then there is a clear case for raising the age at which state pensions are received, for encouraging older people to stay in work beyond retirement age and for encouraging a culture of volunteering in fit older people. Whilst accepting that a proportion of people of 65 and over will be unable to work as the result of frailty or illness we need also to foster a cultural expectation of independence and self-reliance in older age.

1.3 From the perspective of a care provider these changes are broadly to be welcomed, and to some extent have been anticipated. Barchester Healthcare’s workforce has an average age of 41. 31% of our employees are over the age of 50 and 3% of our employees are over retirement age97. Our equalities policy encourages recruitment across a wide age range but we recognise that older people can often bring greater patience and empathy to care roles and our recruitment reflects that, though we also have a culture based on offering apprenticeships and training to the young, and are one of the largest employers of apprentices in the UK. Our homes have an emphasis on activities and community engagement which means that we offer opportunities to volunteers, often older people who have visited relatives in our homes.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?
2.1 As above, as a working population we will need to accept longer working careers. This may mean looking for changing roles in our later working life, reducing hours, changing from strenuous physical work to work that is less demanding, reducing pressure and travelling demands in managerial roles and considering re-training or making better use of established skills. Employers will need to accommodate these changes.

97 These figures and percentages exclude bank workers.
2.2 As above, older people will need to think in terms of greater independence, and of retirement age being a matter of physical limits and of choice rather than of chronological age. A culture of volunteering will need to be encouraged, with adequate training, support and supervisory structures in place. Time bank schemes based on banking volunteer hours should be considered; for example, people could provide two hours per week community care for older people on the basis that the organisation they work for will provide reciprocal help for them in turn when required.

2.3 In a time of financial austerity there is a limit to the extent to which a working population can be encouraged to increase savings and a similar limit to employees and employers raising contributions to pension schemes, though there is clearly both room and need for some rebalancing in the UK. Most informed people accept that a realignment of responsibilities for older age between the state and the individual needs to take place given demographic change.98 However, individuals will need to feel that the state is shouldering a share of responsibilities by establishing sustainable, high quality long term health and social care on the basis of clear and transparent rules, supplemented where necessary by additional resources from taxation. In this context, the Dilnot commission findings may need to be revisited and revised but they must not be ignored. Politicians will need to be prepared to take electorally difficult decisions in order to ensure high quality care options available to everyone who needs them.

2.4 The social care sector is generally a model employer in this context, with a commitment to an older workforce and flexibility around working hours and roles for people over retirement age. As an employer Barchester Healthcare works hard to continue the employment of our staff, especially those of an older age by offering flexibility in their hours, type and location of work as their capabilities and capacities change with age.

In order to sustain itself and continue as a good employer it needs fair fees, however: current underpayment by councils is notorious and will force down standards to unacceptable levels or drive homes out of business if indefinitely prolonged.

3. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

3.1 Options for maintaining older people in the community are likely to broaden and expand through increased use of personal budgets and assistive technology, and the development of the personalisation agenda more generally. However, this trend will not prevent the need for increased residential care and health provision for older people with degrees of frailty and dementia that cannot be managed without 24 hour support. On the rising edge of a demographic that is due to increase steeply, placements in residential care have increased and pressures on NHS beds regularly reach crisis point despite local government efforts to cap demand and to prioritise care packages delivered to the individual in their home. Continued care home growth is inevitable, particularly in the area of the sector involving care homes with sufficiently skilled staff to help frail people and people living with dementia.

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98 The Future of Care Funding, published in 2008 by the caring Choices coalition, shows a broadly consistent understanding of the need for change amongst carers and those in need of support.
3.2 Given that this is the case, the extent to which care homes maximise value for money (and add value) needs to be maximised. Current estimates suggest that at least 25% of hospital beds are occupied by older people with social care needs rather than medical needs and that rehabilitative care (on a ‘step down’ and ‘step up’ basis) could prevent a significant percentage of admissions in the first place. Hospital beds are approximately double the cost of care homes beds. Hospital admissions are widely acknowledged to be damaging for older people, particularly older people living with dementia, undermining independence and eroding choice and dignity. Care homes provide more homely environments, which help retain life skills and facilitate choice as well as offering a better quality of life. Under these circumstances unnecessary admissions and unnecessarily prolonged stays should be penalised, care homes should take over a rehabilitative role based on commissioned outcomes and expensive hospital beds should be decommissioned.

3.3 Care homes must rise to their potential to act as community resources, offering emergency advice and support, inreach and outreach services, also functioning as centres for peer support for community-based older people and their carers, developing networks to advise on creative use of personal budgets, almost like a ‘Cottage Hospital’. This would require outcome focussed commissioning, staff with rehabilitative skills and fees adequate to support development and training but costs would remain substantially below current hospital costs. Community links and vital life skills would be maintained for older people and quality of life would be significantly improved.

3.4 Barchester Healthcare is involved in a number of commissioning relationships with a focus on preventative and rehabilitative care and increasingly designs or redesigns homes to provide resources for local communities. These developments need to be encouraged through creative commissioning and the breaking down of artificial barriers between health and social care budgets.

3.5 Care homes would be supported in this changed role by a similarly upskilled and outcome focussed domiciliary care workforce. The context would be a continued drive in support of the personalisation agenda, encompassing health services as well as social care services, based on portable assessments tied to fixed rate payments applicable across participating UK countries. It would be supplemented by further development of supported living arrangements, extra care sheltered housing and health hotels. A commitment to sustainable long term care would allow insurance companies to develop and market products that would help individuals to cover care costs, supplemented by development of equity release schemes. The effectiveness of this approach would be considerably strengthened by increased support for carers, who at present get little help and whose good will should not be relied upon indefinitely.

4. Do we need to redesign and transform public services for these challenges? If so, how?

4.1 The British Geriatrics Society recently carried out the first national audit of intermediate care. It pointed out that overall capacity for intermediate care is less than half of potential

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99 A point made recently by the Dilnot commission, by the All Party Parliamentary Group on dementia and by Age UK

100 For example in Norwich, with short term preventative beds linked to GP practises to prevent hospital admission.

101 For example in …, where David Cameron opened a café for people living with dementia and their carers, promoting links with the existing home.
demand, and that the average age of intermediate care service users is 81102. In the context of services for older people the current system effectively encourages overuse of hospital beds: because they exist they are filled, despite the risks to older people (and to people living with dementia in particular) being well known. Barchester Healthcare is a leader in the dementia field, providing specialised Memory Lane communities for people living with dementia. Care planning is based around a person-centred approach, on life history work and on dementia care mapping techniques. Training and award schemes are crucial and are rooted in the work of Dementia Care Matters. This allows us to work with individuals on retaining life skills, providing meaningful activities and retaining relationships and a sense of identity. This is an approach it is impossible to reproduce in hospitals.

4.2 A commitment to sustainable long term care would allow insurance companies to develop and market products that would help individuals to cover care costs, supplemented by development of equity release schemes. Care budgets effectively encourage cost shunting, so that local authorities save money in the short term whilst older people are in hospitals; ring fenced budgets and pressures on the system also militate against preventative care. Commissioners are caught in a cycle of trying to commission more for less to deal with immediate demand and the system as a whole is notoriously underfunded, with self-funders effectively subsidising local government funded care home placements103.

4.3 Commissioning needs to focus on the prevention of hospital admissions, and the shortening of stays where admissions are unavoidable. We are in a position where commissioning structures are changing in response to the government’s health and social care policies. That provides an opportunity for a move to preventative and outcome focussed commissioning, with rehabilitative goals where these are practical. Providers need to be engaged in the commissioning process and in strategic planning. Homes need to be properly funded and developed as alternatives to hospitals, with access to therapists and with better trained staff. This will require settled government policy on health and social care, the courage to defend decommissioning of hospital beds and a commitment to a funding policy that supports sustainable long term care.

5. What should be done now and what practical actions are needed?

5.1 Barchester Healthcare’s experience with innovative commissioners (described in the answer to question 3) shows that rehabilitative, outcome focussed commissioning can be achieved and that preventative beds can keep people out of hospital. There are other areas of the UK where similar goals are being met by a variety of innovative approaches, devised where local commissioning and provider relationships are sufficiently flexible. In order to encourage the changes described in questions 3 and 4 barriers between health and social care budgets must be removed. Our view is that encouragement to voluntary partnerships is unlikely to result in radical change and that merging of budgets would be more effective.

5.2 Prevention of hospital admissions and shortening of length of stays should be incentivised. A policy for fair and sustainable funding of long term care needs to be agreed, in order to allow the care home market to develop outcome focussed care and community support functions. Such a policy would also allow individuals to plan effectively for their futures, allow insurance companies to devise and market insurance products to cover care

103 See http://www.bupa.com/media/479673/bridging_the_gap_final.pdf
costs and to facilitate equity release, offering greater choice to older people. It would also allow a national debate on the realities of care for older people and the need for independence, personal responsibility and greater self-reliance.

5.3 Providers must be involved in co-operative work with commissioners, so that strategic planning is informed by the capabilities of both parties, specifically addressing the issue of preventing admissions and reducing length of hospital stays. Care homes must devise plans for changed roles in partnership with commissioners and staff must be trained to work with therapists, concentrating on achieving defined outcomes. Decommissioning of hospital beds must be planned and defended.

6. **How can we stimulate national debate about these issues?**

6.1 The UK is in a paradoxical position, with health and social care issues a constant in political and media debate but against a background of poor understanding of core issues. A large proportion of the population still believes that care home fees will be paid for by the state, for example, and is unaware of the contribution that they will make towards care costs if care is required. To some extent a debate on the issues covered by this paper is inevitable: an ageing population currently means regular crises; more people are aware of dementia because more people have immediate experience of family members of friends living with dementia. Older people will take up the debate as a matter of self-interest if nothing else, and since older people comprise a significant proportion of the electorate politicians are likely to feed that debate.

6.2 Scotland provides an example of a country within the UK where health and social care issues have been more broadly debated, and where the electorate is better informed about the issues covered by this consultation. The issue of ‘free’ care was central to party political argument in the last election but one, and social care has remained high on the agenda since.

6.3 Providers can play a part in the process of informing debate. If homes become community resources more open to local people communities will develop a greater awareness of the realities of social care. Barchester healthcare has made progress in this direction, increasingly designing or redesigning homes with facilities open to the public. A good example would be the KIND café, in the grounds of Middletown Grange in Hailey, Oxfordshire, officially opened for Barchester by the Prime Minister on the 20th of July this year. It provides a hospitable space where people living with dementia and their peers can meet for mutual support, information and advice and broad debate.

6.4 The recent issuing of the Prime Minister’s Dementia Challenge has raised some aspects of the debate about ageing up the political and public agendas, which can only be a good thing: society needs to come to terms with the experience of people living with dementia and to adjust around it. However, whilst the Prime Minister is clearly engaged with the subject of care for older people there is no clear broad direction of travel. It may be necessary to persuade the Chancellor of the Exchequer to take the same degree of interest.

6.5 Action on the Dilnot commission recommendations on the sustainable funding of long term care would be an ideal platform to provoke national debate and to run campaigns to make people aware of the need to think about provision for frailty in older age.

**Overall, Barchester Healthcare believes that increasing longevity is an achievement to be celebrated. Where rising numbers of older people put pressure on existing**
systems we believe that this offers an opportunity to improve services generally and the services offered by care homes in particular, moving to an increased role in support of and greater involvement with local communities. This is a strengthened role we are keen to take up.

Barchester Healthcare would like to thank the House of Lords Committee on Public Service and Demographic Change for the opportunity to comment on these important issues and will be happy to provide any clarification required.

1 October 2012
Options for financing long-term care

1. This note sets out five sets of arguments, discussed more fully in Barr (2010):
   - Insurance can improve people’s welfare;
   - But private long-term care insurance faces major technical problems;
   - Social insurance is one approach to a solution;
   - A sensible division of labour between public and private mechanisms is another;
   - Decisions are strategic, but should not be delayed.

1 Insurance can improve people’s welfare

2. Long-term-care in old age is expensive. Many people never need it, but some do. And many people are risk-averse. These three facts imply that the option to buy insurance covering the costs of long-term care would raise the welfare of many people.

3. Specifically, suppose that one in six people will need long-term care, and that the average duration of such care is two years. Thus a representative person will require care for four months (i.e. one-third of a year). If high-quality care costs £30,000 per year, I could buy actuarial cover for a premium of £10,000. Like all competitive insurance, the premium is based on the average experience. In contrast, if there were no insurance, I would have to save enough to cover the maximum duration of long-term care. I might need care at age 80 and live to 100. Twenty years of premiums would require savings of more than £500,000. The gains from being able to buy insurance are clear.

2 But private long-term care insurance faces major technical problems

4. On the demand side, policies are long term and complex, so that consumers face significant information problems in choosing the right policy (the issues, including imperfect information and bounded rationality, are similar to those involved in the choice of a private pension provider).

5. Problems arise also on the supply side of the insurance market. Perhaps the most intractable is that the probability of a person needing long-term care (often many years in the future) is not well known. Today’s probability is known, but it might change over the course of a long-run contract: medical advances that help me to care for myself would reduce the probability; equally, medical progress, by extending my life, might increase the likelihood that I will require care. Thus not even the direction of change is known. Over a long time horizon, we are therefore talking about uncertainty, not risk. Private insurance can cover risk, but does not cover uncertainty well.

6. A second difficulty is that probabilities may not be independent: a medical advance that does not prevent or cure disability but prolongs life once a person has become disabled affects the probabilities of all policy-holders.
7. These problems mean that the actuarial insurance mechanism is not well-suited to covering the risks associated with long-term care. Yet, as discussed, the ability to take out insurance raises people’s welfare.

3 Social insurance is one approach to a solution

8. In contrast with private insurance, social insurance can cover uncertainty. Thus there are strong arguments for suggesting that long-term care is a suitable case for social insurance. As discussed, these are not risks that fit the actuarial mechanism very well. With social insurance, in contrast, the contract need not be fully specified, making it easier to adapt to changing social, medical, demographic and economic circumstances: government can change eligibility rules and can adjust contributions to match uncertain outcomes as they eventuate. Secondly, the costs of long-term care are much lower than for pensions because on average people require care for a much shorter period than they require a pension.

9. For such reasons, the costs of long-term care in Germany are covered by a specific element of the social insurance contribution, as discussed in Box 1.

10. Again, for such reasons, the UK Royal Commission on Long Term Care (1999, p. 93) concluded that

‘Left to grow without intervention, there seems little reason to think that private insurance will become more important in the UK than it has become … in America. At present only 4%-5% of Americans have taken out long-term care insurance, while 10%-20% could afford to do so and 80%-90% could not afford the cost in any event’.

Thus the Royal Commission advocated tax finance, though its recommendations were only partially implemented.

Box 1 Financing long-term care in Germany

In Germany, workers pay an extra 1.95 per cent on their social insurance contribution to cover the costs of long-term care. The arrangements integrate the contribution into social insurance in two additional ways: a person who has never had any children pays an additional 0.25 per cent, on the grounds that such people do not bear the full cost of raising the next generation of contributors; and, though pension contributions stop when a person retires, pensioners continue to pay the long-term care contribution.

The system pays three levels of benefit, depending on the extent of the person’s incapacity, and offers three types of benefit: in-kind domiciliary care, cash to allow a person to buy his or her own domiciliary care, and residential care. There are additional benefits, for example for adapting a person’s house or to cover the costs of respite care.

These arrangements have significant advantages:

• The system covers the entire population.
• Contributions are based on ability to pay.
• The system provides help for informal carers through the cash benefit and by paying the pension contributions of someone who provides informal care.
• The mechanism offers some protection against demographic change, since the long-term care contribution is paid by pensioners as well as workers.
• The system widens and deepens the market for care.
• Restrictions on benefit have democratic legitimacy.
• The system is based on an existing administrative mechanism.

For fuller discussion see, see Rothgang (2010).

4 A sensible division of labour between public and private mechanisms is another approach

11. The Dilnot Report (UK Commission on Funding of Care Support, 2011), recognising public spending constraints, took a different strategic approach. The report recognises the distinction between risk and uncertainty. Its core recommendation is that individuals should pay the first £X of the costs of long-term care (a figure of £50,000 was one example). Where someone needs care for sufficiently long that their costs exceed the limit, care costs above the limit would be paid by the taxpayer; and the taxpayer would pay from the first pound onwards for people who could not afford the costs of long-term care.

12. The central idea is that capping the maximum a person has to pay turns an open-ended uncertainty into something more like risk, making actuarial insurance a more viable option. In essence, the individual faces the risk, either through self-insurance (i.e. saving £50,000) or buying insurance, and the taxpayer takes on the uncertainty. This approach respects the technical constraints inherent in the actuarial mechanism.

5 Decisions are strategic, but should not be delayed

13. Care by family members is only part of the story and, as family structures become more fragmented, probably a decreasing one. And though medical advances might reduce numbers needing long-term care, the increasing incidence of long-term conditions like Alzheimers might increase it. Policy should therefore be designed on the assumption that the number of people needing long-term care is likely to increase.

14. Long-term care, like pensions, is part of people’s long-run planning. An important task of government, therefore, is to establish a stable long-term framework. As discussed, there is a range of sensible solutions but, given the likelihood of increased numbers, long-term strategic decisions should ideally be made (a) soon and (b) with cross-party support to provide long-term policy stability.

References


UK Royal Commission on Long Term Care (1999), With Respect to Old Age: A Report by the Royal Commission on Long Term Care, Cm 4192-I (London: TSO).

28 August 2012
1. Does our culture about age and its onset need to change, and if so, how?

(NB Response to question 1 as set out below assumes ‘our’ to be society in general)

Prejudice and Discrimination
Ingrained social beliefs, attitudes and prejudice around older people’s (late fifties and above) abilities concerning working lives are reportedly negative. If this is the case, then such attitudes etc. will if unchecked manifest negatively in many ways such as; discriminatory practices during selection and recruitment processes, general workplace discrimination (access to training, consideration for promotion etc.) all which makes for a potentially less favourable environment that accommodates discrimination, harassment and bullying.

This situation is potentially exacerbated as current research highlights increased disability linked with ageing. Where negative attitudes and behaviours persist and less favourable working environment are allowed to flourish older people will undoubtedly find themselves facing proportionally higher levels of prejudice and becoming increasingly subjected to discriminatory behaviours.

Records show that fertility rates have dropped and continue to do so meaning less young people will be available in the future to take up jobs (although not to forget that there are nearly two million 16-24 year olds out of work currently). Organisations need to seriously consider this fact and recognise that the usual pool of potential job applicants is changing its demographic profile.

Proportionately higher numbers of older people in society and less young people means there will be a steep rise in the dependency ratio (retirement age / those of working age). This strongly suggests that it is in the Country’s best interest (to ensure effective management of the economy) that the Government seriously consider whether their current policies and approach and subsequent impact on older people and their working lives ensure positive working experiences. It is of importance that older people are reportedly looking to continue/ extend their working lives – and if organisations overlook this fact and this emerging demographic then older people will become an untapped source of talents and skills, a seriously disadvantaged group and (unnecessarily) a burden on the Government coffers.

Possible Solutions:

a. Government initiative to develop and encourage an increase in the number of positive role models of older people;

b. Government funded initiatives to develop and provide to organisations; information, examples of good practice and training packages (utilising Age UK or other such charitable organisations) to deliver consistent messages about the virtues of ensuring older people have the opportunities to continue working;

c. Government to promote and encourage organisations to introduce well rounded and enhanced Well-being packages - policies and initiatives that go beyond the
current trends of basic provision to build a culture of health including a full range of flexible working practices and work-life balance initiatives;

d. A further call for evidence to establish evidence based understanding of UK attitudes regarding older people and working lives and follow up with initiatives to address the issues highlighted.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

Our expectations and attitudes will have to change. This applies to both employers and employees. Employers need to understand that a substantial proportion of their workforce will be older than they are at present, employees will be working to an older age than they are now. To this end there will need to be a fundamental re-consideration of both work practice and environment. This could include flexible work, reduced hours and working from home. However, more than mere practical considerations will need to be addressed. The age range of potential new employees will change, becoming older. To attract ‘older workers’ employers will need to show that they value their workforce in its entirety and are prepared to train and promote older employees, valuing them without bias or age discrimination. Employment Law may need amending to reflect this shift. Employees will also need to come to terms with changing conditions, understanding that they will need to work longer than their parents did, often in different ways, in order to extend their working life. Flexible working conditions will need to operate both ways, benefitting the employer as much as the employee. With respect to some parts of the public sector, attitudes and expectations of both managers and employees will have to change if more is to be done with less, as will undoubtedly be demanded in the coming years.

SAVINGS, RETIREMENT AND INDEPENDENCE

Increasing numbers of retired people are without savings of any kind. Those presently working need to be made aware that without savings they will be reliant on what is likely to be a much reduced state pension, leaving them little real independence upon retirement. Giving an incentive to save could change attitudes, for example increasing the value of ISAs. Although more people are now auto-enrolling in work-based pension schemes, currently they can withdraw after the minimum period. Consideration should be given to changing this to ensure membership is for the duration of employment as otherwise it could leave them with pension plans that are under-funded at best and non-existent at worst. Many of these people will be totally dependent on the state pension upon retirement. By targeting and educating these groups now, showing how they could well end up living in virtual poverty upon their retirement, expectations and attitudes can be changed.

Government Departments and Public bodies need to communicate effectively with older members of the community to inform to help change attitudes and to listen to feedback and suggestions. This can be done through community groups and targeted events.

3. Do the extent and nature of public services need to change? If so, how and how should they be paid for?

The provision of local services should be based on local need with priority to targeting the most vulnerable and needy in local communities. This approach may shape services that could proportionally favour older people particularly where aged related disability has increased need and vulnerability. This requires a careful and considered understanding of local needs by the service provider utilising the expertise of community groups, voluntary sector providers, examples of good practice, community assessment tools and equality analysis.
There is currently a disconnect in understanding the impact on increasing life expectancy will have across a number of key agencies and the interdependency this places on a number of public sector organisations, especially the emergency services. For example there is clear correlation between the number of accidental dwelling fires and the elderly living with high care needs. The current expectation on the Fire and Rescue Service (FRS) is to lead prevention activities (e.g. educational approaches, smoke alarm provision and home fire safety checks) to reduce the risk of incidents occurring.

Although an incident has a direct impact on the FRS in attendance and associated costs it is also key to highlight that each incident has associated community/societal costs and additionally increases resource requirements on partners including the Ambulance, NHS and the Police Services. Furthermore post incident impact is far reaching including the sometimes slow transition of re-enabling the injured and encouraging independent living, especially where those in the later stages of life are already at greater risk of an incident occurring in the first place. Some of the causes of these risks are currently mitigated through the use of key delivery partners including Home Fire Safety Checks completed by Social Services staff, who are ultimately best placed to deliver the most appropriate messages to target groups in a way they can be understood and responses monitored. The expectation is that as the community swells – e.g. more people living longer lives - so will the number of people requiring these types of support services. There will be greater challenges on FRS partners providing elderly support services and who will be committing ever increasing amounts of resources to meet core responsibilities. As such there is a real risk that joined up partnership approaches will be ‘side-lined’ to concentrate resources on organisational specific aims and objectives. Many of these cross network approaches are increasingly being driven and supported by local Community Safety Partnerships who are ultimately best placed to understand local community need - but the effectiveness and roles of these partnerships differs nationally.

With workloads, outputs and outcomes shared (and ultimately the knock on effect of reduced running and administration costs) the potential for cross agency departmental collaborations should also be considered as a replacement to the existing number of agencies providing similar services or delivering similar messages to older people. The input of greater legislative powers, importance and support must first be given to the Community Safety Partnerships to progress this approach.

Improved joined up approaches governed by a cohesive Local Community Safety Partnership can ultimately reduce duplication of work and streamline activities delivered by several different agencies accessing community groups (e.g. risk assessments in the homes of high care patients trying to maintain independent living).

4. Do we need to redesign and transform public services for these challenges? If so, how?

The Public Sector does not need to be redesigned as such but must evolve. Key to pro-actively modernising the nature of public sector organisations to meet the needs of an ageing population will be agreeing and aligning key aims and objectives across all public sector organisations to proactively contribute towards prevention approaches even when not seen as directly impacting on their own organisation. Multi-agency long term strategic approaches to risk reduction must be more inclusive of not just traditional elderly support agencies (e.g. local pensions services, elderly care services) but actively seek consultation through other relevant and new infrastructures (Local Resilience Forums, local ‘helping hand’ committees) as well as obtaining the views of its own ageing workforce.
By targeting communities across a range of pivotal development stages and ages with a key aim of consistently tackling the behaviours that may compromise their safety and of others community safety departments across the sector can significantly reduce the incidents which impact on the lives of the communities in later life and the resources of the public sector (e.g. rehabilitation into independent living).

Improved targeting that encompasses social marketing channels successfully utilised by private industry (GIS mapping and profiling tools) though still fundamentally infant to public sector communication approaches, will need to be quickly enshrined in day to day approaches. These will ensure improved effectiveness in targeted campaigns and allow improved evaluation against local understanding and need. This may potentially show a shift in emphasis for the FRS as its priority prevention approaches shift to rural towns and villages occupied by elderly maintaining independent living whose risk is compounded by the delayed attendance associated with rural based retained Fire Stations.

To best meet the needs of these groups the public sector may develop rural based Community Departments, for example encompassing staff from trading standards, FRS, Police and NHS where improved targeting or delivery of similar messages can be delivered with reduced resources whilst providing positive outcomes across a range of services.

BFRS is already realigning its approaches to lessen the impact an older community may present. Partnership working across public and private sector is driven by local need and also considers the needs of its partners in its approaches. For example the correlation of data on the location of oxygen cylinders or bariatric patients doesn’t just improve the way Home Fire Safety Checks are prioritised but also allows vital risk information to be communicated to operational crews en-route to an incident. It represents the opportunity to complete tactical plans prior to an incident, plans which can inform other emergency services and simultaneously improve the service we provide to at risk groups and the operational staff of our emergency partners.

5. What should be done now and what practical actions are needed?

6. How can we stimulate national debate about these issues?
Professional bodies and institutes as part of its approach to lobbying the Government can play an important role. Indeed, with regard to the FRS, the Chief Fire Officer’s Association has recently produced The Older Persons Strategy which is fundamental to providing guidance and support to Fire and Rescue Service’s and their partners which in turn enables them to rise to the challenge of keeping the older and more vulnerable members of our community safer from the risk of injury and death as a result of fire in the home.

The importance of this document is considerable when considering the numbers of people living longer, and how rapidly this number is increasing and how this debate can be stimulated. It is imperative that professional bodies with a vested interest should raise awareness of the need for the extension of local strategies and services for older people in order to prioritise budget allocation to refine service provision.

31 August 2012
British Academy—Written evidence

Introduction

1. The British Academy welcomes this opportunity to submit evidence to the House of Lords Committee on Public Service and Demographic Change.

2. In July 2012, the British Academy’s Policy Centre published *Demographic futures*, written by Professor Pat Thane FBA for the Policy Centre’s ‘New Paradigms in Public Policy’ project. In her report, Professor Thane emphasises the urgent need for a change in societal attitudes towards ageing and older people in order to fully appreciate the diversity of a large age group, to recognise the contributions older people make to society, and for the state to provide fairly and effectively for them.

3. This summary, written by Professor Thane, draws on the *Demographic futures* report alongside her other academic works. It addresses the following questions from the committee:
   - Does our culture about age and its onset need to change, and if so, how?
   - Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?
   - Do the extent and nature of public services need to change?
   - Do we need to redesign and transform public services for these challenges?

The views expressed in this submission and the *Demographic futures* report are those of the author and are not necessarily endorsed by the British Academy. The British Academy is taking this opportunity to submit to the enquiry to highlight the key findings of Professor Thane’s report and the evidence collected in it.

Summary of recommendations and evidence

4. As a society, we need to stop generalising about people aged from 60 to past 100 and recognise their diversity.

5. Challenge discrimination against older people in all spheres, including mistaken assumptions about the capacities of many of them to work and learn new skills. And discrimination in the NHS should be challenged too: for instance, as just one of all too many examples, past age 70 women are not automatically called for breast cancer screening, although the disease is most common past 70, thus increasing health care costs. This is one example of the potential to improve preventive and care services to extend healthy life expectancy.

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105 *Demographic futures* is available to download in full at [http://www.britac.ac.uk/policy/Demographic-futures.cfm](http://www.britac.ac.uk/policy/Demographic-futures.cfm). All references to figures quoted can be found in the report.
6. Challenge assumptions that past retirement most are dependents. Assess and encourage retirees' positive inputs into society and economy: 30% of over 60s volunteer regularly through formal organisations; 65% of over 65s regularly help older neighbours; 1 in 3 working mothers rely on grandparents for childcare. Their unpaid inputs reduce public expenditure and enable younger people to work. Those who can afford it give substantial financial help to younger generations. Over 65s make an estimated net contribution to the UK’s economy, after deduction of costs of pensions, health and welfare services, of £40 billion per annum through taxes, spending, donations to charities and volunteering.

7. Challenge generalisations about 'intergenerational inequity', which present older people as having benefited at the expense of younger generations, and reinforce age discrimination. Provide robust estimates of socio-economic inequities within as well as between generations, taking account of net discounted contributions over the life cycle (e.g. 72% of ‘baby boomers’ left school at 15 without qualifications in 1960s, then worked and paid taxes; only 4% went to university, while 40%+ of young people do so now). Assess the generational impact of current financial and welfare policies. Older people lose out from the switch from Retail Price Index to Consumer Price Index as the measure of inflation for pension adjustments. They suffer disproportionately from cuts to social and health services e.g. 90% of Primary Care Trusts recently reported ‘restricting’ cataract, knee and hip replacement operations, disproportionately affecting older people; untreated, these conditions restrict their capacity for independence and increase demand for costly services. And older people, dependent on savings, are losing income due to low interest rates which favour younger mortgage holders.

8. Provide good estimates of the real costs of the ageing population e.g., how far are rising NHS costs due to ageing or other costs, such as of technology, drugs and staff? The OBR Fiscal Sustainability Report, 2012, which stresses ageing as a cause of rising costs, refers, in a footnote, to the 2006 OECD calculation that, 1970-2002, the effect of demographic change on health spending across OECD countries was only 0.4%106.

9. Healthy life expectancy has increased for most people since pension /retirement ages were fixed at around 60/65 in the mid twentieth century. Many are now fit to work to later ages. Government should speed up the rise in the state pension age, beyond present proposals, for most people. However, already about 20% are not fit to work even to 65 (Sir Michael Marmot FBA: Fair Society, Healthy Lives). To protect these people, consider a flexible pension age, paid as a right when people become unfit for regular work; or, as proposed by Lord Beveridge FBA in 1942, retain the current basic state pension age but build in the incentive of higher pensions to work longer.

10. It is fair to tax older people at the same rate as younger. Government should tax winter fuel allowances and, if possible, free transport. Do not means-test these benefits because

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106 Jennifer Gill and David Taylor Active Ageing: Live Longer and Prosper. UCL School of Pharmacy, 2012.
this will be costly to administer and, in all known means-testing systems, many eligible people fail to apply, including some of the neediest. For instance, in Britain between 20 and 30 per cent of those on incomes low enough to qualify for the Pension Credit fail to apply\textsuperscript{107}. Non-applicants tend to be the poorest and most excluded\textsuperscript{108}: those most cut off from advice and information, perhaps past their best mentally and unable to understand the requirements, and therefore people who most need warmth in winter and encouragement to move around.

30 August 2012


\textsuperscript{108} Ibid.
1. The British Society for Population Studies (BSPS) comprises persons with a scientific interest in the study of human populations. Its main objectives are to further the scientific study of biological, economic, historical, medical, social and other disciplines connected with human populations and to contribute to the public awareness of them. Our four hundred BSPS members include the public sector (including central and local government and health services), academia and business. The Society discusses current scientific research at its annual conference which this year meets on September 10-12. Among its 120 presentations are thirteen contributions on ageing which investigate a broad range of impacts on health, social care, families, households and economics.

2. The ageing of the UK population has been achieved through a long-term reduction of mortality that first allowed more people to survive to adulthood and then increased the absolute number of elderly people, along with a reduction of fertility that has shifted the age distribution away from younger people.

3. Ageing has had tremendous impact on UK society in the past fifty years. The strong expectation of living to 60, and the likelihood of living to 80, has given confidence to young adults and given rise to longer independent lives after children have left home. With the separation of generations, whose integration in society has taken place within different contexts and events, age now marks great differences in society. Since society’s traditions and expectations change more rapidly and within a longer lifetime, the experience of the elderly is often seen as less relevant and therefore devalued. The near guarantee of surviving parenthood has contributed to the growth of the nuclear family, and grandparents live in greater isolation, on average.

4. The current discussion of the costs of ageing should be taken in the context of these changes, and within social aims which could encourage integration and cohesion across all ages.

5. Although the committee has focussed on ageing for its discussion of the impact on public services of demographic change, it should be aware that the population’s distribution within the UK and the number and structure of households are also changing, with very significant impact on public services.

6. This submission from the British Society for Population Studies does not attempt to cover all aspects of ageing and public services, nor all the questions posed by the Committee. It addresses some of the issues of measuring population change that the committee has raised and that our members have been able to respond to in the short timescale allowed by the Committee: measurement of ageing; the certainty with which projections of ageing are made; the limits to longevity and the influence of obesity within this; and the causes of the predicted growth in the elderly population, which is particularly important to understand when planning for different time-scales of the future. Inevitably we have identified gaps in knowledge where investment would prove worthwhile. We would be happy to respond to further questions that the Committee may have.
Measurement of ageing

7. Both ageing as a shift in population distribution towards older age groups, and the absolute numbers of older persons, do matter.

8. Ageing may in particular affect macro economic considerations. The predominant view is that ageing will support lower economic growth because it “squeezes” the 20-64 age group, leading to low (or negative) rates of labour force growth. A high-skilled growing labour force is generally needed for sustained economic growth, which may be a government aim. In addition, population ageing causes a shift away from investment to consumption since government expenditure tends to increase to meet the increased demand for pensions and other old age-related benefits (such as health care).

9. The absolute numbers of older people matters because local agencies (health or local authority) need to deliver services and care to frail older people.

10. When measuring ageing – the shift in age distribution – care must be taken to distinguish measures such as the Old Age Dependency Ratio (ODR) and the Old Age Support Ratio (OSR, the reciprocal of the ODR). Expectations of change should use the same numerator and denominator, in particular referring to the same age groups, in order to be comparable. For example, Lord Bichard said “We have talked a lot about increasing numbers of older people, but the old age support ratio diminishes only slightly. It goes from 3.2 now (2010) to 2.9 in 2035” (House of Lords 2012, Transcript Q50), quoting ONS (2011a, p.6). In this case, the OSR was measured as ratios of the population aged 16 to pensionable age to the population of pensionable age and over. Under the Pensions Act of 2011 pensionable age thresholds will rise decade by decade and there is a note that the timetable may be speeded up. So the smallness of the fall on which Lord Bichard remarked is a direct consequence of legislation and implementation of policy. 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).

The certainty with which projections of ageing are made

11. Measures of certainty for population projections are not yet an exact science. When attempted, they distinguish the uncertainty attached to each of the components of future population change – primarily fertility, mortality and migration. A quantified level of uncertainty can be based on expert opinion of future ranges of population change, or on the past instability of trends (measured using statistical time series models), or on the record of past forecasts.

12. In the UK, Chris Shaw of ONS led a project using expert opinion to set the uncertainty around each component of future UK population change, from the 2006-based national population projections (Shaw 2007). The project has not reached completion with publication, but from a progress report (Rowan and Wright 2010), we can see that the confidence bands are widest for the youngest ages and diminish towards the older ages. Phil Rees has computed the ratio between the 95% confidence intervals and the projected populations, finding that the percent uncertainty diminishes from 13% for ages 0-4 in 2031 to 1% for ages 50-69, grows to 3% for ages 75-79 but then increases considerably at very old ages to be 64% for the relatively small population aged 100+. In other words it is 95% likely that the 2031 population of centenarians would be up to but
not more than 32% either side of the official 2006-based projection. Errors we make in forecasting mortality rates pile up in the oldest old ages.

13. However, when we compare these 2006-based projections with the most recent projection based on mid-2010 populations, we see that the 2010 based projected population falls above the upper confidence level for each of children, working ages and elderly. For the population aged 65+, the 95% confidence interval is 2% either side of 2006-based projection, but the 2010 projection is 3% above it, outside the confidence interval.

14. We cannot therefore be very confident in the confidence intervals calculated so far. The calculations use errors for fertility, mortality and migration averaged from those provided by members of the National Population Projections Expert Panel. But the opinions offered were few and therefore the estimate of the errors very uncertain. What this discussion indicates is that ONS needs to invest further in methods for estimating confidence levels in their projections, if they are to answer the reasonable questions made of them.

**Trends in longevity**

15. There are two polar views on this issue. The first, put forward by Jay Olshansky and colleagues (e.g. Olshansky 2001) is that we are approaching the limits to life expectancy and that a number of disease trends (e.g. 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. The second, put forward by James Vaupel and colleagues (e.g. Oeppen and Vaupel 2002) is that the historical record of the countries with the best life expectancy records suggests no limits to improvements driven by progress in well-being and medical science.

**Obesity**

16. A summary of current expert thinking on the potential impact of obesity on projections of longevity can be found in the discussion of the National Population Projections Expert Advisory Group which helped inform the mortality assumptions used in the 2010-based UK population projections published by the ONS (2011b). The panel generally agreed that in the UK obesity is likely to have a greater impact on morbidity than on mortality, but there was no clear consensus on its impact. Much will depend on future changes in behaviour which could increase or reduce the incidence of obesity and the age at which people become obese, and whether obesity is regularly medically monitored, as seems to be the case in the USA.

17. The report of the Foresight programme on Tackling Obesities (Government Office for Science 2007a,b) estimated that if obesity levels increase from 2010 as they predict then by 2050 female life expectancy would be lower by a fifth of a year while male life expectancy would be lower by a third of a year compared to what it would have been without this rise. This though has to be set in the context that female and male period life expectancies at birth are projected to increase by over 6 years and 7 years respectively. Thus obesity will have perhaps a surprisingly small impact on life expectancy at birth, due mainly to greater reductions in mortality from other, non-obesity related causes. The impact on longevity over a shorter, say 10 – 15 year, time span will be much smaller. It should be stressed that these trends depend on current
policy of investing in better survival and on continuing failure to stop the increase in obesity.

18. Just as obesity could potentially have an impact on longevity and health care costs so could other emerging health threats such as pandemic flu or the resurgence of TB. While the likelihood of these occurring may be small the impact could be significant. The impact of major epidemics can be allowed for in population projections but the timing of such events is unknowable.

What causes the predicted growth in the elderly population?

19. The increase in the number of old people is not just a function of improving mortality before and during old age, but it also depends on the size of new cohorts entering old age (e.g. having their 65th birthday) compared with those who went before them. To what extent does the future population of the old grow because (a) mortality is declining, because (b) the birth cohorts entering old age in the future are larger than they have been in the past, or because of (c) the impact of international migration of older people? This is quite a difficult question to answer because it involves designing the correct scenario projections with a careful age-period-cohort analysis, which has not been done. However, the question is an important one to answer. An initial estimate has been made using the scenarios for UK population projections developed at Leeds University (Rees et al., 2012a,b).

20. The effect on the population of projected reduced mortality, adds 3.3 million to the UK population between 2001 and 2026. Making the approximation that all these extra persons are old people (aged 65+), one can subtract this mortality effect from the total population change of 6.1 million to give an approximate estimate of changing cohort size of 2.8 million in 2001-2026.

21. Thus the percentage contribution to a growing elderly population of improving longevity is 54% and of cohort replacement is 46% during this period. The estimates also assume that the net impact of migration is negligible compared to these two other effects: ONS expects a net annual emigration of 2-3 thousand, about 0.1 million over twenty five years. This, and the impact of net immigration at younger ages, will be part of the estimated effect of changing cohort size.

22. Thus it is likely that the impact of longevity accounts for only about half of the growth in the elderly population over the period 2001-26. The effect of changing cohort size, reflecting mainly the baby boom in the UK in the 1950s and early 1960s, contributes the rest of the growth. However, as the smaller birth cohorts born since the mid-1960s reach older age, their impact will be to reduce the size of the elderly population, partly counteracting the impact of longevity. This is the main reason that ONS projects less growth for the total elderly population aged 65+ 2040-2060 (161 thousand per annum) than 2010-2030 (261 thousand per annum).

23. The significant immigration of the 1960s will have reinforced and lengthened the baby boom effect on the current elderly, while the rise in immigration from mid 1990s will help to offset the lower fertility of the 1970s. A more precise disaggregation of the reasons for change in the elderly population in each of the next few decades would be of use to the Committee’s deliberations.
Conclusion

24. Both the changing absolute size of the elderly population and its size relative to other age groups will have a great impact on the nature of public services in the next decades. The dynamics of this change are understood but could usefully be measured by government with greater clarity at both national and subnational scales.

References:


31 August 2012
TUESDAY 4 DECEMBER 2012

Members present

Lord Filkin (Chairman)
Baroness Finlay of Llandaff
Lord Hutton of Furness
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Dr Craig Berry, Pensions Policy Officer, Trades Union Congress, Professor John Philpott, Economist and labour market analyst, former director of Employment Policy Institute and former Chief Economic Adviser at the Chartered Institute for Personnel Development (CIPD), Caroline Waters OBE, Director of People and Policy, BT, and Dianah Worman OBE, Policy Adviser on Diversity and Inclusion, Chartered Institute for Personnel Development (CIPD).

Q514 The Chairman: Good morning, perfect timing—welcome, John Philpott. Welcome to the Committee. I think that you know what we are about, which is essentially asking whether our society is ready for ageing as individuals, in policies and in public service terms, so it is a panoptic view across that question. Clearly the issue of employment is a pretty central one and we are grateful to you all for coming. Would you like to run along the row and say who you are? Then we will kick into the questioning. My apologies, Caroline, for giving you an extra letter in your name.

Caroline Waters: Happens all the time.

The Chairman: We have now removed the letter. Caroline, would you like to start off?

Caroline Waters: Good morning, everybody. I am Caroline Waters, BT’s Director of People and Policy. As part of my role, I take the lead for BT on inclusion. We are also looking at the future implications of demographic and environmental change.

Dr Craig Berry: Craig Berry, Pensions Policy Officer at the TUC. As well as working on pensions, I look at employment issues for older people, which cuts across a number of policy areas.
BT, Chartered Institute for Personnel Development (CIPD), Professor John Philpott, Economist and Labour Market Analyst and Trades Union Congress (TUC)—Oral Evidence (QQ 514-536)

Dianah Worman: Dianah Worman from the CIPD, and I have a brief on diversity inclusion for the HR profession.

Professor John Philpott: John Philpott. I am an economist with an interest in the labour market and employment issues. At present I am working as an independent consultant.

Q515 The Chairman: Thank you all very much. I will start with a question about attitudes to older people. In terms of the format, I will not necessarily allocate questions; people may respond if they particularly feel they want to. Do not feel that you will have to say something on everything if it has been covered. If you differ with something, by all means shout, or, just say, “I agree”. On the evidence of old people’s wishes regarding work and retirement, is there evidence that a greater number of older people would like to work more than they currently do?

Caroline Waters: Let me start from a practical employment point of view. We have conducted surveys of our workers aged 50 and over in recent years—not every year, but periodically—and we are seeing a definite increase, with up to 80 per cent saying that they want to continue working beyond 60. That is in a company that provides a very healthy pension for its workers and is also a longer-service organisation. This year, we will have a handful of people hitting 50 years’ service and 3,500 hitting 40 years’ service. If it is true in that case, then we are probably a very good example.

Dianah Worman: I can corroborate that with evidence from the CIPD that there is a growing appetite among older people to carry on working for longer. We had a figure of about 42 per cent planning to work beyond state retirement age, and the nearer that people get to retirement, the more that they reflect on their position on retiring and are more likely to change their minds if they had thought earlier that they would go sooner.

The Chairman: Any evidence on the drivers? Is it money or is it variety, interests, social?

Dianah Worman: A variety of reasons. Certainly the issue of finance has grown because of the economic circumstances, and the issue of pension funds has influenced people’s appetites to work for longer. The last time that we took a sense check of this, about 72 per cent of people wanted to carry on working for financial reasons, but about 47 per cent wanted to carry on working in order to continue to use their skills and experience and another 41 per cent because they valued the social interaction at work, which is very important as part of the well-being agenda.

The Chairman: Are there any more riches in the survey that would make it worth us looking at it, or have you given us the headlines?

Dianah Worman: We can certainly give you copies of the survey. I will send them to the Clerk.

The Chairman: Thank you. John?

Professor John Philpott: I would broadly agree with the evidence. The point to make is that there is a difference between wanting to work and needing to, and over time there has been an increase in both those aspirations. More older people who are fit and healthy feel that they have something to contribute, probably, unlike in the past, not having worked in heavy industrial sectors that have worn them down but rather having worked in more knowledge-based sectors, so they are still as raring to go at 55 or 65 as they were at 40. By the same token, it is pretty clear that there has been an increase, certainly over the past five to 10 years, in the number of older people who have to work for financial reasons. Well
financed occupational pensions are not as well financed as they used to be. Pension annuity rates have been falling, so the prospect of a decent income in retirement is reduced. With people living longer, there is a greater period of time to finance, and probably a longer period of time towards the end of life when the financial need will be greater in order to fund care and other social support. There is clearly a sort of feeling on the part of many people that they need to work longer for those kinds of reasons.

**The Chairman:** Is there evidence to stack that up?

**Professor John Philpott:** By looking at the increase in employment rates. We have to be clear here who we are talking about; we have seen increases among both the over-50s and those of state pension age and above but, if you are talking particularly about people over state pension age, there has been a marked shift towards more of them working. That seems to have coincided to some degree with the economic downturn. What is interesting as well is that a lot of these people are moving into self-employment. That is a way of combining their income need in difficult times with the aspirational need to work later in life, but managing to combine that aspirational need with not being so tied up in the rat race of employment. Rather, you do it for yourself and on your own schedule.

**Dr Craig Berry:** I think there is a willingness to work for longer. Recent research from the TUC found that even though the people in work would like to work more than they currently do, there is an underemployment problem as well as an unemployment and inactivity problem among older workers approaching state pension age. As some of your witnesses have commented, though, we should not confuse a willingness to work for longer with a desire to work for longer with a desire to work for longer. Often they feel compelled to work for longer for reasons of affordability because of the financial circumstances, when perhaps in other circumstances they would not feel the same compulsion. It is good that employers and the labour market in general are providing for the world of workers, but it is not necessarily something that should be celebrated at face value if it is a financial compulsion rather than individual choice.

There is one important caveat as well that is often overlooked. The female state pension age is rising quite rapidly at the moment, and a lot of the people who work beyond state pension age are women. Study after study shows that women tend to plan their retirement decisions in conjunction with their husbands, who tend to retire later, so that trend of working beyond state pension age may well slow down as the female state pension age catches up and equalises with the male state pension age.

**Dianah Worman:** We have evidence that the appetite for working longer is also associated with opportunities to work more flexibly after retirement, so flexible retirement informs that appetite. Those are the kinds of responses that employers need to be thinking about, and indeed they are.

**The Chairman:** We will come on to that, because it is crucial.

**Q516 Baroness Tyler of Enfield:** Just a quick one, if I may, on what the evidence tells us about people who either are on low income or have had semi-skilled or unskilled jobs staying on. I am just quite conscious that you have talked about knowledge workers and people who might become self-employed in some way. Some of these opportunities are not open to people with lower levels of skill. Do you know what the evidence says about that?

**Dianah Worman:** I think there is some indication, if one looks at what older people feel about their physical and indeed mental health, that they tend to report that the fact that they do not feel that they have their ageing has actually made them less capable of doing
their jobs. That is across the piece. There is some evidence generally that people can carry on working, even if minor adjustments are made, for quite a long time after the perception that they may be past their sell-by date.

Baroness Tyler of Enfield: And that includes in a manual job, for example?

Dianah Worman: Yes, including manual jobs. Although you can talk about repetitive strain injuries and so on, the more that your body is used to doing a certain kind of thing, the more likely it is that you can carry on doing it, whereas if you come to that kind of task from nowhere, you are less likely to be able to do it.

Q517 The Chairman: Craig, your evidence was different on this, was it not?

Dr Craig Berry: We found that among people approaching state pension age there were higher levels of economic inactivity, and ill health and disability were the main reason. Lower earners—more specifically, people in lower occupational groups, such as manual and lower-skilled workers—were more likely to be unable to work due to ill health and disability. Greater age opportunities for flexible working will help to alleviate that, I am sure, but other research by the Resolution Foundation, which I can point the committee towards and I am happy to do so, indicates that flexible working opportunities tend to be less available for those who need them most. The challenge is to spread those opportunities across the entire labour market, not just among highly skilled knowledge workers.

The Chairman: That is very helpful. It sounds as though attitudes are already shifting. We have sometimes debated about whether the dream that people had 20 years ago, where you get to 60, stop and lie down, is no longer the fantasy. It is no longer the reality, and it is no longer what people think that the good life is all about. Are attitudes shifting or do people who are approaching retirement have an attitudinal problem?

Caroline Waters: Our experience is that there has been an attitudinal shift. That is not true right across the economy; we have very different responses. This is where perhaps I will be a little controversial. The whole concept of retirement is fundamentally flawed now. It needs to be radically rethought. When I was growing up, you had a very linear expectation of life. You had a period of childhood, usually framed by education; a period of adulthood, usually framed by employment and parenting; then a period of retirement, framed by absolutely nothing. We are still persisting with that when the period of retirement could be 40 years or longer. BT already has people who have been claiming their pension for more than 30 years.

What we need a new fund-for-life approach which allows people to take retirement, some form of break, at periods during the whole course of their life. What retirement fundamentally does, and we see this more and more with people, at the time you face the biggest unknown—you do not know how long the period will be or whether your money will stretch to cover it—you have no levers. You almost certainly cannot work and it is difficult to get services, particularly if you are also caring.

We need to radically rethink the whole thing. Certainly, younger and middle-aged people are seeing life, not in that linear way, but as a sort of zigzag where they will have periods of work, periods of education, periods of non-work, then periods of work. The whole concept is flawed and I suggest that we need to do something more radical than just think ageing as a concept.
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Q518 The Chairman: Thank you. Very interesting. Are there any other comments on attitudes?

Dr Craig Berry: I would like to point out some recent research by the DWP, by Andrew Weyman and others, which looked at behavioural interventions into this extending working lives problem. It found that attitudinal interventions were probably going to be less successful than interventions which target the situational influences. This is quite technical language but, essentially, it found that there is not necessarily an attitudinal problem towards working in later in life. It is the conditions of work and one’s financial circumstances that are the main drivers and these are the areas that we need to target.

Following on from what Caroline said, there are many different ages of retirement. In many ways, we think about it too simplistically. We do not have a life course perspective on people’s working age and the transition that they make into later life and I encourage all that kind of thinking. But what gives people options in later life is pensions provision. A good pension scheme does not necessarily encourage people to retire early as a result; often it encourages them to stay. It gives them options to retire flexibly and gradually, and that kind of thing.

Professor John Philpott: Just on a brief cautionary note: clearly, if you go back over the past 20 years, there has been a marked shift away from the fashion for early retirement towards staying in the labour market a bit longer. The average age at which people leave the workforce is still of the order of 64. It is not as though loads of people are jumping at the opportunity to work vast periods of time beyond that. The employment rate for men above the age of 65 is about 12 per cent and for women it is about 6 per cent or 7 per cent. If you want to encourage people to work longer, clearly there is still a long way to go, irrespective of how attitudes have shifted.

The Chairman: That is very helpful. Can you send us the latest data on the activity you mention?

Professor John Philpott: It is all ONS data so I can point you to the references, although I guess that you probably have most of it.

The Chairman: We probably have. If you could give us the links so that we know what we are talking about rather than just waving our hands.

Q519 Baroness Blackstone: Just a quick follow-up on that: what is the trajectory in terms of the extension of working life? Have we flattened out at 64 or are we still very much on the upward part of the curve? What projections have been done? What are we expecting to happen over the next five to 10 years? Are we expecting this to go up to 70 fairly soon? What kind of work has been done as regards looking ahead?

Professor John Philpott: Projections on this particular issue are fairly limited, largely because of methodological reasons. It is not entirely clear what impact the increase in the state pension age—both for women moving up to the same retirement age as men and then for both—will have. The assumption, or the conventional wisdom, is that the trajectory will continue to rise for the kinds of reasons that we have been talking about. Probably, in the first instance, it will rise to the late 60s and possibly to the early 70s. One is speculating anyway but, beyond that, all the drivers would say that they are pushing in the direction of increasing working life.
Caroline Waters: That will be tempered, though. We are in a strange period because there are thousands of baby boomers who will leave. There are as many as 19 million people across Europe. That will shift the stats. We are at an unusual crossover where we have got the last of the people who can leave and were expecting to, and just the beginning of the people for whom that will not be the truth. I do not think real trends will come through as quickly as we might otherwise have expected.

Dianah Worman: I agree with Caroline on that. Certainly, we have evidence that attitudes are changing regarding the value attached to older people. But the responses from business tend to be on the basis of knowing an individual and reacting to that, rather than coherent strategies. That is the stage that we need to get employers involved in.

Q520 The Chairman: It is a timely reminder that, after we have taken a question from Baroness Morgan, we will move on to the impediments with Baroness Shephard.

Q521 Baroness Morgan of Huyton: I am just interested in what Caroline was saying, presumably, from her experience at BT. In the present economic situation, to what extent do you as an employer have to give opportunities to keep older workers in employment if they so wish when there are also a lot of unemployed young people to whom you need to give their first opportunity to get them on the job ladder. How do you weigh that generational divide as an employer?

Caroline Waters: In effect, by ignoring it. Our strategy is about finding the best person for the job. In effect, we are saying that we have age-neutral policies. We understand that if you have a mixed-age team you get the best blend of creativity, experience, new ideas and all those things. You do not necessarily see all the creativity in young people and all the experience in older people. We have apprentices who are becoming managers two years into their apprenticeships because they have years of experience of managing teams and groups in after-school clubs and so on.

So we focus on making sure that we have a youth strategy that sees 500 or so young people coming into the organisation every year, as either apprentices or graduates. We also look at the other end, offering people flexible retirement and other things that allow them to continue to contribute in the workplace but also to have options. Flexible pensions—being able to draw a pension earlier—have helped massively with that. The other thing that has made quite a big difference is the fact that we realise that converting a pension scheme away from final salary to career average means that people can take a less senior role as they get older without it having a big effect on their pension. That allows people to come through. But our basic, fundamental principle is merit.

The Chairman: Baroness Shephard will take us on to the impediments to working for longer.

Q522 Baroness Shephard of Northwold: We have covered some of these, Chairman, but I would like to ask the panel what the main impediments are to older people working longer and more flexibly. We have had some practical ideas from Caroline about how BT is trying to tackle this. I then want to come on to examples of good practice. I do not mind in the least if you meld the two together. What are the main impediments? We have heard from Craig that there may be financial, structural or attitudinal problems. And yet, BT is tackling some of these. Would you all like to have a go at that question, followed possibly by examples of good practice if you have any?
**Professor John Philpott:** Just on what you might call the baseline impediments, I still think there are two things that link together. One is age discrimination at the recruitment stage, which, although illegal, still occurs. Linked to that is what you might call the vintage of the older worker in terms of their skills, most up-to-date experience, et cetera. It is interesting to look at the improvement in the labour market situation of older people over recent years. Rather like Dianah was saying, if employers know the person it makes things easier. We are seeing older people being kept on, usually in part-time roles, if they have been with an employer for a long time. That is why most older workers in employment have relatively long employment durations with a single employer. What we do not seem to see a great deal of evidence of is a big increase in enthusiasm for recruiting older workers. At present, you might say that during this recession older people have been more able to hold on to work if they have been in a job, but if they lose a job they are probably finding it as difficult as they ever did to get back in. That is why you have these very high rates of long-term unemployment among older people. In terms of best practice, a lot of employers have clearly been making progress in employee retention of older workers. Perhaps more needs to be done on the recruitment side.

One final point: I guess colleagues will mention this. Clearly a difficulty for some older people is that they might develop minor health problems that make it difficult for them to work. Some of these are occupation-related. There is a case for an improvement in lifelong occupational health treatments so that people are healthier throughout their working lives. That will help them to prolong their working lives. Aligned with that, if you had better lifelong learning, which would enable older people to adapt their skills and abilities, they would become more attractive, both in terms of being retained by their current employer and if they were to lose their job. They would be more competitive in the labour market vis-à-vis younger people with more up-to-date skills.

**Dianah Worman:** I would agree with John that activity in recruitment is still almost as bad as it was. Older people sometimes have to seek work at a lower level of skill than they have to offer, whether they want to do so or not. That is the perception. The reaction to that is often, “Oh, you’re too highly qualified, so you wouldn’t stay”, which is not at all the kind of practice that we would like to see. Certainly, a lot of improvement is needed there.

Within the workplace itself, there is an argument for strengthening the response to people’s well-being throughout their careers at work. You do not want to wait until someone is older and in employment before you offer interventions to enable them to improve their mental and physical health. The evidence we have also shows that older people are more likely to report good physical and mental health than younger cohorts, which is interesting. The exclusion, which is not necessarily deliberate but sometimes self-selected, of older people from training opportunities is indicative of what John was saying in terms of keeping your skills up to date. That is a way of ensuring that you can sell yourself in the marketplace, perhaps when you are not used to being out there because you have been employed for a long time. It is not a comfortable place for anybody to be; selling yourself to an employer—the right way to do it and so on—is a challenge for everybody.

So, participation in training needs to be more seamless and the responses of employers to mental and physical well-being in the workplace have to be better. Also, the management of performance has to be more seamless, rather than the tailing off that can happen to older people in the workplace on the assumption, “Well, you’ll be going soon”, or that it is not a nice thing to do. The challenge of improving approaches to performance management has to happen—we have produced some practical guidance on that—as does overcoming the lack of confidence among employers in doing it and the assumption that you could be being nasty
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to older people. There are lots of improvements to current practice in the workplace that could enable more activity among older people.

**Dr Craig Berry:** I agree with the previous two witnesses on workplace impediments to recruitment and training. I suppose there is a health angle here as well. Employers could support the lifestyles of their workforces from an earlier age and not just think about this problem as people approach later life and retirement age.

I would like to refer to a couple of wider economic trends that might be having an impact here, too, rather than just to issues that take place within the workplace or the labour market. The research on older workers by the Resolution Foundation, which I referred to earlier, also contains evidence that salary growth for workers in their 50s has been outstripped over the long term by that of workers in their 30s and 40s. That is probably quite surprising because you tend to think that your earnings go up as you reach the pinnacle of your career. However, older workers' earnings have not been growing by as much as they have for people in younger age groups. So the pull to stay in employment for those workers will not necessarily be as strong. Obviously, that is a result of much wider economic processes, to which there is no easy solution.

Very much related to that is work by Professor John Macnicol of the LSE, which relates effective retirement ages to the process of industrial change. It maps declining retirement ages in the post-war era to the decline in manufacturing as the kind of skills that people have in these sectors are less in demand. It leads to a process of de facto retirement. Lots of people will lose their jobs, but if you are an older person who loses your job in those circumstances, you end up in retirement. So the process of industrial change is having an impact here, too. Again, there is no easy solution to that kind of thing.

**Caroline Waters:** From a practical perspective, perhaps I can talk you through what BT has done. We have a model that is starting to work. It may be true that some businesses are not recruiting older people, but that does not have to be the case. After the early-release schemes of the 1980s, BT's population of workers over 50 dropped to 12 per cent. It is back up at 30 per cent now because we have taken a proactive approach. It made us think about how all our recruitment activity should be age-neutral. That means that HR people like me have to think about it, because we might use a very lazy shorthand. For example, we might require a qualification that has been available only recently, or five years' recent experience. We need to describe the skills we expect people to have. If you do that in your recruitment activity, our experience is that you get a richly diverse age group applying. We can track the conversion. We know that from recruitment to interview, selection and appointment, you can achieve fair results. Dianah is absolutely right that that must follow through into learning and development; that factor must run right through someone's career, especially for us because we are a long-service organisation. We had begun to pick up some of the normal myths—"you can't teach an old dog new tricks", all that nonsense—so what we did was a deep dive. We looked at the productivity of our older workers compared with that of their younger counterparts. There was no correlation between productivity and age. The correlation was between productivity and training. The more recent and effective the training, the higher the productivity, regardless of age. If you can nail the myths, you will take away some of the excuses. Another famous myth is that older workers tend to have more sickness absence. We found that that was not true. The under-25s tend to have rather more, for various reasons that we will not go into. What we have seen with our older workers is that, yes, they take longer to recover, but they tend to have fewer periods of absence. They are pretty savvy, actually, about how they manage their
workflow. One of the great things about BT is that we truly are a flexible-working company. By giving people autonomy in how they manage throughout their career, they can manage absence well as they get older. Of course, autonomy is a key factor in maintaining good mental well-being. The other thing that we do well is that we have a very good occupational health service. We have something called Work Fit, which is a programme that particularly works with our people. We tell them in their 20s and 30s what they need to know and what they need to do in terms of things like nutrition and mental health to ensure that they are well in their 50s, 60s and 70s. So we are starting very early. This is not a parental relationship, however. What we are saying is, “We will inform you, but you have to self-service; you have to come forward, take the guidance and put it in place”. Talking about age is something that is also incredibly important, because it is a taboo subject in too many organisations. If you can address the subject, your organisation is more likely to focus on how well somebody is doing at their job. Because you have got new people coming in who are older, it also breaks down the myth of capability and recruitment. On physical fitness, again, one of the things that we have found is that it is so individual, you cannot say that a 60 year-old is more likely to have knee problems from climbing the poles than a 32 year-old who plays football every weekend. Again, tackling some of those things and talking about the data makes a huge difference to your business. The other thing that we have found is really important is that we start—we would like to do it earlier, but it is a matter of cost when you have 100,000 people—with our retirement advice, which we do not call retirement advice but career-life planning, at the age of 45. People can make a decision about their long-term future or their immediate future. In answer to your earlier question, one thing we know is that there is a difference between different skill levels. A lot of our manually skilled workers who retire early tend to move on to part-time employment. A lot of our management-level workers go on to become older entrepreneurs. One of the bits of feedback they give us about a definite impediment to their access to the economy is that very often they want their small business to be a small business. They do not have massive plans for growth, and it is very hard to get a loan if your business plan is not for significant growth. That is something that is very important. So is the lack of access to training. Prime provides a fabulous service for helping older people become entrepreneurs, but there is a lack of entrepreneurial training, which needs to start earlier. The final thing is that we encourage our people throughout their careers to volunteer and be part of their local community. What we see there is that they are building attachment skills into the community that make them part of that community into older life. We are not getting feedback from BT pensioners that they feel isolated or lonely because they have built those attachment skills throughout that period. If you have that kind of end-to-end approach, from pre-recruitment to post-retirement, you can say that you have a good ageing strategy.

Q523 Baroness Shephard of Northwold: Are there any other examples of good practice that the rest of the panel might like to quote? I realise that they are not necessarily placed as Caroline is placed.

Dianah Worman: We have some examples. A lot will be anecdotal. The key is focusing on a solution that works for an individual in particular circumstances and that meets the needs of a business. For example, in a high-tech organisation that does a lot of work for the Ministry of Defence, because of the skill levels of its employees it is more than happy to carry on employing people up to 70 and beyond because of their expertise. It offers all sorts of flexible opportunities to retain access to those skills, including, for example, short breaks, with six months working and six months away, or working abroad and then coming back to work. Basically, the answer is that the organisation needs to think about what solution will
work for it. It can do anything it wishes as long as it gets the right answer. It must be
creative and innovative about accessing the skills it needs in a way that makes sense to its
business. That kind of thing does happen, through anecdote. The same thing will not be
applicable to everybody. That would not work. It has to be very much business-focused to
meet the needs on a partnership basis of the individual and of the business.

Q524 The Chairman: Can I push you a little bit on the policy question? That is all jolly
good, lovely, pleasing stuff from BT. It is all very cosy. But in the next 10 years, clearly many
more older people will want to work more, and will need to work more, for reasons we all
know. In economic terms, our society needs more older people to work more, otherwise
our dependency ratio will go seriously wrong and our GDP growth will be less. We need
more older people to work more or we will not be able to sustain the revenues for public
services. So there are three public policy reasons why we will want more older workers.
Not all employers are BT. The CBI’s evidence to us did not even mention the issue. I am
interested in this. Are there any data on employment policies and practices? Is everybody
like BT, or are most people not like BT? Where is the frustrated demand among people
who would like to work more but cannot? And what needs to be done to raise the
availability of more employment opportunities, either for people who are currently in a job
with an employer or of people who are not? You know what I am getting at.

Dianah Worman: One response to that would be the fact that employers have to think
more creatively about how they can access the talent they need and have to stop doing
things the way they did them yesterday.

The Chairman: But how does that happen?

Dianah Worman: One of the important building blocks is flexibility, and access to flexible
ways of working, which we have always promoted as needing to be an inclusive concept.

The Chairman: Is that just saying that the need of employers for workers will make the
problem self-solving and that we do not need to do anything?

Dianah Worman: To a large extent the market will drive this.

Caroline Waters: Not totally. One policy change that would make a huge difference would
be flexible working for everybody.

Baroness Morgan of Huyton: What is that as a policy, though?

Caroline Waters: At the moment there are restrictions within the flexible working policy.
It also, very strangely, has an “in perpetuity” clause, which has nothing to do with flexibility.
So that policy needs to be looked at properly, because the Government cannot be half
pregnant on this—it is either flexible or it is not.

Lord Hutton of Furness: The legislation?

Caroline Waters: The legislation.

Q525 The Chairman: Could you give us a more detailed note on that, just so we are
clear about what the current law is, what you think the changes should be and why?

Caroline Waters: At the moment, the current regulations on flexible working are targeted
at specific groups—minority groups that are seen to have a particular need. Actually, what
that does is create a hierarchy and forces managers to try to make value-based decisions
about individuals' needs, but they are not qualified to do that—they are qualified to make operational decisions about whether or not it is possible. So, one of the first things that the flexible working policy needs to be is available to everyone. Remember, before the CBI gets very excited about it all, we are talking about the right to request flexible working, not the right to flexible working itself. That needs to change.

Within the legislation there is this clause that says if you make a formal change, it is in perpetuity. That was put in for all the right reasons—to protect employees from more unscrupulous employers—but it needs to be reviewed because I believe that it is a barrier and makes it potentially administratively costly for business. The other thing is that the legislation has a qualifying period, so if you join an organisation you have to wait for a period of, I believe, 26 weeks before you are eligible to request flexible working. Very often, if you are a carer for an older worker, you cannot access the job as a full-time worker or on restricted hours for the first six months, so that represents a barrier. Now, most progressive employers have their policy and it starts from day one, but it is a barrier because it creates an attitudinal block as well. From a policy perspective, there are one or two things that could be fairly easy wins.

Q526 The Chairman: Are there any other comments on policy changes that are necessary to open up this market?

Baroness Tyler of Enfield: Chairman, could I come in at this point? That was really helpful. Obviously I am conscious that we had a very high-profile announcement about three weeks ago about the right to request flexible working being extended to everyone in the workplace, but we have yet to see that implemented. I would find it enormously helpful to know what would make the biggest difference in the implementation of the policy announcement that we have already had.

Caroline Waters: Simplification.

Dianah Worman: I think that is true.

Baroness Blackstone: What was your answer? I did not hear.

Caroline Waters: Simplification. At BT, for example, 97 per cent of flexible working requests are resolved prior to the formal process. The formal process is administratively clumsy and expensive, and ties you into the “in perpetuity” position.

Q527 The Chairman: Good. Are other policy adjustments needed to open this up much more as a realistic opportunity for people?

Caroline Waters: Flexible retirement.

The Chairman: We have that already.

Caroline Waters: No, it is not widely understood or implemented. It is all very well having policy, but it has to be taken down off the shelf and used. Some of the policies that are there are good, but employers either do not know about them or are not engaging with them, or employees are not well informed enough to ask the questions that they need to. As you said yourself, not every employer is BT, so not every employer will be proactively informing their employees about what is available to them.

Dianah Worman: Talking about public policy, there is an important role here for access to information guidance and advice. That is what makes a difference over time. It may be slow
but it bites quite hard. So if, as Caroline was saying, employers do not know how to do something, where do they find out?

**The Chairman:** So what is the answer? Where do they go?

**Dianah Worman:** Sources of information that can provide it. We provide a lot, but it should be available through government sources as well with regard to access to information. If there is a policy line generally to reduce that amount of information, we have a problem.

**The Chairman:** Baroness Finlay and then Baroness Blackstone.

**Baroness Finlay of Llandaff:** My supplementary question is particularly for Craig Berry. I am sitting here wondering how much national pay agreements, particularly for jobs in the public sector, are acting as an impediment to flexible working. One of the areas that I am specifically thinking about is the need for seven day services. Yet in the health service, *Agenda for Change* makes employing more senior people with experience on Saturdays, Sundays and bank holidays become relatively prohibitively expensive. Whereas when they are older, those may just be the times when they would like to work and could contribute the most, because they have the experience to deal with all major problems and there are fewer other people around. But the national pay agreements work against keeping them on.

**Dr Craig Berry:** I have to be honest; that is not really an area that I am particularly familiar with. I can understand the logic of what you are saying, but I cannot really comment on whether there is evidence that national pay agreements are acting as a barrier here.

**Professor John Philpott:** I cannot give a particularly informed comment on it, but my initial response is that it is highly unlikely that that in itself would be a major barrier to employing older people. There might be other arguments for or against national pay bargaining, but I do not think that this would be a major reason for making a change in that direction.

**Q528 Baroness Blackstone:** I am just wondering whether the real barrier is a cultural and attitudinal one. It comes back to what Caroline Waters was saying earlier. We need to abandon this misconception that life is divided into education, work for 40 years and then retirement, and address the need for a profound change in attitude. We no longer see this, but we perceive workers continuing until death—not at quite the same intensity and varying according to people’s health and mental ability. But why should anyone retire unless they are either physically or mentally unable to do some work? When that is addressed, all these flexibilities that we have been talking about will happen. Until it is, it will be much less likely to happen.

**Dianah Worman:** I think that is right. As Caroline was indicating, the concept of retirement needs to change because it cannot continue. The issue of having occupation of some kind, whether it is paid or unpaid is very important to your well-being anyway and the contribution you make to society. A lot of people, as Caroline was indicating when she spoke about voluntary activity, are occupied in the voluntary sector. The voluntary sector is very important, whether you are doing it for money or not. One of the issues about attracting more people into paid employment is that it could have an impact on who is taking part in activity in the voluntary sector. I agree with what you are saying. Occupation is very important. Choice of occupation is very important and whether you are paid or not is another matter. But occupation is pivotal.
Lord Hutton of Furness: Just a very quick question essentially to Dianah and John. Corporate social responsibility came to mean quite a lot in the 1980s and 1990s. Essentially, it usually came down to things like climate change and other environmental impacts. Are you aware of any shift in the agenda around corporate social responsibility towards meeting the needs of older people, particularly well-being in the workforce as a precursor to extended working lives?

Dianah Worman: I am not personally aware of particular initiatives, but I hear what you are saying about the issue of corporate social responsibility. At the end of the day, activities under that heading are not just about badging yourself up as being a good organisation. It is about building the communities in which you are actually doing your business to strengthen it. So it is a more coherent development from business in investing in that community because it will benefit that business at the end of the day. That is the kind of activity I would like to see being pushed much more by business following the lines that BT are talking about. At the end of the day, it makes society better for everybody.

The Chairman: Can I just stay with that theme, because you have talked about three shifts: the right to request flexible working, better information and advice and a general attitudinal shift that retirement is not the sudden change and goal of life. But unless employers’ attitudes and practices shift, it is not going to happen, is it? Clearly, Lord Hutton was getting at that for his CSR. So the question really is: what is going to shift employers’ attitudes? If you look at the CBI’s response to the introduction of the abolition of the default retirement age, they fought it hook, line and sinker, did they not? They clearly have the mindset of “Old is a cost and a problem. Let’s get rid of it and it’ll be all right”, so they are not going to suddenly leap on this and say, “Let’s offer lots of flexible working to the growing number of people who may want and need it”. That is a bit of a crude statement, but I think there is evidence to support it. So what is going to shift the employers’ attitudes and practices?

Caroline Waters: The thing that will shift employer practice overnight is when employers promote the right behaviours and are progressive on reward in the way that their stakeholders want them to be, so the City has an absolute role in this. At the moment, the thing that companies are rewarded for is their economic performance. That has to be much more rounded. If you want a CSR strategy, if you want an inclusion strategy to have real value and if you want business to turn from doing business here and a little bit of philanthropy there, we have to integrate the two. If on morning breakfast TV a spokesperson from the City said, “We are indicating that BT’s shares should go up because they are a progressive company”—

The Chairman: Any evidence that analysts think like that? I have never seen any evidence at all that they do. They would think you were barking if you said, “They’ve failed on their margin and all their turnover targets but they’ve got a lovely CSR policy on employing older people, so please keep buying them”. They would laugh at the idea, wouldn’t they?

Caroline Waters: Until we talk seriously about the subject, that will be the case. We should look at why a CSR strategy and progressive employment are important and start to make a business case. For example, Metz and Underwood’s analysis in 2007 estimated that over-50s have a total net financial wealth in this country alone of about £560 billion—that is almost 85 per cent of the total of the UK’s personal wealth. So we start to be able to talk about proper market segmentation and proper inclusion in the workplace. Unless you have social
The Chairman: I think the CSR is worth a try, but clearly one is also trying to look at self-interest. Where does the self-interest of the employer benefit from these policies? That might get the question up the agenda a bit.

Dianah Worman: Picking up on what Caroline said, we come back to the understanding of the business case. We have talked about demographic pattern changes and a lot of the baby-boomers suddenly leaving. That is going to leave us bereft in the UK of enough people from the indigenous population—we will not be satisfied by migrant labour either—to fill the vacancies, unless you continue to target more widely for your talent pool. That is the issue—it is getting businesses to understand the self-interest through the business case. The research that we did on managing a healthy ageing workforce—I can send you copies of this later—demonstrates that, despite the fact that the leading practitioners are doing brilliant stuff, further down in the long tail there is a lack of comprehension. The reactive nature of the response to keeping older workers is fine, but understanding the business case, articulating it and putting it to the top team is where there is a real need for change. That is what you need to do.

Professor John Philpott: On the CSR thing, I would just make two points. One is that I do not think that CSR per se is likely to be a clincher for this issue. Indeed, one might argue that the social climate is not favourable towards older workers at the moment. Business organisations are obsessed with youth unemployment and want to be seen to be doing something about that; they are ignoring what is probably a more serious long-term problem, even though we would all be worried about the problems that young people are facing in this current situation. In addition, what is quite interesting, if you go back to the stats, is that older workers are more likely to be employed by smaller businesses than larger ones. You might have thought that if there was a big CSR drive in this direction, it might have been a bit different.

There are a whole variety of reasons for this. One is that a lot of small businesses are set up by slightly older people anyway, so they have first-hand experience of what older people can bring to the table.

What is also the case, and this is probably of bigger importance to smaller employers than larger employers, is that there is actually a substantial implicit wage subsidy to employing people over state pension age, because they will often do part-time work for a relatively low wage because they have their pension income as a supplement. That indirect low-cost subsidy to smaller employers makes it worth while for them to take older people on.

Q531 Baroness Finlay of Llandaff: I was just thinking about where the evidence might lie. Do you have hard evidence from organisations such as B&Q, which publicised a great deal about employing older people? Their business does not seem to have suffered as a result at all, versus the negative publicity that we have just had of organisations that do not appear to be paying much tax in the UK and the impact of that negative publicity on their businesses. As you were talking, I was wondering how much the public opinion driver of knowing that B&Q was employing older people and also widening access was positively impacting on their business.

Caroline Waters: McDonald’s is a very good recent case study on employing older workers.
Baroness Finlay of Llandaff: Just having some hard data would be helpful.

Dr Craig Berry: I do not know if it is the case that public opinion was more favourable because of the image of those companies employing older workers. More relevant evidence is that their service improved because they better understood their customer base. That is the business case.

The Chairman: We would like any evidence that you have about the range of employers’ practices, so that we have some sense of how much everyone is clustered at the BT end or whether there is an enormous problem. We have not got any data on that at all at present, so we would like anything you have.

Caroline Waters: There is an organisation called ENEI, which used to be the Employers Forum on Age, which will probably have that kind of data.

Q532 Lord Hutton of Furness: Just a quick question. We have spent most of our time this morning talking about how we can extend the working lives of people in the labour market, but if you are one of those people approaching retirement, perhaps in your 60s, and you find yourself already out of the labour market, we know that many of those people, perhaps one in five, want to come back in. We know that people experience problems in finding a way back into the labour market. Could each of you let the committee know what you think the principal barriers are to getting unemployed older people back to work? Is that primarily a matter for government, employers or who?

Dr Craig Berry: I think the barriers to getting people back into work are probably very similar to the barriers to retaining people in the workplace. There is ill health. The statistic referred to of one in five people aged just below the state pension age who are economically inactive who would like to find a job came, I think, from the TUC. Of that one in five, half of them cite ill health and disability as the main reason that they are unable to find a job, although they would like to. That is obviously very similar to the reasons why people leave the labour market in the first place. Everybody has talked about the barriers in recruitment and how some of the discrimination experienced is depressingly routine. You have to consider the fact that people who are approaching state pension age who are unemployed tend to have been unemployed for a very long time. Long-term unemployment is a problem. We know that anyone who has been unemployed for a long time finds it difficult to re-enter the workplace at whatever age, so that is not something which older workers would be immune from.

Dianah Worman: Just as a general response to that, I would add that, as I was saying, we want a situation where there is more choice for individuals and less disaffection from society. If people are trying to do things and they are still getting pushed back, we have a serious problem. You will get disengaged parts of the community, which will cause social problems, add to health costs and so on. I would argue, therefore, that there is a need for government to invest time and energy in promoting more proactiveness in this case and there is a business case for businesses to get on board with the agenda. That is how government can perhaps respond. Businesses just need to get it. They need to understand how to refresh their approaches to recruitment and employment practices to bring them up to date with the 21st century.

Caroline Waters: There are potentially a couple of other areas. One is the cost of healthcare provision and insurance for older workers. That could well be a barrier for some employers, especially smaller employers. Again, BT can use its procurement power to try to help with that, but older employees are potentially more expensive than their younger
equivalents. The other area is that, in terms of the general societal view of older people, we tend to see in the media and in advertising only two models. One is the happy his-and-hers 70 year-olds gambolling along the beach; the other is the desperately poverty stricken. We do not seem to have the role model of the very capable individuals who are still able to contribute. I wonder whether there is something that government can do either with advertising or with working with those who do that.

Dr Craig Berry: I want to make a further point around specific government policies that may assist here. Research shows that older people looking for work tend to have negative experiences of jobseeker support services. The main criticism is that there seems to be a lack of understanding of their particular circumstances. One reason why there is a lack of understanding is that, as well as government considering whether those services are as tailored as they could be to the specific needs of older workers, they could also fund more research into this group of people. Too often, we lump together older workers—everybody aged 50 to state pension age—and we do not do enough targeted analysis of the groups that we are talking about. A 50 year-old is obviously a very different kind of jobseeker from a 63 year-old, or a very different worker in general. There is some research out there targeted on specific segments within that older working population, but I think that more could be done.

Q533 Baroness Morgan of Huyton: In a sense it is always quite easy to say, “What should government do to change attitudes?” and all the rest of it. As you were talking, I was thinking that for a while business was quite proactive on equality rights. I am thinking of the work that Stonewall did with business, for example, where you wanted to be at the award ceremony to say that you were a good employer. It does not feel to me that business is coming together and leading the way at the moment on age. Is that fair? How do we encourage business collectively to say, “We’re going to start being part of leading social change on this rather than waiting for legislation to change it”? That is not to say that there are not good examples of individual businesses—I accept that—but it does not feel to me that there is a business drive saying, “That’s the place that it’s good to be”.

Caroline Waters: That brings us back to the point that I made earlier: we have not made it in business’s interest to do that. We need to look at that and to have a sensible conversation about it. At the moment, in the current economic climate, a lot of businesses are just worrying about surviving. Because it is not always easy to say, in a tangible way, “That adds value”, or even, “The people who do that work add value”, you will see that when tough times hit—to be fair, this is not true of BT or some of the other organisations—some of the first parts of the organisation to go are the equality or inclusion people, because this is still not seen to be able to produce tangible value in tough times.

Professor John Philpott: On that final point, the sexiest thing for employers at the moment is to talk about youth issues rather than older workers. That point needs to be made. On Lord Hutton’s point, on the regulatory side of things, all the sensible stuff has probably been done and it is difficult to think what you could do that would not cause more harm than good. One area that probably does need focusing on is the broader education and training system. I know that it is changing, but there is still a tendency to think of older as being over-25. There needs to be a much greater focus on where there could be interventions for people much later in life, possibly using capacity within the further and higher education system to provide more opportunities for older people who might wish to study at weekends or during breaks.
BT, Chartered Institute for Personnel Development (CIPD), Professor John Philpott, Economist and Labour Market Analyst and Trades Union Congress (TUC)—Oral Evidence (QQ 514-536)

Q534 The Chairman: Now to the issue of the employment of family carers.

Baroness Finlay of Llandaff: I specifically want to ask what can be done to support people who have caring responsibilities to stay in work. I am thinking particularly about how to tide them over at a time when they may have quite a lot of caring responsibilities, but they are thinking about what will happen when the person whom they were caring for has died, when they will be extremely glad to be in work—and they will put 100 per cent-plus into work, because it then becomes the focus of their lives and fills a gap. How can that happen without creating a perverse incentive to not take on who might be carers in the first place? That is always the worry about unintended consequences, if you try to legislate. What can we do to support these people?

Caroline Waters: I am also chair of Employers for Carers. A lot of what I was saying earlier about flexibility for carers is true. The big issue is flexibility and information, particularly in the critical first six weeks of becoming a carer, when individuals can feel completely overwhelmed, and it looks like the only way in which they can cope is to drop out of the labour market. So there needs to be good-quality information and flexibility, as well as empathy at that stage; it makes a lot of difference. Thereafter, we have created a carers’ network, and they also have a sharepoint, where they can share with each other how to resolve issues. The biggest issues remain with local services. We are constantly told that carers are hard-to-reach groups, but that is not the case. The services are hard to reach. I have people who are caring for people with degenerative illnesses, for example, who are permanently stuck in an assessment loop and never actually get to services. Because we have a postcode lottery in service provision, I have a locked-down labour force who have got good services and they are not moving, whatever job offer I might give them, because that is too important. The fundamental thing about this agenda is that people always put their loved one first. That is what we want as a society. The other problem that we have is that we are in a 24/7 world, and I have people working all sorts of shift patterns. Carers would love to work at the weekend, because they can get all the things that they need to do with hospitals, and so on, done during the week. But because there are no services, or no affordable services, they cannot do that. One important thing is that it takes very little to accommodate carers in the workplace. It is about flexibility and providing information as well as about priming your line managers. As you said, the end of caring is often the death of a loved one, and that takes a particular response from the manager of an organisation.

Q535 The Chairman: Do you have anything to add to that, or do you differ from it?

Dianah Worman: No, I totally support what Caroline is saying. That has been the situation for many years. Certainly, signposting to helpful information for the individual, who suddenly finds that they have a crisis in their lives, helps them to overcome it. That is the connectivity between the service provision.

Baroness Finlay of Llandaff: That links to my previous question about the inordinate costs of seven-day services, because those national contracts mean that services are not provided on a seven-day basis. Going back to what you said earlier about performance appraisal, for the provider of a service, whether it be a national or a private sector provider, it is a question of how to get rid of underperformance or of people who do not have a good attitude through the performance appraisal process. You hear people say, “How long have they got? Oh, they only have 18 months to go.” They then kind of sit it out with someone who is underperforming in a post rather than drive the performance appraisal and possibly get rid of them, thus allowing someone more motivated to come back into the workforce.
‘We have published guidance on how to do this better, and I shall be
happy to send you a copy of it after the meeting.’

‘The real issue is that this has to start early. The problem is that most
businesses do not have a grounding in performance-related conversations, so when it comes
to an older worker or anyone from a minority group, there is a real reticence about
approaching them because they have not laid down good principles. It comes back to good
management practice, and surely there is enough guidance and so on. What we have is
partly a failure on the part of some of our management schools and management
programmes to keep up to date with the changing nature of management, coaching and
flexibility, but I think it is actually about how to make businesses engage.’

‘All the things you have talked about are extremely
valid. Briefly on this point, is that the position of small employers and those without big HR
departments, and even those who are self-employed? What can be done to help small
employers become more flexible? Are you aware of any consortium arrangements that have
delivered the goods?’

‘From the research that we have done as employers for carers, the truth
is that most small organisations do this very well. They do not have the fancy labels like BT
or the services of people like me, but they know their workforce. The problem arises when
businesses are at a size where they are just too big to know everyone but not big enough to
be able to afford HR services. There is guidance through the Federation of Small Businesses,
the British Chambers of Commerce and organisations like Carers UK.

‘So it is organisations of a size of around 50-plus that you are
identifying.’

‘Yes, at the point where they get a bit too big to know everyone.’
TUESDAY 27 NOVEMBER 2012

Members present
Lord Filkin (Chairman)
Lord Bichard
Baroness Finlay of Llandaff
Lord Mawhinney
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Paul Broadhead, Head of Mortgage Policy, the Building Societies Association, Nick Leon, Head of Service Design, Royal College of Art, Dr Lynne Mitchell, Wellbeing in Sustainable Environments (WISE), Institute of Health, School of Health and Social Studies, University of Warwick, and Len Street OBE, Former Chair, University of the Third Age.

Q496 The Chairman: Please go along the row and just say who you are. Then we will get into the detailed questions.

Dr Mitchell: I am Lynne Mitchell. I am from the University of Warwick, where I work in a research unit called Wellbeing in Sustainable Environments, or WISE for short. My background is in planning.

Nick Leon: Nick Leon of the Royal College of Art. I am Head of Service Design.

Paul Broadhead: Paul Broadhead from the Building Societies Association. I am Head of Mortgage Policy for the association.

Len Street: Len Street, from the University of the Third Age, and also the Third Age Trust, which is the underpinning organisation of Universities of the Third Age throughout the United Kingdom.

Q497 The Chairman: Excellent. As you do not need reminding, you are all very different and you have got different opinions, but feel free to come in on any question that strikes you as relevant. Let me kick it off by asking how the different public and private
sectors are responding to the changing market and changing needs of an ageing society. It is an invitation for you to talk about either financial services or attitudes or what have you. Just give any comments that you have on that general topic.

**Paul Broadhead:** Shall I just open up on financial services, Chairman, given you mentioned that? I represent the mutual sector, so building societies and other mutually owned mortgage and deposit takers. Just in terms of the customer base that we have, around half of our savers are over 55, so the organisations are very used to adapting to changing needs. Of course, many of them are geographically based and can adapt to those changing needs. The ageing population is something that has been on the agenda for the sector for quite some time now, and some research was recently carried out by one of our members that I thought was very interesting. When people retire, consumers are now reporting that they retire from work and do not retire from life. This is not about putting people at different ages into boxes and so on. It is no longer seen as a single event; it is a continual and ever-evolving journey. Our focus is on providing the right products at the right life stages, rather than saying because someone is 65 they need this particular thing, because ultimately what are a 65-year-old’s needs? They differ from one end of the spectrum to another, so it is just about identifying the changes.

**The Chairman:** That implies that you have already been doing it and there is really no need for much more change by the financial services industry, even though we have got a lot more people getting a lot older.

**Paul Broadhead:** The financial services industry will need to change as people’s needs change. To give you an example of what I am talking about there, very few over-55s and over-65s have mortgage needs, because typically we have seen great capital growth and so on. We have seen the evolution of the equity-release sector to help with things like long-term care or supplementary pension income. In the environment we are in at the moment, we think we will see much, much lower capital growth, which makes it much more difficult for people in homes to upsize or downsize and release that equity to achieve that dream. So we may see a growing older population that actually need mortgages going into retirement, and we have been lobbying the Financial Services Authority very hard to make sure that older people are not disadvantaged if they need that financial support for evolving housing needs, be it adapted homes and so on. So we are evolving, but we will have to evolve further to respond to people’s needs as they become clearer over the coming decades.

**Q498 The Chairman:** Are there comments from others on how different sectors are addressing it?

**Dr Mitchell:** Obviously I am an academic and a researcher at a university. From my particular point of view, the problem for us is the lack of research funding. I am here to talk about design. The importance of design is that it is evidence based with proper research findings to back up what we say should be done, but there is very little research funding available at the moment.

**Nick Leon:** Within the education of young designers, it is evident to me that the thinking about designing for an ageing demographic and the whole concept of inclusive design is very mainstream. The extent to which that has been accepted by business, and of the opportunities in the public sector, is much more limited. Whilst it is mainstream in the sense of the new designers that we have emerging, and a lot of this has also been championed by the Design Council in the UK, it is not fully evident yet that many large
firms, and certainly public services, are really embracing this in terms of designing in an inclusive sense.

Q499 The Chairman: What would you hope to see that you are not seeing?

Nick Leon: Having just been on the Land Registry website last night, and puzzled by that, and comparing it with GOV.UK, which is an absolute exemplar, I would like to see, for instance, more provision of digital public services along the lines of GOV.UK than we have today.

The Chairman: Right, so more accessible to many older people.

Nick Leon: I think they are much more accessible to everyone, and that is the important point going along the lines of an inclusive agenda, where we design for everyone, and not design some things for old people and some things for the young. I am sure all of us feel that about the kinds of things we like to acquire, or the services that we like to be recipients of.

Len Street: We clearly see growth in membership because of the demographic shift. One of the things we find is that as we have an increasing age amongst our membership, those people who are mentally active sometimes find that they become less physically active. We are starting to find a need to explore ways in which we keep those mentally active people who can no longer get to meetings, and keep them active and doing the thing that makes them want to continue their intellectual stimulation, if you like.

So we are thinking about how we cope with that particular drift in the need for older people. I wondered, Chairman, whether you would want me to say something about how a U3A operates and works, because we find amongst our members that it is not widely known how U3As work and the reason for their existence and so on.

The Chairman: Go on then. I do not think there is a specific question, so have a couple of minutes on it, and particularly the relevance of what it does to a terrain of how we as a society should be preparing for more of us getting older.

Len Street: I think the important thing about U3A is it gives people who perhaps feel rejected by society quite often a chance to meet with their fellows, their contemporaries, and share common interests. A U3A is essentially a learning co-operative of people who want to share a common interest. A U3A is self-funded, self-managed and self-organised, and it makes use of the talents, experience, knowledge and the accumulated life experience of its members, and their enthusiasm to share that knowledge with each other. They have a very important social aspect to their work. For example, someone who retires misses the companionship of the workplace and can become isolated. They get a chance to meet new people and join in the activity groups. My U3A happens to be based in Broxbourne, which is on the outskirts of London. Amongst the many groups we operate, one of the most popular groups is called Exploring London. There are eight such groups, which means about 30 members in each of them, that go and plan opportunities to visit all sorts of places in London to find out about the city and do the things that they never had time to do when they were at work. That is acquiring knowledge, but it is also a very important social aspect to their life.

The Chairman: We will come back to you with more questions in a minute.

Q500 Lord Bichard: I just want to press more broadly on this, because this is quite an important area. You said what I expected you to say, if I can be provocative, a bit
complacently. I recently remortgaged, and my wife was not pleased, because she is a bit younger than me, to be told by the mortgage society that we could not do it over the period we wanted because I was too old by the end of the term. I was not a good risk. That will not encourage older people to reorganise their finances for particularly the purpose you suggested.

The Chairman: Lord Bichard is not asking for a second quote, by the way.

Lord Bichard: Throughout these hearings we have touched upon the issue of equity release, and have had different views on whether this is a market that is functioning effectively. We have probably had more negative than we have had positive. That is a worry to us, because although not everyone has got equity, a lot of people have, and that equity adds up to a huge amount of money if you look at it on a national basis, which – there is not a lot of money around at the moment – one would want to feel people could use to keep themselves in their home, which is where they want to be, if that is what they want to do. So in both of those areas I feel maybe the market is not working as effectively as you are suggesting, and maybe we would like to address that. Do you have ideas about how it might work more efficiently and effectively?

Paul Broadhead: Certainly. In terms of the first point that you mentioned, which was not being able to get the sufficient mortgage term, I think in the past that has sometimes been an issue. There has been lots of speculation in the media regarding the forthcoming changes to mortgage regulation disadvantaging those over the age of 55. We fought very hard in terms of conversations with the Financial Services Authority to ensure that that is not the case. For example, when the regulator started to reassess the mortgage market, they were saying that if you are lending to somebody beyond state retirement age, there were far more detailed investigations you had to do in terms of their background and so on and so forth. We thought that was not equitable or right, because we do have an ageing population, and actually the state pension age does not mean people necessarily retire at that age.

Dr Altmann was talking this morning about moving from three life stages to four. Surely the important thing for a mortgage lender to understand when assessing a potential borrower’s circumstances is that they can afford that mortgage over whichever term they wish. So the changes that you will see in the future, Lord Bichard, are that if you need to go beyond what might be the state pension age, the mortgage lender would need to be certain that your income beyond that retirement age is sufficient to service that mortgage, because otherwise they would not be meeting their responsibilities in terms of responsible lending. I think we will start to see more flexibility. I do not suggest this will happen overnight, but I think over the next couple of years we will see much more of that.

Moving on to the equity release market, I think it is quite a thorny issue for many people, and it is an evolving market. At the moment there are lots of different types of products that are often referred to as equity release. People that have been around the sector for perhaps 10 or 15 years will remember what we would call shared appreciation mortgages, where there was some consumer detriment because consumers did not understand the type of loans they were taking out. Over recent years we have seen a “sale and rent back” sector, where people can sell their property, remain in it as tenants, and release that equity in that manner if they want to have a managed exit from home ownership. That has not served people very well, because they have not necessarily been getting the actual value of their property, and they have been rushed into it and perhaps did not understand what they were getting into. The regulator has stepped in and closed that now.
In terms of equity release, we have just seen the recent launch of the Equity Release Council, which covers not only lenders that are involved in equity release but also solicitors and intermediaries to make sure they meet certain standards that protect borrowers that do wish to release equity, be it for social care, a holiday or to supplement their income. One of the important developments is that subscribers to the Equity Release Council now need to give a no negative equity guarantee to borrowers, so that if they do release equity, they are never going to owe more than that even if their property value falls, which I think provides reassurance.

One of the most challenging areas of equity release is what it means for those that might otherwise have inherited 100 per cent of the property. I think it really needs to be a family discussion so that the borrowers themselves know what they are getting into, but the family know as well. It needs to be a very, very informed choice, and we recommend that people get independent legal advice about other opportunities for them, but I think we will see that market become more mainstream going forward.

One note of caution though, just in terms of funding long-term care, is we are moving as a country to a more asset-based approach to welfare, so releasing equity to fund long-term social care or other needs in retirement. We do not want to move all our eggs to that basket, because what we have seen over the last decade is falling levels of home ownership. If that continues there will be a bill to be picked up somewhere else later down the line, so it needs to be part of a portfolio approach, but I think it does have a role to play.

Q501 Baroness Tyler of Enfield: My questions are quite general, but that is because part of the remit of this inquiry is really to try to understand how both public and private life need to change to adapt to the needs of an ageing population. I would be particularly interested in your thoughts, and I address this initially to Len Street. From your experience, what are older people actually looking for these days from old age? Obviously people hope that at least part of it will be a healthy old age, but what are their expectations?

Len Street: I think they really want to be free from isolation. They do not want to be left lonely, so U3A membership is very important to them. It is not uncommon to hear U3A members say that joining U3A was a lifesaver for them, if they had lost their husband or wife or had some other loss in their lives. Touching on the questions that were just raised in terms of finance, if the state is to, as it were, look after people in their old age, I think it is important that the system, the milieu in which they live, is conducive to them living an independent life for as long as is physically possible. I am not quite sure how you would do that, but that does depend on such things as good public transport to be able to get to meetings. It is important for U3A people to get to their meetings, where they can socialise and mix with their contemporaries.

Nick Leon: If one thinks of adulthood beginning at the age of 25, for somebody approaching retirement in let us say their mid to late 50s, they are only 30 years into their working life of being an adult, with another 30 to go. It is a bit soon to peak, if you do not mind me saying. In terms of people that I know, particularly the design community that I now know as well as colleagues from the industrial background that I had, many people feel that way. So when we talk about what we want from older age, they are the same things we want from being young, and to find ways of continuing it, which is why initiatives like the University of the Third Age are so profound. You can add new skills as well as consolidate and exploit skills that have been built up over that first 30 years so you can really peak in the second 30.
Building Societies Association, Nick Leon, Royal College of Art, Dr Lynne Mitchell, WISE, University of Warwick and Len Street, University of the Third Age (U3A) – Oral evidence (QQ 496-513)

Paul Broadhead: I agree with what both of my colleagues on the panel have said, and I think it is this point about how in later life you do not retire from life; you potentially retire from work, and it is about still being treated as an individual that can contribute to society. However, I think it depends on your personal circumstances in age as it does in younger life. So if you are fit and well, what an ageing population will want from financial services providers is access to the full suite of financial services products you would have access to were you 30 or 40. Why can you not have access to that if you are 60 or 70 and fit and well? I think that is an important thing.

If you are in deteriorating health, either mentally or physically, then you need to be able to access the financial services that you need, so things like access to branch networks, flexibility from your providers to make sure you can transact without feeling in any way that you are a burden on your family, because you need them to help you go along to branch, and to be treated as an individual by your financial services provider.

The financial services sector needs to move away—and as I say, I represent the mutual sector—from this big bank, one-size-fits-all approach, and almost go back to where we were a number of years ago, where people in the local branches knew the customers that were walking in there. We still see that sometimes in the building society sector. I think financial services almost need to return to that to understand people’s individual needs.

Q502 Baroness Tyler of Enfield: Could I just press you on that point? It is a question I was going to come in on later, but you have come to it now. I am sure you are aware of a report that came out a couple of weeks ago from the Payments Council and various charities, talking about the problem of so much of banking and financial services being digitised and the difficulties that was creating for older people and some people with disabilities. They were becoming very financially excluded. In your view, is that the case? What could and should your sector be doing about it?

Paul Broadhead: I think there probably has been a bit of a race to electronic transactions over the last few years, particularly from the large banking sector, because that provides those organisations with economies of scale. I do not necessarily think that serves the needs of the wide constituency of customers.

Our members are realising that people want to interact in different ways. Some people want to interact electronically; others that are not e-savvy, if you like, will still want to either go into a branch with a passbook, ring up on the telephone or have a home visit, and it is important to maintain those. It would be wrong for us to say that in the future an ageing population will be less able to interact using digital media, because the young people of today will be the old people of tomorrow, and they are very computer savvy. It is important not to lose the technological advantages and the ease of doing business, but it is also important to recognise that people do have different needs. Some of our members have been providing home visits to those that have difficulty getting out of their homes. Some very small changes can make a very big difference.

We have got one branch up in the north-west of England that provides a drive-through branch, because the majority of their customers are elderly, cannot walk very far, but are car drivers, so they have a drive-up counter where you can wind your window down and transact through your car window as if you were going to McDonald’s, but one would hope the outcome would be far more healthy. Talking about small changes making a big difference, some of the other branches are moving to lower counters, often with stools or seats, so somebody that cannot walk very far can sit down while they are taking their
money out or putting it in over the counter, because it makes it more comfortable. So we are seeing some changes. They are small and they are slow, but where the sector is recognising the needs, they are taking action where they can do.

**Baroness Tyler of Enfield:** Do you think that is likely to be replicated?

**Paul Broadhead:** I think it ought to be replicated. I hope it will be.

**Baroness Tyler of Enfield:** Are there financial incentives, though, for banks and building societies to do that?

**Paul Broadhead:** It depends on whether you are talking about banks or building societies. One way in which I view the two sectors differently is that banks have shareholders to service, so it is much more about maximising profit. Of course we have seen that over the last few years with some of the bad press that the banking sector has had, in many cases rightly so.

The building societies are actually owned by their members, so they do not have those shareholders to service. Often one criticism of the mutual sector is that its operating costs are higher, so people think that because you are mutual, you are inefficient. Actually many of our members are proud to be inefficient, because what that means is they have got more branches. Often they are the last bank in town, so it does cost more to run, but they have the incentive to do it because they are owned by their members and do not have external shareholders trying to drive that down.

**Dr Mitchell:** Can I just say the big issue really is quality of life rather than quantity of years. We hear a lot about how wonderful it is that we are all living longer, but if people in their older age are trapped in their homes and disabled by the environment around them, they are not going to have a good quality of life. That leads on to what Len was saying about loneliness and isolation. If people cannot get out and about for whatever reason, they are going to experience social isolation, so it is the quality of life we need to address. From the research we have done, people are very keen on continuing to be active members of society. They want to take part and have a role in life.

**Baroness Tyler of Enfield:** And does your research tell you what specific practical measures would enable that to happen?

**Dr Mitchell:** My research focuses on the design of the built environment, and there is a lot we can do with the design of a built environment to get rid of the barriers. Although people may have mobility or health problems, they are not so much disabled by those health problems but by the environmental barriers.

**Q503 Baroness Finlay of Llandaff:** I have a very quick question about evidence. Len Street, you were talking about the role and importance of U3A, particularly for people in crisis times in their lives and moving through. Have either you or Lynne Mitchell got any data or evidence on improved morbidity and mortality outcomes in the population who do access U3A? The other question relates to free bus passes and travel, which I wondered if you might be alluding to. Do you see an increase in people joining U3A once they can get there with a free bus pass? Is that then allowing them to create or join a caring community that they might not have been able to if there had not been that travel available?

**Len Street:** We do not have any hard evidence; we only would have anecdotal evidence. But a common expression is that U3A membership keeps you out of the doctor’s waiting room and things like that. You do find that the friendships that people make as a result of membership have a subsidiary caring effect. Someone says they have not seen Mrs Jones
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this week and ask if she is all right—that sort of thing. Living where I do, which is just outside the Greater London area, you do notice a difference between the people who have a Freedom Pass in the Greater London area and the people just outside who do not, in that they find they can travel readily to U3A meetings. Within the Greater London area there is a very big U3A operating in London in Hampstead, but it draws its membership from all across London for the simple reason that they can get there easily at no cost to themselves. So that is bound to make a difference, especially in rural areas, where if you have an increasingly ageing population, an infrequent bus service is not a lot of use. Whether you would see that extrapolated into greater community cohesion I do not know, because I do not know that anyone has ever studied that, but it seems to me quite likely that it would.

The Chairman: That brings us neatly on to the urban planning question.

Dr Mitchell: Sorry, you were asking about morbidity rates. I do not have any per se, but we have found that older people living within 10 minutes of green open space or where the pavements are in good condition are twice as likely to fulfil the recommended amount of walking, which I think is two and a half hours a week. That obviously has a knock-on effect for NHS costs.

Baroness Finlay of Llandaff: Huge, if they do not fall over.

Dr Mitchell: Well, yes, but as I say, if the streets are well maintained, they are less likely to fall over.

Baroness Finlay of Llandaff: Yes, sure.

The Chairman: Question 6, support on urban planning?

Baroness Finlay of Llandaff: I was going to take 6 and 7.

The Chairman: Quite right. I gave you the wrong numbers. It is the urban planning ones.

Baroness Finlay of Llandaff: Who was doing those?

Q504 The Chairman: Never mind. Let me kick off. How should urban planners be responding to an ageing society, and are they up to it?

Dr Mitchell: The 2008 Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society made a wonderful start at looking at how to design for an ageing society, which linked the required housing to placing the housing within the local neighbourhood, and what had to be done within the local neighbourhood as well. We have lost that as we have moved on to the newer housing strategy and the National Planning Policy Framework. We have lost lifetime home standards and lifetime neighbourhoods. To a certain extent it is now at the discretion of local authorities, whereas the 2008 strategy was expecting all local authorities to follow these standards.

There are a lot of things within planning that could involve designing for the ageing society more. For example, the health and housing strategies and planning policy all talk about the important links between health and housing, but they do not specifically say that a housing representative should be on the Health and Wellbeing Boards, let alone an inclusive urban designer. I think that is an important point.

With the neighbourhood planning idea, it is going to be so difficult for people in neighbourhood planning groups to know about all the needs of all the people in their local neighbourhood, their town or city. A lot more information needs to be given to them about what they need to think about in designing for older people. That is designing for
dementia as well as for people in wheelchairs—access-inclusive design. There is so much to consider, and with the cutbacks, I am not quite sure if this will happen. From talking to stakeholders, people are saying everything is at the local authority’s discretion now, and with the cutbacks how much are they going to focus on things that are not statutory? It is to their discretion rather than required of them.

Baroness Finlay of Llandaff: Can I pick that up a little bit and ask about the planning authorities themselves? With cutbacks there seem to be disincentives to tackle any of this, and I wondered if you felt that there were any that were willing to respond and were drawing on any evidence of a difference that was made with better planning. Also, where do you feel the new public health directors being put into local authorities might have a role, and do you feel this would be accepted by local authorities?

Dr Mitchell: There are a number of authorities that have been trying to make their cities, towns and neighbourhoods more age-friendly based on the World Health Organisation’s Global Age-friendly Cities: A Guide. A lot of them have taken that up. They have got ageing strategies and action plans, and a lot of local authorities have an older people’s forum that they work with very closely to deliver these action plans and strategies.

Lord Bichard: Who are the exemplars?

Dr Mitchell: Greater London Council.

The Chairman: I thought it had been abolished.

Dr Mitchell: Oh, Greater London Authority, sorry. I am showing my age there. Manchester and Edinburgh are also good examples.

Baroness Finlay of Llandaff: Have these been evaluated? Have they got data to show that they have impacted on health and social care costs?

Dr Mitchell: I do not think they are at that stage yet, but I am not 100 per cent sure. Sorry, what was your other question?

Q505 Baroness Finlay of Llandaff: Where would public health sit? I am back to decreasing health and social care costs. Where is the driver to incentivise the local authority to really pick this up, other than it being seen to be a good thing for the electorate?

Dr Mitchell: All the strategies are talking about the importance of working together and developing cross-sectoral strategies because of the links between health and wellbeing and the built environment. People have been talking about that for the last 100 years or so; it is not a new thing. In research we are finding that we are being asked to do a lot more health and cost-benefit assessments on the impacts on health and the costs to the NHS for the design work that we are proposing. If we can prove more carefully with more evidence that designing neighbourhoods and cities in this way will help people be more physically active, mentally healthy and have less falls, obviously that is going to have a knock-on effect on the cost to the NHS and health and social care. The local authority has to provide a lot of social care services, so the more independent people are, the less reliant they will be on social care.

Q506 Baroness Finlay of Llandaff: Just in terms of the sections of the local authority that work with that, is anyone doing any work to show that if you have fire doors, for example, that are lighter and easier to push open, older people will access services in those
buildings more? Actually the same applies to mums with pushchairs. Some of these doors are impossibly heavy to open, and older people get frightened as they feel they swing back on them quite hard. But the fire regulations dictate what the fire door is, so there seems to be a lack of joined-up thinking and approach in terms of risk assessment to say that a slightly lighter door might be a little bit worse—you might have to take a few seconds off your evacuation time—but on the other hand the building would be used.

**Dr Mitchell:** Yes. I do not know of any specific research that has been done on that.

**Nick Leon:** I go back to my own design education nearly four decades ago. We considered that the goal of the design was to enable, too frequently it is design that disables. It is the consequence of that, and as we look to the ageing demographic right now, which will see a doubling of the number of people over 80 within the next 15 or 20 years or so, it is clear that the built environment, unless considered extremely carefully through the view of both the urban planners as well as those who provide services in the built environment, is going to disable an increasingly large number of people. That is evident.

Particularly with the move of health and wellbeing to local authorities, the impact will be to reflect on whether those local authorities have, first, the capacity, in terms of the cash, and they have, more importantly, the capabilities to be able to fulfil those responsibilities. They are not going to just get the capabilities by reassigning an organisation and relabelling someone. Someone has to go and get themselves skilled up in those fields.

When policy emerges that says this is the right thing to do to incentivise this set of resources, as you described it—the local authority—to pick up these responsibilities, the other side of that is a responsibility to ensure that those enabling measures are put in place to ensure that they have both the capacity and capability to fulfil that. I think that is a problem.

**Baroness Finlay of Llandaff:** Where can they go to get skilled up?

**Nick Leon:** We, for instance, have just been running a workshop for the Cabinet Office on user-centred design, so that when policy measures are being implemented, someone is actually thinking about what the citizen experience might be like. We have some of the best art and design institutions anywhere in the world, and great technical universities like the Imperial College, which I know particularly well, that have those kinds of capabilities. Those resources can and should be made available to build the capacity locally inside those organisations as well as support the extension of their capability to do that. I do not think you can just come up with a policy, push it down and then expect it all to work without envisaging what the capacity and capability constraints of those on the front line who are going to end up having to make those decisions. Otherwise you will have more design disabling and greater levels of disability.

**Baroness Finlay of Llandaff:** Len Street, you look as if you want to come in.

**Len Street:** What worries me, as a senior citizen of quite a lot of years, is that the lead time for these changes is so enormously long and they will not happen. Already we are seeing the death of town centres through the creation of out-of-town shopping centres. So as the ageing population increases and mobility diminishes, that is going to be a problem, with the loss of the corner shopping localities where people can get their supplies.

**Baroness Finlay of Llandaff:** Can I ask one other short question related to that? It relates to parking. There are a number of town high streets where parking has gone or
been made more difficult, and there has been the pedestrianisation of some whole streets that previously people could drive down. Do you have any comments on that?

**Len Street:** I agree. It does become a problem, but some local authorities seem to be aware of it and others just do not. There is no overall direction, as far as I can see.

**Dr Mitchell:** We found that some people will not go to certain areas because they have mobility problems and have to drive, and they cannot park close enough to the shops or services they need to go to. I do not know if you have heard of shared spaces, where the streets are changed so that everybody is in together.

**Baroness Finlay of Llandaff:** Yes.

**Dr Mitchell:** Some people who can no longer park outside their house can no longer get out and about because of their mobility problems.

**Q507 The Chairman:** Nick, you made some pretty high-level generalisations about urban environments disabling people in the future given an ageing society. Can you give us some more detail on that? In what ways will that happen, and having some account of financial realism, what should be done about it?

**Nick Leon:** I think one of the points that has just been made sums it up very aptly. We are seeing the growth of large out-of-town shopping centres, and those continue to grow and pose mobility issues for an ageing population. So at a planning and incentives level, we are seeing issues that relate very tightly into issues of mobility. The use of the private car by older people is because they need to have door-to-door mobility. Therefore, in the provision of public services, being able to ensure that there is support for door-to-door mobility is an area, for instance, that can help dramatically. We have been ready to put in place legislation around ramps and access, and those things have clearly over the last two decades made an immense difference. We need to encourage people to get out of the house to avoid issues of isolation and to maintain, as we all want to do for our future selves, that degree of independence. I come back to this concept of improving mobility and the ideas and concepts around door-to-door type services being just one element of that.

**The Chairman:** I came across an article recently that made the argument that, for many older people, the rural dream was a myth, and that you were better living in an appropriately designed city centre.

**Nick Leon:** Rural isolation, yes.

**The Chairman:** People differ. We are not all same, and some want to admire cows all day long and others would like a bit more buzz. Assuming there is something in that, it does tie back to comments we were having previously about the lack of city planners and the housing market really providing housing products that would enable people to downsize into appropriate supported accommodation in urban areas. Do you agree with that, and if so what should be done?

**Nick Leon:** I do agree that there are real issues associated with the design of housing for people as they age, but we have to be very cautious of thinking that design for older people is all about commodes, grab handles and ramps. If you design for the old, you can include the young. If you design for the young and cool, you will almost certainly exclude the old, and that is problematic. Let us take as an example my car. The Ford Focus was designed with good access, to ensure that older people could get in and out, and brighter dials, as the eyesight of the over-55s, people like me, requires dramatically more levels of light. But no young person complains that the car is too easy to get into or that the dials are too easy to
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read. I could go through a whole list of different types of products and designs where good design has made it inclusive for everyone, rather than stigmatising people by having the ramp and the grab handle for the old. Let us design it for everyone.

Dr Mitchell: Can I go back to living in cities? We have done some research on this, because we are now advised that older people’s housing should be in high density areas where they can walk to the shops, there is a lot of social activity going around and there is good public transport. We had a look at this with only 200 older people, but we found that people were happy living in high density areas if those areas were not too crowded, noisy or badly maintained. If they were well maintained and they could get away down side streets from the traffic and the crowds, they were happy and it suited their needs very well. In areas that were rundown or not very green, and the noise, dirt and crowds became the biggest features of those areas, a lot of people preferred to live in villages and small towns and accepted that it would be harder to get to their facilities easily, but they put more importance on living in a quiet, green area. So, yes, living in a high-density area where you can walk to facilities is important. We found that for various reasons most people as they get older walk more often than going by public transport or driving, so to be able to walk to the shops, the bank, the GP and everything is obviously extremely important, but it has to be the right sort of environment as well.

Q508 Lord Bichard: We should also remind ourselves we have heard in previous hearings it is more difficult to get planning permission for extra-care accommodation in town centres than it is for a supermarket, just to give some sobering reality. I want to encourage Nick in particular to carry on talking a bit about design, not so much urban design but product and service design. The Royal College has got a fantastic track record in emphasising the importance of design for an ageing population. I think more recently the issue of service design, how we manage pathways, for example, in health and social care, has become more and more important. You were talking earlier, reasonably optimistically, about the new designers that we have been churning out, and less optimistically about the private and public sector’s ability to use those skills. But not everyone—and I think we should perhaps just get it on the record—is even quite clear why this issue is so important. So can you just talk a little bit about why you think design is a central issue in this conversation about ageing?

Nick Leon: I would be pleased to, because I feel that we tend to have a view of older people as a market that is homogeneous. I have heard talk that the three ages are now the four ages. I think there are many more ages than just two to growing older. There are issues in the demographic differences that relate to that community as one ages, let us say those 65-plus, that are at least as diverse as those in the 30 previous years.

Design has a fantastic role to play, and has played a terrific role, in the design of specific products and services, whether it is in the design of devices that are used within the home, for mobility or consumer goods and others. Where design is becoming very interesting is in the design of services, bearing in mind that 80 per cent of employment is in the service sector and almost three-quarters of the economy is in the service sector. Yet up until now design has played a fairly modest role. If anything, the experiences that we have of both public services as well as those delivered by the private sector are not intentional. They are the consequence of someone designing some software, the physical place and the organisation that delivers it. The kind of service that we get was not intentional.

I remember it being put very markedly and in a very interesting way to me that, if we could understand all the elements of what it took to design 90 per cent of a luxury hotel
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experience for 50 per cent of the cost, then we could apply the same principles to transform social services. It was not just a casual comment; it was to say that if we can understand what 90 per cent of an extraordinary experience adds up to, and know how to maintain the quality of that experience while dramatically improving productivity, then you can take that designerly view and deliver that to transform the quality of social care. We have seen sporadic but very, very good examples of where design has been used to create and transform the quality of experience.

In this sense, service design is about being able to take a user-, customer- or citizen-centric approach, or even patient-centric approach if we were talking about healthcare, and figure 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. All of us who use services like Amazon, which has a very customer-centric approach, would prefer to see an organisation like that—even if they do need to pay more taxes—deliver, for instance, financial services instead. Would that be a better experience for us, taking a much more customer-centric approach? That is the kind of area that we are exploring today at the Royal College of Art, and working with some of the largest companies and organisations in the world, from some of the largest retailers to the largest electronics firms. We are all trying to transform the service quality of what they deliver. Delivering that in order to do it inclusively so that older people can benefit is exactly the area where we think design has a major role to play.

Lord Bichard: But it is taking a long time to get there

Nick Leon: It is.

Q509 Lord Bichard: You mentioned some work you did with the Cabinet Office, which crossed my radar recently, but generally getting the public sector to understand the power of design to improve services at less cost is proving very difficult, is it not?

Nick Leon: It is indeed. The concept of designing better services that are centred around the citizen for less is exactly what has been achieved in product design, for instance, but in the service sector is right at its very, very beginning, and particularly in the public sector. The opportunity to be able to apply these skills, from the types of projects that have already been undertaken in healthcare and in other areas, shows that these small-scale demonstrator projects can make a big difference.

We have to be cautious, however. Let us take an area like Telecare, for instance, and assisted technologies. We can think of that as being something that is highly technologically mediated, but without a design component to it that understands the consequences of gluing a gadget onto your granny and plugging her into broadband, and understands what that is going to mean to her and how she is going to react, you are simply getting assisted gadgetry, not making as big an impact as you could otherwise. So it is this combination. Great new technologies bring you possibilities, but it needs design to look from a highly customer-, patient- or citizen-centric view to exploit those possibilities.

Len Street: It is important that the client is adequately consulted. Nothing irritates a Third Ager more than to have a Second Ager tell him what they want and what they need. So it is important that there is a great deal of consultation about what people want in any design project, it seems to me.

Q510 Baroness Finlay of Llandaff: Should we be building in some requirement for field testing of new design on groups across all ages?
Nick Leon: When public services emerge from policy decisions, one can think of a stack: I have my policy; I have got the propositions that it creates; I am going to design a set of processes and put them into practice. Rarely are those all well aligned about what in practice the citizen experience is going to be like. If you are going to design a citizen experience, as Len Street has absolutely rightly said, you have to do it in a highly collaborative way, co-designing, co-creating with the community, not only with those who will be the recipients of the service but those who are responsible for its delivery. Great services happen when people who are really committed to the quality of delivery believe in the service they are delivering, are valued by their management, understand what the proposition is, the processes and what the policy involves, and then deliver that to a recipient because those two things have been designed together.

Lord Bichard: One of the things I learned from my time working with designers, going back to Ilona’s question, is that designers are much better at including the clients and starting with the clients than bureaucrats or politicians are. It is actually built into a designer’s psyche, which is another reason why we need more designers involved in the implementation of public policy.

Nick Leon: James Dyson has got his hand dryers in the washrooms here. James Dyson would not announce his hand dryers or move into a whole business strategy in that space unless he thought what it was going to be like to install it physically in places like this. It is a complete alignment of the business strategy, the products, the processes, the supply chain and putting it into practice. But when we launch policy, we do not align with that level, so there needs to be a kind of health test on policy to ask what it looks like from a citizen’s perspective. Should we not be co-designing the citizen experience with the communities it is going to serve before we launch the policy, come up with a proposition, commission Accenture or Capita or whomever to design a set of processes at great expense, and then wonder why the local authority cannot make this thing work?

Len Street: In that consultation, you have to get rid of the stereotypical image of an older person, which is prevalent in all the media and so on all the time.

The Chairman: It is an extremely interesting conversation, and there is much to think of there. If there are any illustrations of where it has worked, either at a local-authority level or service-redesign level, we would like so that we have some evidence and granularity to it.

Nick Leon: I would be pleased to provide those, because there are some cities and areas where this is being applied, outside of the UK I should add, and some more sporadic projects here in the UK, which we have used as the basis on which we have been both providing our advice on policy and training our students in the design of services. Their interest, which is so profound to me, is in trying to make a difference, and public services are the frontier they really want to work in.

The Chairman: Fascinating. Thank you very much indeed. Baroness Tyler, is there anything else on your question? You have had a bit of a bite at it already.

Baroness Tyler of Enfield: I have already had one go at it. It is really about how the financial services industry needs to adapt to meet the needs of an ageing population. We talked primarily about the issues around digital exclusion and things like that, and you did talk about what various building societies were doing. Was there anything that you or any other witnesses wanted to add?
Paul Broadhead: I think I would just add one thing, which leads on from what Nick was just talking about. Len is absolutely right; let us not try to second guess what an ageing population wants. One thing the building society sector is very good at is having what we could call member forums. These meet quarterly and these are customers of the society. They come in, usually to meet the chief executive or other executive directors, and talk about the products and services and what is going on within the particular society. Naturally, the attendees of these member forums tend to be older people, because typically they are more engaged with the financial services organisations and have a better idea of what they want, and they have more time to attend these forums. It is vital for us actually to ask people directly, “What is it you want as you age in terms of financial services?” That is what I would add to that.

Q513 Lord Bichard: There is a fundamental issue that I think you are missing, which is that people have lost trust in financial services. I do not think they distinguish in the way you are suggesting between mutuals and banks, to be honest. They may be a bit happier around mutuals. For the reasons you have already outlined—you talked about equity release, you talked about two major product areas that have failed, and now you are talking about a third that is going to be successful—people have lost confidence as well as trust. Does this suggest that we need some better, more independent and reliable advice arrangements for people before they get into losing vast sums of money in endowments and equity release schemes that do not work?

Paul Broadhead: To take your point, you hear it referred to all the time—the banking sector. We have got adverts from our members now trying to distinguish themselves from the banking sector, because they are two totally different animals. We have not had the issues in the mutual sector that we did have in the large banking sector in terms of failures. Let me give you one example about the payment protection insurance situation. It is absolutely scandalous what has gone on there across the piece, and we have got claims management companies now. The provision from the banking sector for that mis-selling is £12 billion. The provision for the whole of the building society sector is £200 million. I am not saying that everything that the building society sector does is absolutely perfect. There have been issues across financial services, but in terms of the scale of these problems, I do not think they compare at all.

You talked about trust and so on. We research trust each year about mutuals and the banking sector, and we have seen the trust in our sector really go up in recent times. We did it again recently after the LIBOR situation, and it went up even further, but we do it regularly. We do customer service, so it will give you answers to four questions. This is independent research. “My financial services provider was open and honest”: building societies 11 per cent higher than banks. “My money was safer there”: provider 16 per cent higher than banks. “I felt valued as a customer”: provider 22 per cent higher than banks. “I would recommend my provider to family and friends”: provider 13 per cent higher. So there is more trust in the sector.

Lord Bichard: All of those are comparative figures. My point is that none of you actually any longer carries much public trust. You can be 10 per cent higher than the banks, but frankly, unless you are a politician, journalist or bureaucrat, it is difficult to get much lower than the bank, so that is not the issue, is it? You are doing a good job for the building society, the mutuals here—I understand your role—but the fact is that the perception is you do not trust any of these people.
Paul Broadhead: I think that is absolutely right; from the public’s perspective at the moment, financial services are at a really low ebb. We now have to make sure that we can overcome that. That can be done through some of these member forums, new product developments and through adapting branch networks and so on, and actually some of our members are now opening new branches so they can engage in the communities where there has not been a branch before to rebuild the trust in their own sector. I genuinely do not believe there is a huge trust deficit in the building society sector, but I agree with your assertion that many people just see financial services providers as a homogenous group, and we need to get over that.

The Chairman: We will leave that challenge with you, if we could. If you get some insights, we will read them with interest. We are out of time. Thank you all very much indeed for quite a challenging session, because in a sense we were looking across a whole range of different issues, but thank you for your patience and your contributions. They are much appreciated, thank you.
These recommendations derive from a workshop two years ago at which some 50 citizens of Cambridge discussed problems associated with the increasing number of over-65s in the population.

- 90% of older people live in mainstream housing. While they require a choice of housing solutions they should still remain within, or closely connected to their community. They need advice to help them choose, and to prepare early rather than move in haste.

- All new homes should include the provisions shown in http://www.lifetimehomes.org.uk/data/files/For_Professionals/lthdiagram.pdf. According to http://www.lifetimehomes.org.uk/pages/costs.html the costs of these are modest. It is not sufficient to require that only some fraction of new homes include these provisions. The object is to ensure that, when people become frail or are suddenly disabled, they can stay in their own homes for as long as possible. Therefore all new homes should include the provisions.

- It has been estimated that providing simple things such as level access, circulation space and walk-in showers could save the country more than 5 billion pounds over the next 60 years. A problem is that those who should pay for that now are not those who will derive the financial benefit. It is very difficult to persuade developers to take an interest, so compulsion is necessary.

- Isolation and loneliness are big challenges. Older people must have good access to services, shops, public toilets, green space and other facilities such as community halls, without needing to use private transport. Planners need persuading that much better provision of such facilities is needed in new developments. It is important also to reduce people's social isolation by getting them to help the community.

30 August 2012

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109 Cambridge Past, Present & Future is a civic society founded in 1928 by a group of local business people, town councillors, aldermen, academics and city officials.
Care and Repair Cymru—Written evidence

Care & Repair Cymru (C&RC) is the national body for Care & Repair Agencies in Wales, and the “Older People’s Housing Champion”. We are a charitable body and actively work to ensure that all older people have homes that are safe, secure and appropriate to their needs. There are 22 Care & Repair Agencies covering the whole of Wales. Each agency provides a wide range of services and support for older and vulnerable people, helping them to remain living independently in their own homes and communities.

Care & Repair Cymru is committed to improving the health & wellbeing of older people in Wales by providing advice and assistance with home improvements, adaptations and general repairs. We work in partnership with a number of organisations including the Welsh Government, Local Government Housing and Social Care Teams, NHS, Occupational Therapists, other third sector organisations, the Older People’s Commissioner, and Housing Associations to ensure that older people have access to a range of housing and social solutions that enable them to live in housing that meets their individual needs. Care & Repair Cymru is partly funded by the Welsh Government.

Care & Repair Agencies
The 22 Care & Repair Agencies in Wales operate to the same boundaries as local government, and provide housing services to some 40,000 older people every year. Agencies are also part funded by the Welsh Government and attract funding from local government, local health boards and housing associations. The types and scale of services provided in 2010/11 was:

Core Care & Repair service
• 27,568 older people helped
• 68% of people helped were over 75 years of age
• 12,000 (43%) of people helped received the intensive casework service
• 1,074 people received help to apply for additional welfare benefits which increased household income by £2.1 million
• £500,000 raised on behalf of 475 clients from charitable funds to pay for repairs or adaptations
• £11 million repairs and adaptations facilitated
• 2500 older people helped make their home more affordable to heat

Rapid Response Adaptations Programme
Care & Repair in Wales operate the Rapid Response Adaptations programme on behalf of the Welsh Government. The Rapid Response Adaptations Programme was introduced by the Welsh Government in 2002 and is unique to Wales. The programme facilitates an immediate response to specific needs by providing minor adaptations such as ramps and handrails, to enable people to return safely from hospital to their own homes. These adaptations can also prevent the need for admission to hospital or residential long term care. The programme is a fast-response initiative and requires jobs to be completed within a maximum of 15 working days.

In 2010/11 the Rapid Response programme achieved:
• 13,000 older people helped
• 4160 of whom helped return home from hospital
Care and Repair Cymru is pleased to respond to this call for evidence. We have chosen to respond to the questions where we feel we are most relevant in terms of our work.

1. **Does our culture about age and its onset need to change, and if so, how?**
   
   The greatest public health achievement of the 20th century was the increase of the average human life span. Now, as that achievement helps raise the proportion of older people, this is too often regarded as a burden — a financial burden, a health care burden and even a social burden.

   Wales has been committed to promoting positive ageing — through the introduction of the Strategy for Older People in Wales, National Partnership Forum for Older People and the setting up of the Older People’s Commissioner for Wales. However, in Wales, as is the case elsewhere in the UK, there is a constant struggle against negative media images and negative stereotyping of older people instead of embracing the experience, knowledge and maturity that comes with aging. In terms of cultural change, this is the area where we feel most needs to be done.

2. **Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?**

   People in the UK need to be encouraged to plan better for their expanding older age not just financially, but in many aspects of life.

   The attitude of society toward ageing independently needs to change; with regard to better planning for the future, including housing needs. Research demonstrates that the majority of people would like to remain living in their own homes as they age, yet the majority of people do not make plans for this within their own property until a crisis situation arises when they are no longer able to live there without, for example, additional support and adaptations.

   Care & Repair help to provide adaptations for older people to help them to remain living safely in their home. It is often the smaller, preventative adaptations which make the greatest difference to the older person.

3. **Do the extent and nature of public services need to change? If so, how, and how should they be paid for?**

   - **A greater focus on prevention** - within public services including social care, housing and health services. Proper investment in preventative services would improve the wellbeing of the people of the UK, whilst saving public funds. Helping more people to live independently reduces demand on the NHS and social services. Every year 1 in 3 people over 65 and almost 1 in 2 over 85 experience falls, many of which are preventable. The average cost of a fall at home which results in a hip fracture is nearly £29,000, which is over 100 times the cost of installing hand and grab rails in an average home. Hip fractures are also the trigger for entry into residential care in up to 10% of cases. Postponing entry into residential care for one year saves an average of £28,000 per person. Adaptations can reduce the need for daily visits and reduce or remove costs of home care with savings ranging from, £1200 to £29,000.
Care & Repair Cymru has estimated that our Rapid Response Adaptations programme saves £7.5 million for every £1 million invested in Wales, preventing people going into hospital and enabling speedier discharge. The programme is an illustration of how a relatively minor investment in preventative works can benefit older people, whilst reducing public spending.

- **Develop a nationally co-ordinated Re-ablement Strategy** that supports independence and wellbeing. In Wales, 15,000 older people bounce back and forth between hospital and home every year. To counter this, there should be a strategy and target for critical investment to provide joined-up services involving good quality information and advice, home adaptations and repairs, and domestic and emotional support.

- **Provision of low level support** – The Joseph Rowntree Foundation in 2005 found that older people value ‘that little bit of help’ to enable them to retain choice, control and dignity in their lives but it has become very difficult for them to secure this. Services have become too focussed on those with high support needs. Provision of flexible, low level support would, in many cases delay or prevent the need for higher level support.

- **Services need to be more joined up** - Creating policy and funding links between health, housing and social services around an agreed outcome for improving wellbeing. Providers, individuals, commissioners and government departments need to look beyond traditional sector boundaries and make better use of public money in improving people’s health and wellbeing outcomes.

- **Housing options** – Older people tell us that ideally they would like to remain in their own homes, however they also feel that there are a lack of suitable housing options for them to ‘move on’, if their home becomes unsuitable for them to remain living in. In recent years, housing development for older people has tended to be directed towards housing with care and more intensive support. There is limited evidence that housing policy and practice has fully recognised ageing as an opportunity for personal growth, with increasing time to enjoy life and leisure.

  Some specialist housing has gained a negative image and is not seen as a positive choice for older people. Despite this, research strongly suggests that new housing development, including retirement villages, older people’s bungalows, sheltered housing and extra care housing, can provide positive outcomes for people’s changing lifestyles.

- **Commissioning of services** - based on evidence of what is effective and delivers an impact.

- **Healthcare at home** – Increasing numbers of people are treated at home. Evidence suggests that the mental health and independent living skills of older people, particularly those with dementia deteriorates when they have entered into hospital or residential care. Models of health care associated
- ensure people have access to the right person at the right time
- focus on preventative care – wherever possible avoiding hospital admissions
- reduce the length of a hospital stay when admission is necessary
- reduce the need for complex care packages
- avert crises by providing the right amount of care when needed
- co-ordinate communication by providing a named person for all contact.

4. **Do we need to redesign and transform public services for these challenges? If so, how?**
   
   As question 3

5. **What should be done now and what practical actions are needed?**
   - **Learn from the lessons in Wales** – In particular, the Strategy for Older People in Wales and the introduction of an Older People’s Commissioner for Wales. This has resulted in older people being empowered to expect their voices to be heard. It has also provided policymakers and practitioners with clearer information regarding the ambitions of older people.

   - **Lifetime housing** - Championing across all tenures an ambition to develop minimum requirements for ‘Lifetime Homes’ standards.

   - **Care & Repair services** – Investment and expansion throughout the UK will be necessary to manage the increasing demand. Care & Repair Agencies work to help older and disabled owner-occupiers to remain in their own homes, in their own communities, living as independently as possible, through providing information about choices that can improve safety, security, comfort and convenience.

   - **Housing adaptations** - Simplifying the access to an integrated adaptations service with prioritisation around client outcomes. Homes have to be in good repair, be well maintained and fit for purpose if they are to provide comfort and security. Adaptations and aids have been shown to enhance people’s health and safety and, in many cases, transform their lives.

   - **National Property Improvement Loan scheme** - older people living in their own homes occupy some of the poorest housing conditions in Wales and across the UK- housing which is unfit, dangerous, and in serious disrepair. Many are equity rich but cash poor and the ability to access equity (safely, cost effectively and with peace of mind) to pay for essential renovation and repair would be an invaluable solution for many thousands of older people.
• **Clearer information and advice** – older people tell us that it is difficult to negotiate information and advice, particularly around complex issues such as welfare benefits.

• **Inclusion of older people** - in the shaping of policy, planning and practice

• **Improve public transportation and service access** – particularly in rural areas; involving a flexible approach to public transport and a ‘one-stop-shop’ approach for co-ordinating information and improving service access

**Improved recognition and support for carers** - Carers currently save the economy £119 billion per year. With an ageing population, the UK will need more care from families and friends in the future. By 2037, it is anticipated that the number of carers will increase to 9 million. To care safely and maintain their own physical and mental health and well-being, carers need information, support, respect and recognition.

30 August 2012
Q159  The Chairman: Good morning and welcome. We are very glad you could be with us this morning. Chris Jones, you have done well to get here given the travel problems you had on the way. I will not go through the ritual of introducing us; you can see our name badges. Similarly, we are aware of who you are from your biographical details. If you do want to say a few words of personal explanation when you start, by all means do so. We are on the record, as you know, and we very much look forward to hearing your evidence. I will kick off by directing a question first of all to the National Housing Federation, and then others can come in as they feel appropriate. Could you give us a view as to what sufficient and appropriate provision of housing would be for an older population?

Jake Eliot: Good morning, I am Jake Eliot from the National Housing Federation. By way of context, we are the trade body of housing associations in England. Our members deliver 2.5 million homes to more than 5 million people. Central to our view at the National Housing Federation is that everyone deserves a home they need at a price they can afford. We come to this discussion with some evidence on the back of a project we did called Breaking the Mould. I have brought along copies to share with the Committee. That
Care and Repair Cymru, Joseph Rowntree Foundation, McCarthy & Stone and National Housing Federation – Oral Evidence (QQ 159-214)

A project took as a starting point the question of why we as a society increasingly recognise the contribution of older people as active citizens, carers, members of families, and in the workplace, but often do not match that by a better offer for housing. So it comes with an awareness and understanding that we have not made an appropriate offer to older people, and that needs to change.

For us, an appropriate offer looks like well designed, accessible—sometimes adapted—homes close to the amenities and support older people may need. It means homes and services that are better built around people’s needs and are adaptable as those needs change over time. There is also a need for a degree of flex, so care or support can be dialled up or down over time as needed. It is also about how that housing offer feels, as well as what it looks like. Key to our learning, from our Breaking the Mould project, is that it will feel like greater independence, choice and control for older people. It will reduce the current levels of worry and concern about the lack of a future suitable housing offer and a concern about what will happen if a person’s needs escalate and they are no longer able to continue living independently in the community.

Q160 The Chairman: Those normative statements sound very worthy but are a bit apple pie. Are they evidenced by research or are they just what the National Housing Federation felt was self-evidently good?

Jake Eliot: It is based on research. We conducted a number of focus groups with older residents through our Breaking the Mould project. Yes, they are slightly normative statements, but I was trying to sum up some of the broad and deep research in the area that colleagues like Ilona may want to allude to later. They are at risk of being labelled motherhood and apple pie but are in the context of a massive housing need for the changing demographic, including changing families and households, as well as older people—single people, couples and in families. There is a need for sharper and stronger focus on those high-level principles because the housing offer has not matched those aspirations in the past.

Q161 The Chairman: Who are those normative statements directed to: government, the private sector, RSLs, local authorities or what?

Jake Eliot: The answer to that is all of the above. We come from the affordable home sector, and the starting point for our work in Breaking the Mould was some of the best practice among our membership. That is not standard practice yet. We and many of our members believe it should be. As the affordable housing sector we definitely have a role, but it is not limited to us. To fulfil that role well, a big contribution from the private housing sector is needed, because of the high levels of home ownership. Successful and flexible home projects rely not just on partnership working between housing associations and local authorities but increasingly with partners in the health and social care world too.

Q162 The Chairman: We will come on to more detail about some of the failures of the current levels of provision, both in quantity and quality, but could you make the argument to us about where we are at? Are you saying we are worse than we were, or worse than other European countries, or that we will get worse at meeting these normative standards in the future, or are they just general, worthy, arm-waving statements?
Jake Eliot: We start from the point of view that we are not where we should be now. There are current needs we are not meeting and we have not delivered the quality and variety of housing offers to older people that we should have done. So we need to do more for now. Members of the Committee will be more aware than most that the changing demographics mean that we will need to up our game as a society in the future to better meet these needs, because levels of need and demands on public services will only increase.

Q163 The Chairman: Do you think the Government, and CLG in particular, accepts that, recognises that and is responding to it?

Jake Eliot: There is increasing recognition across government of the need for housing for older people. I think DCLG understand this, and we have been working alongside McCarthy & Stone and others to produce some planning recommendations and advice for local authorities to better deliver for older people. What will be critical over the next couple of years is how far that argument penetrates across government. The benefits of housing are not just felt by the residents themselves and local authority housing departments; they are also critical to improving the quality of health and care services that we have. That includes both the quality of outcomes and the effectiveness of those services.

We have seen through the Government’s social care White Paper are increasing signs, now coming through the draft Care and Support Bill, that there is a need to talk about integration, not just of health and care but of health, care and housing. That is a critical area that the National Housing Federation wants to develop and take forward in the next couple of years.

Q164 The Chairman: We might come back to that later, but do any other panellists want to come in on these general questions about what we should be aiming for?

Ilona Haslewood: I am Ilona Haslewood, Programme Manager in the Ageing Society team at the Joseph Rowntree Foundation. We want to understand the opportunities and challenges an ageing society brings so we can come up with helpful solutions as to how we can make an ageing society a good place to live for all of us. We also work closely with the Joseph Rowntree Housing Trust, and I believe you took evidence from John Kennedy a couple of weeks ago. We work with the Housing Trust on practical solutions—on putting our research into practise.

On the question of evidence, there is a lot of evidence that tells us what older people want from housing. It has been brought together in the Breaking the mould: re-visioning of older people’s housing report and also in a recent publication, the Market Assessment of Housing Options for Older People, which we commissioned. We have a pretty good idea of the kinds of things older people say they want from housing. They want space, a good location and to live in places where they remain connected—that is very important and is something I would like to expand on. Too often the thinking focuses on specialist housing for older people, which if it is not planned and managed carefully can isolate people and separate them from their local communities. We are currently running a programme called Neighbourhood Approaches to Loneliness. The evidence coming out of this action research is very clear about the benefits of social connectedness and links.

So we have lots of evidence as to what good housing would look like. We have quantitative evidence on what is available and how much is available. There is a need for a higher
volume of housing, both general and specialist housing for older people. It needs to be good quality housing that people actually want and we also need a wider range of choices, because often there are only two choices within specialist housing considered: sheltered housing or housing with care.

**Q165 The Chairman:** Other panellists can come in now or later depending on what you wish. If there is nothing you wish to add, that is fine, and we will drill down into the specifics of supply and support of services.

**Gary Day:** I am Gary Day, Executive Director at McCarthy & Stone. I would like to add one point. I would endorse what has been said already: the main issue is to ensure that we have genuine housing choices available for existing and future older people in the country. You asked the question of how the existing stock provision or specialist housing compares with other countries. We commissioned some research by the University of Reading a couple of years ago, and their conclusion was that less than 1 percent of older owner-occupiers currently live in some form of specialist housing, compared with 17 percent in the USA and 13 percent in New Zealand and Australia. So for one reason or another, other countries seem to be ensuring that older people see that type of housing as a much more favourable option than they do in this country.

**Q166 Lord Griffiths of Fforestfach:** Could I just ask what specialist means in that piece of research?

**Gary Day:** It means specialist retirement housing, so it is purpose-built housing for older people, often in the form of a group of self-contained apartments with a range of communal facilities and a particular management regime to go with the lifestyle.

**Q167 Lord Griffiths of Fforestfach:** Would that include conversion of existing housing?

**Gary Day:** It may do, but the context of the research undertaken was looking at new-build, purpose-built, specialist housing.

**Q168 The Chairman:** Why do you infer, as I think you do, that means we are out of step? It could be an expression of what people prefer in the UK. They may not wish to live in some gated community surrounded by fellow 80 year-olds; they may want to live in the community in a more mixed environment. Why do you think we are wrong and these other states are right?

**Gary Day:** There is other research that shows that, given better housing choices in terms of specialist housing, older people in this country would most definitely consider this type of housing as an option.

**Q169 Baroness Blackstone:** Could I ask you to speculate on why that is? Why is it that it is only 1 percent in the UK? Why is it that the private sector has not decided building
good quality accommodation with some community facilities, but allowing older people to live independently, is a good market to enter? Why is it that housing associations have not done this or not done it adequately? It is sometimes argued that one of the reasons you cannot encourage older people to move from housing that is too large for them and difficult for them to maintain is because the alternative is often very pokey, tiny flatlets in housing association or private-sector-built accommodation, and that is just a step too far. They will not move to that sort of accommodation; they want better quality. So why is it not being provided by the state or, particularly, by the private sector or housing associations?

Gary Day: We have touched on the role of Government both nationally and locally, and CLG in particular. Housing and planning policy historically has focused on public sector issues and provision. Private sector provision of specialist housing is still relatively in its infancy. McCarthy & Stone is the market leader in the field, and we have only been delivering this type of housing for the last 30 years, so it is a relatively new form of provision. You are correct that we do have a legacy of some poorly located and poorly designed public-sector sheltered housing. I think everybody has learnt their lesson from that but unfortunately that perception lingers. There is a challenge for all of us to innovate and improve standards of design. Certainly that is what my company is seeking to do.

There are barriers to entry. We have a 70 percent market share, which is perhaps fantastic from a business perspective but is rather unfortunate in terms of delivering housing choices for older people; it is an unhealthy situation. There are significant barriers to entry. We may talk about the planning system later on. You would expect any developer to talk about the planning system, but there are particular concerns in the context of the delivery of this particular type of housing. Public policy does not proactively encourage innovation and increasing supply in this sector.

Q170 Baroness Shephard of Northwold: I have a supplementary on Baroness Blackstone’s question. Is the discrepancy between our position and the position in the United States, Australia and New Zealand anything at all to do with the age of the housing stock we have and the pattern of settlements within cities and larger towns?

Also, what are the gaps and unmet needs in the housing market for older people? I would specifically like you to try to answer what could be done to enable really sensible conversions. I do not just mean a handrail; I mean the creation of space, bigger doorways, wet rooms and all of these things in the kinds of houses that many older people are living in. Is there research on that? Anecdotally I would have thought a tremendous number of older people would rather remain where they were if they did not have to worry about getting up and down stairs and falling over steps. I wonder if there is any research on that. I rather think that Chris Jones may have some evidence. That is a long and rambling question; I am afraid that there are about three in there.

Chris Jones: I am Chris Jones, Managing Director of Care and Repair Cymru in Wales. Our premise and the reason we exist is to keep older people living independently at home. Regarding the first question, about what sufficient and appropriate provision of housing will look like in an older population, for us it is about having choice. Other people have also said that. It is not about having one type of housing or another type of housing, whether specialist or not; it is about giving people a choice about where they want to live when they are older. One of those choices, and the one we try to help people achieve, is to live independently in their own homes.
In Wales we see around 30,000 older people every year across the country. There is not a research document on this, but predominantly the people we see tell us that they prefer to live at home, where they have grown up, with their families around them and in their own communities. That might be because they do not think there is another choice. They might not have information or advice about what those choices might be. It might well be that there is good specialist provision locally but they do not know about it, or it might be that they assume it will not be somewhere for them. However, our premise and what people tell us is that they want to live independently at home, and our services help make this possible.

Your question about adapting the house they are living in brings me naturally on to the thorny issue of the Disabled Facilities Grant system, which you will probably all have heard of. In Care and Repair, in relation to adaptations, the first thing we try to do is make sure that people do not have to use that system for smaller things like handrails, grab-rails or maybe a stair-lift, because it is long and bureaucratic. For people who do need those larger adaptations, such as significant ramping, door widening, accessible bathing facilities, a stair-lift or combinations of these—something that becomes a bigger project—we try to help them navigate through the Disabled Facilities Grant process.

However, it is the process itself that is unwieldy. A lot of research has been done on this. It is very prescribed and bureaucratic, it is means tested and requires the input of both social services and housing, which requires social services and housing to work closely together. Sometimes that is not achieved within the local authority setting. So in relation to providing appropriately adapted housing in a timely fashion there is a big barrier we need to overcome in this country about doing that better. That involves looking at the DFG system very closely.

**Q171 Baroness Shephard of Northwold:** So to revert to my question, which I have almost forgotten, you see a gap or an unmet need in housing for older people as things stand and would say that the sheer difficulty of getting adaptations through the system is a barrier.

**Chris Jones:** Yes, I think the system is too long and too complex. It is also a system that needs capital resources at the end of it, which are often scarce and rationed. Sometimes people do not get what they need because of that. Hopefully I will talk a bit later about how providing those types of services and keeping people at home for longer is not just a housing issue but a social care issue and an NHS issue. But when it comes to funding good housing, that is not something those services provide funding for. For Care & Repair in Wales, there is a mission to get the NHS to understand that providing good quality housing not only makes sense for people’s well being but makes economic sense for NHS budgets.

**Q172 Baroness Shephard of Northwold:** I want to ask McCarthy & Stone how you choose where you will build your specially arranged apartments with warden management. How do you decide where to put these developments? Is it in response to local need? What do you do?

**Gary Day:** We have a tool we use called Addressable Market Space Analysis. We look at the population characteristics of everywhere in the UK and, in very simple terms, existing stock provision. So it is a simple analysis between supply and demand first and foremost.
That will give us an indication. Pricing comes into that as well, because there are issues around affordability. That will give us an indication across the country of where we believe there is unmet need and where different degrees of that need exist. So we will try to target accordingly in our business plans. It is not easy to do that though. Land availability is an issue generally for any house builder, but when you are seeking to develop this type of housing accommodation the particular site requirements are critical. We would not contemplate developing a scheme that is more than half a mile easy walking distance from everyday needs such as shops and services. We would always look for a site within an existing, established community with very good public transport links. Those sites are quite difficult to find. Often we are developing sites that are within or adjacent to shopping centres because they are ideal for our customers. We also find our customers tend to like sites that are quite prominent in the streetscape. It is quite surprising; you would think a nicely designed scheme in a tree-lined avenue would be the favoured location, but in fact it is not.

Baroness Shephard of Northwold: No, people want to see life.

Gary Day: Yes, they want somewhere on the high street so they can see life and activity. So it is very hard to find good sites for the type of housing that we provide, not least because we are often in competition with other interests for that site, not necessarily other residential interests but retail and commercial interests. We will be in competition for sites with the likes of McDonald’s, Lidl, ALDI, or other small supermarkets, care home operators and even national car parks. I have lost prospective sites to the national car park operators.

Q173 Baroness Shephard of Northwold: Are you approached by local authorities, health authorities or consortiums of such groups who when planning overall provision can see the need for the kind of development you would provide?

Gary Day: No, very rarely are we approached. It is only when a local authority has a site it is seeking to dispose of and wants to go out to tender that it may well contact us. One of my main concerns is the lack of proactive planning for any kind of housing provision for older people. You ask why we believe other countries make better provision for this type of housing; I think it is because they do proactively plan and allocate sites for housing for older people of different kinds. They will demand that in wider housing developments some of that land is set aside for that type of provision. Over here you would use the instrument of a Section 106 Planning Obligation but rarely, if ever, do you see a Section 106 Planning Obligation that obliges the developer to provide an element of housing designed specifically for older people within that wider housing scheme.

Q174 The Chairman: I saw Ilona nodding; do you want to agree with that point or differ?

Ilona Haslewood: I would agree with many of the points that Gary has just made. There are big issues with planning but also there is a big issue with a mismatch between what is on offer and what people want. For example, in terms of tenure, nearly 80 percent of specialist housing on offer is for social rent. Nearly 80 percent of older people own their own homes. Not all of them would wish to move into rented accommodation. There are also disincentives in the system. If someone was to sell their property, they might lose eligibility
for state help with social care funding. There are loads of things that can come between people actually wanting to move into specialist accommodation and it being a viable option.

There is also an issue about thinking of older people as a market segment in general housing. You do not generally see much targeting of older people in marketing, even though there is evidence that, at the higher end of the market, town-centre locations and riverside developments are popular with older people in their late 50s or 60s who make a proactive move. Instead they are mostly marketed as options for young professionals or buy-to-let. Wider than that there is something about the PR image of housing or marketing of housing for older people. Somehow this does not seem to exist.

**Q175 Lord Griffiths of Fforestfach:** I have two quick questions to Gary Day. First, in what you have built so far, typically how many units would there be in your various projects? Secondly, what is the income level of the people who are your present clients?

**Gary Day:** We currently deliver two types of specialist housing. The first kind we call later living accommodation, which is very similar to conventional sheltered housing and is most people’s impression of specialist housing for older people. These are a group of self-contained one- or two-bedroom apartments with a range of communal facilities, typically a residents’ communal lounge, a residents’ laundry, and there will be a house manager—known as a warden in the public sector—to look after the scheme and the management regime that goes with that development. We found that our residents were saying they did not want a resident house manager and did not want to be paying for the rental of that house manager’s flat in their service charge, so most schemes now do not have a resident house manager but a day manager. That is very similar to what is happening in the public sector schemes now as well.

So we find we can deliver much smaller schemes now, because the important thing with any type of specialist housing is that it is a sustainable form of housing for those that choose to live in it. It is not development economics that determines the size of the development, although that comes into account. Ultimately, for it to be a successful housing scheme it is about whether or not the residents can afford to live there. For that type of housing we go down to about 25 units as a minimum and up to around 45 as a maximum.

Then we have another form of housing, which we call assisted living and is a form of extra-care housing or housing with care, which we referred to earlier. That is aimed at the frailer, older person. Our typical customer in our later living development will be a widow just under 80 years of age. In our assisted-living, extra-care housing, the typical age of our customer is 83 to 85. That form of housing has inbuilt personal and domestic care provision, tailored to meet the needs of the individual customer, and a wider range of communal facilities. In our case that will include a restaurant on site and can also include a health and fitness spa or suite with various treatment rooms. There is also 24-hour cover in that scheme. For that type of development we need a minimum of 50 units to be sustainable and keep the service charge at a level that is affordable to our particular customers.

We are very much pitched at the middle market. We say we are aiming our products at ordinary mums and dads. Typically our customer is downsizing from a three-bedroom detached or semi-detached property. Often they are under-occupying that property, so one of the benefits is that they are releasing that property for more efficient and effective use by families. I cannot tell you what the particular categorisations of our customers are,
although my colleagues would be able to give you those answers. We are very much aimed at the middle market and there are other companies in our sector that produce products for a higher range of the market or conversely there is the housing association. We are the ham in the middle of the sandwich.

**Q176 Baroness Shephard of Northwold:** When you provide that level of shelter, how do you decide where you will put that? Is it thinking that there are a lot of elderly people in Eastbourne, so you will go there? Are you ever approached by a local authority? No, you are not; you already said that you are not.

**Gary Day:** No, we are not approached by local authorities. We would love to be but we are not. We try to talk to them and maybe later we will talk about the Housing Needs Assessments that local authorities undertake. That has been referenced already by Jake in some of the work we are doing jointly on that.

The site characteristics are very much the same, and it is the same process that we go through. We know we have an ageing population and, as the Committee will be well aware, that does not just mean more older people but a shift in that older age group as well, so we are going to face more older old people as we move forward. We are the only company at the moment providing extra-care housing for older owner-occupiers. Most of that provision, like specialist housing generally, is public-sector provided at the moment. We are trying to grow that part of our business and develop it to 30 percent of our business as we move forward. We know there is a huge existing demand and a demand that will only increase. The more we and others provide specialist housing and enhance the quality of it, the better the public perception will become and the more will choose this type of housing in later life.

**Q177 Baroness Tyler of Enfield:** I wanted to go back to your interesting statement a few minutes ago about the lack of proactive planning in this country for this sort of provision and, by implication, that there is more proactive planning in other countries. I just wanted to understand why you think that is the case. Is it simply to do with the National Planning Policy Framework, or are there other incentives in the system in other countries for that proactive planning to happen? Are there additional obstacles and barriers to it happening in this country?

**The Chairman:** Other panellists can come in on this as well, because it is not just a private sector question.

**Baroness Blackstone:** Can I just follow that up because my question relates to that? I wonder whether part of the issue is the availability of land. Australia, New Zealand and the US have hugely more land space than the UK. If there is an issue of identifying land where you can do this kind of development, why do you not approach local authorities to see whether they might have some land available where they might perhaps want to pull down inadequate housing that is no longer fit for purpose, rather than you waiting for them to approach you? Following in a way from what Claire was saying, is there some need for some kind of national commitment to providing land for provision for the elderly of the sort you are describing and want to provide, especially for owner-occupiers? If you can provide that, you will release larger houses that can go on to the market and deal with some of the desperate shortage of family housing.
The Chairman: Can at least three of you have a go at that, and we can then hear from Chris in more detail later on?

Gary Day: Would you like me to go first?

The Chairman: No. If you would not mind, I think I would like to hear from either Ilona or Jake just to get an overall perspective, and obviously a perspective from the National Housing Federation.

Ilona Haslewood: Perhaps I am not the best person to comment on land availability, but we do know, as Gary has already said, that there is a mismatch between where people want to live in specialist housing, often in town centres and where there would be some brownfield sites, and where major house builders or developers hold land banks, which would often be out of town. Beyond availability of land, we do know there is also great regional variation between the availability of specialist housing. There is a lot more available in London and the south east and much less in Yorkshire and the north east. That may not be a question of availability of land; it would not seem logical if it was.

Q178 The Chairman: Are you talking about the private sector?

Ilona Haslewood: I am talking across the board. To give you an idea, there are about 1,300 schemes at the moment UK-wide, of which 200-plus are run by private developers. The majority, about 900-odd, are run by housing associations. This is how the market is divided.110

The other point I want to make about planning is that there is a question of expertise and the distribution of expertise here as well. For example, specialist developers such as McCarthy & Stone have expertise in putting in place all the other services and support facilities that supported housing requires, whereas general house builders would not necessarily have this. So there are these factors and tendencies too that will impact on what gets built and why.

Q179 The Chairman: Can I press you on that? I was talking about this with a friend who has been a housing specialist for years. He said that you would all say it is a problem of land supply and the planning system. He said that is much too simple and in fact it is partly a problem of demand as well; there is not evidence of clear enough demand. If you are a housing developer and have land, why would you not build it if there was a demand?

Gary Day: The answer to that is that it is very specialist. It is not just about bricks and mortar but the lifestyle you are offering to that particular customer. The management and care regime is an integral part of that form of housing.

Q180 The Chairman: It is not rocket science; we have been doing sheltered housing for 50 years.

110 This number relates to ‘housing with care’ schemes where, for example, there is 24-hour staff cover and care is available on-site if required. In addition to these schemes there is a larger stock of retirement (mostly sheltered) housing where the available support is more limited.
Gary Day: Yes, but unfortunately it is alien to mainstream house builders. I agree with you; I think it is amazing that the other house builders are not waking up to the housing implications of our ageing population and looking at the opportunity that is there. But you cannot sell this type of product off plan. We have two customers: one is the older person that ends up living in the property and the other is the son or daughter of that person. They need to see what mum or dad is buying into, and mum and dad need to see what they are buying into. They want to see the full range of communal facilities, they want to meet the house manager and they want to know who the management company will be. You cannot sell off plan. So it is entirely a different model than that delivered by the volume house builders.

Jake Eliot: I will come in from the social housing sector perspective. The challenge your friend made of it being more complex than just planning and land is spot on. The answer to that lies in the earlier challenge from Baroness Blackstone. From a housing association point of view, the reason why that offer is not being made—and this is possibly put too simply—is that everywhere along the development and delivery chain people are making decisions, or have made decisions in the past, that try to squeeze the maximum possible result to stretch the public subsidy as far as possible. In the past that has had some unintended consequences, with schemes or developments shoehorned in or not of the size and space standards and accessibility to make an enticing offer for older people looking to downsize. That stretches right from the public subsidy for affordable homes for older people and through planning and land availability, which I will come to in a second.

As Gary was indicating, with some of the complexity of some of the developments with care and support on site, you need not only that initial capital investment but ongoing revenue commitments from the local authority to make that development viable. That is particularly true in the current climate, where there has been a 63 percent cut in affordable grant funding for the Affordable Homes Programme and local authority revenue cuts across the board. That kind of stability really is not there. There are a lot of signs that things are changing. We may get on to some of the examples today, and you will certainly come across them in your inquiry, that show things are changing. The rise of a greater variety of much more enticing extra-care offers is part of that. So things are shifting but there is a lot more that still can be done.

We do have to acknowledge, from the affordable side of things, that the kind of capital level of grant subsidy we saw in the past has gone. Our members are making a number of responses to that. There is an important element of it, which involves looking at different ways of funding developments for older people where there is some asset to work with. So a number of our members are now looking at cross-subsidising affordable developments with private sale, where you see a much higher quality, more exciting offer for older people looking to downsize.

I also think there is an important strand here that relates to the earlier question about how you get people talking about - and decision makers prioritising - better quality, more accessible, more exciting housing for older people. That comes back to the issue of land in particular. We think there is a big opportunity in looking at NHS land over the next couple of years. The NHS are under huge pressure to make colossal productivity savings. It seems natural that, as part of that, individual trusts and also NHS Property Services will look to relieve some of the burden of that land. There is a huge opportunity for development there. Understandably, individual NHS trusts have their own business plans and need to seek a good return on that land. Increasingly a number of our members are going out to NHS trusts and making offers that include a decent financial return for that land but also an
offer for a mixed development. Sometimes that is with private sales to cross-subsidise affordable home developments, but it is also thinking about bringing housing on to that land with accessible care and support so we can get both a financial return on that land for the NHS but also think about safeguarding proper investments in housing with care and support on hand. That also helps to deliver some health outcomes.

**Q181 Lord Bichard:** My question was to Gary Day. We talked a lot about land planning and land availability, unsurprisingly. It has been a really good conversation. I am interested in whether you feel you could be making a bigger contribution to the development of strategies for older people, such as more general public policy both locally and nationally. I do not want to put words in your mouth but I am getting a feeling that you feel you are slightly excluded from that discussion, despite the fact you have 70 percent of the private sector market.

**Gary Day:** Yes, you are right. We have been campaigning for many years now for better housing and planning policies for older people across all tenures, but in particular in the context of older owner-occupiers. We were very pleased when the previous Administration published this country’s first ever national housing policy for older people, *Lifetime Homes, Lifetime Neighbourhoods*. That had some very positive things in it, which we felt might, at long last, result in local authorities being more proactive. Unfortunately, a lot of the recommendations in that document seem to have been shelved.

Again, we worked hard to ensure the National Planning Policy Framework includes recognition of the housing implications of the ageing population. There is reference in there. We would have liked it to say more and think it should have said more, given the size of the issue we face in the country. As a result of the National Planning Policy Framework we have been working with the National Housing Federation, the Department of Health, the Department for Communities and Local Government and others to produce a toolkit for local authorities to help them better assess the housing needs of their older populations. Housing Needs Assessments that have been undertaken historically by local authorities have been fairly narrow and have really only ever looked at public sector housing issues. They have looked at: what to do with their hard-to-let sheltered housing stock and how to try to encourage older tenants under-occupying family council houses to release those and move into sheltered housing so better use of the existing housing stock can be made. Rarely do they say anything about older owner-occupiers. In fact, not many local authorities have actually undertaken Housing Needs Assessments in a proper way. Very few, according to research we have undertaken, have a housing strategy for older people. You need to assess needs to adopt a strategy before you can develop policies that will help deliver.

We are hoping that the toolkit will receive endorsement from the Department of Health and CLG. The Department of Health are happy with it but we are still waiting for CLG, and that has been held back through the recent reshuffle. Hopefully we will be publishing that fairly soon. Then we have a foundation upon which local authorities can plan better.

**Q182 The Chairman:** When will that be coming out and can you send us copies of it?

**Gary Day:** We certainly will when it comes out.
Q183 The Chairman: Will it be before Christmas?
Gary Day: I would very much hope so.

Q184 The Chairman: Can we have a draft of it before then?
Gary Day: Yes, we can send a draft. We may well have to publish it without the endorsement of either department, which would be unfortunate because it would carry more weight if it has that endorsement, but we are struggling to get the CLG to give us final approval at the moment. The officials are very happy with it.

Q185 The Chairman: So is that by you and the National Housing Federation?
Gary Day: There is also the Hanover Housing Association and a range of interests.

Q186 The Chairman: Is it essentially about trying to encourage appropriate strategies for housing services by local authorities?
Gary Day: It is providing local authorities with a tool by which they can undertake those housing needs assessments; it is providing them with a methodology to undertake assessments.

Q187 The Chairman: They need to be told that, do they?
Gary Day: We believe so, yes.
Jake Eliot: It is also trying to look at the new National Planning Policy Framework and, taking it as a whole, where the opportunities are in that framework to sharpen the focus on better planning for older people. Some of the work we have been doing at the National Housing Federation is talking to local authority partners about the value of working with housing associations on developing specific older people’s housing strategies, in which planning is an important element, but it is broader.

There is always a tendency with such things that they become very generic and that a planning policy for older people essentially stops at identifying a couple of schemes or sites where specialist housing would be developed. The toolkit that we have been working on with McCarthy and Stone, Hanover Housing and others is looking at the whole process of the National Planning Policy Framework and trying to introduce opportunities and ideas at the different points at which local authorities can bring partners in and try to do things a bit differently and a bit better.

Q188 Lord Bichard: If there is not much evidence of local authority or central government having a vision or strategy for older people—whatever you want to call it—it is not likely that there will be many examples of a good housing strategy, because that should be part of a broader strategy. You seem to be painting a picture of that as the reality: you knocking on the door, rather than being invited into the lounge, and there very rarely being
clear strategies that go beyond housing, health and care for the whole of the elderly population. Is that what you are saying?

**Gary Day:** Yes, and I can illustrate that point. A few years ago I was approached by housing officers at one local authority, and they said, “What we need in our city is your assisted-living, extra-care housing”. I said, “Where does it say that in your housing strategy? Your housing strategy says that you need more specialist housing for older owner-occupiers, but falls short of going any further. It does not talk about how you will help the private or public sector deliver leasehold housing for older people”.

There are other policies, to illustrate the point, where there is a lack of foresight. We have affordable housing policies, we have the Community Infrastructure Levy, which I am assuming Committee Members are familiar with, otherwise known as CIL, and we have the Code for Sustainable Homes. They have serious cost implications on the provider of this type of housing, particularly when one considers that we are competing for sites where others would not face any of those obligations: for example, the supermarket developers that we compete with do not have enhanced building costs through a Code for Sustainable Buildings, because that does not exist. They do not have an obligation to provide affordable housing, and in some instances their CIL charges are lower than we face, because the local authority will want to encourage retail activity within their shopping centre. That is understandable, but it does mean that we are not operating on a level playing field at the point of land acquisition. If you had properly worked out housing strategies, you may have much more balanced consideration of some of these development control policies.

**Q189 The Chairman:** Can we just ask others on the panel? I am putting this rather crudely, but essentially I am hearing an assertion that by and large local authorities are failing to prepare adequately for their older population. There is not much evidence of strategies for addressing an ageing population, and as part of that there is not much evidence of holistic strategies for housing for older people in their area. I am putting it crudely, but that is what I am hearing. Do the rest of you, apart from Gary, think that is true, or is that just a calumny?

**Chris Jones:** I would support what the others are saying in relation to how narrow local authority thinking can sometimes be. There are exceptions to that; you do have some good local authorities that look at all tenures and have a comprehensive strategy for housing for older people. Certainly my experience in Wales, and of working in Bristol for 10 years, is that very often there is a predisposition to concentrate on local authority housing, social housing stock, rather than thinking about the wider market provision. I would support those points.

I would make a couple of points, which are not about the housing market but related to gaps and unmet needs. One of the things that I think happens a lot is that local authorities and housing associations spend money on adapting housing but then waste that resource down the line by not allocating adapted housing to people who need it. Again, I am not saying this happens across the board, but very often you will have a property that is adapted and has a lot of money spent on it, whether it is through DFG or the housing association’s own finance, or through the council’s own finance, and not enough thought is given to how that property is allocated when it becomes available to rent at a later stage.
In Wales some lawmaking powers have recently been given to the Welsh Government, and I am pressing to make it a duty on local authorities to work with their local housing associations to have proper strategies and systems for how they allocate properties that have been adapted. That is to ensure they go to people that need them, rather than going back into general needs. That was one point.

My other point, in relation to unmet needs and gaps, is about people knowing and planning in advance what they are going to do in later life. There is a real need across the UK for better early advice, better public information, to enable people to think about what they are going to do in terms of their housing in later life, and to understand what options are available to them. Very often we find ourselves dealing with a crisis; for example a crisis in terms of somebody who has fallen and has gone into hospital, and we will try to make the property safe for them to return to. If people plan and they are in appropriate housing before a crisis happens, that is going to make much more sense. A lot more needs to be done in terms of helping people plan for their housing in later life.

My final point, which might be at the edges of gaps and unmet needs, is about lifetime home standards. It is not something I am an expert at, but I do not think the system is robust enough in terms of getting developers to develop properties that are readily adapted in later life or have adaptations built in so that people do not need to make them at a later time. That might be something the Committee would take into account.

Q190 The Chairman: To Jake and Ilona—crisply if you could, because I realise I have let us go quite beyond time—are you asserting that local authorities are failing to prepare properly for an ageing population in their localities and, as part of that, there is a lack of strategies for doing so, with a lack of housing strategies as part of that?

Ilona Haslewood: I would say that practice is very variable in terms of local authorities’ vision and boldness to think through what is needed, and in terms of the analysis of whether the thinking is there in the first place or not. There are examples of good joint working with local housing providers, but on the whole I would not say that it is good.

Q191 Lord Bichard: I think it is a slightly unfair question. You describe a situation where it is not just local authorities that are failing; it is central Government and central Government Departments that are failing. If we have got a National Planning Policy Framework that has got very little in it, it is not surprising that it is difficult to get local authorities to focus on it. Let us be fair on poor old local authorities, who usually get the blame for all of this: it is not just them, is it? You are describing a picture where we should be concerned about Government—local and central—and its ability to create some sort of strategy for an ageing population.

Ilona Haslewood: Is the question addressed to me?

The Chairman: I think you are being invited to have a go at central government as well as local.

Jake Eliot: I think it is incredibly important to make sure we do not give local government a hard time here. It is right that, as a range of partners, we are not doing enough for older people’s housing, and those local strategies either are not there or are not clear and
Care and Repair Cymru, Joseph Rowntree Foundation, McCarthy & Stone and National Housing Federation – Oral Evidence (QQ 159-214)

emphatic enough about local delivery. I would not want the Committee to go away with an impression that there is not some excellent practice out there: sometimes that is happening with the grain of central government policy; sometimes that is happening just by experienced local partners taking an opportunity to do something differently. We have some great examples of both housing associations and local authorities with very detailed and very action-focused local strategies. There is a range of useful examples about what local authorities are doing with our housing association members to make much better use of things like hard-to-let sheltered housing stock.

To come crisply on to where some of the issues are with these priorities more widely, one of the challenges of improving the housing offer for older people is that, as a priority, it can fall somewhere in between housing, health and social care. From a development side, and from a planning side, I would put the question of whether people around decision-making tables on planning know about the full range of housing options for older people and know some of the data and demographics that you have been talking about. Throughout the whole chain of commissioning and delivery of health and care, there is not yet a sufficient focus on the importance of safe, sustainable, accessible homes to those services.

Q192 Lord Tope: That is very helpful and very good. There may be few examples, but I wonder whether we could ask for some examples of the good practice. While I have got the microphone, we are hammering the public sector—national or local—but is there not some considerable failing in the private sector? Why do McCarthy & Stone have 70 percent of the market? We could say, “Good for you,” but is that not a failing as well? If there was a demand and a pressure on local or national government, particularly local government, and local government by and large reacts and responds, it would be responding to that demand. Why is it not there, or, if it is there, why is it not being responded to?

Gary Day: It is a very good point. I mentioned earlier that there are barriers to delivery. Probably the best way to illustrate that is it takes us around a year to secure an interest in a site, for all the reasons I have mentioned. We are not dealing with greenfield sites; we are dealing with sites where there is a lot of interest. There is often an existing, viable use on that site, so we are trying to entice the landowner to sell that site to us and relocate his business somewhere else.

It takes about a year to secure interest in a site; it takes about a year to secure planning consent, with all the community consultation that has to take place now, prior to the submission of a planning application. Then it takes us about a year to build the scheme. As I said before, we cannot sell off plan, because we are selling a lifestyle. It would take us, on a typical 40-unit scheme, around 18 months to two years to sell the scheme, because, again, we have to hold the hands of our customers during that buy-in process. When you are in your late 70s and mid 80s, it is quite a traumatic period in your life, because often, as has been mentioned before, the decision to move into this type of accommodation comes around because of some instance that has happened. It could be the death of the partner, it could be a trip or a fall, or it could be an accident in the car—there are all sorts of circumstances that generate that thought process. It is a whole different development and buying process compared with other mainstream house building.

Whereas that perhaps is a disincentive for other house builders to come into our market space, the Government have incentives for it to continue to focus where it does at the
moment, which is at the other end of the housing chain. A lot of the initiatives and financial incentives that this Government have recently launched, as commendable as they are, do little more than assist a first-time buyer to buy a starter home. In my view, it would be much better if they assisted a first-time buyer to buy any property, not just a starter home. Even if they assist a second stepper, somebody who needs to move on from their first-time home to a second home, that has a beneficial impact throughout the whole of the housing chain. The biggest issue for my company currently is pent up demand.

Our customer tends to trade down. They are trading down from their larger family home; they do not need financial assistance, because they have sufficient equity, but they need to sell their property, and somebody in that housing chain needs a mortgage. There are too many incentives that make it easier for other house builders to stay where they are and not seize the opportunity.

**The Chairman:** Lord Griffiths, I am slightly worried about where we are on time; we are way behind, because it has been so fascinating and we have been probing well. Could I reinforce that we would like to hear from all of you where you think there are examples of good practice by local authorities in terms of housing planning, planning for older people, either or both, and what was good about it, so we can learn from that and see whether we want to interrogate it further. Lord Griffiths, do you want to press your point or shall we move on to other things?

**Q193 Lord Griffiths of Fforestfach:** Mr Day, if I was a potential entrant into your market, what sort of return on capital would I be expecting?

**Gary Day:** I would rather not be specific, but the return on capital would be a good one. It is the internal rate of return that is most important, and that could be significantly different from a volume house builder, who can sell off plan or, if they are building conventional housing, build to meet the needs of a particular customer.

**Q194 Lord Griffiths of Fforestfach:** The point is it would be attractive.

**Gary Day:** Yes it would be, but it also comes with a high risk. The returns are good, but it is very high risk, because we have to build the whole block, with all the communal facilities, deliver everything, all the landscaping, before we can sell.

**Q195 The Chairman:** I am going to suggest we move on to question 10, and ask on question 5, which was about what housing associations are doing, because I think we know what they are doing, to get evidence of where there are examples of innovation that would be of interest. Could you submit that to us in writing, rather than us having the time to do it justice now? Let us move to the topic of housing and independence, because a number of you signalled, as we have, and perhaps many people, that is their goal, and it is an appropriate form of independence. Baroness Tyler, over to you. Welcome to Baroness Finlay who was seriously caught by the train, rather than anything else.
Q196 Baroness Tyler of Enfield: We have already touched on this as the morning has proceeded, but I am interested to know what can be done to help older people to stay living in their existing homes, where that is feasible: how can they be supported and who needs to be involved? In particular, do you see a role for a financial incentive, tax benefits incentives, that sort of thing?

Chris Jones: I am conscious that this should not be a public information film on behalf of Care and Repair, but everything that you have mentioned there is what we do. The reason that we exist as a charity across Wales, and also in England and Scotland, is to do exactly what you are suggesting, which is to help older people live independently at home. The way we do that is to provide individual, tailored solutions for them. It is not one size fits all in terms of what people need to stay safe and comfortable in their own home, but generally we find that we are not talking about big capital expenditure schemes. It can be just that little bit of help and support in a number of areas that will make a big difference.

With the sort of support that we provide, the focus is on doing it quickly, because if people have to wait it defeats the object, and very often the accident happens and they are admitted to hospital or they go into care. We provide support for getting small adaptations done quickly and help people through the bureaucratic system for larger adaptations. In terms of repairs, a lot of older people are living in the owner-occupied sector in some of the poorest housing. Energy efficiency is also a huge issue for older people, and while there is quite a lot available in terms of help with getting work done to make the property more energy efficient, this can mean that people do not know where to turn first. Regarding home safety, we look at the risks in the property, identify them and deal with them. Through all of this, we identify the best help available for them and draw that in as a tailored package.

But it is not just providing older people with physical works to the property. We also look at their finances. Very often they are not claiming all the benefits they are entitled to, which for example can have a big impact on whether they can afford to put the heating on. Increasing the household income is a big part of what we do, by making sure that older people claim what they are entitled to claim under the welfare benefits system. We also work in partnership with others. A lot of this is about older people needing social support: help with their shopping; they may be socially isolated, so they would be put in touch with befriending schemes.

What we do is go in and look at all of those things and provide a tailored package that helps keep older people living safely in their home.

Q197 Baroness Tyler of Enfield: This is very interesting, but could I ask what you see as the respective roles of you as a charity in this area and public agencies, the local authority or whatever?

Chris Jones: We are a charity, but we are mentioned and are included a lot in local authority housing strategies. We work really closely with local authority housing teams and occupational therapists. One of the strengths of Care and Repair in Wales is that we have got all-Wales coverage, so there is a Care and Repair agency in every county, which is something that we are pleased about. It enables us to work with 22 local authorities and really sell the benefits of our services to local authorities and say, “Look, we can do a lot of
this stuff, maybe quicker than you can and help you deliver your housing strategies and strategies for older people."

We are supported by the Welsh Government, we are part of the National Housing Strategy in Wales, and we are referred to in that as an important delivery agent. One of the things we are trying to do more and more is work with local health boards, and the NHS generally, in trying to get that message over to commissioners and professionals in the NHS: if you work with us, we can provide services that have a huge impact on whether people need NHS treatment, through falls prevention or keeping them healthy at home. I said I was conscious of it not being a public information film for Care and Repair, but we do a lot of work locally that brings partners in public bodies and statutory sector together. One of the conditions of our funding from the Welsh Government is that every Care and Repair agency in Wales needs to provide its own annual strategy, and that strategy must be signed off by health, housing, social services, and other local third sector organisations as being a holistic approach.

Q198 Baroness Tyler of Enfield: You say that you have some coverage in England, but is there any equivalent across the board in England of the sorts of services you provide?

Chris Jones: Yes. Care and Repair exists very strongly in England, but it does not have all-country coverage in the same way Wales does. Care and Repair England is a national lobbying and campaigning body and Foundations looks after the Care and Repair Agencies.

Q199 Baroness Tyler of Enfield: The final thing I would like to know from anyone here today, in terms of independent living, is what is the greater weighting between the physical property and the care and support element? I am conscious that you talked about things like lifetime houses, or homes for life, and I know there is more thinking about the design of houses these days to enable someone to get right the way through their life in one property if they so wish. Is that package equally weighted, or is it more one than the other?

Jake Eliot: This is not trying to get out of your question, but from our point of view both really matter. A lot of today’s discussion so far has been about new development and planning, which is absolutely right. What is important about this area to us is the recognition that most homes people will be living in as they age are built now. It is critical to look at both what Chris was talking about around adaptations to existing properties and the kind of support and care services that can be plugged in around owner-occupiers or around people living in their own homes.

One example, which, given we are under time pressure, I will share with the Committee more in writing, is about using hard-to-let sheltered housing stock and converting those into home-from-hospital flats, to enable people to move out of hospital quickly after an operation, while their home is either being adapted or they are finding more suitable accommodation. The savings that would bring to the NHS are colossal; it is about £150 a week rent from the housing association, versus just under £3,000 a week average cost from staying in hospital, before you even start to look at the relative health and wellbeing outcomes for those individuals. It is about use of the home, adaptations to the home, and many housing associations run their own adaptation services, and have agreements and

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protocols in place with local authorities to try to speed up and improve the process of adaptations, both small and large.

There are two points I would add on; again I will submit these in writing rather than go into detail. One example is around end-of-life care, which throws that point of balance between physical structure and service into really sharp relief. It is not an issue we as a society spend a lot of time talking about, but one of our larger members, Home Group, has done some really interesting piloting work trying to probe this issue: why is it that when any of us are asked about it we would all have a preference to see the end of life in our own homes, but so few of us do? Their answer to it in a pilot project is a mixture of personalised support in an individual budget, with some community support, and partnership work with local cancer charities.

The challenge for us in the future, given some of the new architecture through the Health and Social Care Act, is how we, as provider sectors, and local authorities and health service partners, use those structures to make an impact on some of this. We see a lot of goodwill around, a lot of broad acceptance of high-level points, but what we really want to see is some of these services and adaptations using sheltered housing as a hub for support, and better co-ordinated end-of-life care coming through in local priorities and commissioning strategies.

Baroness Tyler of Enfield: Those two examples you mentioned would be very helpful.

Q200 The Chairman: Could we get a view from JRF, Ilona, as well on this question about supporting independence?

Ilona Haslewood: Your question was on whether the physical-practical or care and support part was more important. I would agree with Jake that both are important and they come in a package, because some of the support will be emotional and some will be practical, and they mutually reinforce each other. The wider point here is that a lot of support is happening informally: people just do it—neighbours, friends—without thinking that they are providing support. It is worth bearing this in mind, because, for example, when I was talking about not severing local ties or keeping personal relationships going, that is also a housing question as well as a social care question, and it goes into various other fields too. If people do not have to move out of their community and can keep their ties going, the health and emotional outcomes are much better; there is evidence on that.

Although not widespread, there are some very interesting and promising initiatives, for example, Homeshare, Shared Lives, and various forms of mutual housing, such as co-housing or housing co-ops, that promise to provide both practical and emotional support. There is no reason why Homeshare or Shared Lives could not be incentivised to take place on a wider scale.

Q201 Baroness Tyler of Enfield: Do you mean financially incentivised?

Ilona Haslewood: For example, financially incentivised.
Q202 Baroness Blackstone: On the theme of people staying in their homes, of the various physical modifications and adaptations that are done, do we have evidence about which are the most cost-effective? What things would you be most likely to put into an elderly person’s house to make it possible for them to go on living independently? What is the range in terms of costs? Do we know what people need most? I assume we do.

Chris Jones: The most cost-effective ones are the cheapest ones: for example handrails, grab rails, small ramps, and repairs to paths that are uneven or broken. Those sort of low-cost works that can be done quickly are the ones that we think save the most money, particularly for the NHS in terms of falls prevention and stopping people going into hospital, but also getting them out of hospital more quickly and dealing with delayed discharge of care. There are so many things that people might need in terms of small repairs, energy-efficiency work, adaptations, or help with understanding their finances and how they can afford to heat the home. There is a whole host of things that could be done to help people stay comfortable in their own homes.

One of the most successful things that we have delivered, which has been going now for 10 years, is a scheme called Rapid Response Adaptations. That scheme touches on an earlier question which was about working with the NHS, with social care, and housing. The scheme is about getting early referrals from professionals about what small works are needed to keep people out of hospital or get them out of hospital more quickly. In Wales, over the last 10 years, we have calculated that 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. For example, a hip fracture operation costs about £30,000. If you put in a small adaptation when maybe a GP or other health professional says, “This lady or gentleman needs help and they are at risk of falling,” and you get that adaptation in quickly, there is a big chance you are going to stop an accident that will cost the NHS £30,000, £40,000, or £50,000. If you do many thousand small adaptations early at a cost of £150, you can see how the economic benefits will start to add up.

That is it in terms of the range of works that can help older people live independently: it is a huge range, but in terms of cost-effectiveness, the low-cost adaptations and small works are probably going to be the most cost-effective.

Q203 Baroness Blackstone: Are there any barriers from the point of view of getting public expenditure to provide these sorts of aids to help people stay independent, particularly the more expensive ones like stair-lifts, so that people can get up and down their stairs?

Chris Jones: There are. Perhaps I am having a bit of a go at the NHS here, but Care and Repair is predominantly a housing-funded scheme, and when it was developed it was more to do with older people living in poor housing in terms of disrepair. Nowadays the balance is more about keeping them safely at home and about adaptations. I argue quite frequently that a lot of what we do should not be housing funded; it should be Health funded. At the moment, we are on a really big mission, doing quite a big media and communications drive, trying to get Health professionals and Health budget owners to understand that what we do delivers a huge amount for them in terms of cost savings. It would be a really big step forward to have some mixed funding coming into this important area.
Q204 Baroness Blackstone: Does it matter where the money comes from, as long as it’s provided?

Chris Jones: It matters if you cannot get it, yes.

Q205 Baroness Blackstone: Your hope is that the NHS budget, which is bigger, even though it is shrinking, would be a better source of funding than housing?

Chris Jones: My hope is that it would be an additional source of funding. I know NHS budgets are under huge pressure and the issue for the NHS is they need the money and to make savings now. Our argument is that you are going to save money down the line. Health managers are under huge pressures, so it’s a difficult argument for us to make.

Q206 The Chairman: We would all hope that putting grab rails and handrails in would reduce the incidence of falls, and obviously falls are a big cause of cost and a big cause of premature death. But is there proper evidence that is true? We would like to see the evidence if there is such evidence, apart from it being what you would hope.

Chris Jones: There is a lot of published work from Care and Repair and others.

The Chairman: Just send us the gist of it, and we will read it with interest.

Q207 Baroness Blackstone: Can I just ask two questions, and they are rather different. The first is to you also, Jake: do you ever find ways of subdividing elderly people’s properties? You talked about Homeshare, but that is rather different. If a woman or a man is left on their own, and their house is quite big, creating two units out of one house might be one way of letting people stay in their house and remain independent, and also create a new unit of accommodation. My second question is about social support. You mentioned help with things like shopping: how far can volunteers be used to do this sort of support, both younger elderly people or young people, as part of an approach to volunteering that they ought to get engaged with anyway?

The Chairman: If you could keep it relatively crisp, that would be lovely.

Chris Jones: Volunteering among older people already happens to a huge extent in the UK, whether it is unpaid carers or people who volunteer on behalf of organisations like WRVS. I genuinely think that already happens a lot. We are not a volunteering organisation in the sense that we do not have volunteers, but I know that organisations like WRVS and Age UK, Age Cymru, do focus on volunteering to do things for older people, like befriending, dealing with social isolation, and helping them with basic day-to-day activities, like getting their shopping done. That already happens to a huge extent in the voluntary sector.

Jake Eliot: I am going to have a bash at trying to answer all those questions as succinctly as I can. Firstly, on the DFG you made a very sensible point: does it matter where the money is coming from if you are getting homes adapted? The answer is: no, it does not. What we have with funding for home adaptations through the DFG—the Disabled Facilities Grant—is need vastly outstripping supply. That is why Chris’s point about the NHS coming in to pay for their share of some of those benefits is a reasonable ask. There are also challenges
around some of the delivery issues in partnership with local authorities, which Chris alluded to earlier.

On subdividing properties, there are a lot of examples out there of housing associations trying to make better use of existing stock through remodelling sheltered housing schemes, or renovating and reusing older and multipurpose buildings. I do not have any examples of subdividing properties; obviously there are issues that would need to be considered around space standards, and contractual agreements around the number of units delivered with the Homes and Communities Agency as well.

On the social support, there is a big role for volunteers. It is important for all providers, no matter what sector they are from, to recognise that older people are important citizens, and givers of support as well as receivers of support. There is an increasing role for older people in that peer support, and there is some very interesting research out there—and Ilona may know more about this—about the particular benefits of support from peers, rather than support perceived as professional assistance.

One caveat to that: there is also an increasing need for blending support that traditionally might be labelled as health care, functions and services that traditionally might be labelled social care, and housing-related support. That is a very skilled mix of professional competencies and abilities. There is an important role for volunteers, and there is an important role for professionals. We need both.

Ilona Haslewood: Just a couple of very short points, one about volunteering. As well as the big national organisations that run volunteering schemes, there are lots of very small local initiatives that do that. A word of caution: if volunteering is viewed in the light of cost savings, there is quite solid evidence that volunteering is not going to save huge amounts of money in comparison with paid services, because volunteering has its own costs, but it has its own benefits as well. Regarding volunteering that is primarily aimed at doing practical tasks, there is increasing evidence of the benefits of other types of social networks, book clubs, etc., where various other things happen as well as the actual tasks they were formed for.

Q208 Lord Griffiths of Fforestfach: We have heard from a number of previous witnesses that equity release has improved noticeably recently. I wonder if you could tell us in which way it has improved, because there are so many savings embedded in existing housing. What do you see as the potential for equity release releasing even more? If there were more sophisticated products, a better range of products, and so on, to what extent do you think that could help?

Chris Jones: We think there is huge potential for looking at how we can effectively use the tied-up equity in older people’s properties. I do not think the market is particularly strong at the moment, but, as the question implied, it is stronger than it used to be. Back in the 1980s there were some very dodgy products that gave equity release a very bad name, and that bad name has stuck. I think older people find it difficult to think about equity release in ways other than, “We do not want to touch that,” because of their past experience or what they have heard about it in the past. There is also a big barrier for older people using their tied-up equity; they see it as their family’s—their children’s inheritance. They do not want to use equity; they want to leave it to their children.
We need to try to help people get over that, because it is important that as you get older you live in a decent property. The situation might change as later generations grow older, and their understanding of the market is different. We recognise there are a lot of people who are cash poor but equity rich. We see a huge number of older people in Wales who are living in very poor housing conditions; we are talking about the roof leaking, there is rising damp, the windows are rotten, the electrics are dangerous. There are significantly poor housing conditions with no funding solutions. There used to be quite a lot of public finance out there in terms of local authority housing grants, but that has died off to the extent that it is hardly available now, certainly not in Wales and I do not think in England either. We need to fill this gap.

The Chairman: Can we move along the row and get comments from others quickly?

Q209 Lord Bichard: Can I just ask the obvious supplementary question? What would you do to improve the situation? You are dealing with a generation that has had its endowment policies mis-sold and has got no faith in the financial services market and will stay away from it as far as it possibly can. For all the problems that you have mentioned, what do people think you could do?

Chris Jones: We think there could be some public investment to seed fund a scheme that loans people money and is paid back when the property is sold. That is what we are lobbying the Welsh Government to do. We are not looking at the private market equity release currently; we are looking at some seed funding, public funding, to get a loan scheme going and that will revolve over time as properties are sold, with that money used for further lending.

Q210 The Chairman: Can we go along the row and answer both of those questions: what is the problem, and what would you do?

Jake Eliot: Equity release has to be part of the solution. As Chris was mentioning, it is a clear opportunity to try to release some of that equity. The opportunity is to add to some of the successful examples so far, where equity has been released for the benefit of making adaptations to an existing home to bring up the standard of the home and enable people to live there longer. The new opportunity is to develop newer products and a newer focus that helps older people downsize to a positive housing offer but maybe also a smaller housing offer and release some family housing stock into the market.

The challenges are significant: we underestimate them at our peril. There are the things Chris has mentioned around the appetite of the market, and concerns about the viability of an equity-release offer. There is also concern from the lenders’ market. It is chicken and egg regarding what would break that, but we see more successful delivery of cross-subsidised, housing-association-delivered older people’s housing for private sale as part of that, gradually bringing the market confidence up, alongside more information and advice work to communicate what that equity-release offer could do.

Gary Day: I would endorse much of what has been said. We are in an unfortunate situation where there is a lack of trust, poor reputation, and some poor reporting, sometimes quite justified, through experiences of companies who have delivered this facility
in the past. I think the challenge for us is better education, more bold communication, because, as we move forward, it should not be seen as a last resort; it should be seen as an integral part of retirement planning.

We have just entered into the financial services market, and this is one of the projects that we are delivering. We are working in partnership with a company that will provide our customers with a whole-of-market option, so we can tailor the facility to that individual need. We are putting a lot of trust in our partner—justified trust—but we are hoping that companies like us, with our current brand reputation, can begin to enhance the perception that there is of equity release as a way forward in retirement planning.

Q211 Lord Bichard: Would you make that available to people who are not buying your properties, or are not involved with you in some other way, or is it related to the purchase of a property?

Gary Day: We are still at an embryonic stage. At the moment, it is something that we are only offering to our customers, but as we develop that part of our business it would be our intention to take that to the wider market.

The Chairman: Could you send us your plan for development as a note?

Q212 Lord Griffiths of Fforestfach: I wonder if I could just ask Mr Day one question: in terms of not you but the market as a whole, is there any potential in some public body giving an endorsement to certain institutions in order to create more confidence in the product?

Gary Day: Yes, I think so, but it is even broader than that. We need to start talking about the positive beneficial implications of using equity in retirement planning. As we move forward, as we all are aware, we are going to have to find something other than conventional pensions.

Q213 The Chairman: You cannot spend it twice.

Gary Day: Exactly.

Ilona Haslewood: We are aware of some signs of growth, although not a very large amount, both in terms of using the equity for debt consolidation and for paying for care, which is perhaps a sign that things are improving. There remains a huge gap in knowledge and confidence. One of the general ways of improving knowledge and access would be enabling access to good financial advice, preferably by people who have the right skills and knowledge in decision-making in later life about finances and various products. JRF has contributed to working out a particular equity release product called the Home Cash Plan. It was a few years ago, and we also supported pilots in three local authority areas, which partly speaks to your question on public endorsement. It was found that it did not lead to an awful lot of enquiries about equity release on the whole, but maybe that is because local authorities might not be the best avenue to those people who would want to enquire about equity release.
However, since then FirstStop, which is a large advisory service, and Age UK Enterprises, have the Home Cash Plan on their horizons, so there is some knowledge and endorsement already available. Generally speaking we think that equity release can be the right product for some people, although it will not be right in every case. In terms of its future use, we think that it might decrease over time, as new generations of older people may have more debts, so may not have the equity that would justify high hopes of wider use. We think that clarity, for example, around care funding, could do a lot in terms of confidence to use equity for funding care.

**Q214 Lord Griffiths of Fforestfach:** Could we ask Mr Jones if he would send us his proposal for public sector seed funding to get the thing going?

**Chris Jones:** Yes, sure.

**Lord Griffiths of Fforestfach:** That would be terrific.

**The Chairman:** Good. Thank you all very much indeed. It has been an extremely interesting and useful session. We have set you quite a bit of homework, so I would be most grateful if you could follow through with that, and we look forward to reading the further evidence or examples you submit. Thank you so much.
To appreciate the role of home modifications; such as adaptations and repairs in preventing accidents and falls in older people, it is necessary to contextualise the extent of the problem, in both severity and number.

**Injuries in Wales (Public Health Wales findings)**

In 2009 there were 1102 deaths, 41,817 hospital admissions and at least 444,274 Emergency Department attendances due to injury, incurring direct costs of at least £25.9 million. The leading cause of death from injuries was falls (23%). Falls also account for 48% of injury inpatient admissions. In addition, the inpatient injury admissions led to 309,844 bed days, an average of 7.4 bed days per admission.

**Costs**

The direct medical costs of these injuries in Wales were £25,944,352 (related to inpatient admissions and emergency department visits.)

**Falls**

The leading cause of death and in-patient admission in Wales, due to injury, is falls.

**Summary estimate of epidemiology of falls in Wales in 2009**

![Diagram showing the numbers of deaths, in-patient admissions, and attendances at emergency department in Wales]

**Falls Rates**

**Death**

Fall death rates were low in all age groups until 70 years when they started to rise, from 9.7 per 100,000 (males) and 7.2 (females), to 138.7 (males) and 120.8 (females) by age 85+.

**In-patient and Emergency Department**

Both In-patient and Emergency Department rates had two peaks; in childhood and in old age. However, whilst male rates were higher in childhood, amongst the older population,
female rates are higher. Falls counted for 48% of inpatient admissions related to injury and 10% of Emergency Department admissions.

Costs of Falls
According to the Public Health Wales figures, the cost of emergency department visits and inpatient admissions alone in Wales was £10,419,451 in 2009.

Older People
Serious fall injuries mainly affect older people. Amongst older people falls are extremely common; 30 to 60% fall each year and 15 to 30% fall more than once. This high incidence means that fall injury incidence and serious fall injury incidence is high; 2-6% of falls lead to serious injury and 1% lead to hip fracture

Falls in the Home
The majority of falls occur at home. The cause of a fall at home is often multi-factorial, involving both environmental hazards and an underlying medical condition. Strength, balance and gait, decline in vision, mental health problems and deficiencies in the diet are all contributory risk factors.

Environmental hazards are largely preventable. Care & Repair agencies for example, complete a home safety check with clients to assess their home for hazards and then help to make the necessary modifications, adaptations and repairs to improve safety in the home.

Home Modifications/Adaptations
Home modification includes converting or adapting the environment in order to make performing tasks easier, reduce accidents, and support independent living. Home modification, ranging from low-cost to more expensive adaptations, includes removing hazards (e.g., clutter, throw rugs), adding special features or assistive devices (e.g., grab rails, ramps), moving furnishings, changing where activities occur (e.g., sleeping on the first instead of second floor) and renovations (e.g., installing a walk-in shower). In some cases, modifying the home may also require repairs such as improved wiring to eliminate the need for dangerous extension cords or fixing loose stair treads.

Home modifications and adaptations can reduce the demands of the environment while making the home safer and more supportive. A review by the Office of Disability Issues of the outcomes and costs of adaptations stated ‘For older and disabled people, the choice between adaptations and other options is a choice between independence and dependence.’

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Evidence for the benefits of home modification in falls prevention

Prevention of falls and injuries has been a major focus of research, stimulated by aging populations and by growing awareness of the mortality and morbidity resulting from falls. Reviews of falls prevention interventions have concluded that interventions are successful; including assessment of hazards at home and modifications of the environment, such as adaptations. Reviews have concluded that home assessment and modification reduced the risk of falls, particularly for those discharged from hospital and for those with a history of falling.

A recent trial of falls prevention of older people who were determined at high risk of falling found that those who received falls prevention, such as improving home safety, were significantly less likely to fall than a control group. Another trial specifically looking at environmental factors found that home safety assessments reduced the risk of falling by up to 39% in those who were at high risk.

Cost effectiveness

The office for disability issues found in a review of current evidence that provision of housing adaptations and equipment for disabled people increased people’s quality of life and independence.

Such provision also produced savings to health and social care budgets in four major ways;

- Reducing or removing an existing outlay – residential care and home care
- The prevention of an outlay that would have been incurred – prevention of hip-fractures and other care costs
- The prevention of waste – delay in supply of adaptations
- Achieving better outcomes for the same expenditure – improving quality of life.

The Rapid Response Adaptations Programme

The Rapid Response Adaptations Programme (RRAP) allows equipment such as ramps, handrails, safety alarms and door entry systems to be fitted in people’s homes quickly so that their hospital discharges are not delayed and future admissions can be avoided. The


scheme is administered and monitored by Care and Repair Cymru and delivered by Care and Repair agencies. For every £1 spent on the RRAP, £7.50 is saved from the NHS and social services budgets by preventing hospital admission or speeding up hospital discharge. Nearly 14,000 RRAP jobs were completed in 2010-2011, of which over 9,500 prevented hospital admission and 4,500 enabled hospital discharge. The jobs were completed on average in 7 working days.

Conclusion

Adaptations and home safety advice are cost effective methods in preventing falls for older and disabled people.

The review conducted by the Office of Disability Issues\textsuperscript{120} stated; ‘The evidence from the review is that, unless the cost of the adaptation is very high compared with the life expectancy of the person concerned, adaptation (and independence) will always be the better value option.’

\textsuperscript{120}Heywood, F. and Turner, L. Better Outcomes, lower costs. Implications for health and social care budgets of investment in housing adaptations, improvements and equipment; a review of the evidence. Office for Disability Issues 2007
Equity Loans for older people living in poorest housing- outline proposals for public sector seed funding “a scheme that loans people money and is paid back when the property is sold”

What is the problem?

- In Wales, and across the UK, older people live in some of the poorest housing in the private sector- typically unfit, damp, serious disrepair pre 1919 terraced properties in cities or valley communities, or old rural housing.

- Care & Repair in Wales visits some 20,000 older people in their own homes every year. Our experience is that the most difficult problem is finding funding for those older people living in housing which is unfit, damp and suffering serious disrepair such as leaking roofs and dangerous electrics (category 1 hazards under Housing Health and Safety Rating System (HHSRS))

- Local government housing grants for disrepair are now virtually non-existent, and Care & Repair caseworkers are finding that charitable and benevolent funding is increasingly difficult to access as there are increasing applications for this in the current financial climate.

What are the options?

- Care & Repair Cymru advocates a public policy option that could be put in place to help tackle the problem, namely public funding to establish a loans programme for undertaking such repairs for older people, which is repaid on sale of the property from equity in that property.

- In essence. These would be equity linked loans, paid back on sale, for further lending thus creating a recycling fund for further lending.

How could this be delivered and work in practice?

- In Wales, a voluntary sector organisation such as Care & Repair Cymru could set up, manage and co-ordinate access to such a loans fund for older people in need, working in partnership with local government. Care & Repair could specifically ensure:
  
  - the right funding solution for disrepair for every older person in need based on their circumstances
  
  - Equitable access through a consistent approach to delivery across Wales
  
  - Local delivery through the network of 22 Care & Repair Agencies in Wales, but based on nationally agreed rules
  
  - In close partnership with Local Government
  
  - Full compliance with FSA Regulations in relation to any loan based solution
• Training of Care & Repair caseworkers and Technical officers to ensure national consistency and equitable access to funding is achieved

**What would this achieve?**

• Filling a significant gap in services for the most vulnerable older homeowners living in poorest conditions

• Delivering cost savings for Health and Social care by keeping more older people living independently in their own homes

• In the case of loan solutions, an innovative and efficient way of making best use of public funds, with repayments of loans being recycled over time into further small grants and loans

**Why Care & Repair?**

• Care & Repair has a proven track record over 25 years in co-ordinating and delivering housing repairs and adaptations for older people. We have a trusted brand and reputation and our sole aim is to find tailored solutions for housing problems faced by older homeowners

• One of Care & Repair’s strengths is how it plans and delivers services in partnership with Local Government and Health, making sure that older people receive good quality, consistent services to make their homes fit for habitation, and accessible. Partnership delivery is critical to how we work locally.

• Care & Repair would deliver national consistency and equitable access to repair solutions

November 2012
1. Care & Repair England
1.1 Care & Repair England is an independent charitable organisation set up in 1986 which aims to improve older people’s housing. Its vision is that all older people have decent living conditions in a home of their own choosing. It innovates, develops, promotes and supports practical housing initiatives and the related policy and practice which enable older people to live independently in their own homes for as long as they wish, particularly for older people living in poor or unsuitable private sector housing.

1.2 Older people want to live safely and independently at home for as long as they can. This aspiration lies at the heart of Care & Repair England's work. Our aim has always been to improve the housing and living conditions of older people, particularly for disadvantaged home owners. This work is as critical as ever as the availability of affordable home repair and adaptation help is decreasing at the same time that the number of poor older home owners is rising exponentially.

2. The focus of Care & Repair England's evidence
2.1 Our submission focuses on the needs and aspirations of older people living in poor and unsuitable private sector housing. We want to ensure that the House of Lord's Committee recognises the concerns of this group and identifies the current and future role of public service, funding and support in this area of policy. We do so by setting out evidence of the circumstances and impact for older people living in poor and unsuitable housing. We identify practical solutions that will continue to require a public service response now and in the future. Our submission focuses on two of the questions set out by the Committee – the extent and nature of public services responses in this area and what practical actions are needed.

3. The situation for older people in poor and unsuitable housing
3.1 Poor homes, home ownership and low income
3.1.1 There are approximately 14.7 million older people, and 7.3 million ‘older households’ in England today. This is equivalent to more than a third of all households. Home ownership is now the majority tenure for older people with dramatic increases in home ownership over the years. The proportion of older homeowners is set to increase further as levels of home ownership in the population have risen in recent decades. Although older people own a lot of housing equity by no means are all older people wealthy. Housing equity varies regionally. Many older people rely on state benefits as their main source of income and savings rates are fairly low. The number of low income older home owners is set to rise significantly, fuelled by two main factors – the ‘Right to Buy’ and peak home ownership generations growing older whilst many pensioner’s incomes (particularly private pensions and annuities) are falling. This means that low income and poverty will rise amongst older home owners.

3.1.2 Many older people live in poor housing. Whilst the majority of homes are in a reasonable condition poor housing conditions remain particularly for the ‘older old’, low
income, long term resident home owners and private tenants. The Care & Repair England report, A Perfect Storm\textsuperscript{121}, quantified these issues

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\textbf{Home ownership is now the majority tenure} \\
- There has been a dramatic increase in the level of home ownership since the 1970s, rising from less than 50\% in 1971 to 70\% by 2006. \\
- Most of the increase occurred during the 1980s, partly as a result of the ‘right to buy’ policy combined with increased access to mortgages, particularly for lower income groups. \\
- Whilst home ownership amongst younger groups is falling dramatically, home ownership in older households is still around 75\% and is set to rise. This is even higher in some rural areas and amongst those in the 60-70yr cohort, where home ownership is approaching 84\%. \\
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\textbf{Data from the 2007 last English House Conditions Survey shows that: }- \\
- Almost 84\% (3.2 million) of older and elderly householders in non-decent homes live in private sector housing. \\
- Vulnerable householders\textsuperscript{122} aged 75 or more are most likely to live in non-decent homes (36.5\%) \\
- Over 1 million (67\%) vulnerable older and elderly householders in non-decent housing live in private sector housing. \\
- 86\% (865,000) of older and elderly householders in houses in serious disrepair live in private sector housing and over 76\% (380,000) vulnerable older and elderly householders in houses in serious disrepair live in private sector housing. \\
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3.1.5 The situation for this group of older home owners is likely to be exacerbated by predicted housing market problems, albeit with a widening geographical divide. 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. This might be a viable option for some though it should be noted that the majority view of older people is to stay at home for as long as possible.

\section*{3.2 Unsuitable housing}

3.2.1 Our report Time to Adapt\textsuperscript{123} identified the trends and projections for the number of disabled older people living in un-adapted, unsuitable housing.

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- By 2025 almost 1.5 million people aged 75 or over will be unable to manage at least one mobility/daily living activity on their own \\
- There has been a 60 per cent increase over 5 years in the number of people over 85 who report that they have a serious disability or medical condition \\
- There is a higher level of ill health and disability amongst lower income groups. \\
\hline
\end{tabular}
\end{center}

\textsuperscript{121} A Perfect Storm: An ageing population, low income home ownership, and decay of older housing. Care & Repair England. Nov 2010

\textsuperscript{122} The definition of vulnerable households for April 2005 to March 2007 was households in receipt of: income support, housing benefit, attendance allowance, disability living allowance, industrial injuries disablement benefit, war disablement pension, pension credit, child tax credit and working tax credit. For child tax credit and working tax credit the household is only considered vulnerable if the household has a relevant income of less than £15,050. It does not include being in receipt of council tax benefit or income-based job seeker’s allowance

\textsuperscript{123} Time to adapt: Home adaptations to older people: the increase in need and future of state provision. Care & Repair England. Sept 2009
• By 2036 there will be 17 million people aged 65 or more. On current trends 33% (5.6 million) of people over 65 and 50 per cent (4.5 million) of people over 75 will experience a limiting long term illness.

• Based on current population projections, this would mean in 2036, around 810,000 people aged 75 or more would be living in properties that they considered unsuitable for their needs. The vast majority (around 70 per cent) 567,000 would be living in owner-occupied properties.

3.2.2 With regard to meeting the cost of home repair and adaptation, the availability of affordable or ‘fair’ equity release or social loan products for the moderate and lower income groups is declining and becoming more expensive. There is a strong geographical divide with regard to property values reducing the viability of equity release products. There is also continued concern amongst many older people that current products are just not suitable for them.

3.2.3 The future of state help with home adaptations for disabled older people is also in the balance. Disabled Facilities Grant (DFG) capital funding for local councils was retained in the 2010 CSR, but the ring-fence of the funding ended. Although DFG funding was retained at about £180m annually there has been no allowance for inflation. So whilst national funding has increased over time, many local areas have seen an overall budget decrease despite rising levels of need. Whether such funds will continue into the future is a matter for debate. Funds for adaptations work will remain a crucial ingredient to enable people to remain at home in comfort and to reduce funding pressures on other services most notably social care and health.

3.2.4 Also as a result of the 2010 CSR the private sector renewal budget has been discontinued. This budget, which has its origins in 1949, provided assistance to at least 200,000 poor or disabled families annually to carry out urgent repairs and adaptations. Until recently at least £300 million was provided annually. For the life of the present government there is no provision for private sector renewal. This is an effective cut of more than £1.5 billion over five years and will mean about one million homes will not receive assistance. It is surprising that government has chosen to make these cuts when the people most affected are disabled and older home owners.

3.3 Linking housing responses to social care and health

3.3.1 To date, social care policies have been strongly supportive of enabling older people to live independently their own homes for longer. Reform of adult social care, and particularly its funding following the recent Dilnot124 review, has been delayed until the next CSR. Decisions about Dilnot will impact on the capital resources of older homeowners for repairs and adaptations so the impact on housing will be an important consideration for the Committee. Living at home for as long as possible requires a decent, suitable home. The state of the housing stock is critical.

3.3.2 The health sector is still committed to the provision of health care ‘at or closer to home’, with targets to reduce hospital bed days, increase community provision and targeted reduction in health service use by people with long term health conditions (primarily older people). Housing standards and suitability are pivotal to achieving these but receive

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124 Fairer Care Funding. The report of the Commission on Funding of Care and Support. July 2011
inadequate attention in health planning and the cost benefits to health of suitable, decent housing is under-reported.

3.3.3 Housing conditions have a significant and quantifiable effect on health. The Building Research Establishment quantifies the costs to the NHS of specific aspects of poor housing as over £600 million per year\(^{125}\). Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions\(^{126}\). This housing/health link becomes more important with age, as people become more prone to trips and falls and more susceptible to cold or damp related health conditions. Poor thermal standards in the homes of older people are a quantifiable contributor to excess winter deaths. There have been many reports that have identified where housing spend has led to savings to health.\(^{127}\)

3.4 In summary the Committee is asked to consider:
- The state of older people’s housing and access to funds for the most vulnerable to ensure all people’s homes are both decent and suitable in later life
- The link between state housing investment and the corresponding health and social care gains to highlight how small amounts of public investment and help in one sector can lead to reductions in spend in other areas.

4. Practical responses and current pressures

4.1 Home Improvement Agencies (HIAs) Home improvement agencies remain the only source of comprehensive, practical housing help for low income home owners facing repair and adaptation problems. At their best they provide older people with advice, help and support to repair improve and adapt their home – or move to more suitable housing if this is seen to be the best option. In a survey in 2011, Foundations – the coordination body for HIAs - estimates that about a quarter of HIAs were closing, with a third of the remainder experiencing large scale cuts of over 20%, a third cuts of 0-20% and the remainder standing still or a few with small growth. Caseworker capacity to provide a holistic service was the main reduction and independent Care & Repair services (that is those not linked to a council, housing association or private company) seem to be the most vulnerable. This has been due to the squeeze on funding such as Supporting People and private sector renewal funding to local councils. These practical local services are a critical support for older households and need to both continue and expand.

4.2 Adaptations

In 2007/08 38,130 Disabled Facilities Grants were awarded to help with the costs of home adaptations. Approximately 70% of grants were for older people. The average grant was £6,559 with total expenditure of £250 million\(^{128}\). Whilst spending has increased on adaptations it falls short of meeting current need and there is evidence that the squeeze on spending coupled with demand are leading to reductions in availability and delays in delivery of adaptation funding via DFGs. For some this can result in months, if not years, of waiting.

\(^{123}\) The real cost of poor housing Building Research Establishment. M Davison et al. 2010

\(^{126}\) Housing risks and Health Inequalities in Housing London Department of Health /Housing LIN Blackman T. 2005


Care and Repair England—Written evidence

for help. Home adaptations are crucial to many policies that enable older people to live independently and also reduce spend on more intensive services. Spending on adaptations and improvements in delivery should be a priority for public service if people are helped to stay at home avoiding falls and accidents and living better lives.

4.3 Handypersons services
Handypersons services offer older people help with small practical jobs around the home which contribute to home safety and security, home adaptations and general comfort and well-being. They are run by many local agencies and including Home Improvement Agencies and funded via local councils with some using charitable funds for the work. In one or two areas older people are working with other older people to offer some of these practical help services, which is a relatively new development. An evaluation of a Government funded handyperson programme has identified value for money and the success of the programme in meeting needs.129 However, as a result of the CSR in 2010 the budget for handyperson schemes has been reduced by almost half from £20 million in 2010/11 to just £10.5 million in 2014/15. Yet there is no doubt that these services will continue to be needed as the population ages.

4.3 Housing advice and information
Home Improvement Agencies have provided older people with bespoke and independent advice, information and support services to manage the complexities of maintaining their homes and consider their housing options in later life. Other local agencies such as local Age UKs and charities, and increasingly local older peoples groups, have played a role in delivering independent advice and information for older people to tackle our increasingly complex world. The Government has always recognised the role of advice and information across areas such as care, housing and finance but has often had a piecemeal approach to their delivery. In relation to housing there is currently government funding for First Stop which is an independent, free service offering advice and information for older people, their families and carers about housing and care options and related financial advice in later life. It has a website, national advice service, local partners and a training and support programme for peer advisers. Various reports over the years have identified how crucial such advice is including a recent evaluation of First Stop130. If support for self-help and the continued personalisation of public services is to remain a priority then the need for specialist housing advice and information is becoming even more crucial and is a significant area for the Committee to prioritise for public services support.

4.4 Help with repairing and maintaining housing and the role of equity release
Action by and assistance from the state has played a major role in tackling poor housing conditions since the slum clearance programmes of the 1930s with the emphasis shifting from demolition and clearance to, in the 1980s, renovation of existing properties through block renovation or incentivising householders to make improvements to individual properties through grant aid. In the 1990’s the focus of policy and funding shifted to the occupants with the introduction of mandatory means tested grants. Then in the 2000s the mandatory nature of help ended and discretionary assistance by local authorities came into being, alongside a greater emphasis on use of home equity and preventative provision such as handyperson services for older people. From the late 2000’s there has been no specific

130 First Stop Evaluation. Cambridge Centre for Housing and Planning Research, University of Cambridge. Feb 2012
allocation from Government to tackle private sector housing disrepair and non-decency. The Committee is urged to review the impact on vulnerable older people and ensure that help available to continue to tackle housing disrepair. Whilst equity release options have developed over the last few years and have been used by a small number of older people with major works to their homes there are concerns that the right products have not yet been developed. Evidence has shown that even where older people do have value in their homes they are often nervous of using these options. State support for social lending possibly coupled with some grant help is an important measure to ensure that equity release options become a viable option rather than one that is talked about as a solution but is not effectively used. This would need to be coupled with the strengthening independent financial information and advice.

5. What must continue to have a public service response
Poor and vulnerable older home owners cannot fund all the work needed to their home without state help, information, advice and incentives. They need practical help in using the limited resources they have to stay at home in comfort for as long as possible or make the right move so as to have a better life reducing, in many cases, later demands on other public services. We believe there will continue to be a need for a public services response to the following, which will require funding as now by general taxation and funding to local councils.

- Housing advice and information services coupled with care and finance advice that can offer choice and control enabling older people to help themselves by having the right information and support at the right time.
- Practical local help and support in the form of local Home Improvement Agencies and other local services such as handypersons services to help older people to repair and adapt their home or to move if this is appropriate.
- State resources for home adaptations services which benefit the individual and the state in reducing costly interventions. The 60 year old budget for private sector renewal must be restored.
- Serious consideration of the state’s role in tackling the state of the nation’s housing stock and suitability is needed focused on the private sector targeting specific interventions for those who are vulnerable so that older people can live comfortably at home in later life.
- State developed/regulated ‘social equity release’ products that work for older people to use their homes to raise capital which also recognises regional differences in values.
- An empirical assessment of how the value of state investment in housing options such as adaptations, housing advice and repair adds value for people and reduces health and other public expenditure.

6 September 2012
1. Introduction

1.1 About Care & Repair England
Care & Repair England is an independent charitable organisation set up in 1986 which aims to improve older people’s housing. Its vision is that all older people have decent living conditions in a home of their own choosing. It innovates, develops, promotes and supports practical housing initiatives and the related policy and practice which enable older people to live independently in their own homes for as long as they wish, particularly for older people living in poor or unsuitable private sector housing.

1.2 Original submission to the Committee
Our original submission focused on two of the Committee’s key questions
• How the extent and nature of public service responses need to change
• What practical actions are needed now

In summary
We asked the Committee to look specifically at
• The state of older people’s housing and access to funds for the most vulnerable to ensure all people’s homes are both decent and suitable in later life
• The link between state housing investment and corresponding health and social care gains

We called for
• Housing advice and information services coupled with care and finance advice that can offer choice and control enabling older people to help themselves by having the right information and support at the right time.
• Practical local help and support in the form of local Home Improvement Agencies and other local services such as handypersons services to help older people to repair and adapt their home or to move if this is appropriate.
• State resources for home adaptations services which benefit the individual and the state in reducing costly interventions. The 60 year old budget for private sector renewal must be restored.
• Serious consideration of the state’s role in tackling the state of the nation’s housing stock and suitability is needed focused on the private sector targeting specific interventions for those who are vulnerable so that older people can live comfortably at home in later life.
• State developed/regulated ‘social equity release’ products that work for older people to use their homes to raise capital which also recognises regional differences in values.
• An empirical assessment of how the value of state investment in housing options such as adaptations, housing advice and repair adds value for people and reduces health and other public expenditure.

2. This response
We have followed the questions set out by Committee members (session 30 October 2012: ‘unrevised transcript’) where we have additional information to submit.

2.1 Q 159 (p 1) A view of what sufficient and appropriate housing would be for an older population and Q160 (p 2) are the normative statements made backed up by research?

2.1.1 Appropriate housing

It is important to consider the views of older people in relation to what is appropriate housing. There have been many studies that have done this. Care & Repair England consulted with older people’s groups in 2009 whose members identified what is important to them in their housing.131 This is what older people said then: -

• Homes that are safe, secure & warm
• Practical help with repairs, maintenance, adaptations and low cost equity release
• Access to public transport, shops and facilities
• Impartial information and advice
• Homes that are accessible, easy to move around in and which enable independent living
• Homes with enough space - with storage and room to have friends and family to visit and stay
• Homes that enable us to stay part of the community, living and socialising with people of all ages
• A variety of housing options for all stages of older age
• Involve older people in designing and planning homes and services

Similar issues were identified in the focus groups for the National Housing Federation’s Breaking the Mould project mentioned in the session. We are currently doing a further exercise talking with older people about why their home is important to them and aim to have a brochure available early next year which we can send to the Committee.

2.1.2 Sufficient housing

90% of older people live in ordinary housing in the community and most want to stay in their own home for as long as possible. Only about 7% of older people live in specialist housing. (Source: Older people’s housing: choice, quality of life, and under-occupation, Jenny Pannell, Hannah Aldridge and Peter Kenway, 28 May 2012)

Whilst it is clear that there is a shortage of housing options for older people in all localities across England this is not just about specialist housing options. There are many homes that are unsuitable and in need of adaptation and repair to enable older people to live at home in comfort, security and safety. For example

• almost 84% (3.2 million) of older and elderly householders in non-decent homes live in private sector housing
• On trends set in 2009 33% (5.6 million) of people over 65 and 50 per cent (4.5 million) of people over 75 will experience a limiting long term illness. Based on 2009 population projections, this would mean in 2036, around 810,000 people aged 75 or more would be living in properties that they considered unsuitable for their needs.

131 Older people’s views of their housing http://www.careandrepair-england.org.uk/pdf/kmfop_aug_09.pdf
The vast majority (around 70 per cent) 567,000 would be living in owner-occupied properties.

(Statistical source – Care & Repair England’s original submission)

Older people often seek solutions to their housing in later life that offer decent, manageable housing not necessarily with scheme based support. If we built all new homes to Lifetime Standards many of the issues of adaptability in later life would disappear. If we considered older people’s needs for a range of housing options in national and local housing strategies we might not only help more people in later life to meet their needs and achieve their aspirations but also help society as a whole. Whilst we have some concerns about the focus at present on the ‘under occupation’ of housing we do recognise that giving people a positive housing choice in later life can, where this is what the person wants, free up some larger housing for others.

We need a much more focused and holistic housing strategy from Government and local councils that sees older people’s needs as a significant part of the local housing market. After all older people make up one third of all households so this is certainly not a marginal issue.

2.1.3 Market/needs analysis

There continues to be a requirement for better market analysis locally to assess need and sufficiency yet many local authorities do not have a strategy on housing for their ageing population. This has been a frustration for many of us in the sector. Whilst there are pockets of good practice and we would include here the Mayor’s London Housing Strategy, where older people were engaged, there is still more to do to encourage politicians and planners locally and nationally to focus on older people’s housing needs. Tools and guidance exist to make this happen - such as the expectation to produce local strategic housing needs assessments - but far too often the range of housing options for older people are overlooked. We have to also remember that older people are like all of us - with different circumstances, needs, aspirations and expectations - and so the solutions need to be broad too.

2.2 - Q 170 (page 8) What are the unmet needs in the housing market for older people?

2.2.1 Adaptations

We agree that there is a barrier in relation to accessing adaptations as highlighted in the transcript and above.

2.2.2 Repairs and improvements

There is a further gap in relation to tackling repairs and improvements to the existing homes of older home owners. In particular we are concerned about the expected rise in the number of low income home owners and we know that many older people live in poor housing. At present there is a strong focus on housing supply which is crucial to meet growing needs but we would want to ensure that there is also state support for repairs and
improvements targeted at the most vulnerable so that the housing stock is fit for them and for the future. This is set out in our original response – section 3.1.

### 2.2.3 Housing advice and information and practical support services

We would also argue that there is a role for the state in supporting housing advice and information services and linked care and finance advice to help older people help themselves in an increasingly complex world. We discuss this aspect in our original submission – section 4.1 and 4.3

### 2.3 - Q 189/191 Are local councils (p24) and Central Government (p26) failing to prepare adequately for their older population

We would agree in the main with the panel at the 30 October session that both Government and local councils fail to address the needs of the ageing population. Care & Repair England’s Chief Executive chairs the Housing and Ageing Alliance\(^ {132}\) which has argued for a more strategic approach to ageing in national and local housing planning and policy. The group also argues for greater recognition of the role of housing in meeting the health and care needs of older people highlighting how decent, appropriate housing options can help to prevent the need for more costly interventions in health and care. In health and care policy there have been calls for more integrated commissioning of health, care and housing services especially in the recent Health Select Committee report.\(^ {133}\) The recent Social Care White Paper\(^ {134}\) is championing greater integration locally between housing, health and care provision.

Whilst not all housing needs and issues are linked to health and care provision housing does play a significant role for many older people with long term health conditions so concern about meeting the needs of the increasing numbers of older people with health and care needs must consider their housing.

Whilst the national planning framework does make mention older people we would argue that there is a need for a broader housing strategy at a national and local level that identifies how the public, private and voluntary sectors can work together and with older people to develop a more strategic approach to housing our ageing population.

### 2.4 - Q 192 (page29) Examples of good practice in terms of housing planning, planning for older people

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\(^ {132}\) The aim of the Housing and Ageing Alliance is to bring about improvements to the housing and living conditions of older people. Its members include Age UK, Anchor, Care & Repair England, Chartered Institute of Housing, Elderly Accommodation Counsel, Foundations, Hanover, Housing Learning and Improvement Network, ILC-UK, McCarthy & Stone Retirement Lifestyles Ltd, National Housing Federation, Retirement Housing Group and Older People’s Action Groups and Forums representatives from London and the North East of England. [http://www.housinglin.org.uk/AboutHousingLIN/HAA/](http://www.housinglin.org.uk/AboutHousingLIN/HAA/)

\(^ {133}\) HC 1583, Fourteenth Report of Session 2010-12 8th February [www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/12-02-02-socialcarereport/](http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/12-02-02-socialcarereport/)

We would suggest the London Housing Strategy is one example. We would also suggest Manchester Council which has an ageing strategy called ‘A great place to grow old 2010 – 2020 that includes housing. Manchester is also active in developing itself as an age friendly city so would be worth looking at in terms of engaging older people and looking at housing and the environment as a whole. Newcastle council, too, has a housing strategy that looks at older people’s housing in the round and has a history of engaging older people through the Elders Council, a network of older people very active in the City on a range of issues affecting older people.

2.5 - Q 196 (page 30) What can be done to help older people stay in their own homes/how can they be supported and who needs to be involved?

2.5.1 Advice and information

We have identified in our original submission and above the need for better advice and information to facilitate choice.

2.5.2 Practical help through local Home Improvement Agencies/handypersons services

We have also argued for a renewed focus on support for repairs and improvements and for services such as local Home Improvement Agencies and handyperson services to offer practical help for people with the work needed around the home to stay at home in comfort and security. We also believe that self-help initiatives can play a significant role too.

In England according to Foundations – the national body for Home Improvement Agencies and Handypersons - there are approximately 200 home improvement agencies in England and around 85% of residents in England have access to a home improvement agency. They offer a range of services which vary locally and are run by councils, the private sector and voluntary agencies. We would want to see better coverage across all England so that all older people have access to a broad advice and practical help service. Agencies will differ locally in what they do hence the importance of good local advice and information. Many are funded locally via the council and some have health funding where they are working to support people to move out of hospital quicker or prevent the need for more costly health interventions.

2.5.3 Home from hospital services

Care & Repair England has been working with a number of these agencies to enable housing and care help and support to be available in hospitals to facilitate early discharge from hospital. Our project – If only I had known - which has had support from the Department of Health – has evaluated the impact of this help and we recommend the report to this Committee as it identifies cost savings to health and social care of a range of housing interventions. We have identified later (in response to Q 202/5) examples of the evidence the Committee is seeking on the cost effectiveness of physical modifications to prevention. Our reports offer many more examples of how housing interventions can not only save on health and care spend but also offer a better quality of life for older people.

135 If only I had known reports http://www.careandrepair-england.org.uk/homefromhospital/pdf/if_only_I_had_known_integrating_housing_help_in_hospital_2012.pdf

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We have also just published a resources pack to provide information for people working in health, housing, social care and the voluntary sector to help them to support older patients to return home safely after a hospital stay and reduce the risk of readmission. This focuses on the role that housing can play. Care & Repair England initiated a group of key sector agencies to produce and promote this pack across all sectors to facilitate change.

2.5.4 Self-help and housing action

Care & Repair England has worked with local home improvement agencies and older people’s groups to develop peer support services and local housing action. This has focused on promoting mutual support for older people and galvanising local action to develop new service options particularly for older people to stay at home.

In recent years we have been working with First Stop providing training for older people’s groups on housing and care options so that they can support other older people to make housing choices in later life. We have also worked with many local groups of older people to influence local housing policy and practice over the years.

We see this as an important development and have just started a project with funding from the Big Lottery – called Silverlinks (our blog on the project) – this is working in Leeds, Manchester and Bristol with the local Care and Repair agencies to develop mutual support through volunteering. It is also an important part of the project to encourage people to think and plan ahead in relation to their housing and care in later life and to enable people to influence their local neighbourhoods.

2.6 - Q 202 (page 35) evidence of cost effectiveness of physical modifications and adaptations

In our report - If only I had known (section 2.5.3) - we identify cost savings to health and care of a range of housing interventions. Two specific examples focused on physical adaptations/modifications are as follows:

<table>
<thead>
<tr>
<th>Small adaptations, equipment enabled independent living in mainstream home and savings to health and social care</th>
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<tbody>
<tr>
<td>Miss C is in her 70s, she lives alone, and she fell trying to reach a bathroom window and did not receive help for several hours. She was subsequently admitted to hospital for four days followed by a readmission via A&amp;E three days after discharge home because she had not been able to get out of bed or to reach the toilet.</td>
</tr>
<tr>
<td>The local Care &amp; Repair worker arranged a pendant alarm, installation of self-closing</td>
</tr>
</tbody>
</table>

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136 The Hospital 2 Home pack http://housingling.org.uk/hospital2home_pack/136
137 First Stop offers national and local advice and information services for older people, their families and carers about housing and care options in later life and has some financial support from DLGG
138 Silverlinks blog http://silverlinksprogramme.wordpress.com/
hinges on the bathroom and kitchen windows (to avoid future falls risk), obtained a special chair that has reduced Miss Crest’s back pain and is easier to stand up from and organised a second key holder in case of further problems.

SAVINGS TO HEALTH of earlier housing intervention
2 x unplanned hospital episodes @ £2,334 per episode £4,668
2 x emergency transport @ £260 per episode £520
Total £5,188

SAVINGS TO SOCIAL CARE
Prevention of residential care admission @ £28,080 per year

Illustration from North Somerset Care & Repair

Adaptations and handyperson resulting in health savings and better life

Mrs P is in her 70s and lives alone in Rugby. Her bedroom and bathroom are both upstairs. Mrs P had a fall, which resulted in a fracture and a stay in St Cross hospital. When she was discharged Orbit Care and Repair were asked to carry out a home safety inspection.

During the inspection the Care and Repair case worker realised that Mrs P was struggling with the stairs and her bathing needs. Her method of coping with both was dangerous. The case worker thought that without help she was likely to suffer additional falls. A referral was made to Social Services for an Occupational Therapist to visit and assess Mrs P.

While this was happening rails and smoke alarms were fitted by the Care and Repair Handyperson......A stair lift and a level access shower were put in by Care & Repair Rugby, funded by a Disabled Facilities Grant (DFG). This hugely improved Mrs P’s life; she could use her whole home and bathe safely.

Without the referral by the discharge scheme Mrs P would not have been helped. It is likely that she would have fallen again, with the potential for an emergency re-admission, expensive rehabilitation and a greater subsequent need for care. Either a move or similar adaptations to those now installed might then have been needed.

Key public cost savings: avoidance of fall and expensive hip fracture
Cost of adaptations: £6,302, potentially preventing costs of hip fracture of £24,000

Alternative scenario:
Mrs P falls and fractures her hip. She subsequently needs the same adaptations and a care package to be able to return home.
Cost details: [Adaptations costs from PSSRU unit costs 2011. Hip fracture costs from NICE]
Handrails @ £52
Stairlift @ £3,293
Level access shower @ £2,957
Average cost of hip fracture to health service: £12,000
Estimated average social costs of hip fracture: c. £12,000 (Mrs P may have to pay this)
There are many other illustrations of the impact of housing interventions in the If only I had known reports.

We would also draw the Committees attention to a further report which summarise recent projects that demonstrate the preventative role of housing. This offers some useful links to work that highlight prevention and cost savings. It is from the Housing Learning and Improvement network.139

2.7 - Q 206 (page 37) evidence of falls prevention though adaptations

The report above from the Housing Learning and Improvement Network includes some evidence on falls prevention.

2.8 - Q 207 (page 37) how far can volunteers provide support (in helping people to live at home)

Our work with older people’s networks and groups has identified that older people can play an important role in supporting their peers particularly with option seeking in later life. It has been shown to be helpful for someone who has had to make housing choices to move or stay put to talk with others and to offer practical support throughout the process.

We are also keen to look at how older volunteers can help other older people with some practical tasks around the home which is a key ingredient of our Silverlink’s project mentioned in section 2.5.4. However this will not replace the need for professional services for older people and public support for repairs and adaptations and professional advice and support.

2.9 - Q 208 potential for equity release

We would echo the concerns from panel members at the 30 October session about equity release and have suggested in our earlier submission that there is a need for the Government to consider a regulated social equity release product for older people. However we would suggest a note of caution on looking at equity release as an easy solution. Experience has shown that older people do not like using their home as capital even though there have been products available for many years. We expect greater take up with a state backed product though this is not guaranteed.

There is also the current debate about the future of social care to resolve where the use of the capital in the home to fund care is still under discussion. Whilst the capital in the home is a useful source of funding if it can be released effectively it can be limited. There are also older people who live in homes with limited value so this may only be a viable option for a

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small number of older people in certain locations and would not mean the end of state support for care and for repair and adaptations services particularly for the most vulnerable.

3. Concluding comment
We hope this submission is a helpful addition to the Committee’s consideration of the issues in housing and provides some further useful evidence of how housing is fundamental to the quality of life and well-being of older people.
12 November 2012
Transcript to be found under Age UK
Q607  The Chairman: Good morning, and welcome. Thank you very much for coming, some of you for a second helping. It is very much appreciated. In a second I will ask you to say a brief word about who you are, just so we are all sighted and the record is well sighted on that. You know what the Committee is about. It is essentially asking a very simple question: are we, as a society, ready for ageing, as individuals, in terms of public policy, in terms of public services? That is what we are doing, asking that question and then, in the light of what we think and the conclusions we come to, maybe making some pointers to Government and to wider society. So that is what we are about.

This is a key session where we are looking again at the health and social care systems and trying to get towards some understanding and view of what are the major impediments and what really needs to change. You have probably heard of, if not seen, about half a dozen other evidence sessions around that area.

Jennifer, would you like to say a word of hello and then we will go into the first question.

Dr Dixon: Thank you. Hello. Do you want to know who I am? Jennifer Dixon. I am Director of the Nuffield Trust, which is an independent think tank focused mainly on health but we do some work on social care as well.
Professor Ham: Good morning, I am Chris Ham, Chief Executive of The King’s Fund and I have a chair in health policy at the University of Birmingham.

David Behan: Good morning, I am David Behan. I am the recently appointed Chief Executive of the Care Quality Commission.

The Chairman: David, would you mind mentioning your past as well because you also used to be DG—bits of it.

David Behan: What, all? Prior to that, Chair, I was the Director General for Social Care, Local Government and Care Partnerships in the Department of Health, and prior to that was Chief Inspector at the Commission for Social Care Inspection, and prior to that was a Director of Social Services.

The Chairman: Thank you. Chai?

Dr Patel: Thank you, Lord Chairman, for the opportunity to appear here today on this most important of topics. I had asked permission if I might say a word. Would you like me to do that at this stage? To those Committee Members who do not already know me, my name is Chai Patel. I worked in health and social care for many years in a number of contexts, including starting my career as a physician, a doctor in the NHS, and was involved in a number of care companies, most latterly the Priory Group. One year, one month and 18 days ago I became Chairman of HC-One, a company formed in just 94 days following the collapse of Southern Cross, which threatened to leave thousands of vulnerable elderly people without a home. Today we care for 10,000 elderly residents in over 230 homes, with a kind and dedicated staff team comprising 14,000 people, and are gradually developing a reputation for providing kind care in our homes.

I wanted to make a very brief opening statement, given the importance of your work. It is my strong and personally held belief that we have what amounts to a prejudice against older people in this country. This prejudice exists in society at large and is reflected in our public services as well as our institutions, be they public or private. The most concerning expression of this is seen in public resources and policies affecting older people. In short, we would never treat children as we treat older people in our society. Against this background and as you formulate your report you may wish to consider the following questions, all of which I see as crucial.

The Chairman: I thought we were asking the questions! I had not realised.

Dr Patel: How appropriate is the term “social care”? Is it appropriate in the future as it has been in the past? Is it, as The King’s Fund says, time to think differently about health and social care? Increasingly, I would contend that the issues facing older people when they need support are due to underlying medical conditions and chronic diseases rather than physical conditions resulting from poverty or malnutrition. How can we prevent poverty in old age, whether it is on pensions, on housing, other incomes and costs? How do we actually prevent it, thereby enabling older people to make real choices? How do we stem the progression of long-term conditions in old age and reduce their impacts while continuing, of course, to research on the primary causes of the said conditions? If we were starting again, what would residential care for elderly people really look like? Is the current model, whose origins lie in the advent of the workhouse, fit for the coming century? What sort of interventions do elderly people actually want in terms of competence and quality? There is indeed a lot to think about, and I am grateful for the time.
The Chairman: Thank you very much indeed. The first area we would like to discuss with you and get your comments on is, in a sense, the obvious one, the issue of fragmentation. There are issues of funding and there always will be, but the issue of fragmentation clearly applies at all sorts of levels: at national level, between different institutions of Government, and between health and social care. We would like each of you to give your view on: do we need to resolve the fragmentation issues before we are going to be likely to get the quality of outcomes we want for older people? Let me leave it in that looseness and broadness. Jennifer, would you like to start off?

Jennifer Dixon: Clearly, care is fragmented. I think anyone who works in hospitals at the moment will see the results of that fragmentation, in 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. I think that is pretty axiomatic. Most people would say that across the health service. It is striking that if you go and walk around a medical ward now it is more like a geriatric ward.

So the question, which I guess we are going to get on to more fully, is how this fragmentation could be stopped, because we have been talking about it for decades. Others will have views but, firstly, from my observations it is not an easy solution. I think that is pretty obvious. Secondly, there is no one thing. I know there is some emphasis on the questions later down about funding, but if you think about the barriers between health and social care there are huge ones to do with cultural and professional barriers, institutional barriers, payment barriers, contract barriers as well as funding barriers.

All of those things need to be addressed. It does not have to be addressed through merging organisations; it does not have to be addressed through merging budgets. It is a combination of things that would need to be worked out, which would take a while to develop. Just skipping around a minute, going down the questions and looking at the US experience, which we will perhaps talk about later—Chris and I have looked at this over the years—the organisations that have the best co-ordinated care in the States in health, not necessarily across health and social care, have taken decades to develop. So I am afraid there is no easy answer, but I do believe that we have to put more effort into trying new and radical experiments—“experiments” is probably not the right word, demonstrations, let us put it that way—of a different order than we have had before.

There is no doubt that, across the health service and the social care service there is huge willingness to work together to try to make things work, but I think in many cases we have fallen short of really having effective integration or care co-ordination. I think we are now in the position, given the financial squeeze, where we really have to give it our best shot. That probably means not just supporting people locally to bust barriers where it is stopping them from integrating but also, dare I say it, some kind of central support to help the most promising sites accelerate without being dirigiste.

The Chairman: What might that mean, the last bit?

Dr Dixon: I think it is a combination of allowing local economies to come forth with their ideas about how they really think it is going to work, mindful of the kind of resource envelope they are likely to have in future; it is this, not that. That is the first thing. The second is to work with those sites to provide them the kind of support that they need, whether it is leadership, whether it is information, whether it is thinking about the financial physiology across providers, whatever it is—whether it is more community-based services. It is also providing some kind of central evaluative help to evaluate in an ongoing way what the result is in what we would say in the trade was “formative evaluation”, which means
ongoing feedback to help people understand in a real time way what impact is happening. There are also some development techniques called rapid cycle development techniques, which are management tools to try to get rapid change that have been trialled elsewhere. I think a combination of those things, and I would be interested to know what my colleagues think, could give a better shot than we have done, rather than leave it all to local—

Q609 The Chairman: Clearly that is the default at present, I am sure, when the Secretary of State says, “We have CCGs. We have Health and Wellbeing Boards. Stand back and wait”. Chris, do you want to come in on that?

Professor Ham: Yes, thank you. I agree with much of what Jennifer has said. It seems to me there are two levels of addressing the challenge of fragmentation. One is to say, “How do we make the existing arrangements work more effectively?”, like sticking plaster-type solutions. The other way is to say, “Will they ever work well at all?” and be much more radical in thinking both about the funding model and the way in which care is actually delivered to meet the needs of older people.

I would add to what Jennifer has said by saying, in a world of not just ageing but also multi-morbidity, increasing numbers of older people who have four, five or six long-term conditions, including mental health long-term conditions, it is a no-brainer really. You need to have services joined up and co-ordinated around the needs of those people. We might have a debate too about the role of generalism versus specialism in addressing those needs, because that is equally important.

If I focus, first of all, on making the existing arrangements work better, although the debate is often framed around fragmentation of service provision, I just want to highlight the fragmentation of commissioning and of budgets as well. There has always been a separation between health and social care budgets, but if we think about the recent changes to the NHS and what has happened, that has led to even more fragmentation of NHS commissioning budgets. Whatever you think about the strengths or otherwise of primary care trusts, at least they held a population-based budget to cover all of the NHS services for the population for which they were responsible. That has now been split in three different directions: the clinical commissioning group will commission local services, the NHS commissioning board will commission specialised services and primary care, and the public health budgets, which the PCTs formerly had, have gone over to local authorities. If the ambition is integrated provision of care, that requires, it seems to me, integrated commissioning and we have made that more difficult for ourselves through the recent changes within the NHS in particular.

I think there are some examples around the country we might talk about, where people have found a way around that fragmentation, where there is pooling of budgets and local authorities have worked effectively with primary care trusts to achieve greater integration of commissioning, and we would hope that clinical commissioning groups would do the same in future but it has been made more difficult for them. Equally, we have some great examples, in some parts of the NHS in England where the NHS and local authorities, with other partners, have come together to provide much more integrated services for frail, older people. The point I would raise is the more fundamental one, going back to the beginning: will we ever be able to make this system work effectively, when it was designed in the post-war era for a very different population? Do we need to think more radically about the post-war settlement?
Q610 The Chairman: We are interested in that as well because our time horizon is essentially 2020-2030, for obvious reasons. You see the bigger changes there. Clearly nobody is going to reorganise in the next five or eight years, for all sorts of reasons, I would not have thought. All the evidence we have had has argued against that, not that they think where we are is perfect but just more churn and turmoil. We are interested, therefore, if you are thinking 2020-2030, 10 years ahead. If we were thinking 10 to 20 years ahead, what are the sort of changes we should be thinking about making? You were implying you had an agenda.

Professor Ham: I think it is an agenda of questions rather than answers. The agenda is if society and government in the post-war period made a settlement around healthcare being universal, comprehensive, tax-funded, free at the point of need, and social care being funded in a very different way around means testing and entitlements, which may have made sense at the time—we do not need to revisit that—how appropriate and fit for purpose is that arrangement today if we anticipate the next 10, 20, 30 years? Our thinking is it is not fit for purpose.

Q611 The Chairman: Let me push you, because most of us think that moving to totally state-funded care is mad because you then remove all of the contribution of individuals and families and we cannot possibly afford that. We certainly had in our last session almost a challenge to think about the socialisation of different risks. People were saying to us, “Why do we have everything free in health and fierce double means testing in social care?” You are saying the same thing but you are being more coy about it. Tell us what would we do then or what should be done? Where are the big savings, either in incentives or in money, by shifting the funding model for the eventual NHS?

Professor Ham: I think on the one hand you are right. I agree that the thought of funding social care in the same way that we fund the NHS in the current financial climate is not a runner. Equally, we all know that raising questions about moving away from the current funding basis for the NHS, and particularly considering things like more co-payments or increased co-payments and greater cost sharing between the public on the one hand and the Government on the other, is a very difficult argument too, on which there are strongly held views.

The Chairman: Does it save any money though, I think we are interested in, because we are not elected, you see? It is one of our pluses. Does it save any significant money?

Professor Ham: Does what save any money?

The Chairman: Co-funding. The evidence we have heard on that is mixed.

Professor Ham: It depends how radical you would want to be when it comes to cost sharing and co-payments. If we simply build on the very limited co-payments we have at the moment, no. There are also additional costs associated with the collection of those payments from the public, but some people would want to be much more radical than that. The point I would make is that, if you are, there will be adverse distributional consequences by expecting people on low incomes to contribute more of the direct costs of healthcare. We know from studies that are quite old now, that will deter people, often people in the greatest need of early access to good healthcare, from seeking help, with adverse consequences for their services going down the track.
Baroness Morgan of Huyton: Just a supplementary on that: if I framed it in a different way, would it be fair to say that in a sense at the moment there is almost an incentive to use the free NHS because that is what is available and that therefore, arguably, that is producing a high cost for the Exchequer? What is paid for is emergency treatment in hospital and then staying in hospital as long as is necessary, whereas there is no contribution at all on the care side. So is another way of framing it, if we want to have some level of public debate, to emphasise the unhelpful incentives or disincentives in the system for things to change?

Professor Ham: Yes, I agree with that.

The Chairman: Is there a paper that unpacks this difficult territory, because clearly we have limited time? Has either King’s Fund or Nuffield or others looked at the potential for changing incentives, raising additional funding? It is not the only issue we are looking at, but it would be nice to think that we got ourselves up to speed on it. Jennifer, you look as if there is.

Dr Dixon: We have looked at payment reforms and how the incentives in the system could be changed. I take what you say, and what you say is correct, but there are balances in the system, as you know, and giving GPs the budget to keep it is one thing. On the future funding of the NHS, this is something we are working on but we do not have anything to show yet, but probably within your timescale—

The Chairman: Do you have anything you could give us, at least some of the questions and some of the analysis?

Dr Dixon: Yes, we could give you that.

The Chairman: Would that be possible?

Dr Dixon: We could give you a briefing note, yes.

Q613 The Chairman: That would be very helpful. David, this is dangerous stuff for officials to stray into, is it not? I do not need to warn you of that, but what can you say that would be helpful to us?

David Behan: From the current job I am with Chris, really. The issue we are dealing with, and your timeframe of 2020 to 2030—and you have had previous evidence on the demographics and the implications of that—and if you come at this from the perception of the people that use services, what we are going to have are more older people who will take into their old age two or three co-morbidities, which is really why people end up being in hospital and staying in hospital. They are exactly the same, in the social care language of “critical” and “substantial”. My argument is that these are the same people and, therefore, the challenge of fragmentation is to make sure that care is personalised around those individuals. The paradox I think—as both Jennifer and Chris have talked about—is we are doing that at a time when a lot of medicine is going to be increasingly specialist. Therefore, there are more people involved in the treatment of individuals, which then requires that more people need to come together around individuals. So I think the issue about integration is not just between health and care. There is that issue, but there is also the issue of integration within healthcare as well. We do need to look at that.

There is a need for a broader debate. On the reference in this back to 1948 and what the settlement is, I would argue that in spite of what Dilnot has done there is still very little traction in a public debate about what is to be paid for, what is not to be paid for—the co-
payment debate. It has largely been a debate that has been about inheritance. It has not been a debate about why we save, and the pensions debate really did lead to discussion about why do we save in our old age but it neglected, in my view, a significant component of saving for care. This is something that has happened since 1948 but it is almost as if it is the thing that does not speak its name, and therefore I think a broader debate is required. I thought it was going to happen at the last election. This is where I do get into trouble, is it not, Geoffrey, but I thought it was going to happen at the last election. It did not, so let us see what happens next time in relation to it.

**The Chairman:** How could we contribute to that?

**David Behan:** I think there is an important issue about why do we save—what is it that we are saving for? I think people need to have that debate, not what they would do with inheritance. You have taken evidence about intergenerational equity and I think there is a really important conversation to take place about intergenerational equity. The conversation about saving for old age in care is as much a thing for people under 30 to engage with as it is for those of us that are coming to the end of their 50s, in my view, because they need to strike a different deal. I think there is a requirement for younger people to be involved in what the 2020 settlement is for the funding of age, in the same way that there was the debate of the settlement previously.

The other issue is fragmentation and the conversation about incentives is hugely important. I am not sure we do incentivise integration in the way that the contracts run, the payment systems run, and so on. I would go back to learning disability services. We have had co-budgets, we have had a common vision for the best part of a decade, and we still have poor quality care being delivered to people with learning disabilities, so I think we need to think more challengingy about: is it just about leadership? Is it just about clarity? I would argue the same in services for people with severe mental ill health. People have come together in community learning disability teams, community mental health teams, there has been drug provision, and there has been some quite exceptional work done at a local level in relation to that, but there still remain issues about the quality of care.

One of the challenges is about how services come at this from the perspective of people using services, and beginning to ask people what is it that is required to support particularly people with long-term conditions who require support with their care. So I think much more incentives need to take place around personalisation and ensuring that services are built around individuals. A few weeks ago the CQC published a report on the state of care. I thought it raised serious questions about whether the culture in both health and care is sufficiently personalised to ensure that care is wrapped around people. It is very often individuals that are left with carrying the weight of arranging co-ordination of their care rather than the system taking that weight off them.

**Q614 Lord Bichard:** I feel increasingly depressed as this conversation goes on, simply because what you have been talking about is what some of us have been talking about now for a decade or more, and not just in relation to ageing but in relation to public services. We want less fragmentation and more integration and collaboration. We want more of an emphasis on prevention. We want more design around clients of the services. We sit here and have these conversations, and yet nothing much seems to happen. In a way I am getting to the point where I am thinking, “That is the big issue. How do we make this happen?” We are not going to disagree with each other today, I suspect, and yet we carry on with a public sector reform programme that obstinately refuses to grasp these big issues and carries on
Moving the deckchairs around the Whitehall Titanic. Is there anything that we can do that could help break through this?

Professor Ham: I agree with that. I think you are right to be depressed. If you were optimistic I would be worried, because the way you describe it is the way I have seen it for the last 10, 15, 20 years. Well, longer than that. If you go back to the health and welfare plans in 1963, alongside the hospital plan of 1962, those talked about collaboration between health and social care, so there is a very long history and very little in the way of good practice and innovation here.

I think the reason for that is, first of all, the system that we work in between health and social care was not designed at a policy level to create the right incentives and framework to make integrated care the easy thing to happen around the care of older people. So where there are good examples—and Torbay is one and there are a small number of others—it is people who have been swimming against the policy tide. They have been saying, “For our population it absolutely has to be the right way of doing things, so even if we are not getting the right level of support around how we pay for care, and how we plan our services, it is what we are going to do here”.

The second thing I would say—and it is not just in this country but in other countries too—integrated care does not come naturally, even where there are policies that are more supportive. For a whole bunch of reasons, professionals tend to look at their own service rather than looking in a more whole system way, which is back to Jennifer’s point around the role of leaders and leadership in public services as a whole. I was just looking at an Audit Commission report from 2002 recently around whole system working for older people. It was saying all the things that I suspect we will be talking about in the next two hours or so. Making it happen, Michael, is absolutely where we need to have that debate.

Q615 Lord Griffiths of Fforestfach: Mr Behan, could you expand just a little on what you said about saving and the nature of saving? Are you thinking of compulsory saving, voluntary saving, earmarked saving? Could you expand on that?

David Behan: I was not making any conclusions about what the nature of savings should be. Just to come back, some of us have trod the same path as well, Michael, in terms of the debate. I remain optimistic. If I think about when I was a 21-year-old social worker going into a long stay institution for people with learning disabilities, and I go into a group home now, even though it might not actually meet the standards that I think it should do, it is a bloody lot different than those institutions were and it is absolutely transformed. So I think these things are relative. If we are going to put this in a broader, historical perspective for people with learning disabilities and people with mental health problems, I think they have been transformed, quite frankly, over that period of time.

This is about when you get to a particular point, what is the stretch and where do you go to next? I will travel optimistically in my job, not just pessimistically in relation to it, and it is your job in this House to challenge those of us that are out there doing other jobs to be clear what that stretch is. But what you can do is lead a public debate on the future of care in relation to these trade-offs. I do not know whether it needs to be compulsory saving or not. That is not my job. What my job is is to raise the questions, and then I think it is for these Houses to raise that question with the public about what the settlement is in 2012, 2015 and 2020, for how care is going to be provided going forward. We know demographically what is going to happen, and we know that those people are going to take dependencies into their old age and there needs to be a settlement across our society about
how that is going to be paid for. I will have views about that, but my views, quite frankly, Lord Griffiths, are no better or more important than anybody else’s.

Lord Griffiths of Fforestfach: Clearly, neither are mine.

David Behan: The nature of leadership is how you make things happen and begin to change the nature of the debate. There is a very important conversation to go on about old age in particular, about how that care is going to be paid for and what the nature of it is. Dilnot had a good go at reshaping that conversation and shaping some of the questions. Then there are choices, and those choices are essentially political choices, which will need to engage with the public about how they are to be taken forward. So that was what I meant about payment. If we accept, as Geoffrey has said, there is going to be a co-payment for care into the future—and I personally do accept that is the nature of it—then I think you have choices within that about how you incentivise people to save, how you incentivise that system to operate. As my colleagues have said, it raises important questions about, where people are using health and care, what is the nature of the system that is being developed.

Dr Patel: Perhaps I can try to bring this to a slightly different level. One is that if you are going to look at 2030, let us say, because 2020 is too close, the demographics are going to not only show we have older people but we have wealthier older people, so this is going to change for the first time. The home ownership in the older person increases very radically over the next 10 to 12 to 15 years, so their ability to monetise some of that, if they so choose and if the policies follow that, is going to be different. The expectations of those 80-year-olds who are 60 today—I will be 60 in 18 months time, so it is going to include me—is going to be a very different expectation to the expectation of today’s 80-year-olds. So that is the first thing I want to say.

We have been talking a lot of top-down, and I would like you to think for one moment bottom-up. There are bottom-up possibilities even today—and we heard the words “co-ordination” and so on—of helping people to navigate through the system in a different way, even the complex system that we currently have. There are many models around the world where navigators are already incrementally improving people’s ability to go through the built-in disincentives that are currently in the system.

The third thing I would suggest is we must accept that all large systems are going to have barriers in them. If you think you can draw a box and join all of this up and put a funnel and put money in it, by the time it comes out at the other end it will be broken up because that is the way we manage things generally, where we need to manage things and control things. It is in the nature of the beast. If we accept that, what we then need to say is, “How do we fundamentally change the attitude of the system?” The system is currently not designed to be helpful to the people in it. It means well, but it does not do it because there are not appropriate incentives. They should be greater than most incentives of money and profit and benefit. They should be on a higher plane, but somehow that higher plane in the day-to-day practice is dumbed down by managerial process, by bureaucracy, by a whole range of other things. So there is something here, which we have touched on, which needs to be looked at, about how do we change the attitude inside large systems, and how do we empower the end user.

The reason I started with my point about wealth is that if you want to simplify this you just look at a person who has the money. If they have the money they can navigate through even this complex system right now and get themselves to the right place at the right time. When we work with charities and various people on systems design, the one thing older people always tell us is, “All I want is the right care in the right place at the right time”. It is actually
quite a simple expectation when it is summarised in that way. I was able to show when I worked in Sheffield with one housing estate that if you have a navigator with just a cellphone, she looked after 500 older people’s timing of where to turn up for appointments, where to be in the right place, just on a cellphone, not even a smartphone. You could help people who are incentivised to enable people to navigate now. In the next 10 years we could run multiple pilots in our systems, right as they are now, of seeing how well we can integrate and how we create the right incentive on behalf of the individual, the community, the resident and their relatives, rather than look at trying to create one large, congealed, big organisation with £120 billion or £130 billion of today’s money going into it and somehow it will all come out in the right place at the end of it.

Fundamentally, as I started in my talk, I said the reason why people end up where they do end up at the moment is because partly the settlement is wrong, so I am glad we are talking about how we do the settlement. It is not about free at the point of delivery or not. It is about enabling people to get what they need. The biggest reason why people end up in the worst situation, particularly when there is mental health as well as physical health, is that they are unable to make those choices for themselves and there is nobody expert on their side who works with them to make the choice. Each one of these choices can save money. If you end up with the right appointment, if you have Parkinson’s disease, get your tablets on time, you do not fall down, you do not break your hip, you do not have a hip replacement, you do not end up in a care home because you did not rehabilitate well. It is just one simple case. There are many of those you can multiply on a daily basis that result from people being in the wrong place at the wrong time.

There can be incentives. The question is where do you want to put the incentives and how do you put the incentive back into the local community or wherever you think those incentives should be, and we need to think about that. Some of the projects around the world have shown that when the resultant saving from a system is put back into the system, people are more willing to save it than to spend it. How we do that is a different point.

My last point is, while you are discussing this, let us look at the public services and then look at the providers. You have been talking about the provider primarily as a public sector provider right now. One of the ways to generate real change and catalyst for change is to introduce new elements. The third sector is coming up with brilliant ideas. The private sector is coming up with great ideas. Technology is breaking down so many different parts of what we are doing at the moment, and that is very easy to use. Apps are now really cheap. There is a whole way that technology can act as a catalyst for change before we try to break up the health and social care system and try to re-join it under a top-down approach. So my plea would be let us look at bottom-up approaches right now. Let us start writing up some of these experiments, if we can call them that, or pilots, that are already happening, and stimulate some of this in the huge £120 billion or £130 billion health and social care budget that we have right now.

**Q616 Baroness Blackstone:** I want to ask a question that I have agreed to ask now, rather than later, because I think it follows very much from what you have all said—perhaps not quite so much from what Chai Patel said, but what the rest of you said. Is it possible to make any improvements in terms of the integration of social care and health while they are completely separately funded? Is that part of the radical solution, that we should merge the funding for these two services, or is that not going to be terribly pertinent to making this more effective in the future?
Dr Dixon: To have effective integration and co-ordination, so many things need to happen. The budget is one part of it, but it is not the only part and it may or may not help, is my conclusion. We have had experiments with pooled budgets, have we not, over time? From memory of the Audit Commission’s analysis of that, that was not necessarily helping. It is other things: the culture, the leadership, the aligned mission, the other incentives, and so on. It is not sufficient really and it could be—

The Chairman: Is it necessary? The evidence we had from the local practitioners, Leeds, North East London and Torbay, was all that the separate funding streams, and the separate accountability that went with those funding streams, was an enormous problem. They agreed with you, it was not the only problem, but they thought this was not helpful at all and it would be good if it could not be a problem.

Dr Dixon: Yes, agreed. It may be necessary but not sufficient.

The Chairman: In which case, what would one do?

Dr Dixon: I go back to what I was going to say to Michael Bichard, and his plea that we are all getting older and greyer, the thing is not being solved after decades, and whether or not we should try something that is more radical. If we rely on looking at the system level, it strikes me that we are just going to inch forward over time. Things will get better, as David says, if we can tweak this and tweak that with respect to incentives and policies, but we are not going to get a bigger change. Neither do we want to be top-down dirigiste, because we know we cannot have a central solution because everything is different locally, but what we could have is something where we have more risk taking in, say—I do not know—10 or 15 sites where we really throw at it all that we know and understand and take risks for a certain period, to see whether that can be the future. We can accelerate the future in those spaces. That is what I would recommend that we do in the next couple of years. We are going to need to do it anyway because of the financial squeeze, but I think that could get us to see what the next 20 years could look like more quickly. But we have to do it differently than we have done it before, and I have more observations if that is helpful.

Professor Ham: Can I add briefly to that? We cannot wait for the radical solution, can we? There is so much hanging on the discussion we are having. We know there are some examples of innovation and really good practice at the moment, so it can be done within the confines and the constraints of the current system. I think it is as much about removing the things that get in the way of local authorities and the NHS wanting to work together as introducing new policies that help to facilitate that. Partly I think it is about pooling of budgets. That does help. We know that places like Torbay which have made more progress, have done precisely that. David and I have had a conversation too about where CQC regulation fits in. I think we should have a focus of regulation on how does the whole system work to meet the needs of older people rather than our current system, which is too much focused on how the social care departments perform and how the NHS organisations perform. Some look across the two but mainly it is institutionally focused rather than system focused. Those simple things could help quite a lot in the confines of the current system.

David Behan: One of the interesting things to bear in mind is that 50 per cent of all people in residential care are self-funders. When we get into the issue about pooling budgets—coming back to Chai’s issue about the equity that those of us of this generation are going to take into our old age compared to our children, who will not take the same equity in—there is an issue that needs to be sorted. It strikes me, in terms of the barriers, that that is a big one, hence the importance of a public debate about why are we saving and what is the
money being used for. Until that is punctured in some way, I think these barriers will continue to exist. We spend, as Chai said, about £130 billion on health and social care. You put a few more billion into what self-funders pay and what the private market is in relation to this. I think the last time I looked there was about £4 billion in a pooled budget. This point about what the barriers are to pooling money becomes an important point that Chris is saying, and that was my earlier comment about how can you incentivise more of that.

But knowing there is a fundamental issue, because of a co-payment and free at the point of delivery, there is some serious policy heavy lifting that needs to be done about how you bring those together. The local view is that you can just put these together, and at one level I would say there is nothing to stop people at the local level putting these together. I suspect a lot of local people want the force of government to insist that people come together, so this is a press-ganged wedding rather than a voluntary wedding. There are some important issues there about incentives and how people come together. All this stuff around a common vision, you will not get people to have a common vision if you force them to do it. There is a real paradox to be managed.

Q617 The Chairman: Staying with Baroness Blackstone’s question, are the options for trying to remove some of the funding barriers written up, in terms of the policy options and the pros and cons for us to get our heads round?

David Behan: I am not aware of it. My colleagues read more than I do, Geoffrey, so I am not—

The Chairman: You see what I am getting at. We have limited time and limited money. What is it, taking Jennifer’s point? This is not a total fix, but it certainly does not help. You do not want a system that disincentivises local authority funding or that disincentivises the NHS, and obviously there are real tensions about how you have pooled budgets when you have three funding streams—individuals, local authority and NHS. How does one get pooled budgets in that context?

Dr Patel: The new legislation that is to come through the Health and Wellbeing Boards, which are being set up under the local government, for the first time enables local government to have oversight over health-related services, and I think there are beginnings in the Health and Wellbeing Boards for oversight over an integrated—

The Chairman: They are not budget holders, Health and Wellbeing Boards.

Dr Patel: But they have rights to make things happen.

Dr Dixon: Do not forget the Northern Ireland experience where they have had health and social care budgets together for many years. Has it resulted in integrated care? No. If you pool budgets you might just risk a kind of block budget inertia. So that has to be guarded against. That is why it is not the only strand here, and beneath the block budget you will need to think carefully about the incentives within that. The paper we have written to do with health on what kind of incentives are around financially—payment mechanisms effectively—could be of help and we will send it to you.

Q618 Baroness Finlay of Llandaff: The small topic of the increasing numbers of long-term conditions and chronicity. If there are to be service moves from acute to chronic care, because we have a limited budget, I have a particular interest in asking you how the acute-on-chronic situation is going to be managed. We just had in the paper that A&E departments are now completely bursting at the seams to the point they are unable to
function properly. The pressure on the acute sector is massive. There have been arguments that we have heard that if a service is not there then other services will come about. I think in some areas we are already seeing that the acute services are not there but we are not seeing the other services come about that need to come about for people with long-term conditions.

In particular, if you are going to have a shift from acute to chronic without making the acute sector unable to function or, even worse, unable to function at all, how are the current health service reforms going to deliver such changes and such shifts, and are there other things that need to be done?

**The Chairman:** Can we stay with the initial question: do you agree with the need to shift, effectively, services and funding from acute to community and primary and out-of-hours, no doubt? Do you accept that premise? Then the second question is: if so, how do you make that happen?

**Professor Ham:** I would accept the premise. I think there is a paradox at the moment, exactly as you describe, of hospitals under huge pressure but, on the other hand, we know from many studies over many years about 30 per cent to 40 per cent of people in the acute hospitals today do not need to be there if we could provide better alternatives in the community. I think part of the reason for that is the hospital and the A&E department is the only bit of the system that is open 24/7. So is it surprising that people default to a hospital? We have people in hospital that could be more appropriately looked after elsewhere. I think we have to find some way of shifting staff, resources and expertise into the community. There is a lot of evidence, again, about the way in which we can avoid many of these admissions, especially for older people with complex needs. The areas of the country that have done that have invested a lot in their community nursing and their social care services, where they have pooled their budgets. They have often used what is nominally NHS funding to increase investment in social care, around having rapid response teams not available 24/7 but maybe available 16/7, and people who can then be called on when there is a crisis in the care of an older person that could be avoided around the hospital admission not taking place and the support being provided in that person’s home.

**Dr Patel:** It is also the quality of life of older people. I keep coming back to this. It is not about the system or saving money. It is about a person with co-morbidity or chronic illnesses whose quality of life increasingly gets worse if they end up in the wrong place getting wrong interventions, and it costs the system a lot of money. We need to progressively plan this. This is where IT is now available. You can have case management. You can understand people’s life cycle of where they are in any of these conditions, so you know what medications they are on, you know what interventions they are receiving. If they can have an earlier intervention and be stabilised at each point you reduce the next step down in their condition. This is well recognised and, by putting them in the wrong setting and then leaving them there, you add additional mental health problems on top of everything else and you institutionalise people, and that creates a whole new level of issues.

Again, this is where it is depressing. This is all known. We all know this. It is actually saying, “Can we move the funds from the tertiary and secondary centres, or secondary centres rather than tertiary centres, into the community?” Now there is a very large expanse of knowledge and availability of competence within the charities, the specialist charities within the private sector, within the statutory sector, and again there is no funding currently moving for this. If we can release the funding and work in pilots we can demonstrate that
this can be done. It is then: how do you make the public purse accountability happen without it sludging everything up?

**Dr Dixon:** There are lots of little primary care GP practices which are not federated. They are for commissioning but they are not for provision. It is very difficult for a large hospital to try to coordinate care with a federated, patchy quality primary care system. So there is a big issue here, which you must have been around before, which is about how to federate primary care to get it into a decent space to be able to dock with the hospital at that level. There are places around the country—I am thinking about Vitality in Birmingham—where there are primary care providers that are now covering 50,000 to 75,000 of the population, and we can provide a briefing note on this.

In organising that way, they preserve the micro environment of doctor/patient relationships in their practices, which is what everyone wants. But also there is much more corporatisation or development that goes on across primary care providers, and they can then start thinking much more strategically about the care they offer into the community, how they dock with the hospitals, how they work better with social care—it is very difficult to do this—and the quality of the care they offer, because the quality of primary care is clearly an issue. How to up the quality of primary care, both of the provision but also the strategic thinking there, so that they can link more carefully with hospitals and social care providers in order to give the lift that we all want is an issue. I am not convinced that it can be done with general practices being just sole operators as they are at the moment. Many have said that; it is not new.

**Baroness Finlay of Llandaff:** With the health service reforms, are there any levers at all to make that happen that you can see?

**Dr Dixon:** The Bill is absent on primary care provision. It is all about primary care as CCGs. The kind of things that CCGs need to do to develop, to federate, may be quite different as commissioners to what needs to be done on the provider side. The two things may help but they may also be in tension. I think this is a key area and it would be very helpful if your Committee could point it up.

**Q619 The Chairman:** I am not sure that we are expert enough to be able to think about how you move forward from where we are, but I think that we ought to try to say something about what would a system look like in 2025, given what we know about the increase in social care—a 30 per cent demand increase by 2020. We know the funding pressures—see the Nuffield report. We know the demographics. We have a pretty horrific picture of the changes on health and social care demand increases. So it would be quite useful just to be normative and say, “Given this, this is what a good health and social care system would look like”. We have hints of it, and much, much better out-of-hours services and diagnostics to try to reduce admissions into A&E, clearly much more funding and a much more integrated way on community health. Federated GPs are too small at present. Acute hospitals, fewer of them, much more specialised, giving higher quality—I am a layman; is that the package that we ought to be arguing for?

**Dr Dixon:** Yes, I think there are some perceptions around the system that that is what is needed, without losing the micro environment of the doctor-patient relationship practices.

**The Chairman:** Yes. Is there anybody who has written it up posh, rather than me making it up as we go along, that makes that articulated? At least we could say, “We think there is
evidence that this is what a good system would look like; you have to think about how you get there”.

Baroness Morgan of Huyton: Is there anything about commissioning? You appear to be saying to us that going for joint funding or pooling of the budgets is a really tricky one. Is there something sooner than 2030 about joint commissioning that would move things in the right way, or is there something about the Health and Wellbeing Boards that could be built on? We have had lots of evidence and, where there is a consensus, it is useful to highlight consensus. Everybody seems to be pointing to the Health and Wellbeing Boards, but they do not seem to have any teeth so far as I have heard. So are there any pointers around commissioning in particular?

The Chairman: Could all of you respond to both those questions? I was talking structurally and Sally was talking in funding and incentive terms. The exact question is: what would a health and social care system look like in 2025, within the realities of how we are in Britain? We are not going to suddenly become mega rich. How would you advise Ministers and the public, “This is what you should be hoping for”?

Professor Ham: We had a stab at that in the paper we put out in September called Transforming the delivery of health and social care.

The Chairman: That was more about what was wrong. You have not given us the answer to it.

Professor Ham: The third chapter in that talked about the outlines of a better, different system, along the lines that you were—

The Chairman: I thought it got less good there, Chris, to be honest.

Professor Ham: I am happy to accept the challenge and we will do some more work to flesh out the detail, because we did not want to close off the debate. The whole point was to say, “Here is the diagnosis of what is wrong. Here are the outlines of a better system for the future. Now let us engage with a whole range of—”

The Chairman: I thought by about now you were going to take chapter three and give us your prescription, because we were hoping to look at it. Are you nearly there?

Professor Ham: We will do more work on it during 2013. It is in the pipeline and will appear at some point next year.

The Chairman: Could we have your thoughts by about mid-January?

Professor Ham: We will do our best.

The Chairman: It would be sensible and useful to say in the public debate about this, and how the public need to accept change, that the politicians need to work towards the change and this we think, in truth, would work better if it was like this.

Q620 Baroness Finlay of Llandaff: Can I come back very briefly to various comments by Dr Patel and Dr Dixon? You spoke about navigators for people going to care, and the role traditionally used to be viewed that the GP in a way would help. You talk about the personal relationships, but in reality the person with the chronic long-term condition is looking for a secondary care provider because they are the person that they have confidence in, knows about the complexity of their condition, knows what else might happen, knows about the
drugs they are on in depth, and so they may even be going straight there. The involvement of a general practitioner is often remarkably little once somebody is found to have a particular long-term condition. Neurological conditions and many long-term conditions, rheumatological as well, go on for years and years. These patients may hardly ever encounter anyone from primary care, and when they need to the person who they have this so-called relationship with is not there anyway. So is the whole model sustainable as you laid it out?

Dr Dixon: There is an issue here about information. If we had integrated information across different providers—community, nursing, general practice, hospitals—then when the patient turned up or phoned it could be possible to see all the drugs they are on, all the interactions care and so on. For me some of this is about a relationship with whoever, it does not have to be a GP, as long as that person knows the patient well and can see all the interactions, in the way that we have seen in the United States for example. There is much—

Baroness Finlay of Llandaff: That is not really primary care in the States. It is very much more secondary care.

Jennifer Dixon: No, it is not. In the organisations we have looked at it is not a general practitioner often, it is somebody who works in a more primary care setting who is often a nurse who is the care co-ordinator, who can see all this stuff and sees the patient on a much more day-to-day basis. Some of this is about—

Q621 Lord Bichard: Can we explore this a bit more? Every one of the local providers that we had here a couple of weeks ago mentioned information and data as being one of the key—

The Chairman: Data and funding were their two points.

Jennifer Dixon: Integrated information is critical.

Lord Bichard: They all mentioned data and information and they all mentioned funding, but let us talk about data and information for the moment. I think Torbay said to us that in order to get anywhere near the situation you are talking about they had to ring up 24,000 people and say, “Would you mind if we shared the data?” 22,700 said, “I thought you were doing it already, why do you not get on with it?” and 300 had a problem with it. Without putting words into your mouth, do you think that we ought to be recommending that this issue is grasped more imaginatively by maybe, let us say, the Information Commissioner? So much of our emphasis over the last 25 years has been on protection of information. Hardly any of it has been about sharing of information that is in the hands of public bodies. Is this an important point for us to make?

Dr Dixon: Absolutely critical.

Q622 The Chairman: So free up the data exchange barriers nationally? David, you are nodding. You are not allowed to nod, are you, but you are?

David Behan: I do not know what I am allowed to do, but I think Michael is absolutely right. The foundation stone for true integration of services is the exchange of information and until we grapple that then I do not think it is going to happen. One of the things I was going to share, Chair, is we are doing some work on dementia over the next few weeks, just to the point of data that Baroness Morgan asked. Every Health and Wellbeing Board, whether they have teeth or not, could take the incidence of dementia in the community that they are there to serve, then work out what the level of service
 provision was across that in both acute hospital and in terms of care services and look at data like the length of stay, mortality data, readmission, look in terms of preventable admissions from care homes into hospitals and what is required to tackle things like urinary tract infections, dehydration and so on, and look at where there were multiple admissions from care homes into A&E, which then might be beginning to suggest about how strongly primary care service is supporting people in care homes. The big issue is about how you get access to a GP if you are in a care home. There are some that get well served and some get very poorly served.

You begin then to build that data and then from that data you begin to ask questions of those preventable admissions: what services are required to prevent admission? Is that training for staff in care homes or is that community nurse provision? Is it issues around the co-morbidity and what we do about other issues? Then you begin to build services based on the evidence of both the incidence in the population and the effectiveness of services rather than a service design that owes as much to art as it does to the use of evidence and science.

I think the premium on data to drive those conversations at the local level has to increase if we are going to get this right.

Chai talked earlier about the right care in the right place at the right time. I think that is absolutely right and the way that you do that is by drilling into your data so you are absolutely clear. I think there are key issues about what is predictable and what is, therefore, preventable in relation to that. I do not think we should escalate that. There has always been an issue about whether you can identify those people that will go from a care home into hospital. You know some are going to but not each individual. But basically services would be designed based on that data and predictability. As Michael said, you need personal data to be shared to allow that to happen.

Q623 The Chairman: Michael started off earlier talking about what the local people were talking about, the data protection inhibitions on having a common patient record. I think that we got nods that most people thought that needed sorting out. It was a no-brainer. If you have those sorts of numbers there is clearly a public consensus for doing it, so whatever national government needs to do to sort that one out. Then David was talking about a different thing, which was the better use of data to understand the efficacy of different treatments in care pathways.

David Behan: Those two come together, Geoffrey. Some of this is about the use of personal data of the people that are in the system at a local level, and that being used to set along the aggregated data at service and population level and that is used to inform and plan services.

The Chairman: Very helpful. I was just trying to catch that I had understood it.

Q624 Baroness Tyler of Enfield: I would like to pursue this point that both Jennifer and Chai have raised about a navigator or a co-ordinator. We had evidence a few sessions ago about this concept of someone who would be a very enhanced care worker, who would have considerably more skills than a current care worker, perhaps doing some of the role of a current district nurse or a community nurse or, in some cases, even what a GP might do, and working with a much smaller population, around about 500, 800, something like that. Do you see that sort of person providing the sort of navigator role that you have both highlighted as so critical to what a different system could look like?

Dr Dixon: We have had case managers before, care managers, nurse care managers, who concentrate on high risk patients, so we have examples of those, but they have been probably battling in a system that is often hostile so it is a question of working with that
model. I think we are on the right track, but should give it more oomph by busting the barriers, as Chris said, and possibly through more radical, braver demonstrations.

**Dr Patel:** This is where the empowerment comes in. If I turn it into commercial language, if you have a contract between the navigator and you on their behalf, you go in with a card that has a lot of weight when somebody says, “No, I am not going to treat you. I will not let this happen.” There is an accountability trail that comes, and I know there are consequences with this, but the fact is the contract is not clear right now and then when the contract is not clear people can buffet you along the way. In the systems that you have examined in the States, the whole contract is relatively clear and inside there are opportunities for arguments and negotiations and challenge. There is no point having a navigator who knocks and nobody opens the door and nothing happens—it does not matter—so they have to have power on behalf of the patient, the resident, the service user.

The other part is the information piece, and I think that is so critical. It does not necessarily always have to be somewhere big. Obviously it will be stored somewhere, but the individual could even have the basic part of that about their medication, about their key issues, about the things that have been done, in a swipe card or something close to that, that somebody has a chronic condition. If people did not know my medications, that would create a problem for me. It is my responsibility to carry it with me most of the time and my community, whoever that may be, my family, my friends—and immediately it improves my chances of every interaction materially.

**Professor Ham:** Can I just add very briefly? The way I have framed this discussion in my mind is that there are two ways of thinking about integration around the needs of older people. One is from a population perspective, the other is around the individual, Mrs Smith. In the work we did with Jennifer and colleagues of the Nuffield Trust, in the paper we put out in January this year, which we can send to the Committee, we talked a lot about this. Let us be very clear, what should be the offer to Mrs Smith who is 85? She has five or six long-term conditions; she is living independently at her home. What are we offering from our public services to help her to remain independent? I think this is at least as important as trying to tackle the population-wide issues because they are really hard, getting big organisations to come together and work effectively. What we said was the offer should include people with the appropriate needs. You should have a named care navigator. You should have a care plan. We have been saying this for as long as I can remember but not everybody who needs a care plan has a care plan setting out what the system will deliver for them. You should have access to a personal health budget if you meet the appropriate criteria. You will be supported through telecare and telehealth in your own home if you meet the appropriate criteria. If we could be really clear what the offer should be, based on evidence about what works—not just the care navigator but these other elements too—I think we could go a long way.

**Lord Bichard:** The care navigator is the social care co-ordinator idea that Torbay have, is it not?

**Professor Ham:** What I would say is that different people with different needs will need a different care navigator. So in Torbay where the focus is around frail older people, yes. I think the many other patients who are not in that position will also need a care navigator but it might be a different person.

**The Chairman:** Could I add a question? I think I have done this to you before. Would you not also have some statement about giving the person the level of independence they sought and avoiding institutionalisation when it is not fundamentally necessary, by which I mean not having to go into a care home or into a hospital when it is possible to manage the condition without that? Ought that not be part of your little list as well?

**Professor Ham:** Yes.
Dr Patel: It comes to the right place, does it not? Most people do not want to be in a hospital or a care home. The right place for care is where you are comfortable. Whether it is your home or whatever, it is the right place.

Baroness Finlay of Llandaff: Are there any studies that you can steer us to where people themselves have been given all of their information so they can become their own care navigators, people with long-term conditions who have open access to their results, open access to the opinions on them—not just that they have a copy of bits of their record, which seems to be like tokenism and duplication and we know it does not work as clinicians do not fill them out?

Professor Ham: What you are describing, Ilora, is exactly what you see when you visit the best of the US integrated delivery systems.

Q625 The Chairman: Jennifer, do you want a closing word?

Dr Dixon: I do not want to be depressing here, but over the last four years Nuffield has evaluated quite a lot of what could be called integrated care in health care, and we have been looking at the impact on service use and costs: have they prevented avoidable hospitalisations? I have to say in most cases the answer has been no. What we have seen in these interventions, if you can call it that, has been everyone seems to know what they want to do, everyone has goodwill, but somehow or other the intensity of the intervention is weak, it is limp, it fizzles out after a few months, with the exception of rare cases like Torbay. There is something about the oomph in the system that is lacking—it just fizzles and disappears. I think people know what to do. There is not the energy there, in all the things we have looked at, beyond the first few months. So that is why I get back to not just having some really good goes around the place but also having some kind of, dare I say it, central help to keep the spotlight and energy levels high in these places, otherwise we are not going to get anywhere. You get all these little pilots and then you have the evaluation over here and this whole thing just—

Q626 The Chairman: Some of us—I look at Lord Bichard—spend our lives trying to improve public services and nobody will, but you come back to, do you not, different forms of incentive to make systems change?

There is lots else to cover. Lots of what you said was very helpful. I thought that what Chris said about thinking about what Mrs Smith wants might be quite a good way for us to articulate what we think and what the evidence shows people would really like in a health and care system and being quite explicit about that. We have struggled at times to get those normative statements from others we took evidence from. If you have that, and you gave us a hint of that, that then begs the question: if that is what good looks like, what sort of health and care system do we need to have by 2025 to deliver that? I choose 2025 for obvious reasons. It takes us slightly away from the immediate rows and nobody is saying that we can tear up where we are, but it allows you to think a bit more freely about what ought to be the fundamentals of both the structures and the funding systems. I gave you a crude pastiche: fewer acutes, much better quality, much better out of hours, much better diagnostics and bigger GP functions and so on.

Could I ask each of you, if you think that is a valid question, to give us a note on what you think 2025 would look like? Does that feel a good enough question? That would be helpful to us to focus our thinking on what we might say. Thank you very much. David, we are including you in this if we can.

David Behan: Okay.

The Chairman: David, you want to go at 11 am, is that right?

David Behan: I thought the session was ending at 11 am.

The Chairman: It may well not be depending on others. How are others, because we have quite a bit to cover still? Are you all right for a bit longer after 11?
Professor Ham: I ought to be away by 11.30 if I may.

The Chairman: That is no problem.

Dr Dixon: By 11.15.

The Chairman: If we can go to 11.15, that would be helpful. Then we should take David next because, David, you have to go at 11, do you not?

David Behan: I need to be back for 12 pm, I think. Let me just check.

The Chairman: Let me not confuse my small brain. Why do we not take you next since I have that in my sights?

Q627 Baroness Tyler of Enfield: David, as you know we are interested in pursuing this whole issue about improving the quality of social care and we all know the current horror stories around, because there are too many of them. We have had a lot of evidence submitted on this, individual case studies with absolutely horrendous things happening in care. I would be very interested in your take about what the key drivers of quality improvement are likely to be. Clearly regulation is one of them, but it seems to me that there are a number of other important drivers. Could you briefly give us your take on that?

David Behan: I think on the last question, you need to look at personal health budgets and personal budgets and the evaluation on that as well, just to pick up. I think there is the stuff from America, but I think we have some really interesting stuff here as well.

My set speech at the minute is that there are five influences on quality. First is how commissioners specify calls in the work that they are doing. Second is the responsibility for providers to ensure that quality is in their systems, and that is a responsibility that goes from the board and indeed in the care system I think there are questions for equity investors about how quality is involved in the decisions that they make, straight through to what happens in the individual services. Thirdly, I think there is a responsibility for professionals. I reregistered as a social worker at the end of November—I do not know whether you are still registered—and when those of us that are nurses and doctors and so on reregister we commit to uphold a set of standards of behaviour and conduct. There were six psychiatrists in and out of Winterbourne View. There were about a dozen nurses in and out of Winterbourne View. I think there is a responsibility that we have as professionals. The last time I saw somebody thump somebody it was a criminal offence, so even if you are not qualified there are still certain codes of conduct that we live by where people know it is wrong and they need to be part of the services.

The fourth influence is what regulators do, and I include professional regulators as well as quality regulators in that. Then the fifth—and Chai has already made reference to this—is the voice of people that use services and for those people without capacity it is people who speak on their behalf, whether that is a family member or an advocate. My argument would be that over the past few years there has been too much emphasis on the regulator for quality and services. The debate post-Winterbourne about quality was about what the regulator did and did not do. Where was the commissioner in this, where was the debate about what professionals did, and where was the accountability of the provider in relation to it? Clearly the voice of people using the services was just ignored by all.

The metaphor I have been playing with, Claire, is of a graphic equaliser and if I put that on my computer and listen to the music it is more relaxing when those five bars are in some kind of harmony. If one of those bars is bouncing along all by itself there is no harmony in that system. While it does not end the, “Who is accountable? It must be you” conversations, if we want to drive quality improvements into systems it needs all five to work together and, as I say, there has been an over-emphasis on the regulator and too little emphasis on others. I think Chris and Jennifer and others have been leading the conversation, which is really about how you begin to change the nature of that
conversation. I have to say I have not quite seen that play its way through Panorama yet or the way the public debate is taking place, but that is what needs to happen. Then there are some important conversations to take place, which comes back to this optimism-pessimism theme for the conversation. I think one of my challenges in CQC now is: where do today’s quality standards become tomorrow’s essential standards? How are we going to move the standard distribution to the right and what is my role, alongside commissioners, providers and professionals, to move that standard distribution to the right? Winterbourne did raise some of these but bad cases do not make good law. 30 years-odd of dealing with child protection services just make me realise how bad cases do not make good law, quite frankly. I think we need to look at what is required to move to the right.

Jennifer has been asked to do some work by the Secretary of State on aggregated ratings. I think that is a hugely important conversation about how you drive improvements in services. How Chai does that in individual services of care homes is a completely different conversation to how you drive that in complex institutions like teaching hospitals, but effectively it is the same question about how you drive improvements in quality. You will know how you do this in schools or you will be having that conversation, Baroness Morgan: how you do it in care homes, how you do it in primary medical services, how you do it in hospitals. What we have been saying through our consultation and our strategy is that we need to be much more differentiated. The way we do it in hospitals and the way we do it in a three-bedded care home for people with autism—I do not mean CQC, I mean “we” collectively, the five influences—is going to be different. I think we have too much of a one size fits all in this debate and we need to be much more granular about how we drive improvement.

I think there is a very important debate about push-pull. Regulators can push things but true improvement is pulled through by excellence and the innovation that we talked about. Technology is playing a very important part in the way that some people with dementia are being cared for in their own homes and that is pulling through the standards rather than pushing it through. I think we need to look at a system that has push and pull in the way that you drive improvements in quality.

On this pessimism stuff and to say some of the things that I said to Michael, the State of Care Report that reported on the year 2010-11—so this has absolutely nothing to do with me at CQC—I thought flagged up some quite important progress in relation to basic quality in the system. One of the things I tried to say in the publicity around that report is there are some very good services being delivered in this country, and what the poor services do is open up the gap. Even within the same financial envelope, which is one of your themes, it opens up the question about why some people in the same financial envelope can perform at a high standard and some people perform at a very poor standard, and I think there needs to be an important debate on that. We know one in 10 hospitals did not meet the standard on dignity. Interestingly in adult social care it was 93 per cent that did meet the standard on dignity. What is that about? Why? I think it comes back to what is systemic, what is about leadership, what is about the development. I think one of the themes from this morning for me is there are not silver bullets for these things, but we also know that 72 per cent of nursing homes and 82 per cent of care homes met the care and welfare standard that we set. Another way of looking at that is 28 per cent and 18 per cent did not. That is one in three and one in five basically, so those are too high, in my view. Therefore, we come back to this issue about how you drive improvements in quality and services and regulation as one part. Part of my message on the State of Care Report is there are some important messages here for people commissioning services and people providing services.

The last thing I would say, Geoffrey, coming back to these five influences on quality, when services register with CQC they undertake legally to continue to meet those standards and
there is too little debate about what people are effectively contracting to do when they register with CQC. I think we should have a system that is much more about holding people to account for that initial registration of them continuing to meet standards at that level. In other sectors you see much more of the responsibility—so housing associations, for instance, are regulated by the Homes and Communities Agency. They talk about co-regulation between the regulator and the providers—you will know this better than I, Geofffrey—where the basic transaction taking place is that those providers are committing to uphold the standards that were introduced at registration. I think that is a hugely important transaction that people enter into. I suspect we have not made enough of that and I want to open up a conversation about how we can make more of that in the future, about the importance of registration. The emphasis is on people committing to register and deliver to standards rather than whether we go in and find out whether they are meeting them or not. That is also important, but that is where unannounced inspections come in and statements of continued compliance with those standards from providers, because it is their responsibility to meet those standards. I think we need to drive this.

In answer to what do we need to improve them, I think we need to emphasise the importance of commissioning, provision, professionals, regulation and the voice of people and make sure that they are acting in some kind of tandem together.

Q628 Baroness Tyler of Enfield: Does the fivefold framework—which I very much agree with, particularly that focus on commissioners and providers and the whole issue of corporate accountability for providers—also apply for care that is delivered in the home? I think you were talking mainly in that bit about care provided in residential settings.

David Behan: No. If I was, I have given the wrong impression, as I think that has to apply right across the board.

Baroness Tyler of Enfield: So it goes across the board, yes.

David Behan: The emphasis on the voice of people is really important in both adult residential care and domiciliary care where people are self-funders. There is this issue. One of my concerns would be that I think people buy care and it is a distress purchase. In order to make that purchase, you need to be informed and there is lots of evidence that people are not making informed decisions.

The Chairman: Partly because the data is not there, is it not?

David Behan: Partly because the data is not there and partly because people do not know where to go, where that data does exist.

The Chairman: You can sense that we are going to say something about the fact that there has to be more a transparent and informed market and, therefore, that says government is going to need to make sure it happens, if not do it itself. You would not disagree, by the look of it.

David Behan: I think that is absolutely right.

Q629 Baroness Morgan of Huyton: I wanted to pick up on the commissioning point. I think your description of the five leaders is absolutely right. The thing that concerns me, or maybe it is partly solved by the information point, is that if you are a self-funder in the system, particularly a self-funder and carer at home in the system, commissioning, as far as I am aware, does not play. So who is the person who is giving the guidance on the basis of a minimum standard registration? No matter how high a level you set a minimum standard, there is not a range at the moment of descriptors of the level of service. If the local authority is not involved in commissioning for that individual or for that family, how can an intelligent decision be taken at the moment?

David Behan: I think with difficulty, if I am being brutally honest. Certainly people could go on CQC’s website and look at the historical data about the way that those services are performing and they currently use that to inform a decision, but I think that demands a form
Care Quality Commission, The King’s Fund, Nuffield Trust and Dr Chai Patel CBE FRCP, HC-One – Oral evidence (QQ 607-638)

of literacy and ability to get around those systems and then process that. The reports are written pretty clearly. On a wet Sunday I put my postcode in your website and looked at the children’s centre that came up at the top of the road and then I pulled off the nearest thing that we register, which happens to be a respite care unit, and put the two reports together and thought, “What is the difference between those two?” Yours was a bit shorter and it was probably better written, but it was exactly the same information and you banged a rating on it and we did not. If I had read it I would have had a good feel for both the children’s centre and that respite care unit, but it demands that I have to process that. When I was in the department there was an important debate about what the local authority’s role is in providing information to all its citizens, whether they are self-funders or not, about the services that are in their area. They have a broader responsibility to their citizens, not just to the people that they fund, and so I think there are some important issues about how that is taken forward into the future.

Baroness Morgan of Huyton: We were told that legally that was not possible when we interviewed the chief executive. We were told that legally they could not give information on services except the ones that they had decided to use.

David Behan: I thought that the 1986 Disabled Persons Act meant that local authorities had to make some provision to provide that—

Baroness Morgan of Huyton: That is certainly worth looking at, is it not?

David Behan: I may be wrong but—

The Chairman: That is very helpful. Just a bit of signposting, as we have about 15 minutes left. We must talk a little bit about Dilnot funding. If there is time, I would be keen to get a view from Chai on what else the private sector could be doing and maybe the voluntary sector as well. Jennifer, would it be possible to get your international experience in a note? I do not think we are going to get to it in time. Would that be all right?

Dr Dixon: That is fine.

Q630 Baroness Morgan of Huyton: I will not do the long question. In a sense everybody knows the score. I think what I would like to ask is: should Dilnot be implemented? How should it be implemented? What are the implications of it in terms of the cost? What does it not sort? So what is left? Were Dilnot to be implemented, what is left?

The Chairman: What is missing?

Baroness Morgan of Huyton: What is missing?

Professor Ham: Our view has been to welcome Dilnot on the same lines as the Fund argued for with the Wanless review. It offers a solution that seems to be the one on the table at the moment. Dilnot is not perfect. Going back to where we started at the beginning, Geoffrey, if I may, if there is a bigger debate to be had about the post-war settlement then Dilnot is only a partial solution within that debate and it is something we will be coming back to. We hope that the Government will make a very clear commitment and a timetable to implementing Dilnot. We will lean on the side of generosity around where the cap should be.

The Chairman: Meaning higher or lower?

Professor Ham: Lower.

The Chairman: Really? Why?

Professor Ham: A cap around about £35,000 seems to us to be about the right place to place that cap, even with well known constraints on public spending. I think there is a debate then about how much of a market there will be for the financial services industry to come in and offer more innovative insurance or equity release products to cover the costs that will not be met if there is a cap at that level, and I am sure other people here will have views on that, too.
Dr Dixon: Support Dilnot. Support the cap. Probably again around £35,000, but it is not the main issue, the cap, is it? The main issue is how to get more money into the system to support older people. I would be very interested to see what is going to be addressed, if anything. I suspect that it will not be.

The Chairman: It looks to us as if Dilnot is necessary but vastly not sufficient, but it has hijacked the debate essentially.

Dr Dixon: It has hijacked the debate.

Q631 The Chairman: There was almost belief that if we do Dilnot the problem is sorted and from what we have seen that is blatantly not true. Would you share that view?

Dr Dixon: I agree. We do not know whether or not the insurance industry will come in and offer products that are any more affordable than they are at the moment. We do not know that. The issue is funding social care and we are back to the idea about the settlement and whether or not we need some different post-war settlement. How any Government can address such a big issue I have no idea, which is why we have not sorted it in the past, but how this could be done, maybe incrementally, is something that we have to think about.

Q632 The Chairman: I suppose again ducking it by going to 2025. Our eyes are on 2020. If you think of the Department of Health’s budget, even if there was nothing above inflation you would expect that to have been changed in its balance, would you not? There would be less on conventional health services and more into social care funding, whether mitigated through local government or not. Would you not expect that would be the logic of what we have heard in evidence?

Dr Dixon: Maybe. It is such a big step. If we go back to this idea about demonstrations, that cannot solve the whole thing but locally it could join these two budgets together and mix and have cross-subsidisation of health for social care and vice versa. Maybe that is the way forward—that you have enough of those that demonstrate their workability to then be able to do something more nationally rather than a White Paper on a solution.

Professor Ham: The other bit to play is if there is going be a radical review it should not stop at health and social care funding. What quantum do we need to fund what kind of services? There are these two issues, are there not? There is the model of care, the one you have been asking us to respond on, and then the quantum of the funding to resource that level of care, but there are other public spending pots we should be looking at too. The IFS put out a really helpful paper earlier this year suggesting precisely this, that depending on the ambition involved we should be looking at some of the existing universal benefits provided for older people even though we know this is a very tricky territory to get into too.

The Chairman: When was that? I think I have seen it. What was it called?

Professor Ham: You put out one too, did you not?

Dr Dixon: We put out one too. We will send that in.

The Chairman: Thank you very much.

David Behan: This is where I am not sure what I should be saying, having just left the department.

Baroness Morgan of Huyton: You are independent now.

David Behan: Yes, but there is this long lead, is there not? Maybe Michael should tell me what it is, but anyway, somebody told me to be brave. Dilnot did what he was asked to do and, therefore, to criticise him for not doing other things is really tough.

The Chairman: We were not but we were—

David Behan: To come to your question, Sally, and Chris has alluded to this, of course it is not civil servants that make the decisions, it is Ministers. That is right and proper and I believe that that must be case here as well. The system that we have for adult social care going back to 1948 is broken and the system needs to change. The absence of transparency
about the co-payment element of it is one of the issues that needed to change. I thought what Andrew’s report did is make absolutely transparent that the future moving forward is co-payment. Therefore, what his report was about was how the system should change. If you believe, and I personally do, that co-payment will be a feature of the future, for the reasons that Chai has given and the stuff earlier about intergenerational equity, then I think Andrew has given a set of propositions that allow the appropriate policy debate to take place to allow it to be settled. I do not think this is about ‘do Dilnot’ ‘or do not do Dilnot’. I think it is about responding to the questions that Andrew Dilnot has raised in a quite intelligent and thoughtful work, quite frankly. There is then an issue about the quantum of resource, given the demographics and population that come through, and they are two separate questions. They are related, but Dilnot by itself will not bring in the money that is required to meet the future demand in terms of care services and he never set out to do that. That was not the exam question he was set. He was set a different exam question, to redesign the system on which co-payment should take place.

My personal view is that was the right way to do it. I wish previous Governments had asked the question why we save in old age and what we need to save for. They said, “You are right to save for your income”, but I thought they should have added in the question of saving for care. But you cannot live this backwards, you can only live it forwards, and therefore we are where we are. The challenge is whether those two things can be brought together and I think what is required is a social policy solution as well as a political solution.

The Chairman: What does that mean?

David Behan: Within some of the political choices that exist for any Government of any complexion there are some choices—how do you design a system that is going to operate?. A cap is not just a political choice; there is also a policy choice implicit in that as well.

Q633 The Chairman: The Dilnot debates apart, if you think about the next 10 years, we know what the fiscal situation is going to be by and large for the next 10 years. We have seen the Nuffield paper on it. Is it more difficult to get funding into social care because ultimately the Department of Health knows it is going into local government? It is not ring-fenced into local government so there is always a feeling that you are pouring it in a way that you do not have certainty that you get the bangs for bucks if you are the Department of Health, or even less likely the Treasury thinking about whether they put another £5 billion into health and social care. Chance would be a fine thing. You take the point, do you not? Local government administering the means-testing seems, at one level, totally sensible, does it not? Somebody has to do it and they are well placed to engage the community. Yet many of us around this table know that the funding mechanism through local government brings certain problems with it, in terms of departments’ attitudes and the Treasury’s attitude. It is not a clear question.

David Behan: They are some of the choices that exist in relation to how that money is going to go into the system in the future. You have been pressing, quite properly, around integration and whether pooling of money is the way to go or whether it is not the way to go. The department has put £2 billion into adult social care with a transfer from the NHS. That was a decision that this Government had made. It is largely going into building community-based infrastructures. So some of the places that Chris talked about that have developed reablement, rehabilitation services and support into the community have largely been done on the back of that money. There are some quite outstanding examples of where people have done that. I think the evidence is that that has led to improvements in services for people.

The difficulty is where that money went into the local government baseline and the absence of transparency about where that has gone. There is a trade-off to be had. There has been a debate about localism, which local government have led and championed and said, “We
want the freedom to spend”, and the money goes into the baseline and evaporates, versus, “This was money to go in to provide care largely for these people”. There is complete transparency on the NHS transfer to local government on that billion that went in and you can see where that is being used and what impact it is making. The evidence appears to be that that is an example of an incentive and a change in the system that has led to improvements in the quality of services.

Dr Dixon: You must have been around this issue before about hypothecation and relooking at it. The old chestnut is that the Treasury do not like it, but there is a question whether this could be a route to lever more public willingness to pay. Clearly health is priority number one in all the polls and all the rest of it and I suspect, if framed properly, social care would be near the top as well. Could we relook at this in a more intelligent way than we have done before, using NI as the vehicle? It is a question. I am sure you are yawning at this thought because you have been around the houses, but it now may be the time to do that.

Q634 The Chairman: It is well put. Can you help us with that either now or later?
Dr Dixon: It would have to be later but it is something we are looking at.
The Chairman: By later I mean within our timespan.
Dr Dixon: Which is by the end of January?
The Chairman: This is a short report, my colleagues tell me, covering an enormous terrain so it is very focused in terms of what are the significant things that we ought to be saying publicly.
Dr Dixon: I am sure we could give you some intelligent points that would be useful even if we do not crack the problem.
The Chairman: That would be very helpful. Thank you.
Professor Ham: Nothing to add.
Q635 The Chairman: Chai, care funding?
Dr Patel: I think the point has been well made. Dilnot starts the debate and there is honesty around the fact that it is co-payment. I think the public will now have clarity around it. My two points to it would be that it is an opportunity to now redefine people with chronic illnesses having more rights to free healthcare even though they may need accommodation, so we need to redefine the group of people with chronic co-morbidity and how we might treat them with the intermediate care solutions, the rehab solutions and so on. They need to be free at the point of delivery, because there is an unfairness or a co-payment if we are going to do that. That would be a fairer way to progress because then we move into the health budgets where the primary reason why somebody older is using them is that they have some specific illnesses.
How we define that contract will need thinking about and so on but we need to think that through because right now everybody who is basically old is being put into a social care box unless they are in a hospital bed. That to me just feels unfair, so they end up in a hospital bed. We need to take that budget—probably umpteen billion in hospital beds right now being used—and put that out in another setting where by rights you should be able to get that and it is free at the point of delivery because the reason why you are there is that you have an illness. Then you will be left with primarily social reasons for needing care of either choice, which some people make, and for some their frailty is of a different nature. The issue that I think you should touch on, because I think it will shine a light on it, is what we do with dementia, where there is very little to see. It is clearly an illness and yet we are treating it like social care, which is totally unfair because it is means-tested.
The Chairman: One rather slick trick of putting health funding into social care would be to take the burden of dementia from social care funding by defining it as totally eligible for continuing care. Is that just too glib? It is too glib, yes.
Dr Patel: It is glib because it is money associated on the other side and this is where I think we need to be true to the equation and then come back to pragmatism rather than fudge the whole thing.

Q636 The Chairman: A closing comment on all this?

Professor Ham: The point I would make is that, if you did that, and I can see there would be some attraction, you would simply be adding to the real and growing pressures on the NHS at the moment. I am a little concerned at the moment with these transfers of funding from the NHS to social care, which is a great help for the reasons that have been articulated.

The Chairman: The NHS is not going to get more funding in the next five years above its trend rate, is it? What happens to the rest of public services if you do?

Professor Ham: No, absolutely, but if we are therefore saying we are redefining the scope of care, what previously we thought of as social care is now to be funded out of a non-growing NHS budget—

The Chairman: I take the point.

Professor Ham: These are the projections that Jennifer and colleagues have put out there recently about the decade of austerity that lies ahead. The logic is clear behind what you are saying but the consequences could be adverse.

Dr Dixon: You asked about Japan and we will send a note on that. Just two things on Japan I thought may be of interest. One is that it introduced in 2000 compulsory payment by everybody aged 40 and above for funding for social care. Secondly, they were very liberal as to who in Japan should provide social care and some of the most interesting innovations in Japan have been coming out of the acute hospital side, which is now providing social care. We will send a little note on that.

The Chairman: Thank you very much.

Q637 Lord Bichard: I do not want to ask a series of questions but I think it would be good to give Chai Patel in particular, but others may want to come in, a chance just to talk about, following up that very point, what new kinds of organisation and what contribution they might make to this issue. I would be interested to hear particularly from you about how you feel the climate is. How encouraging and sympathetic is, for example, the public sector to new forms of provision? What are the barriers? How can we encourage more of it? Has Southern Cross done a lot of damage? I just want to talk about those sort of issues really.

Dr Patel: I think the high level point is, and I made it at another setting, that in the last five years the climate for the involvement of private sector has got less clement than it was before. It has become inclement in the sense—

Lord Bichard: Less?

Dr Patel: Yes, less so. Curiously, we seem to have gravitated back towards public services provided by the public sector rather than public services provided by all comers. I think there is a general sense of tension around for profit organisations operating in this space, which I think is rolling across from the banking environment and a variety of other places, so there is a general tone there. I think the investment community is definitely concerned about health. They look at health on demographic and on other parameters in the US and other countries—Canada, Australia—and see it as an opportunity for investment, for innovation, for creative destruction and all these things. Then they come to the UK or socially-driven healthcare economies and they think maybe this is not where the

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opportunity is right now. There is no clarity around where the regulation is going—where
the public sector attitude towards funding private operators is going.

We need to do some work around that in terms of encouraging capital because I think if
you look at services for older people in the last 20 years, over £25 billion has been invested
without a single PFI, in this whole change since 1979 to 1999, the major demographic push
that came through and since then it has dropped off and we have another one coming, as we
have just mentioned, Chair. How are we going to fund some of this? We have a plant right
now of accommodation alone that is 25 to 30 years old. It is really not fit for purpose for
the new generation of older people. We need to think about that. Will everybody’s home
be adaptable for old age or would they choose to live in another sort of physical
environment that is more enabling and more attractive at that point in time? Where is the
funding for that going to come from? There are fantastic innovations taking place around the
use of technology right now in protocol management in terms of care, in terms of nutrition
and medication, in terms of dementia, some really interesting work going on around life
history and narrative and how we integrate that now, intergenerational, working with
grandchildren and so on because there are very savvy old people who are learning. There is
a new relationship building up. All of these are part of the progressive development of care
services.

Interestingly, companies like HC-One are just now partnering with charities like Macmillan
and Stroke Care to see how we develop specialist innovative envelopes of services, where
we work with their knowledge of their constituency, with our ideas and capital, and
collectively go to the public purse and say, “Here we are with the solution. Would you like
to work with us?” Talking about the fact that this is a crisis decision for most people, a
branded badge relationship between Macmillan and HC-One, or Macmillan and somebody,
or Stroke or Alzheimer’s, becomes that much more validated. What we are trying to do is
to unpack the envelope a little bit bottom-up—going back to Mrs Smith and what does she
want—and create little pathways and packages to fit in while this global solution is being
debated so that we can help the current generation of people. One of the critical ones we
are working on is prevention of admission into hospital before people die. Just because staff
are getting panicky towards the last few weeks of somebody’s life in a care home, the
default switch is ‘call an ambulance’ and then the person ends up in the hospital, so we are
going to work on training and packages with Macmillan to do this.

So what I would encourage is new ideas into the system because the system loses its oomph
at some point. I think what the independent sector often brings is this oomph because it is
kind of small and agile and pushy, and the big system by definition is to maintain the status
quo a little bit, so we have to work alongside it. If that tension is lost I think it will be lost in
the system and some stuff needs to happen, so reports like yours that create a vision for the
future will encourage people who want to come with solutions to participate in that vision
in some way.

Dr Dixon: We did some work—I do not think there is any study like it—that looked at the
impact of Marie Curie home care nursing for people at the end of life and showed an impact
on reducing hospitalisation unlike anything else we have looked at, so that is a very
promising area. If that is of interest, we will send that on.

The Chairman: Yes, please.
Q638 Lord Griffiths of Fforestfach: Chai, for potential investors in this sector at present, what do you think they would like to hear the Government saying and doing in order for them to commit capital?

Dr Patel: There needs to be a sense that provision is open to all comers rather than the funding is available only within the public sector for public services. I think what happened in the last 15 or 20 years was that there was a sense of openness that the funding would travel to the best provider, regulated, protected and so on. Now it starts to feel like the system is going to develop from within rather than needing people from outside and I think, as you know, capital requires a return. If it does not see that then it is not going to want to—and scale, I think the other thing is there is a desperate need for scale in health and social care economies for big capital to move into it, which we have talked about today, so we want both a federated small local but we also want big, and how do we create that mix? However, there is genuine desire for capital to move in this space because this is capital with purpose and there is, as you know, a new movement in the investing community about looking for investment with purpose and health is very important.

Baroness Blackstone: Is not the main problem really that the return on capital is just not going to be big enough and it is a very heavily regulated sector, and many private providers are nervous about whether they can meet the quality of care now required, given the cost of doing it well?

Dr Patel: That is absolutely a very fair point. My view on that is that if health and social care become a utility alongside other utilities and economies then they should be safer. So one of the things, if you want a lower return economy and capital to come in, it must not stop being so volatile. The problem we have is a combination of volatility in the economy and you get the funding collapsing without any warning, and therefore people have no chance to prepare for that collapse in funding. If you get a utility, one of the ways—I have always voted for this in the past—is we need a quality regulator and a price regulator so that you create a way of modulating these bumps that happen in our publicly-funded services. Pension funds will be very glad to invest in relatively low but safe returns like they put alongside any other investment, and I think this kind of service delivery healthcare falls into that utility, but one needs to articulate that it is not going to be hugely volatile alongside that. The regulatory burden is there, but then I think that is part of the expectation in the community so it is for us to innovate around some of that.

A fundamental and slightly important point I want to make is that the social care economy—certainly the private sector and the public sector if you look at the data—is built on low wage, entry level jobs. To me that is one of the fundamental things, if you are going to look at the quality of future services, that needs to be dealt with once and for all because I think this is an anomaly that cannot be tolerated in the long run. If you are going to have people moving out of Sainsbury’s into a care home and back into Sainsbury’s as a way of working, that cannot be the way to look after frail and vulnerable elderly people. They need training. They need a sense of identity, a sense of cohesion with their community and a desire to aspire to improve and do better. I understand the financial constraints but there were financial constraints when the minimum wage came in and we did not all collapse. So I think we need to look at this carefully and I think it would be a missed opportunity in the quality piece if we did not talk about it.

The Chairman: That is well put and I sense both the panel and the interrogators are all nodding on that point. On that note, we should probably leave you in peace. Thank you all very much indeed for a very challenging and interesting session. I am sorry about the
homework but we really would be grateful if you could send us what is already in the tin but also address the 2025 question because it may help us to clarify what we ought to be saying in public on this. Thank you all very much.
Health and social care in 2025 – a personal think-piece from David Behan

The health and social care system in 2025 will look different to today’s system. Demographic and morbidity changes will provide significant challenge to the system as people live for longer but not healthily. Healthy life expectancy will not keep pace with life expectancy.

A reformed system will be required, responding to further monetary constraints, greater focus on integration, and changing roles for hospitals, doctors and GPs over time as the needs of the population change. CQC will need to look at the quality of these services as they develop, focussing on effectiveness, safety and people’s experience, and how bespoke, personalised care is delivered.

Demography and morbidity changes

- More people will be living longer. Although people will be living longer, many will be living with multiple long-term conditions. People will need more specialised care to meet their medical needs as well as their care needs. For some people with long term conditions such as diabetes, self care will increase. By 2025, more than 1m people will have been diagnosed with and be receiving treatment for dementia. It is expected that one in three people aged over 65 will develop dementia.
- More disability from birth. Scientific advances allow premature and disabled babies to survive where they may have died previously. With this come higher rates of disability, meaning there will be more people with lifelong care needs. As with the population generally, people with disabilities will live for longer, and may well develop other conditions which need to be treated.
- More demand for care. As people will be living longer, and the general population ages, there will be a greater demand for care to support people’s needs.
- Expectations increasing. The current ‘baby boom’ generation has grown used to technological developments and high levels of customer service. With this come increasing expectations and demands which the system may not be able to meet. The quality of care provided will become more important, and services will need to increase the quality of care they provide to meet the demands of a more vocal and demanding generation.
- Resources. Other commentators are better placed than CQC to comment on the available resources to fund health and social care in the longer term. However, the availability of resources may be the main driver for reform of health and social care delivery in the next 10 – 15 years.
- Prevention rather than cure. The ‘big’ killers in the early 21st Century are lifestyle diseases, many of which are preventable. Focus should be on wellbeing and prevention as dependency on services will be mainly due to lifestyle related disease. According to Diabetes UK, two in three adults in the UK were overweight or obese in 2012. Incidence of obesity will continue to increase and with it the rate of type 2 diabetes, cardio-vascular disease, and the incidence of cancers will also increase. All of these can be expensive to treat and, in many cases, are preventable through
sensible diet and exercise. It is anticipated that by 2025, 5 million people in the UK will have diabetes.

- **Inclusivity.** Focus should be on working with people and inclusive behaviour, to allow people to take responsibility for planning and arranging their own care where appropriate and in taking action to prevent further diseases developing.

- **Policy changes.** As policy changes over time to reflect the growing needs of people and diminishing funds to pay for it, alternative solutions will be sought. There will be a greater trend to keep people at home or in the community, not in institutions such as hospitals or care homes until their needs become such that they need more interventionist support.

- **The role of hospitals.** As medicine develops further, and consideration is given to what is actually the best place for people to be treated, district general hospitals will change over time. Services will become more specialised than they are currently, and, where geography allows, services will be consolidated between local hospitals, with different hospitals specialising in different areas. Length of stay will be optimised and long stay hospitals will no longer exist. There will be a greater emphasis on rehabilitation to enable people to return to their own homes more quickly, with the adaptations made to their homes to support this. More care will be delivered in community settings, with outpatient clinics becoming increasingly held outside hospital settings and being the main location for treatment to be delivered. Hospitals will become a place of last resort. There will be greater integration between primary, secondary and community care, as well as with social services.

- **The human genome project.** As scientific research continues, we will learn more about the genetic basis of disease and an individual’s propensity to disease through their genetic makeup. Whilst advances have been made in some areas, such as breast cancer, further developments may lead to wider genetic screening allowing people to make choices about managing the risk of developing disease and taking preventative action where necessary or appropriate. Pharmaceutical research will become more focused on a molecular basis. Bespoke treatments will be developed based on the genetic make up of disease, with more specific pharmaceuticals being developed to treat specific cancers and other diseases.

### Specialisation in medical training

Medical training will become increasingly specialised, partly in response to specialisation of services in some hospitals, and partly in response to decreased training time as a result of the implementation of the European Working Time Directive. Technological and medical advances will also encourage further specialisation. There will be fewer general physicians working in hospitals, with their role being taken by community based doctors.

There is a paradox, however, that as the focus for delivery will be on people. Implicit will be a challenge to a profession which is increasingly specialised to provider personalised care

Within current recognised specialist areas there will be increasing specialisation. Whilst we currently have, for example, Gerontologists, there may be further specialisation within this so there may be more doctors specialising in treating people with acute dementia.

### The role of genericism and GPs

The role of GPs will also change over time. As clinical commissioning groups develop their commissioning role, GPs will increasingly be responsible for oversight of the full range of
David Behan, Care Quality Commission – Supplementary written evidence

care needs of their patients, which will put them in a unique position to be able to ensure their needs are effectively met. They will also be able to take on some care which has traditionally been delivered in hospitals. General physicians will no longer exist in hospitals; they will become community based doctors looking after patients in their own homes as part of their rehabilitation and recovery when discharged from hospital, working in partnership with GPs and community nurses.

Integration will be pushed further
The boundaries between health and social care will become increasingly blurred over time as people will generally be living with multiple medical conditions in addition to their continuing care needs. Services will become more integrated, allowing the development of bespoke services to meet the needs of individuals. Budgets will be shared between commissioners of health and social care, and those eligible for funding for their care will see a seamless service which continues to meet their needs.

There will be greater integration between primary and secondary health services and community care

Social care system will be reformed
The way social care services are currently provided will need to be reformed to ensure services are available to those who need them, when they need them. There will be a greater shift to people being looked after in their own homes with support from care workers, district/community nurses and community based doctors. A single person may be responsible for coordinating all of the care a person needs, working in partnership with GPs and community doctors and nurses.

Money will continue to be tight.
Budgetary restrictions will continue for the foreseeable future. The Department of Health/NHS Commissioning Board has already said that the ‘Nicholson’ Challenge will continue beyond 2015, with savings of up to £50bn to be found. Funding will become a bigger issue in social care. Unless the government moves to introduce the recommendations from the Dilnot Commission, such as a cap on the overall costs of care, it will be difficult for local authorities to continue to fund adult social care. It may well be that it is this which has the greatest influence on changes to patterns of care delivery over time.

Other scientific and technological advances
Stem cell therapy will enable repair of damage, such as spinal cord injury, and will allow for the growth of new body parts such as heart valves, livers or kidneys. This approach would allow people to live in better health, needing less support to enable them to live and, in the case of new body parts, less requirement for expensive anti-rejection medication and the threat of needing another transplant later in life.

All of these will come at a price – it is important that the NHS can be clear on what will be funded and the rationale for this – and it will be important to balance the costs of testing and early intervention with the longer term costs treatment or management of disease.

Regulation and assurance
People will continue to want assurance that safety and quality are essential qualities of services. The role of regulation will be to assure people who use services that services are
safe and high quality but the approach and methods will change over the period to 2025 recognising the changes in the way services are commissioned and provided.

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**Duty of local authorities to provide information about services**

The Disabled Persons [Services, Consultation and Representation] Act 1986 is the full title of the Act which David Behan referred to in the Committee.

It amends the Chronically Sick and Disabled Act 1970 which, among other things, sets out obligations on local authorities in relation to certain types of disabled people as described in section 29 of the National Assistance Act 1948.

Section 29 of the National Assistance Act 1948 enabled local authorities to “promote the welfare of persons who are blind, deaf, dumb, or who suffer from a mental disorder of any kind, or who are substantially and permanently handicapped by illness, injury, congenital deformity or such other disabilities as may be prescribed by the Minister.”

Section 1[1] of the Chronically Sick and Disabled Persons Act 1970 imposes a duty on local authorities with section 29 functions [above] to “inform themselves of the number of persons to whom section 29 applies within their area, and of the need for the making by the local authority of arrangements under section 29 for such purposes.”

Section 1[2] of the Chronically Sick and Disabled Persons Act 1970 then goes on to provide that “every local authority must --

[a] publish general information as to the services provided by the local authority under section 29 which are available in their area; and

[b] inform any disabled person who uses such services of any other service provided by the local authority and of any service provided by any other authority or organisation which in the opinion of the local authority is relevant and of which the local authority has particulars in its possession.”

The words in italics were added by the Disabled Persons [Services, Consultation and Representation] Act 1986.

Section 1[2][a] obliges local authorities to publish information to the world generally about their own services to the disabled.

Section 1[2][b] obliges local authorities to make available information about their own and any other organisation’s services, but only to disabled persons in the local authority’s area who are using local authorities services -- not to the general population.

In 2006, the Department of Health published ‘Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services’, which can be found at
This statutory guidance outlines the role and responsibilities of the Director of Adult Social Services. Clause 25 of this guidance extends the range of people to whom the local authority should provide information about services locally:

“The local authorities shall ensure that the DASS is made responsible for effectively communicating information about the services available in the local authority area, eligibility criteria and charging policies to service users, including young people with long-term care needs and other potential users of adult social services, their families and carers in the most appropriate format. The DASS shall also be made responsible for ensuring appropriate involvement of, and consultation with, service users, their families, carers and the wider community in the planning, design and provision of adult social care services and for considering how accessible services are to service users, their families, carers and the wider community. In taking forward such communication the local authority shall ensure that the DASS takes account of any national and local guidelines.”

January 2013
1. About Carers UK
1.1 Carers UK represents the views and interests of the six million people in the UK who care for their frail, disabled or ill family member, friend or partner. Carers UK is an organisation of carers, run by carers, for carers, with a reach of around 1,500 organisations, including many run by carers, who are in touch with around 950,000 carers between them. Carers UK runs an information and advice service and we answer around 16,000 queries from carers and professionals every year. We also provide training to over 2,600 professionals each year. Our website is viewed by nearly 60,000 unique visitors a month and nearly 4,000 carers are registered members of our website forum. Carers UK has offices in Wales, Scotland and Northern Ireland. This response reflects the views of the organisation, UK-wide.

2. Summary
2.1 Demographic change is likely to have a significant impact on families who provide unpaid care to disabled and frail older people. By 2025 the number of people aged over 85 is set to double to 2 million. The number of carers is set to soar from 6 million to 9 million by 2037. Without further investment in care, both private and public and reform of services, this will place unacceptable pressure on families, in particular those juggling work and care. Currently one in 7 employees work and care and one in four carers has given up work to care. Without further investment in care services and reform, the outlook looks bleak. Leading UK employers increasingly recognise that public services such as social care are critical to supporting families in work, keeping productivity high and UK business globally competitive. If carers are not kept within the workforce, then this will impact on private pension provision, the benefits system and other areas of public expenditure.

2.2 Research by Age UK, published with Carers UK suggested that £5.3 billion is annually wiped off the economy by the failure to invest sufficiently in the right type of social care services.

2.3 An ageing population will make greater demands on a social care system, which is already on the point of collapse. More people will require social care and an expansion of social care services at all levels is needed to meet these needs. A fairer settlement between the state and the individual is urgently needed and proposals should be put before Parliament urgently. Along with the more than 60 members of the Care & Support Alliance, we believe the Dilnot Commission’s report, alongside that of the Law Commission, forms a strong foundation for fundamental reform of the social care system.

2.4 As well as challenges, demographic change also presents an opportunity for economic growth. We are seeing increasing demand from families willing and able to buy care, from service-users with personal budgets, and from employers who see a sufficient supply of care services as essential to retaining employees with caring responsibilities. Yet the market for care remains unresponsive.

140 One million give up work to care (2009) Carers UK, DWP and Ipsos MORI
2.5 Carers UK has produced a series of research reports looking at the impact of demographic change which the Committee may be interested in:
  • Tipping Point for care: time for a new social contract (2010)
  • Growing the Care Market: Turning a demographic challenge into an economic opportunity (2012)
  • Care and technology in the 21st century (2012)
  • Forthcoming - report by Cass Business School on GDP and demographic change

3. Does our culture about age and its onset need to change, and if so, how?
Do our expectations and attitudes about work, savings, retirement and independence need to change and if, how?

3.1 Even without the current recession, given the rise in the older population and overall fall in birth rates we will all have to work, and work longer, to balance the books. Without changes to retirement patterns, by 2060 the dependency ratio – people working to those not working - will be only 2 to 1, compared to 4 to 1 today. The UK - and many other - economies will need a shrinking workforce to work longer to meet growing care and pensions bills, and action is already being taken to extend the retirement age.

3.2 Demand for the unpaid care provided by families and carers is increasing. The bulk of care is and has always been provided within families, with twice as many unpaid carers – nearly 6.4 million - as there are paid staff in the health and social care systems combined. It has been estimated that in the UK nearly 3.5 million additional carers will be needed by 2037, and by 2017 we will reach the 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.¹⁴¹

3.3 Raising pension age at the same time as expecting more people to care, unpaid for family, leads to a collision of responsibilities. For business this means a loss of staff, reduced productivity and competitiveness; for the families affected by disability including older people needing care they become significantly more likely to suffer inequality as our research shows.

3.4 Carers UK’s research has consistently shown the high cost of caring can bring to families’ resilience, health, finances, careers and social inclusion:
  • 1 million carers have given up work or reduced working hours as a result of caring responsibilities¹⁴² and those carers are, on average, £11,000 a year worse off as a result of giving up work to care.¹⁴³
  • A 2008 survey of over 1,700 heavy end carers set out the cost to family finances. Over half of respondents were in debt and nearly three quarters were struggling to pay household bills.¹⁴⁴

¹⁴² 1 million give up work to care (2009) Carers UK, DWP and Ipsos MORI
¹⁴³ Out of Pocket (2007) Carers UK
¹⁴⁴ Carers in Crisis (2008)
Carers are twice as likely to suffer ill-health and one in four has put off medical treatment because they are caring and cannot get the time off. These are avoidable additional costs to the NHS and other public services – apart from the personal cost to carers themselves.

There is also growing evidence that insufficiently or unsupported caring and the huge stresses this brings, actually undermines families and relationships, causing family break-up and marriage breakdown.

3.5 Carers UK set up the employer led body, Employers for Carers with over 60 members. They help their employees balance work and care with flexible working practices and using technology to enable home working. However, flexibility within the workplace cannot compensate for poor quality, unreliable or inaccessible social care. Over 40% of carers who gave up work did so due to a lack of sufficiently reliable or flexible services. A similar number, 41% of those who describe themselves as looking after their home and family (85% of whom are women), said ‘they would rather be in paid work, but services available do not make a job possible’.

3.6 The peak age for caring, 45 to 65, also often represents employee’s peak of 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. The average cost of recruitment, retraining and lost productivity is around £11,000 per staff member lost.

3.7 Our expectations for retirement should include consideration of social care needs. Nearly all of us will require care at some point in our lives. Half can expect care costs of up to £20,000, but one in 10 can expect costs of over £100,000, in some cases hundreds of thousands of pounds. At the moment it is very difficult for people to manage this risk. The current availability and choice of financial products to support people in meeting care costs is very limited.

3.8 A cap on care costs as recommended by the Dilnot Commission, together with much better information and advice should give people the certainty and knowledge to plan and make provision for future social care needs. Without the implementation of such a cap on care costs, people will continue to run the risk of losing much or all their savings to meet care costs.

3.9 Our attitude to care and caring needs to change. No-one expects to care and yet most of us will do so at some point in our lives. Research report after research report shows that people are are unaware that most of us will need some extra support in our lives – whether from extra household tasks to more complex care. And most people do not expect to pay for social care. These attitudes need to be

145 Figures taken from six reports from Carers UK’s Action for Carers and Employment partnership, research by University of Leeds from 2004 to 2008


147 Fairer Care Funding (2011) Commission on Funding of Care and Support
changed far earlier, thinking about planning for care at the time of planning for pensions, for example.

4. **Do the extent and nature of public services need to change? If so, how, and how should they be paid for?**

4.1 11 million people alive today will live to 100.¹⁴⁸ People are living far longer with long-term conditions and disabilities, and the number of working-age adults with learning disabilities will rise by almost a third over the next 20 years. This will create demand for health and social care services which simply cannot be met by our current systems.

4.2 It is not possible to continue to raise productivity in certain areas. If 3% efficiency year on year is assumed, in some services this will equate to a cut. We need to look at the differential impacts of “efficiency” savings across different services.

4.3 Tightening of eligibility criteria has meant that despite an increasing demand for social care, the number of older people receiving services has gone down. In 2011-12, nearly 80% of local authorities set their eligibility threshold for adult social care at ‘substantial’ and a further 3% set their threshold at ‘critical’, meaning that hundreds of thousands of people who don’t meet these criteria are missing out, despite possibly having considerable care needs. Local authorities facing budget cuts have struggled to maintain low level and preventative services.

4.4 Further research is needed to understand the extent and nature of unmet need. Age UK have estimated that of the 2 million older people in England with care-related needs, over 800,000 receive no formal support from either public or private sector agencies.¹⁴⁹

4.5 The Dilnot Commission’s final report of the Commission states that ‘the Government must devote greater resources to the adult social care system.’¹⁵⁰ As the social care system struggles to meet the challenges of long-term underfunding and accumulated unmet need, the current spending reductions and increasing demand, Carers UK believes that, alongside greater integration and better use of existing resources, this need for additional resources in social care cannot be avoided.

4.6 The funding gap for social care services poses significant challenges to the NHS where avoidable emergency admissions and delays to hospital discharge are often the result of insufficient care services. Carers UK believes that there is considerable scope to improve care and deliver cost savings through better integration of health and social care services. For example, hospital discharge procedures continue to let down families and result in avoidable costs to both health and care services.

4.7 To continue to meet growing demands the Government has set ambitious efficiency targets for the NHS. In order to make efficiency savings, it is essential that future health services are better integrated with social care.

4.8 Hospital discharge is a key moment for families, if done badly with little consultation or planning it can lead to carers being forced out of work as they take on unsustainable caring responsibilities without a supporting care package in place. A lack of rehabilitation can also significantly prolong caring responsibilities as early

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¹⁴⁸ Number of Future Centenarians by Age Group (2011) DWP

¹⁴⁹ Forder and Fernandez (2011) The cost of social care for older people: the importance of unit cost growth. PSSRU report for Age UK

¹⁵⁰ Fairer Care Funding (2011) Commission on Funding of Care and Support
discharge hinders recovery and the regaining of independence from the older or disabled person. Again, this takes a huge toll on family resilience but can also lead to substantial costs from avoidable readmissions, particularly emergency admissions and early admission to residential care.

4.9 As a result, Carers UK believes that in the future there must be a new emphasis on prevention and reablement across health and social care.

4.10 Local authorities driving down the amount they pay for care has contributed to low quality domiciliary and residential care, which is increasingly worrying for families and also causes people to give up work to care because they do not “trust” services. As well as increasing choice, a better funded system with more self-funders purchasing care increase competition and should drive up quality.

4.11 A funding model which brings more money into the social care system and finds a fair balance in meeting costs between families and the state is needed. Carers UK supports the Dilnot Commission’s proposals to raise the means-test for care costs. Families can feel a deep sense of unfairness at losing their savings and assets as a result of care bills. This can be doubly the case for carers who feel that they have worked hard and contributed to the economy throughout their working lives, and made a substantial contribution through caring, yet still face losing the majority of their assets.

4.12 This leads to many families putting off buying care early, because they do not know what the future will hold in terms of care costs. A reticence to invest in preventative support because of this uncertainty can damage family resilience – making it less likely that carers will remain in work and healthy as they can be pushed to breaking point before they invest in support.

4.13 Carers UK believes that the introduction of a cap, as proposed by the Dilnot Commission, would give families the ability to plan for care arrangements and costs and invest in care and support early on. The opportunities for new insurance products opened up by the provision of a cap to cover tail-end risk, would also help give peace of mind, and would encourage and enable families to make plans for care.

4.14 By levering more money from self-funders into the system there is the potential for a wider range of services to emerge to meet a range of social care needs. However, the experience of those on personal budgets and self funders is that they often cannot find services that are appropriate or meet their needs. To address this, intervention is needed at the local and national level to stimulate a more varied and care market and encourage the development of different kinds of services.

5. Do we need to redesign and transform public services for these challenges? If so, how?

5.1 Existing services struggle to match the way families live and work, and so often do not provide the help vital to managing competing priorities including childcare, work, family and care for older and disabled relatives.

5.2 As well as putting in place a model to pay for care, we also need a fundamental shift in how we approach care provision. The challenge of growing demand should also be seen as an opportunity to reshape how our public services, society and economy fit around the changing shape of families.

5.3 Evidence from Carers UK suggests that there is a significant demand amongst families for low level home care and domestic services that can mean independence for the user, and peace of mind and time for their families and carers.
5.4 As with childcare, a mixed economy in care for older and disabled people could offer individuals better opportunities to work flexibly around other family commitments, but it could also present new and diverse opportunities for small business start-ups providing family support services. New flexible models of service provision would have the potential to deliver the wider spectrum of services that families need – integrating care with lower level support such as companionship, shopping and household services.

5.5 Although not statutory services, the Government has a role to play in stimulating and developing such services. The French Borloo Development Plan of 2005 and a second Development Plan in 2009 led to a huge growth in the care market and a massive boost to the French economy by focussing on the growth of homecare services by incentivising training and providing tax incentive including though a voucher and reduced VAT and national insurance contributions.  

5.6 New solutions to caring are needed which include different types of services and the greater use of technology to care. There are new markets to be developed for care and support services that reflect the way people actually live and new opportunities as our expectations change in a high-tech world.

5.7 The market for health and care technologies – both ICTs and hardware - is currently underdeveloped and still largely targeted at statutory agencies such as health and local authorities. There are real opportunities for the private purchase market, but it needs incentivising and shaping, and investment not only in products but in end-to-end services, and above all in marketing them to the consumer.

6. What should be done now and what practical actions are needed?

6.1 Implement the Dilnot Commission’s recommendations in the draft Care and Support Bill, by introducing a cap on care costs and raising the means test on social care support.

6.2 Set up a Health and Care Technology Taskforce, with independent expert leadership, which will bring together UK Governments and key stakeholders - researchers, developers, businesses, policy makers, providers, employers, employer organisations, regulators and end users - to lead on actions to unlock the potential of technology.

6.3 Publish the full results of the Government’s whole system demonstrator programme.

6.4 Recognise the growth potential of the care sector and take action to stimulate and incentivise it, so that localism becomes a driver, not a barrier, to innovation and growth. The Social Care (Local Sufficiency) and Identification of Carers Bill currently before Parliament seeks to put in place a duty on local authorities to map and plan services that enable disabled people and carers to remain in or join the workforce. If enacted, this Bill could allow local authorities to begin work by 2015 to stimulate local action to meet those needs, in conjunction with new mechanisms such as

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151 For a more detailed account of the Borloo Development Plan, see the Carers UK report; Future care: Growing the Care Market - turning the demographic challenge into an economic opportunity 2012

152 http://services.parliament.uk/bills/2012-13/socialcarelocalsufficiencyandidentification
Health and Wellbeing Boards, the Joint Strategic Needs Assessment, and Local Employment and Local Enterprise Partnerships.

6.5 Explore tax incentives for new care businesses. An existing example is the success of the ‘progressive beer duty’ tax in generating rapid growth amongst real ale microbreweries. A similar ‘progressive care duty’ for microenterprises in the care market could support the expansion of a new generation of small businesses, including social enterprises, providing flexible solutions to families in local communities.

7. How can we stimulate national debate about these issues?
7.1 The draft Care and Support Bill includes provisions to expand advice and information services both locally and nationally. Accessible information to enable people to navigate the social care system is essential in stimulating national debate about what services are available and where gaps in services exist.

Carers UK research suggests that people know very little about technology solutions. 46% of carers in the State of Caring Survey 2011 said they were not aware of or did not know how to access technology solutions which could support their caring role. Access to the internet is essential for families to explore what technology products and services are available through statutory services and in the private purchase market. The internet is also the delivery mechanism for many services such as telehealth monitoring or remote consultation.

1 September 2012
Carers UK, The King’s Fund, NHS Commissioning Board, Professor David Oliver, Care Quality Commission and Age UK – Oral Evidence (QQ 215-288)

Transcript to be found under Age UK
Carers UK – Supplementary written evidence

Case study submission:
Select Committee on Demographic Change and Public Services

The following case studies and quotes are from Carers UK members and illustrate a range of the challenges carers face in accessing support, and the impact on family finances, carer health and their ability to juggle work and care. Their circumstances are real, but names have been changed to protect their privacy.

The case studies are listed under four headings but each example highlights several different issues and a lack of timely, affordable, flexible and good quality services runs through all of them.

**Giving up work to care**

**Jenny – caring for a disabled husband and supporting her mother**

Jenny is in her 40s and cares for her husband Paul and her mother, who has had two strokes.

Two years ago Paul suffered cardiac arrest at home and was resuscitated on the kitchen floor by paramedics. They did not immediately realise but Paul had suffered hypoxic brain injury which has resulted in him becoming diabetic, experiencing unpredictable mood swings, forgetfulness and requiring an oxygen tank because his heart is too weak to pump oxygen around his body.

As a result Jenny needs to provide round the clock care, as Paul needs help and to be reminded to complete basic tasks from taking medication to eating, and getting in and out of the bath.

When Paul first came out of hospital Jenny tried to juggle work with caring for him, but they were offered no support despite his relatively high level of need. Jenny was told by their district nurse that she would have to give up her job because Paul needed her at home, but she felt she had no choice but to carry on, with no-one else to earn and pay the bills. However she struggled to cope caring for Paul with no support and also supporting her mother who did receive a care package but still needed Jenny to check in on her. After several months Jenny’s GP signed her off work with stress and she then made the difficult decision to resign.

With the loss of two full-time salaries the financial consequences were devastating. They went from both having relatively well-paid jobs to falling into debt and behind on their mortgage. Eventually their home was repossessed and they had to be declared bankrupt to clear their debts. Initially they missed out on financial support which contributed to a rapid fall into debt, now Paul receives Disability Living Allowance and Incapacity Benefit, and Jenny gets Carer’s Allowance and Income Support however making ends meet is still a huge struggle.
They have also received some support from a charity day centre where Paul can spend a few hours to give Jenny a break, and they do now get occasional breaks together paid for by their local council. But they feel this is just a sticking plaster and doesn’t allow Jenny to have a life alongside caring, or any opportunity to work.

"Me and Paul have always worked - whilst many people are finding it hard to find work at the moment I strongly believe that there is work out there for anyone, even scrubbing toilets. But it is just impossible for me. Me and Paul had good jobs and were doing well, but it all fell apart and I had no choice. Now it is horrible, you’re looked on like a scrounger."

Availability of suitable services

Sheila and Tony – caring for a disabled son

Sheila and Tony care for their son Alfie who has cerebral palsy. Both in their forties, Sheila and Tony have to cover alternate shifts between work and home in order to give Alfie the care he needs and support their family. Alfie, who is 14, has a younger brother, Sam, 13.

Alfie has required round the clock care since birth, but recently a decline in his health has brought the family to crisis point. Following a five-day stay in intensive care, critically ill with pneumonia and MRSA, Alfie’s care needs have increased dramatically. His lungs are badly damaged and he needs not only medication, but regular physio and oxygen. He needs oxygen throughout the night and cannot be left alone to sleep as he often takes his oxygen mask off. Sheila and Tony have had to juggle extended time off work while Alfie has been so critically ill. Sheila and Tony are struggling more than ever to continue to work with caring for Alfie and managing a healthy, supportive everyday family life for Sam. Having taken so much time off work Sheila says she is worried she may not have a job to go back to.

The family are unable to get suitable support for Alfie’s care needs. They have previously received respite through a family link carer scheme (where another family looks after Alfie to give Sheila and Tony a break). However this family are not able to give the level of medical care Alfie now needs. The local hospice which may have been able to provide suitable respite provision is currently closed for refurbishment and the family simply cannot find other suitable services in their area.

Additional carers’ quotes:

When services fail to match families’ needs around work patterns:

“I had to give up work at fifty to care for my husband and our savings for retirement are being taken up in care costs. It took me two years to find my way around everything I needed to know - we should have been picked up at diagnosis. There was also a fourteen month wait for a place at the Alzheimer’s day club, and this daycare runs from just 9am until 2pm when the transport services pick them up and take them home. But I am outside the transport area so have to collect my husband myself. This makes it impossible to work. Daycare needs to transport everyone and be available from 8am till 6am so that people can still work.”

When additional support can enable carers to work:
“I have a son with Down’s Syndrome and I was trying to return to work 17 years ago. Every step of the way I struggled as I could not get childcare for my son and as soon as registered childminder knew my son had a learning disability they refused to take him. I eventually found out from a friend who had been in the same situation that she had approached her local authority and they had agreed to provide help before and after school so that she was able to return to work, the time was also extended to provide the support during school holidays. I made contact and they also agreed to help me. This enabled me to drop my son off with someone who was on their register before he went to school, the taxi would then pick him up from there and drop him off there after school also. This help and support enabled me to stay in full time employment as my parents had been looking after my son before this but were getting elderly and unable to manage. This proved a great help to me over my son’s schooling years and I am still in the same job now.”

Carer health and hospital discharge

Marge – caring for a husband with dementia

Marge is in her mid 60s and has cared for her husband James, who has Alzheimer’s Disease, for 13 years. James has poor mobility and eyesight, is incontinent and can often grow very distressed and angry - he requires round the clock care.

Marge cared for 11 years without any support and only when she reached crisis point did they eventually get some help in the form of occasional respite care and James began to attend a day care centre. This enabled Marge to continue working part-time as a teaching assistant which she loved, and gives her a sense of normality and time away from caring. But the pressure of caring took a toll on Marge’s health she experienced depression, and has put off knee replacement surgery – unable to find replacement care. Last year, when their day centre was due to be closed due to funding cuts, Marge and her daughter led a successful campaign and secured its future for another two years.

However, at the start of this year James had a seizure at home – he fell, injured his head and was admitted to hospital. When James was discharged he spent a short period in residential care but was then judged to have recovered enough to come home. But, needing to provide even higher levels of care was too much for Marge’s health and she fell ill and James had to return to residential care.

However, the service wasn’t suitable and could not provide the care James needed. He frequently grows upset and aggressive when receiving personal care and the residential care centre could not manage this behaviour and made the decision to have James sectioned.

Marge was incredibly upset, knowing that this isn’t the right place for him and is furious at the care he received, often finding him in his own urine and the staff just leave Marge to wash and change him herself. She was so desperate for him to leave the mental health ward, that, with residential services unable to provide the care James needs, he has now returned home for Marge to care for him.
The costs and quality of care

Terri – caring for her mother who has Parkinson’s Disease

Terri, 58, has cared for three years for her mother who is in her 80s and has Parkinson’s Disease, vascular dementia and has suffered a stroke.

Terri cares round the clock - supporting her mother with everything, particularly personal care and medication. After her mother’s stroke, her mother went into residential care and sold her own home to pay for it. But her mother wasn’t doing well in the care home and Terri made the difficult decision to bring her mother to live with her, on the condition that they received social care support.

Terri has had to fight to get help. Her mother has some savings so they have to pay almost £150 a week for just 7 hours of support from care workers who come into the home. The care workers are often late or too early and are rushing between clients so can be unreliable. Earlier this year their care package was cancelled because the care company could no longer deliver services to a rural area on the rates the local council was paying, and they only found out that alternative arrangements were being put in place two days before their care ended. It took six months to have a hoist installed after Terri became unable to get her mother in and out of bed – in the meantime she just had to struggle and risk injury to her back.

Terri only ever has time off when her brother or friends can occasionally come in to look after her mother, as she can’t leave inexperienced care workers alone with her mother because her condition is so fragile and changeable. So, apart from the 7 hours of support they get a week, Terri is just left on her own to provide constant care. Occasionally she can call up a local care home to see if they have a place free and they can pay for her mother to stay there for a few days but her mother often returns in more pain and distressed which makes Terri very guilty about taking any time off. She has recently been ill herself, she thinks this has been exacerbated by caring and has no time to recover or recharge her batteries.

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November 2012
Carers UK – Further supplementary evidence

Background

Currently 300,000 carers in the UK are forced to give up work each year to care, at a cost to the economy of £5.3 billion\(^\text{153}\). As the number of people caring for older and disabled relatives continues to grow\(^\text{154}\) the UK quite simply cannot afford for this to be the impact of caring, and how we manage care and caring must be seen as an economic as well as a social issue. Carers UK believe that individuals, families and employers have a right to expect an infrastructure of support for care which enables people to sustain care within families and relationships while having productive working lives. In the same way as a good system of childcare is seen as a condition for employment, so must a good system of care and support.

In this way services become facilitators of labour market participation and a market imperative is created, as was the case with the UK National Childcare Strategy. Launched in 1998 and updated in 2004, its aim was to provide access to affordable childcare and early years services, to support child development, alleviate child poverty, and remove barriers to parental employment. Recognising employment as a key driver of demand for these services, Government introduced a duty on local authorities to ensure a ‘sufficiency of supply’ of childcare to stimulate a mixed economy of provision which would meet that demand from both employer and employee.

International evidence

The same approach has been used in France but has gone beyond childcare to develop integrated services to individuals and families that include childcare, homecare, domestic and adult care services – services that are seen as contributing to the well-being of citizens at home. In the mid-1980s France began to move away from a welfare model of social services to a system in which meeting social demand and job creation went hand in hand, with the implementation of policies designed to create a dynamic market in ‘services a la personne’, loosely translated as ‘personal and household services’ (PHS). This turned the issue of how to meet huge demand for public services on its head, with the focus instead on how to develop a market to provide effective and affordable services to individuals and families to support them across a lifecourse of care.

The Borloo Development Plan of 2005 and a subsequent Development Plan in 2009 were aimed at doubling growth in this service sector through:

• Raising the sector’s professional status
• Stimulating demand by reducing cost and improving quality
• Simplifying and facilitating access to services through a universal subsidy, delivered through a voucher system.


A single agency, the ANSP, was set up to implement the Plan, taking on the responsibilities of 18 different ministries for the development, delivery and sustainability of a range of services to individuals and families. This effectively dealt with the integration of services previously delivered through diverse agencies, often in ‘silos’, much as we see today in the UK with the disjunct between health, social care and other local authority services, all of which in reality make up the tapestry of services which support real people’s everyday lives.

A system of subsidy through tax credit was introduced to make services more affordable, and delivered through a universal voucher system – the ‘Chèque emploi service universel’. The CESU can be prefinanced – with some or all costs met for example by employers, unions, mutuals, pension funds or local authorities – or ‘declarative’, allowing users to ‘pay as they go’ by registering use online. The CESU can only be used to buy registered services, as with childcare in the UK. The French system allows for registration of provider organisations and individual workers, and has also introduced quality standards for both to promote professionalism in the sector. There is even a national trade union which represents individual workers in the sector, and ensures their employment rights. Provisions for individual workers have meant a reduction in France of undeclared or ‘grey’ labour in the sector, and a consequent increase in tax revenue for the economy.

We can see several common factors with the UK National Childcare Strategy: the promotion of labour market participation through services to families; the stimulation of supply; a universal system for subsidy; a mixed economy for delivery; and the engagement of employers as key stakeholders.

Carers UK believes that we now need to see a similar revolution in the provision of care for older and disabled people, beginning with investment and incentives, and a duty on local authorities to ensure a sufficiency of supply of care as well as childcare, to stimulate the mixed economy of services needed to satisfy the demands of today’s citizens. This would ensure access to services in a climate in which public spending constraints will see tighter and tighter eligibility criteria for statutory services, even where people have to pay for them. We need a reliable supply of good quality affordable services that people can access when they need them to meet their changing needs, through local authorities where appropriate, or to simply buy.

The role of the care market in economic growth in France

The success of this revolution in care has been in seeing it first and foremost as a growth sector, and incentivising it to stimulate supply. Services a la Personne is one of France’s biggest growth sectors, with a 44% increase in its value between 2004 and 2007.

In the first phase of the Borloo Plan 100,000 jobs a year were created year on year in the sector, with around 2 million employees working in Services a la Personne at the end of 2008. In 2007 one in three jobs created in the French economy was in this sector. The second Development Plan was affected by the global economic crisis but despite a significant slowdown in 2009, the ANSP’s Observatoire 2010 predicted annual growth of 50,000 jobs for 2010 and 2011 - a success story not only for the economy, but also for the social economy, with families getting more support through a supply of flexible services to manage their increasingly complex lives alongside paid employment.

Belgium – assessing the ‘earn-back effect’ of investment in support services
Belgium has followed a slightly different development path, but based on the same principle of investment for affordability, stimulation of demand and growth. The Belgian equivalent of the French CESU, service vouchers, are used in Belgium for domestic and homecare activities delivered within the home (cleaning, laundry and ironing, cooking etc) and outside the home (shopping, assistance with transport etc). Currently service vouchers are not used to provide personal care services, as they are in France. However, they work on the same principle of delivering more affordable and higher quality services to individuals and families while increasing revenue to the Exchequer by bringing people in the ‘grey’ economy into the formal economy and creating new jobs.

The Office National de l’Emploi subsidises services at a cost of €13.30 per hour, which means that each user pays €7.5 per hour for a service delivered at a real cost of €20.80. In addition to the subsidy, the Belgian Government enables households to deduct their spending on vouchers from their taxable earnings, resulting in an hourly cost of just €5.25.

A study carried out for the Belgian Government has calculated the net cost to the state of its subsidy as a result of its direct ‘earn back effects’ in terms of increased tax revenue (from a move of workers from the grey to the formal economy) and the creation of new jobs, and indirect ‘earn backs’ from supporting people to juggle work with family responsibilities:

- Gross cost €1,430,432,704
- Earn back effects €629,734,509
- Indirect earn back effect between €418,275,083 and €534,575,083
- Net cost between €382,423,112 and 266,123,112

However, according to the report, users were prepared to pay €8.59 for ‘cash in hand’ services, and if the Government pegged the subsidy at the same level the tax deduction on services could be removed and the price to users of a service voucher increased to €8.59. The net cost to the state is then €82,478,861 or becomes a negative cost (or benefit) of €-33,821,139. With a net cost of €24,328,860, and so far 80,000 jobs created, this amounts to a subsidy of just €304 for each job created.

The report also showed an interesting indirect impact of the service voucher, with 10.4% users stating they could increase their own working hours as a result of buying support in this way, and 0.6% of users stating they could use the support to re-enter the labour market. 10.8% of the users stated that without service vouchers they would have to reduce their working hours.

Making a cross-government case for investment in care

A document produced by the European Commission earlier this year to launch its consultation on Personal and Household Services (PHS) pointed out that when looking at the costs of this type of public investment we must recognise that costs to one part of Government might result in benefits to another, so return on investment in terms of earn back effects needs to be viewed globally across Government, not by department or sector.

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This helps us to understand the real net cost of public support for job creation in this sector. We should also take a global view of beneficiaries of different systems of subsidy: for example, a tax reduction mechanism favours higher income families while lower-income families benefit from exemption from co-payments, leaving middle-income families somewhere in the middle of the system.

However, the long-term impact of growth of the PHS sector should also be taken into account when considering public investment in their supply and/or demand. By a simple extrapolation, taking into account a range of factors (demography-related needs, primary occupations, limited net fiscal costs), some basic calculations can be made to illustrate the potential for job creation of incentivising growth in personal and household services across Europe:

- An extrapolation of the Belgian system to the EU 27 (taking into account the respective size of both populations, using a simple multiplication by 50) results in a net cost of 1.2 billion euros to create 4 million new jobs in household services.
- If each person currently employed in the EU (215,000,000) were to pay for just 1 hour per week of household or care support (compared to the 2.5 hours each day which adult Europeans spend on average on household and caring activities), it would create almost 5.5 million new jobs.

A final point should be made about the opportunity for innovation in this market. Technologies – health, care and information and communications technologies - have the potential to transform the way people manage their lives, and that includes both managing care and managing work. These technologies do not have to be seen only as an industry in themselves, but as an enabler that should be embedded across all sectors.

**Recommendations**

Recognition of the economic importance of care services is beginning to grow – for example, Lord Heseltine’s *No Stone Unturned in Pursuit of Growth* report identified the ‘obvious potential for growth’ of the social care sector. To deliver this Carers UK has urged Government to embed childcare and care services for older and disabled people in national growth strategies and in guidance for local growth mechanisms, particularly Local Enterprise Partnerships.

We welcomed the establishment of a cross Government Carers and Employment Task and Finish Group which will start the process of building a coherent evidence base on caring and employment.

To drive policy across Government, Carers UK has also called for the introduction of a National Care Strategy, supported by a business-led taskforce, to identify the potential and the mechanisms for growth in the care sector, and produce a roadmap for action.

Such a Strategy should include the following outcomes:

**Incentivising the care market:**

- Duty on local authorities to ensure a sufficiency of supply of care services, to stimulate supply, which could be delivered through the draft Care and Support Bill;
Carers UK – Further supplementary evidence

- Universal information service, on the whole range of services available in any locality, to support access to supply;
- Tax incentives, including care credits, tax allowances and tax exempt Care Vouchers, to promote affordability and greater private purchase capacity, and stimulate demand.

Cross-government work to identify the benefits of growing the care sector:

- Department of Health with regard to the health and wellbeing of the population;
- Department for Business, Innovation and Skills with regard to reconciliation of work and care, the growth of the care sector and economic productivity;
- Department for Work and Pensions with regard to employability, use of the benefits system, and meeting the future pensions bill;
- Department for Education with regard to skills, workforce and sector development;
- Department for Communities and Local Government with regard to meeting the needs of whole local populations;
- Government Equalities Office with regard to equality of opportunity and mitigation of the opportunity costs of caring.

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November 2012
Carewatch UK, Professor Julien Forder, University of Kent, NHS Confederation and Geoff Alltimes, NHS Future Forum joint lead – Oral evidence (QQ 289-326)

Transcript to be found under Geoff Alltimes, NHS Future Forum joint lead
Confederation of British Industry (CBI)—Written evidence

Summary

1 The CBI is the UK’s leading business organisation, speaking for some 240,000 businesses that together employ around a third of the private sector workforce. With offices across the UK as well as representation in Brussels, Washington, Beijing and Delhi the CBI communicates the British business voice around the world.

2 The CBI represents businesses as users, funders and providers of public services. We believe that involving a diversity of providers in the provision of public services can help to deliver increased savings, as well as improvements in service quality. To deal with the UK’s demographic challenge, we argue in this response that:

- **Public service delivery should be opened up to a diversity of providers to generate savings and improve service quality**
- **Public service transformation must be prioritised with strategic choices made about how, where and what services are provided**
- **Alternative approaches to funding and paying for services must be developed**
- **A public debate is needed now about the demographic challenge in advance of the next parliament’s Comprehensive Spending Review**

3 The impetus for public service reform today comes from the need to reduce our present budget deficit. The CBI believes taking action now to deal with this deficit is imperative, but as statistics about the future fiscal challenge from the Office for Budget Responsibility (OBR) highlight, it’s clear that a longer term perspective is also needed.

4 Based upon current trends, by 2030/31 a budget deficit of 0.6% of GDP is expected, rising to 3.2% of GDP by 2060/61 as demand for services increases while tax revenues remain static or fall slightly. Most of the additional cost will come from age related spending linked to health, long-term care and pension payments. While there is significant uncertainty associated with making such long term projections it is highly likely that the UK will face a fiscal squeeze and services will face different pressures as the needs of service users change.

5 The CBI believes bold action is required now and over the next few years to reform public services to meet the challenge of demographic change. Borrowing more money or raising taxes are not sustainable solutions to meet rising demand and therefore moving further and faster on public service reform is necessary. We need to open up service delivery to a diversity of providers to generate savings and improve services, as well as transform the way in which services and funding streams are configured to deliver the best outcomes for service users in the long term.

6 Reforming health and social care services is critical, but transforming these services alone will not go far enough to deal with the potentially significant costs of demographic change. Government needs to look at public services strategically
Confederation of British Industry (CBI)—Written evidence

across the board and identify how services should be delivered, configured, funded and paid for to deliver the optimum outcomes for society and the economy. This response therefore looks at public services in the round.

Public service delivery should be opened up to a diversity of providers to generate savings and improve service quality

7 The CBI believes there is scope to deliver significant savings to the taxpayer, as well as drive improvements in service quality for users by opening up public service delivery to a diversity of providers from the private and third sectors.

8 A recent CBI survey of public opinion revealed there is support for diversity of provision, with 75% agreeing that a range of providers would be more successful than just one at coming up with new ways of doing things. 65% also agreed that that a variety of providers would be more successful than just one at reducing costs to the taxpayer.

9 Independent providers have both the capacity and expertise to drive innovation in service delivery, stimulate new ways of working, drive up productivity and ensure services remain responsive to the needs of service users, while also delivering savings to the taxpayer. In the short to medium term, opening up services will help with reducing the deficit and in the longer term contribute towards keeping the public finances in check as spending comes under pressure as a result of demographic change.

10 The CBI supports the principles underpinning the Government’s Open Public Services White Paper, but believes there is a need to move further and faster to open up services. While there has been progress in some areas, many frontline and back office services remain closed to private and voluntary sector involvement meaning that the greatest gains both for now and the longer term are not being realised.

11 Government should work with business, charities and the public to identify areas where there is most scope for independent providers to play a role in improving services and increasing savings. Later this year the CBI will be publishing a new report that highlights some of those areas where the involvement of independent providers could deliver substantial savings year on year.

12 Savings could be generated reasonably quickly by harnessing the involvement of independent providers in the delivery of many transactional and back office services across central and local government. These include benefits processing, HR, payroll, management of documents, call handling and logistical tasks. These are services that the public do not typically interact with on a regular basis and could be delivered much more efficiently and at lower cost by the private sector.

13 The private and voluntary sectors also have a role to play in supporting frontline service delivery and even providing these services directly, with scope to move further and faster here. Progress is already being made with the introduction of the Work Programme and reforms to justice services (e.g. prison and probation reform) but there is still further to go in other areas such as healthcare and education where
the expertise and capacity of the private sector is not yet being utilised as well as it could be.

14 Opening up public services to a greater diversity of provision means Government will need to improve its ability to manage markets. This is important for ensuring that public service markets function effectively and that there is continuity of service for users in the eventuality that a provider fails. This is an issue the CBI will be looking at in the coming months.

Public service transformation must be prioritised with strategic choices made about how, where and what services are provided

15 Opening up services must be accompanied by action to transform the way in which services and funding streams are configured and delivered to bring about the best outcomes for service users and the taxpayer in the long term. Decisions will also need to be made about how spending on public services is prioritised to meet key social and economic objectives.

16 Public service transformation will depend upon breaking down silo working in central and local government and then integrating services and funding streams. For example, at a local level the widespread rollout of Whole Place Community Budgets could make a real difference; this involves pooling all relevant local funding streams in an area together to tackle the problems most important to that area and its residents. The CBI believes a Community Budgets approach could save local areas up to 15% of their annual budgets, which when applied to local authority spending in England translates to a saving of around £18 billion per annum.

17 Across central government a more joined up approach is also required to cut out waste and efficiency, as well as deliver more user-focused services. Government departments should not only share their own back office functions, but also identify where they are commissioning similar or complementary services and where these could be integrated or aligned more effectively. To enable this joined up approach, commissioning cycles will therefore need to be brought into line in many cases. As an example, there may be scope to use the Work Programme as a hub for joining up services and funding streams that jobseekers require access to, with providers potentially paid for achieving a range of outcomes including reducing re-offending or substance use.

18 Against the backdrop of an ageing population the CBI believes there is a clear case for going further to transform healthcare services. Our recent report The right care in the right place highlights how delivering care closer to home can dramatically improve patients’ quality of life and at the same time deliver significant savings to the NHS by keeping them out of hospital. In the report the CBI estimates that delivering care closer to home could deliver £3.4bn a year in savings.

19 Strategic choices will also need to be made across the board about where spending on services should be directed to deliver the most economic and socially desirable outcomes. For example, shifting from a focus on ‘reactive’ services to ‘preventative’ services could make a significant difference. At present spending on public services is
mainly directed towards addressing social problems once they have manifested rather than preventing them from arising in the first place. Focusing investment on prevention, to deliver savings in the long run could, for example, mean prioritising early intervention approaches for children, schemes aimed at reducing re-offending or public health initiatives. There are challenges in making this shift, however, especially due to the upfront cost that early intervention often entails.

20 We could also choose to prioritise scarce resource in different ways. For example we may want to spend more on services that could help to raise the employment rate (e.g. childcare) and help to broaden the tax base. Alternatively we could prioritise investment in services that are an important source of national comparative advantage (e.g. higher education). We will undoubtedly need to look closely at how much we spend on welfare – which comprises a vast amount of public expenditure – and how effectively this money is being used.

Alternative approaches to funding and paying for services must be developed

21 The Government should consider alternative ways of funding and paying for public services going forward. In some situations, there may be a case for co-payment, with individuals asked to contribute directly to the cost of accessing a particular service. There is also more that could be done to leverage private sector investment into public services through more widespread use of payment-by-results.

22 Co-payment is not a new phenomenon (e.g. university tuition fees and road tolls) and there is potentially scope to extend this approach to other areas of public service delivery that are considered to be ‘non-core’. In adopting this approach, it will be important to ensure that essential services remain accessible to all and that the most vulnerable and least well off can always access the support they need.

23 The balance between funding by the state and service users is especially important in the case of social care services, which will come under increasing pressure with an ageing population. The Dilnot Commission proposals highlight the need for co-payment, with users paying for care up to a cap (on a means tested basis) and the state paying any additional amount above this. The CBI believes that this approach is a sensible one, but questions still remain about where the Government will find the additional money it needs, highlighting the importance of realising savings by transforming public services in other areas.

24 There is also scope to leverage in private sector investment to fund public services going forward through use of payment-by-results approaches. Payment-by-results means that only successful outcomes are rewarded, which is especially important when resources are limited. In the case of the Work Programme, service providers are being paid for supporting individuals into sustained employment – it is estimated that the prime providers invested £580 million upfront in the programme in its first year.

25 Social impact bonds offer an alternative approach and are already being trialled in the justice space, with investors making a return if reductions in re-offending outcomes are achieved. There are questions however, about whether this approach is scaleable.
Across a range of services there is potential to introduce payment-by-results, but further work is needed by Government to identify areas where it is most applicable and to build up the evidence base required. The most effective application of payment-by-results in public services will come when the achievement of a particular outcome can be linked directly to savings (an ‘invest to save’ approach).

A national debate is needed now about the demographic challenge in advance of the next parliament’s Comprehensive Spending Review.

Beyond reducing the current budget deficit, the implications of demographic change mean big decisions will need to be made about our public services and public spending over the next few years.

The CBI believes we need to have a national debate about the future of our public services with service users, businesses, charities, public sector staff and politicians all contributing their views. This will be critical for ensuring that the choices made carry the support of as many people as possible.

This debate needs to happen in advance of the next parliament’s Comprehensive Spending Review when decisions will be taken about how public spending is allocated. At this point the Government will need to have a clear idea about the type of services that should be funded and how they should be configured and delivered. The CBI is ready and willing to engage with and help to stimulate this debate.

29 August 2012
Central Government (Department of Health, Department for Work and Pensions and the Department for Communities and Local Government)—Written evidence

Central Government (Department of Health, Department for Work and Pensions and the Department for Communities and Local Government)—Written evidence

OVERVIEW

1. This memorandum to the House of Lords Committee on Public Service and Demographic Change call for evidence has been compiled by the Department for Work and Pensions on behalf of HM Government. In preparing this memorandum the following government departments have contributed and the comments received have been summarised:
   - Department of Health
   - Department for Work and Pensions
   - Department for Communities and Local Government

2. Although this memorandum is on behalf of HM Government, where the areas of policy have been devolved, the memorandum will cover England only.

INTRODUCTION

3. The number of older people in the UK is projected to rise substantially over the coming decades as a result of a combination of falling mortality rates and past high fertility rates. The former relates to rising life expectancy and the latter relates to the large number of births in the period following WWII, the ‘baby boom’ cohorts. The numbers of people in England aged 65 and over are expected to rise by 51% between 2010 and 2030 and the numbers aged 85 and over are expected to rise by 101% over the same period (according to the Office for National Statistics 2010-based principal population projection).

4. This demographic change of an increase in the older population will have a significant effect on health, adult social care, state pensions, and pension related benefits. This memorandum will examine the effect this demographic change will have on:
   - Health and adult social care
   - Improved efficiency and productivity in the NHS
   - Improving standards and public confidence in services for older people
   - The extent and nature of services for older people
   - Impact on pensions
   - Reforms to the State Pension
   - Encouraging saving and automatic enrolment in pension schemes
   - The length of working life
   - Housing
Central Government (Department of Health, Department for Work and Pensions and the Department for Communities and Local Government)—Written evidence

FUTURE PRESSURES IN HEALTH AND ADULT SOCIAL CARE

Public sector health spending

5. Under the Office for Budget Responsibility (OBR) central projection, public sector health spending rises from 6.8% of GDP in 2016/17 to 9.1% of GDP in 2061/62, rising smoothly as the population ages.156 This central projection assumes that, demographic effects aside, real spending in the health sector rises 2.2% per year to match projected GDP growth over the period. Population ageing contributes growth of around another 0.6% a year in real terms, which leads to the year on year increase in health spend as a proportion of GDP.

6. The OBR central projection of health spending is relatively low compared to similar work by others including the European Union, McKinsey, Wanless and The King’s Fund. However, it is difficult to make direct comparisons because these forecasts include private expenditure on health and cover a shorter period.

7. The OBR present alternative projections exploring three issues that could have an impact on longer-term health spending: productivity, morbidity and the influence of rising incomes on demand. Simple sensitivities around the central case for each of these issues are given, with productivity appearing to be most significant and to have a greater impact than demographic change under the OBR’s assumptions

Adult social care

8. The demographic change of an increase in the older population will impact more substantially on social care than on health care. The reason is that social care for older people is so heavily concentrated on the oldest old, the very group whose numbers are rising the most rapidly. The average age of older people admitted to publicly funded residential care is around 85 years. Around 54% of older publicly funded home residents are aged 85 and over, and around 34% of publicly funded older home care users are aged 85 and over.157

9. The Office for Budget Responsibility’s latest projections show public expenditure on adult social care rising from around 1.1% of GDP in 2016/7 to around 2.0% of GDP in 2061/2. This analysis takes account of projected changes in the population by age and gender, assumes that unit costs of care rise in line with per capita GDP and assumes unchanged policy. This means that it does not allow any changes in the other factors discussed below.

10. The Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) has periodically produced projections of long-term care expenditure. The most recent PSSRU projections are those they produced, in collaboration with the University of East Anglia, funded by the Department of Health, for the Commission on Funding of

Central Government (Department of Health, Department for Work and Pensions and the Department for Communities and Local Government)—Written evidence

Care and Support. They are published in the Commission’s report and in two PSSRU discussion papers.\(^{158-160}\)

11. Under the base case assumptions, the numbers of disabled older people, defined as those unable to perform at least one instrumental activity of daily living (IADL) or having problems with at least one activity of daily living (ADL), would rise by 61% between 2010 and 2030, from around 2.5 million to around 4.1 million. The number of older people with moderate or severe disability, that is, needing help with one or more ADL tasks, would increase by 66%, from around almost one million in 2010 to just over 1.6 million in 2030.

12. Public expenditure on social services for older people is projected to rise under the current funding system from around £7.7 billion (0.6% of GDP) in 2010 to £15.4 billion (0.8% of GDP) in 2030 in constant 2010 prices. Private expenditure is projected to rise from £6.8 billion in 2010 to £16.7 billion in 2030, but this needs to be treated with caution.

13. The analysis shows that the numbers of disabled older people receiving informal care are projected to approximately double over the next 20 years if the probability of receiving this care remained constant. It is not clear however that the supply of informal care will rise to meet this demand.\(^{161}\)

14. Sensitivity analysis shows that projected future demand for social services for older people is sensitive to assumptions about future mortality rates and future prevalence rates of disability among the older population. Projected future public (and private) expenditure on care is also sensitive to assumptions about future rises in the real unit costs of services, such as the cost of an hour’s home care.

**IMPROVED EFFICIENCY AND PRODUCTIVITY IN THE NHS**

15. Improving efficiency and productivity in the NHS and social care is crucial to coping with the demographic challenge of an increasing older population.

**Expenditure and efficiency savings**

16. The government has protected the NHS in the Spending Review (SR) settlement, with cash funding growth of £12.5 billion by 2014/15. However, in the context of the challenges arising from demographic pressures, the NHS needs to make up to £20 billion of recurrent efficiency savings by 2014–15, which will be reinvested in frontline services.

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17. The Quality, Innovative, Productivity and Prevention (QIPP) programme will support the NHS to do this by focusing on areas where it is possible to increase quality and productivity simultaneously.

18. The local NHS is best placed to identify the scale of the financial challenge they face over the next four years and the opportunities for making savings whilst driving up or maintaining quality. Each local health economy is currently working towards their own vision of how they can transform their local health system by 2015, so they can make efficiency savings whilst continuing to provide quality care to their populations.

19. In addition, there are a limited number of national QIPP workstreams aimed at supporting the changes being made by Strategic Health Authorities, commissioners and providers to improve quality and productivity. The workstreams were chosen to cover areas in which there is substantial gain to be made from changing the way things are done and where the degree of challenge in making change is sizeable – perhaps because the problem spans organisational boundaries.

20. In the first full year of delivery, the NHS has delivered strongly, with efficiency savings of £5.8bn reported in 2011/12.

21. At the same time, key quality and access ambitions have been maintained or improved:
   - Infection rates at their lowest since mandatory surveillance was introduced
   - Lowest ever level of patients waiting more than 18 weeks for their treatment and both standards met each month
   - Performance measures on A&E, cancer care, and dentistry waiting times have all been met

22. The NHS’ strong performance in 2011/12 provides firm foundations for sustained delivery over the next three years, as the NHS continues to face ongoing challenges from rising demands in a funding-constrained environment. However, these challenges are unlikely to come to an end in 2015. This suggests that QIPP is therefore no longer just a strategy for managing the NHS up to 2015; it may become a key way we manage the service for the foreseeable future.

23. Delivering transformational change through clinical service redesign will play a significant role in helping the NHS to deliver a high quality sustainable service. The Government has been clear that savings from transformational change will be weighted towards the later years of the Spending Review to ensure that appropriate clinical leadership and local engagement takes place.

Social care efficiency

24. On social care, the Department of Health’s A Vision for Adult Social Care set out some of changes that local authorities should look to take forward in order to maximise value for money in adult social care. These included:
   - Maximising the potential of re-ablement services. Re-ablement can help people to regain their independence after a crisis, and can have a significant positive impact on
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people’s quality of life. The Personal Social Services Research Unit and the University of York has provided evidence that re-ablement services improve outcomes and are cost effective for local authorities.162

- Rolling out telecare support, which can help people to live at home independently for longer by providing technologies that make their homes more safe and secure.

- Reducing spending on long-term residential care for reinvestment in other services. In A Vision for Adult Social Care, the Government set out how supported housing and extra care housing can offer flexible support in a community setting, which may provide better outcomes at lower costs than traditional high-cost nursing and residential care models.

- Ensuring that the separation of responsibility for commissioning and providing services becomes standard practice. As set out in A Vision for Adult Social Care, the Government believes that local authorities with substantial in-house provision should look to the market, including social enterprises, mutual and voluntary organisations, to replace them as a local service provider.

25. The Government is working with the Local Government Association’s Adult Social Care Efficiency Programme to support local authorities to deliver these savings.

Improving public health through local action

26. We also have an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives. The Government is returning responsibility for improving public health to local government because of their unique potential to transform outcomes through their population focus and their ability to shape services to meet local needs. Local authorities are leading for public health and will have a new duty to improve the health of their population. As part of this shift to a more preventive approach to care and support, the Government will include a duty on local authorities to commission and provide preventive services in the draft Care and Support Bill. This means that local authorities will work with their communities to commission support that helps to keep people well and independent.

27. There is wide body of evidence around the effectiveness of various preventative interventions for local commissioners and professionals to use, including through the National Institute for Health Research, Social Care Institute for Excellence and National Institute for Health and Clinical Excellence.

IMPROVING STANDARDS AND PUBLIC CONFIDENCE IN HEALTH AND CARE SERVICES FOR OLDER PEOPLE

28. Kindness and compassion, dignity and respect must be central to care, whoever provides it and wherever it is provided. Many of the solutions lie with the local NHS, social care

The Government has a part to play too. By sharing best practice, bringing people together, and putting in place the right system incentives, the Department of Health can encourage providers to increase the quality of their services to older people. Actions already taken include:

- The NHS Operating Framework, which establishes the issue of high quality, dignified and compassionate care as one of four key priorities for the NHS in 2012-13;
- The Nursing and Care Quality Forum, which was created in January 2012 to spread best practice across the sector, and to make national recommendations about tackling the barriers to delivering high quality, safe and effective care; and
- The Equality Act 2010, which, from 1 October 2012, will introduce a ban on age discrimination in health and social care. Adults of all ages will benefit from better access to services, and for the first time people will have a legal right to redress from the courts if they are unjustifiably discriminated against because of their age.

29. In March 2012, the Prime Minister launched a Challenge on Dementia, which builds on the achievements of the 2009 National Dementia Strategy to push further and faster to improve the quality of life for people living with dementia and their families. It focuses on three key areas: driving improvements in health and care; creating dementia friendly communities that understand how to help; and better research.

30. On social care, the key proposals are set out in the White Paper *Caring for Our Future: Reforming Care and Support*, which was published in July 2012, following a public engagement in 2011. Key proposals include:

- A national minimum eligibility threshold will make access to care more consistent, and all carers will have the right to an assessment for the first time;
- People will have clear, practical information and advice on the care system and new ways to report poor quality care;
- More care workers will be trained, including an ambition to double the number of care apprenticeships by 2017. Dignity and respect will be at the heart of a new code of conduct and recommended national minimum training standards; and
- People will have an entitlement to a personal budget, and there will be more independent support to help people develop a care plan. £300m additional funding will be transferred from the NHS to social care, to develop better integrated health and care services.

**THE EXTENT AND NATURE OF HEALTH AND CARE SERVICES FOR OLDER PEOPLE**

31. When responding to the challenges of an older population in health and social care, there will need to be a balance between the responsibilities of the state and the individual.
32. Good health and wellbeing brings widespread benefits to society and the economy. We all therefore need to take responsibility for it. On the whole, people are now living longer and spending more of their lives in good mental and physical health.

33. We believe that everybody should:
   - be free to make informed choices about how they live their lives, without excessive interference from the state;
   - have the opportunity to enjoy good health throughout their lives, regardless of who they are or where they live; and
   - take responsibility for their own and their family’s health and wellbeing, recognising the impact of their behaviour on themselves and other people.

34. Supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, is central to our vision for promoting health, wellbeing and independence. The recent Government White Paper on care and support, *Caring for our future*, set out the steps that the Government, local authorities, the voluntary sector and community organisations should take in order to make it easier and more attractive for everyone, regardless of age or ability, to contribute to their own wellbeing and the wellbeing of the communities around them.

35. The Government is committed to a health service which is available to all, free at the point of use, and is based on need rather than the ability to pay. Providing financial support to those who cannot pay for themselves is also an essential part of the Government’s role in adult social care. However, the state only provides social care support to those with the least ability to pay. This leaves those with some wealth with the risk that they could lose almost all of it, if they need care. Evidence gathered by the Commission on Funding Care and Support highlighted this risk and stated that people can do nothing to protect themselves against it. With an ageing population, more people, and their families, will face this problem.

36. Since the Commission reported in July 2011, the Department of Health has been working closely with the social care sector to analyse the proposals, and other priorities for social care reform. This engagement informed the Progress Report on Funding Reform, published in July 2012.

37. As set out in the Progress Report, the Government supports the Commission’s key principles of a cap on care costs and an extended means test. This would restrict the amount that people have to pay for their care. It is our intention to base a new funding model on these principles if a way to pay for it can be found.

38. However, any such system will have a cost. At this time, the Government is committed to reducing the structural deficit, and we are unable to commit to introducing a new system. The Government needs to take a broad view of all priorities and pressures before coming to a final decision. This is why it is essential that we take this decision as part of the next spending review.

39. As we move towards the spending review, the Department of Health will continue to engage with the sector, including users and carers. This open discussion aims to resolve
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particular aspects of reforming the way care and support is paid for, to develop the reforms collaboratively.

IMPACT ON PENSIONS

40. There’s an increasing number of people over State Pension Age. This means increasing spending from the state on State Pensions and Pension Related benefits. The UK also relies more on private pensions than other countries. The last decade has seen falling membership of private pension schemes, with estimates suggesting around 11 million people aren’t saving enough for retirement. This is a significant number and together with the ageing population shows the need for further reform.

41. The Pension Commission identified that with an ageing population we have a choice between saving more, taxing more, working longer or having poorer pensioners. This is a choice for both Government in policy making, and also individuals in making decisions about how long to work or how much to save. Though pensioner incomes have been rising and pensioner poverty is at a historic low but there are concerns for the future given the reduction in numbers saving in a private pension.

42. Many reforms have already been made:

- The Government has reformed State Pension to provide a better foundation for saving.
- The Government has also increased State Pension age to balance the cost more fairly across generations.
- Equality Act and DRA abolition helped to change attitudes around older workers.

43. But we are also looking to make further changes:

- We will introduce a simpler Single Tier pension further reforming State Pension.
- Automatic enrolment is being introduced in autumn 2012 to encourage more private saving. This will be accompanied by a major communications campaign to raise awareness about it.
- We will be setting out further measures to encourage saving and to increase confidence and trust in pensions in a reinvigoration strategy to be published later this year.
The challenge of an increased older population

45. Increasing life expectancy is good news, but comes with a cost. The Office for Budget Responsibility projections for FSR 2012 show pensions expenditure\(^{163}\) rising from 5.7% of GDP in 2011-12 to 8.2% of GDP in 2060-61. Pensioner benefits\(^{164}\) remain fairly constant at around 1.2% of GDP\(^{165}\).

46. The increases in state pension age\(^{166}\) reduce the growth in expenditure but do not change the underlying trend.

47. There are risks associated with these projections. The OBR principal projections use the 2010 ONS low-migration population projections. In the old-age variant projection pensions expenditure is 10.1% of GDP in 2060-61 (pensioner benefits 1.7%). The young-age variant projection has pensions expenditure at 6.6% of GDP by 2060-61 (pensioner benefits 1.0%).

48. Other risks that may impact on the accuracy of the projections include changes in migration and overseas pension claimants as well variations in GDP, earnings growth and inflation from those assumed.

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\(^{163}\) basic state pension, state second pension, pension credit, winter fuel payments

\(^{164}\) housing benefit, council tax benefit, disability benefits

\(^{165}\) OBR use earnings to uprate these benefits. If the current policy of uprating by CPI inflation is used then Pension benefit expenditure is projected to be 0.5 per cent of GDP in 2060-61 (http://research.dwp.g...00712.xls)

\(^{166}\) Women to 65 by 2018, 66 by 2020, 67 by 2028, 68 by 2046
Central Government (Department of Health, Department for Work and Pensions and the Department for Communities and Local Government)—Written evidence

49. Department of Work and Pensions has long recognised the challenges an ageing society presents. It has been embarking on a large reform programme for many years to deal with the associated pressures. Reform is continuing in a number of areas.

REFORMS TO THE STATE PENSION

50. The key priority for this Government has been to help current pensioners and make support for them a clear priority in an exceptionally tough economic climate.

51. On coming into office the Government commenced legislation to restore the earnings link and introduced a triple guarantee for the basic state pension to increase by the highest of earnings, prices or 2.5%. This will provide pensioners with a more generous State Pension, giving a solid financial foundation from the state.

52. Alongside this the Government has protected key support, such as free prescriptions, free eye tests, free off-peak bus travel, free television licences for those aged 75 and over and Winter Fuel Payments that make a real difference to the lives of pensioners every day.

Changes to State Pension age

53. The Pensions Commission report of 2005\(^{167}\) described reform of the State Pensions system as an “unavoidable long-term trade off” between increases in public expenditure on pensions and rises in State Pension age. In order to consider this trade-off effectively, and to inform public debate on the issues, the Commission recommended that demographic data and its implications for State Pension age should be subject to regular review.

54. The rate at which life expectancy is increasing has accelerated. Each set of life expectancy projections has shown a greater increase than its predecessor. For example, since the 2007 timetable to increase State Pension age was agreed, a man retiring in 2012 can expect to spend more than an extra year in retirement.

55. It is critical that we tackle the fiscal challenge presented by demographic change now to ensure the State Pension remains sustainable over the long-term and fair between the generations. International organisations such as the IMF and OECD have highlighted that governments should prioritise reform of the State Pension age, as part of wider measures to ensure long-term sustainability of the public finances.

56. The Government has already acted quickly and legislated to accelerate the rise in the State Pension age to 66 by 2020 and it has also announced that it intends to bring forward the increase in the State Pension age to 67, subject to approval of parliament. Under these proposals the State Pension age will rise from 66 to 67 between 2026 and 2028 (as opposed to the current legislation which will increase the State Pension age from 66 to 67 between 2034 and 2036).

The table below summarises how the date State Pension age is reached has changed so far under successive recent legislation, and these latest proposals.

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The key fiscal benefit of bringing forward the increase to 67 is that it delivers net benefits-related savings of £58.9 billion in real terms, with a further £9.7 billion gained in increased income tax receipts and National Insurance contributions from people working for longer.

The graph below shows how increases in State Pension age have helped to put the State Pensions system on a more sustainable footing over time through legislation and proposed legislation. With the increase in State Pension age to 66 as a result of the 2011 Pensions Act and the proposed increase to 67 by 2028, there will be a ratio of around three people of working age to each person in retirement into the early 2030s. However even with the proposed changes, the support ratio declines in the future.

Figure 1: UK Residents over State Pension age

As longevity continues to increase, the Government believes that there is a strong case for considering changes to State Pension age in a more systematic way. The Chancellor confirmed at the 2012 Budget that further changes to the timetable for increasing State
Pension age will be required to reflect increases in life expectancy. In autumn 2012, the Government will publish more details of how a more automatic mechanism to consider changes to State Pension age will work.

**Single tier reform**

61. In addition the Government has announced that it will reform the state pension system to introduce a single tier pension for future pensioners. It will be a flat rate pension that will replace the current two part system of basic and additional State Pension\(^{168}\).

62. The complexity and uncertainty of outcomes in the current State Pension system makes it difficult for people to know what they will get when they retire, meaning it is more difficult to plan and save for retirement. There are high levels of means testing within the system, which can deter people from saving as the incentives are not sufficiently clear.

63. A single tier State Pension will usher in a simpler and fairer system that reduces the need for means testing, supports saving and so better supports automatic enrolment. It will be set at a level above the standard minimum guarantee in Pension Credit, which will help to ensure that those of working age will be able to save for their retirement with confidence.

64. The Chancellor confirmed in the Budget on 21 March 2012 that the single tier will cost no more than the current State Pension system. The Government will publish further details in the white paper in autumn 2012, with final decisions on the policy detail being taken at the next spending review. The reforms will be introduced in the next Parliament.

**ENCOURAGING SAVING AND AUTOMATIC ENROLMENT IN PENSION SCHEMES**

65. Whilst the state can provide a basic level of income in retirement, many people will need to save privately in order to realise their expectations of income in retirement. However, current estimates suggest that 11 million people are not saving enough into a pension to meet their expectations of pension income in retirement\(^{169}\).

**Automatic enrolment**

66. In order to increase savings levels, the Department has introduced a legal requirement for individuals to be automatically enrolled into a workplace pension scheme by their employer, with the ability to opt-out. The employer is also compelled to provide a minimum level of contributions.

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\(^{168}\) This follows a green paper and public consultation in 2011; the paper and a summary of responses can be found here: http://www.dwp.gov.uk/consultations/2011/state-pension-21st-century.shtml

\(^{169}\) Estimates of the number of people facing inadequate retirement incomes, DWP 2012.
67. Automatic enrolment is intended to work by playing on the inertia that currently inhibits saving. Evidence from the Department for Work and Pensions suggests that, once automatically enrolled, less than one-third will take the active decision to opt-out\textsuperscript{170}.

68. Automatic enrolment will be rolled out gradually, starting with larger employers. The new duties will not apply to small employers (those with fewer than 50 workers) until June 2015 at the earliest. When automatic enrolment has been fully introduced in 2018, there should be a significant increase in the numbers saving for retirement. Departmental estimates suggest that there will be 6-9 million newly saving or saving more into a private pension. This will be a critical mechanism to increasing the numbers saving privately for their retirement.

69. We are also examining whether automatic escalation schemes, such as the Save More Tomorrow\textsuperscript{TM} schemes which exist in the United States, might be a good approach to increase the amount people save as we move into an automatic enrolment world.

**Increasing engagement**

70. Increasing awareness, both of automatic enrolment and more generally of the importance of saving, remains a key part of our strategy. In the Department’s Attitudes to Pensions survey, 71 percent of respondents considered pensions to be so complicated that it is difficult to understand the best thing to do\textsuperscript{171}.

71. The Department is set to launch a major communications campaign this autumn. The campaign has been underpinned by departmental research which segments the attitudes of the population to saving for retirement\textsuperscript{172}. The activity aimed at workers will provide information about automatic enrolment and explain the benefits of a workplace pension to encourage individuals to remain enrolled. The activity aimed at employers will help them understand what they need to do, and when, in order to comply with the new legislation, as well as supporting them to communicate the changes to their workers.

72. The campaign will include advertising (including on TV, national press, radio, trade press and digital) as well as partnerships with third parties and public relations. Overall, the campaign aims to create a “social norm” – encouraging individuals to save for later life through a workplace pension, and to see this as normal behaviour.

73. The Department for Work and Pensions has also published an Automatic Enrolment and Pensions Language guide, which helps to remove barriers to engagement with retirement planning and saving caused by the use of jargon and lack of clarity.

74. Increasing trust and engagement in pension saving is a critical part of ensuring people are saving sufficiently for retirement. We intend to publish a reinvigoration strategy later this year, setting out further measures to help achieve this.


\textsuperscript{171} Attitudes to Pensions: the 2009 survey. DWP research report 701.

\textsuperscript{172} *Individuals’ attitudes and behaviours around planning and saving for later life*. DWP Working Paper 72.
LENIGHT OF WORKING LIFE

Working longer

75. Increasing State Pension Age will challenge attitudes about length of working life. In addition a number of reforms have been enacted over the last decade which we would expect to make it easier for older people to continue to work, and again challenge attitudes.

76. The Equality Act 2010 and Public Sector Duty require equal treatment in access to employment and public and private services regardless of age. Experience of equality legislation in the UK and abroad suggests that over time this will impact on attitudes and practices.

77. The Default Retirement Age (DRA) has been abolished which means employers can no longer force employees to retire just because they reach the arbitrary age of 65. Now retirement ages can only be set where it can be objectively justified in particular circumstances - but this is open to challenge at Tribunal.

Flexible working

78. Flexible Working practices are key to helping many older workers to stay in the labour market up to State Pension age and have more opportunity to work longer if they wish.

79. Many older workers currently face barriers to remaining in work or returning to work due to caring responsibilities, ill health or disability –around 1 in every 6 inactive people aged between 50 and State Pension Age cite caring responsibilities as the reason for inactivity (LFS Q3 2011). Flexible working can help them manage these pressures.

80. The Government will be publishing it’s response to the consultation on extending the right to request flexible working to all employees, later this year.

Changing wider attitudes

81. The Department of Work and Pensions recently published research173 which looked at Jobcentre Plus’ readiness to deal with increasing numbers of 60+ claimants. Several Jobcentre Plus districts are looking at ways to change the way they work with older claimants, for example through tailored back to work provision. They are challenging negative perceptions and behaviours around working beyond 60 among claimants, staff and employers.

82. The Department of Work and Pensions is working with employers and employers’ organisations through a variety of forums, to challenge attitudes around employment. This is something which is not just for Government, for example the Employers Network on Equality and Inclusion (ENEI) and The Age and Employment (TAEN) are both active in the discussion, and often non-Governmental organisations will be more effective.

173 How ready is Jobcentre Plus to support the growing number of claimants in their 60s to find work – findings from a rapid research exercise.
HOUSING

Fire safety

83. A recent review of the Department for Communities and Local Government’s Incident Recording System data has confirmed that the elderly and particularly the geriatric remain particularly vulnerable to fire risk. Working smoke alarms remains at the heart of the Government’s efforts to reduce accidental fire deaths and injuries in the home. We believe Fire and Rescue Authorities are best placed to use their local knowledge and understanding of risks to consider, in partnership with other agencies, how best to deliver improved fire safety outcomes and help to protect the vulnerable from the dangers of fire.

84. During 2012/13, we will continue to support Fire and Rescue Authorities to promote the key messages to householders of having a working smoke alarm in their home, through the Fire Kills media campaign.

Housing

85. Nearly two thirds (60%) of the projected increase in the number of households from 2008–33 will be headed by someone aged 65 or over.

86. The Government is committed to ensuring that housing and planning policies positively reflect the wide range of circumstances and lifestyles of older people.

87. The Coalition Agreement includes the commitment: “We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.”

88. Laying the foundations: a housing strategy for England (November 2011) set out what we are doing to meet this commitment.

- We have protected funding for Disabled Facilities Grant, which helps fund home adaptations. By the end of the Spending Review period the national DFG budget will increase from £169m in 2010-11 to £185m in 2014-15. We have, this January, announced an additional £20m funding, bringing the total in 2011/12 up to £200m.

- We are providing £51m to local authorities for handyperson services (2011-15) to deliver small home repairs and adaptations. The independent evaluation of handypersons services, published January 2012, shows that these services offer value for money, enabling older people to live independently and reducing the need for other more costly services. Older people value the trustworthiness of these services and the protection they offer from rogue traders.
We are supporting **home improvement agencies (HIAs)**. HIAs provide a range of services to around a quarter of a million elderly and disabled households every year, including home repairs and adaptations, home safety and security measures, energy efficiency advice, and housing options advice, including help to move to more suitable accommodation if needed. DCLG funds the HIA national body, Foundations.

We are also investing £1.5m (2011/13) in the independent charity-led **FirstStop information and advice** service to enable older people to make informed choices about their housing, care and finances in later life and to access local services which can help them to repair and adapt their homes, or support them to move to more appropriate accommodation. FirstStop is also piloting a peer-to-peer service.

**89. Supporting People** services provide housing-related support to around one million disadvantaged and vulnerable people at any one time. Older people make up the largest client group (around 800,000), but only account for around 20% of spend because of the relatively low cost per person of preventative services such as alarms, wardens, and floating support.

**90.** Investment in Supporting People services enables vulnerable people to avoid crises, such as falls, and hospital or residential care admissions. This means better outcomes for the individual and reduced costs for the state. Overall net financial benefit is estimated to be £3.41bn from an investment of £1.64bn per annum, i.e. each £1 spent saves a further £2 in downstream costs.

**91.** We secured £6.5 billion investment for Supporting People, which equates to an average annual reduction over the 4 years of the Spending Review of less than 1% in cash terms. The previous Government removed the Supporting People ringfence in 2009, and so councils have had the freedom to spend the funding as they think best, in line with their local priorities. We believe that local authorities are best placed to understand local needs and set priorities accordingly. By rolling Supporting People funding into the main formula grant, we have given councils the maximum flexibility to meet their local needs in the best way.

**92.** Housing design can help older people to retain their independence for longer. Some design standards to make properties more accessible and adaptable are already required by the Building Regulations and National Standards. A choice of different types of home can help to ensure that their individual needs are best met. This can be achieved by ensuring a mix of property types, including **Lifetime Homes**, are included in new developments. The Lifetime Homes standard is widely adopted in mainstream housing developments and incorporates a range of features which makes homes more accessible and easily adaptable.

**93.** Future needs will vary considerably at a local level and we believe that decisions on the number of Lifetime Homes within each development should be made at a local level, in proportion to local need and aligned with other local housing support and information services. To help local authorities in understanding their future needs, in July 2012 the
Department for Communities and Local Government published research it had commissioned on various aspects of accessible housing to help inform local authorities in developing their policies at a local level. DCLG will also explore how this could be used to develop a toolkit to analyse current and future needs.

94. We are also supporting industry to encourage innovation, for example through the Housing Design Awards that promote innovative approaches to the design of new homes that are suitable for older people.

95. The National Planning Policy Framework: We are asking local authorities to plan for a mix of housing based on the current and future demographic trends, and the needs of different groups in the area, including older people and disabled people. Their evidence base should ensure the plan meets the full requirements for housing in the area.

96. The recent care and support White Paper, Caring for our future, announced a new care and support housing fund, worth £200 million over five years, to support the development of specialised housing for older and disabled people.

CONCLUSION

97. In conclusion, the demographic change of an increased older population will bring new challenges across Government. It will affect areas of policy such as pensions, health, social care, housing and longer working lives, amongst many others. Current policies and future reforms should be informed by this demographic change.

11 September 2012
TUESDAY 9 OCTOBER 2012

Members present
Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope
Baroness Tyler of Enfield

Examination of Witnesses

Shaun Gallagher, Acting DG for Social Care, Local Government and Care Partnerships, Department of Health, Trevor Huddleston, Chief Analyst, Department for Work and Pensions, James Richardson, Director, Fiscal and Deputy Chief Economic Adviser, Fiscal Group, HM Treasury, and Jon Bright, Director of Homelessness and Support, Building Regulations and Climate Change, Department for Communities and Local Government

Q56  The Chairman: Good morning and welcome. I am Geoffrey Filkin, the Chair of the Committee. Thank you for coming. I will not go around and introduce the Committee because you will know many of them and can certainly see their names if you need to. We have quite a lot, in fact an extremely large amount, of ground to cover, so we will move straight in. We have read your CVs. Are there any introductory remarks you want to make? If not, we will go straight into the business.

We have slightly changed the order of the questions, partly because some Members of our Committee have to go to other parts of life. You have had sight of all these questions so you should know roughly where we are coming from. We probably will not cover all the questions, because there is an enormous amount. We will certainly want to ask you to put in writing responses to ones we have not covered and we may want to add some
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supplementaries to that. I would be grateful for your tolerance on that. We are going to go straight to questions about the fiscal issues and fiscal projections.

Q57 Lord Griffiths of Fforestfach: Given the demographics we are facing at present, with the ageing population, when you are making fiscal projections at the Treasury or Office for Budget Responsibility, do you assume, given current trends, that taxes will have to rise or the provision of public services will have to fall because of the pressures?

James Richardson: I should pick this up. There are two things worth saying. First of all, the projections are made by the Office for Budget Responsibility, not by the Treasury, so they are independent. If you look at its figures they show that pressures build up from demography over the next 50 years. Clearly Governments will face a set of choices in the fiscal space.

The starting point is that you cannot borrow your way out of this problem; it is a structural problem that will be there indefinitely. It is driven by people living longer, which is a good thing. In the end you have to make some choices about how you address that. Those choices could involve putting up taxes; they could involve reducing spending in other areas.

There are other things that one might do. In the pensions space, which is obviously one of the biggest drivers of increased cost, we have seen successive Governments raise the pension age. We are in the middle of major reforms to public service pensions; there is a Bill before the House at the moment. That drives costs the other way. So on public service pensions you will see the OBR’s projections now show almost 1 per cent of GDP saved on the cost of that over the full projection. On the state pension, costs continue to rise but they rise more slowly at certain times because of increases in the state pension age. Future Governments will have choices to do more there. So there are alternatives within the policy.

In the other big area of health and social care, one will also look to efficiency improvements and so on to make up part of the story. I suspect that the story will be made up of all these components but there are a range of choices available for future Governments.

Lord Griffiths of Fforestfach: I see that there are a range of choices but to me the key question is: without changing the parameters of policy, if we carry on as we are, am I right in thinking that we will have to either raise taxes or cut expenditure unless we redefine the pension age or something like that?

James Richardson: On the basis of current policies, as projected by the OBR, the Government would need to make savings of around 0.4 per cent of GDP per decade if it wanted to have a sustainable level of debt at 40 per cent of GDP. If you had a slightly higher level of debt you would need lower savings; they did projections at 75 per cent as well. To get that baseline figure they say 0.4 per cent of GDP per decade.

To put that in context: the current consolidation is reducing the structural deficit by 8.5 per cent of GDP over somewhat less than a decade. So it is a challenge for the fiscal position, undoubtedly, and it is the biggest long-term challenge from demographic and technological change in health, but it is not something that is unmanageable compared with things we are doing at the moment or compared with changes that past Governments have made in the composition of public spending.

Q58 Lord Tope: We are going to jump to local government now, as I have to go a little early to deal with the Local Government Finance Bill. Can you tell us a bit about how DCLG works with local government to assess the demands and challenges of an ageing population,
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and in particular what steps the Government are taking regarding the planning system and housing stock, to try to meet that challenge?

**Jon Bright:** First, in terms of calculating local authorities’ allocations, the annual local government finance settlement is based on population estimates, so this will take account of age bands in different places. The money that local authorities get will be based in part on the nature of their population and how that population is going to age over time. In terms of the planning, the national policy planning framework has recently been reduced from many hundreds of pages to a few tens of pages, but we have strengthened the reference to the importance of planning for an ageing population within the national policy planning framework. That now puts a requirement on planners to take account of the demography of their area when planning, to make sure their plans are properly evidence based.

**Lord Tope:** Are they also looking to the longer-term future—not just the next year or two?

**Jon Bright:** Absolutely. They are looking at demographic trends, which vary fairly significantly from place to place.

**Baroness Morgan of Huyton:** What does the Department do in terms of actually getting underneath that and assessing what is really happening and what are the real challenges on the ground—whether it is about the elderly being in houses that are not suitable for them any longer and so on? What serious thinking is the Department doing on the more challenging areas to do with housing?

**Jon Bright:** The first question I answered was around the planning framework, so that creates the framework within which local authorities should be thinking about planning and housing for an ageing population. The general disposition of the Department is to give people choice. So, for those older people who want to remain in their own homes, there is a suite of programmes available—such as the Disabled Facilities Grant, Home Improvement Agencies, handyperson services, the Supporting People programme—which are, by and large, managed by local authorities to enable people to remain safely, successfully and independently in their own homes.

For those older people who do not want to remain in their own homes and want to move to more specialist housing, the planning framework should be creating an increased supply of housing for an ageing population—£300 million has recently been made available by the Department of Health for housing for disabled and older people. There are various bits of guidance, such as the guidance on *Lifetime Homes*, *Lifetime Neighbourhoods* and the HAPPI report produced by Lord Best.

There is another bit of work we are doing in the Department, with the Homes and Communities Agency. We would have thought the market would generate more specialist housing than it appears to be doing. We are trying to understand why it is not producing the housing we thought it would be and there seem to be a number of disincentives, on local authorities and the developers, which make it more difficult for the market to provide. So, with the Homes and Communities Agency, we are looking closely into this to understand how these disincentives operate.

**Lord Tope:** What sort of disincentives are there?

**Jon Bright:** For example, if a local authority goes out of its way to build more housing for an ageing population it may be worried that more older people will come and live in that area, thereby increasing their adult social care costs. Developers may be disincentivised to build
more housing for an ageing population because they may not think the demand is there; the consumer may not be aware of what is available to them and older consumers will remain in their own homes, sometimes substantially under-occupying their own homes. Therefore, if we get the supply right and can get the incentives in the system right—and this is a proposition that has been put to us by Lord Best—more older people would happily move from their family home into more specialist, perhaps smaller, accommodation, thereby freeing up a large amount of family housing for the wider population. We are actively engaged in these discussions with the Homes and Communities Agency, the other Departments and a number of local authorities.

Q59  Lord Bichard: I have two supplementaries, one related to that specifically. The providers of extra care housing said in their evidence to us that they are unable to build in the way they would wish because of the planning restrictions placed upon them and because their housing is regarded in exactly the same way as any residential development would be and that does not need to be the case. Is that so? If it is, who can do something about that? What is the timescale for the work you are talking about? That seems to be very important. I would also like to ask a second supplementary but it is not for you, you will be glad to know.

Jon Bright: I think the developers have a point. As I said, the incentives at the moment, for example the new homes bonus, may disincentivise the building of homes for older people because you will build fewer homes in a particular development. I mentioned the issue of the community infrastructure levy and various planning issues around Use Classes Orders. We need to get under the skin of this to better understand how they are operating as disincentives in order to come up with options for responding to that.

Lord Bichard: What is the timescale?

Jon Bright: We are on the case now. We had a meeting with the HCA to talk about this very issue a few days ago. We are doing it now and we expect to be asked to feed through our thoughts into the various housing strategy statements that will be coming forward over the next few months. The housing strategy was launched last November. There is going to be a one-year-on document and we expect to be feeding into that.

The Chairman: So you will have work in progress by Christmas on that.

Jon Bright: I hope so. If I may, I will get back to you with the timescale for this work because I do not want to overcommit and raise expectations.

Q60  Lord Bichard: My second supplementary derives from the question and your answer. You talked about the importance of people being able to stay in their own homes if they are able to do so; everyone is telling us that. A lot of people have a lot of equity. I am looking to the Treasury representative on this. We do not seem to have found a way of unlocking what is a significant resource. I am interested in what deliberations and considerations have gone on around this in the Treasury and what discussions may have taken place with the bankers or the building societies about this. It seems to be key to a lot of the things we are looking at.

James Richardson: It clearly is something that comes up very substantially in the policy debate when one is looking at how you fund areas. Social care is particularly where it comes up but it is a broader question. There are things that one could do and there are proposals. For example, there are Dilnot’s proposals around enabling people to defer payments by using the equity in their property. So there are things that one can do.
At the same time there are more fundamental questions that underpin that; about who is going to pay for what. Is the individual going to pay, is the state going to pay or do you have an insurance model that sits somewhere in between? Saying that this resource is available is implicitly assuming that you want the individual to pay. If you do want the individual to pay there is a question around the means by which you assess that. You are taking the approach that you want to assess that on people’s wealth and their housing wealth. That is not an approach that is taken very widely in the UK system, outside of support for housing itself. So Housing Benefit and residential care, which includes a substantial housing element, are currently means-tested against housing but other support from the state is not. So there are certainly things that one could do but they would be quite significant changes and are beyond the kinds of things we are already looking at on the back of Dilnot, which are about enabling people to free up the resources, if they wish to themselves. Of course, such products also exist in the private sector but they are not very widely taken up and there are big adverse-selection issues.

**Lord Bichard:** There are good reasons why they are not taken up, are there not? That was my question. You have given a very good exposition of some of the issues. I am trying to get at whether it is a very live issue in the Treasury. It seems to be such a huge potential resource and people are not going to use what is available in the private sector at the moment, although that could be changed. Is the Treasury treating this as a major issue for consideration? Can we expect something from the Treasury in the next six months on this?

**The Chairman:** Irrespective of what you decide on Dilnot; it is not just a Dilnot issue.

**James Richardson:** We are not looking at whether we should means-test a whole series of currently free public services on people’s houses. That is not the Government’s policy. Have we considered in the broader context how one could do this? Well, of course, these issues have come up over many years and the Treasury has considered those things. Are we actively looking at introducing a series of asset tests in either the health system or pensions? No, we are not.

**The Chairman:** We were not asking that. We were asking how to make an equity release market more effective for those people who wish to take advantage.

**Lord Bichard:** Is there an equity release market somewhere else in the world that is working effectively?

**James Richardson:** I do not think there is. It is a market that does suffer from quite considerable market failures. We have had discussions from time to time with the providers of these products about some of the issues there and, as I say, there is this proposal from Dilnot that would have the state provide that. That is something you could do but it would score in the public finances, so it would be a use of the Government’s fiscal space and that would have to be considered against alternative uses of that fiscal space.

**Lord Bichard:** I understand the complexity of the issue; I understand it is not easy; and I understand the private sector is not currently working. The simple question was: is this a matter for live consideration at the moment? Can we expect the Treasury to be producing something in the foreseeable future to try and crack this problem?

**James Richardson:** We do not have a plan to bring forward a policy in this area imminently.

**The Chairman:** The answer is no. Is there anything from DCLG on this? Is it right that DCLG has the lead on equity release?
Jon Bright: Perhaps I might give an example of a related approach that has been taken by some places, which is to enable older people who want to retain the equity of their home but want to move to something smaller and more specialised to let a housing association manage their property. They will then rent that property to another family and use the rent to pay for their specialist housing so they hold on to the equity. That is a slightly different question but it is a way of using their equity.

Baroness Shephard of Northwold: If the Treasury is not taking a lead on this, is anyone across Government, or any Department?

Shaun Gallagher: I am Shaun Gallagher from the Department of Health. James Richardson has already mentioned the Dilnot report. One of the publications the Government put out in the summer was our response so far on Dilnot's recommendations. One of the things we said we would do is to work with the financial services sector to look at where there might be possibilities for a market to develop in relation to paying for care. That does not fully cover the broader question Lord Bichard has asked, but there are some discussions under way on that particular area.

On the broader question of Dilnot, in a sense the issue here is that people do already use their housing assets to pay for care but they do so rather inefficiently, with great unhappiness and a sense of unfairness about the way it happens. The outstanding question as to how the Government responds to the Dilnot recommendations—whether we pursue those and, if so, how and when—is essentially about trying to equalise and pool risk across that area. In relation to paying for care that is still a live discussion but that is only one use of the assets that people hold.

Baroness Shephard of Northwold: So the answer really is that you are going to wrap it up in Dilnot bit by bit, but nobody is the lead Department.

Shaun Gallagher: We are having discussions about what possibilities there may be in relation to paying for care, which is one major use, but that is as far as that goes.

The Chairman: Eloquently put.

Baroness Finlay of Llandaff: Listening to you, it sounds as if there is a risk of perverse incentives potentially coming in, if you look at Dilnot in isolation. Can I ask about housing? When somebody wants to move into more suitable housing they often need to take some kind of bridging loan or mortgage to tide them over, because they are not necessarily able to sell straight away. Are you in discussion with those who might lend to look at more appropriate lending rates? At the moment those people over 65 are quite severely penalised financially and can find it almost impossible to get that kind of mortgage to bridge them over so they can move into more appropriate accommodation and free up equity.

Jon Bright: No, we have not been in touch with lenders on this issue but I will certainly go back and consider that point. There is an organisation the Department funds called FirstStop, which gives advice to older people. It will not necessarily give advice on loans and equity release and so on, but it can help older people identify the best places for that advice. I will take that question back, though, if I may.

Q61 The Chairman: Could you tell us what mechanisms exist for considering demographic projections as part of the policy-making process? We are tending to focus on ageing as a significant one but clearly it is affected by fertility and migration. We are really interested in those medium-term to long-term projections, particularly their reliability. Ageing is fairly certain and we are going to see lots of debate about morbidity and mortality.
How does that get looked at in a holistic way by Government as a significant change to our society and what are the policy implications of that?

**James Richardson**: Shall I talk about the OBR side of it and then colleagues can talk about the wider public services? In terms of the Fiscal Sustainability Report and the fiscal challenges, obviously the OBR’s Fiscal Sustainability Report is a key part of the fiscal framework. It is one of the things the OBR is required to do every year and builds on the previous Long-Term Public Finance Report done by the Treasury. That is then considered through the Treasury’s standing fiscal fora—through the Treasury’s fiscal risk group and fiscal strategy group—and the various interests around the Treasury, which then interact with Departments, that are represented on those. So we can make sure that within the Treasury we are joining up across the set of policies.

Then, from a Treasury point of view, it is largely a set of issues around pensions, both the state pension and public service pensions, and then around health and social care. We typically then follow those up bilaterally with the relevant Departments. On public service pensions we are the lead Department so we then follow that up multilaterally with all the Departments that have an interest in public service pensions. There is obviously a major reform under way there, which is informed precisely by these demographic challenges. That is not so much from the OBR as from Lord Hutton’s report, but there is essentially the same fundamental analysis informing that.

In pensions, this is obviously the biggest issue; it has been for many years. It has informed a series of changes in pension policy and those are discussed continuously between the Treasury and the Department for Work and Pensions. Within health and social care, it is one of a series of issues. The timescales are slightly different here. If you want to change anything in pensions there are very long lags between when you make a policy change and when you see the impact. You really do have to consider these issues a long way out. Within health and social care, although one cannot make changes overnight, the lags are not quite as long. You do not have to be asking what the Health Service will look like in 2050 today, whereas even the OBR’s projections do not show the full set of savings from the public service pension reforms that are before the House at the moment. If you want the full implication of that you have to go out to about 2080, which is beyond even the OBR’s numbers. Timescales do vary and that affects the conversations and when one brings these things up. This is particularly true in those two areas: if you think of pensions as one area—although in some senses it splits between state and public service—and health and social care as the other. These are key parts of the discussion because they are so important in those areas. Some of these public service issues could be discussed as less of a fiscal concern and more of a service delivery concern. Colleagues may wish to say more about those.

**Trevor Huddleston**: Perhaps I could come in on the pensions side. What the Office for Budget Responsibility use for their projections comes from a range of forecasting and simulation models that we have. So what they publish as a single line of expenditure or percentage of GDP has had a huge amount of other work going in to produce those numbers. We have simulation models that run out to 2075 and 2100, which look at not just demographic changes and demographic scenarios but also labour market scenarios, trends in pension coverage and different scenarios around that, trends in retirement behaviour and trends in ill health and disability in older age. We need to do this amount of detail because quite a significant part of the expenditure is on means-tested benefits. To get under the skin
of means-tested benefits you have to really know the distribution effects of policy. There is an awful lot more information that we consider within the Department with Treasury colleagues and others that actually underpins thinking in this area.

If you take recent estimates of the number of people under-saving at the moment—the number of people we think are not saving sufficiently for retirement—that involves looking at people’s behaviour and habits up to today and then projecting that forward over the rest of their lives to say what their replacement rate is likely to be. The sophistication of the tools is actually quite a bit greater than you would see from the single line in the OBR numbers. Those tools go back a long way. These are not new capabilities we have built in the recent past. They underpin the Pensions Commission analysis and people like the Government Actuary’s Department have been producing long-term projections of expenditure since just after the war. So there is a huge amount of work in this area and quite a sophisticated range of debate.

**The Chairman:** I am sure that is so but, in a sense, it is about articulating the current model, which is fiscally focused—and there are good reasons for doing so in part—and on a departmental basis. Clearly, the Government is doing lots on this issue. There is Dilnot—you will decide on that—what happened with Hutton and what will happen with the state pension age, which are all big shifts. Nobody is saying the Government is doing nothing. The central argument we have put to you is that these are big, societal changes that are going on. We are helped by them not being sudden. It would seem a classic example of the criticism Bernard Jenkin’s Public Administration Committee has made about the strategic issues not being addressed and what the Civil Service Reform Plan argued about needing more thinking in the Civil Service on the medium-term challenges. I am not really getting a clear sense of anything different in the way in which you are studying or assessing what we think is quite a big societal shift. It sounds as if it is still fiscally focused and departmentally run.

**Trevor Huddleston:** Clearly the fiscal focus is there but the distributional focus is looking at what is likely to happen, on the basis of current trends, to the distribution of income in later life. A lot of the thinking about a simplified state pension system, with a higher guaranteed basic state pension, is looking precisely at the potential spread of, or high levels of, means testing and what the incentives are to save and so on. Although the fiscal part of it is important, the distributional part is utterly key for understanding what the incentives to save are. Again, we are still talking about people’s incomes.

**Baroness Morgan of Huyton:** This is slightly going back to the previous question but it picks up on the same point about cross-Government working. This is not a criticism of you as individuals; it is about how Government works. I am really struck that there does not seem to be a joined-up approach on older people’s housing between the Department for Communities and Local Government and the Treasury. You are the lead Department talking to the banks, yet the issue of the ability for the elderly to potentially fund the period when they are moving into a smaller property does not seem to be on the Government agenda, or has not been, as far as one can tell. Are you saying that there is not any mechanism at the moment within Government, on a policy basis, to look more broadly than at very small micro issues?

**Trevor Huddleston:** This is not an area that I am that well sighted on but the Ageing Society Strategy Group meets regularly, amongst these four Departments plus the Cabinet Office. That is looking at things at an official’s level and, by the nature of the subject matter, one is looking over a reasonable time horizon. Over the next 10 or 15 years there is quite a
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lot of certainty about the way things are likely to move because we have a lot of policies still to be implemented.

Lord Bichard: Is that group looking at population projections and the like or is it a wider policy group on the elderly across Government?

Trevor Huddleston: I would describe it as much broader than just population projections, which becomes quite a technical debate among specialists in the field.

The Chairman: Are you satisfied that that is going far enough and that is adequate to deal with these issues? That is an impossible question to answer.

Lord Bichard: Can I just add a supplementary to the supplementary and save myself asking the same question? The challenge of an ageing population is one of the major issues facing this country. How often do your Permanent Secretaries meet together just to discuss the challenges of an ageing population and when did they last meet?

Baroness Blackstone: Can I add a supplementary to that? I do not think these discussions should necessarily just be at Permanent Secretary level. What kind of mechanisms are there, through the Cabinet Office or any other central co-ordinating group, to establish some sort of cross-Whitehall group looking at these issues across the piece and establishing what the really difficult ones are to solve and what priorities might be in terms of policy initiatives? Is there such a group? If there is not, why is there not and how difficult would it be to form one?

The Chairman: Then we will draw a line at the supplementary’s supplementary, you will be pleased to know.

Trevor Huddleston: I am not sure which of the supplementaries I am answering here but I will have a go. There are a couple of groups. There is the UK Advisory Forum on Ageing, which is jointly chaired by the Minister for Pensions and the Minister for Care Services and involves a range of external stakeholders, local government and so on.

The Chairman: Is that all available on the web?

Trevor Huddleston: It is. Then also there is the Age Action Alliance, which is relatively new. There are a couple of hundred bodies, including several Departments and local government reps as well as external bodies. They are looking at these big, public service delivery questions and engaging older people as the customer voice in there. So there are two significant groups looking at these big issues. Whether they are quite looking at what you are getting at I am not sure.

Baroness Blackstone: I was more getting at intra-Government debate on this issue rather than these wider stakeholder type groups, which are important too.

Jon Bright: Could I just add a little to that? I would not want you to get the impression that we are not working cross-departmentally. My Department has been working closely with the Department of Health over various grant regimes: the Disabled Facilities Grants and the £300 million recently identified for housing for older and disabled people. There is a lot of close working around that issue. There is an ageing strategy board, which consists of directors from the relevant Departments. We meet six-weekly. We will no doubt be talking about some of the questions you have been asking us today, how we might respond to them in a more medium-term way and consider whether we do enough across Whitehall on these issues. There is a lot of debate and discussion between our respective Departments on this.

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**The Chairman:** From this conversation it has come out that there are a number of processes in place, with both external and internal players. Could you put that in a consolidated note for us so we are sighted on it? Also, if I could tease this out a bit more, what would you think are some of the ways you ought to be taking it further to better address this? We will leave that with you.

**Lord Mawhinney:** Can that note include an answer to Lord Bichard’s question, which has not been answered?

**Shaun Gallagher:** Was that the question about the Permanent Secretaries? This is not a complete answer, but a partial answer is that there was a meeting between the Permanent Secretaries of the Department of Health and the Department for Communities and Local Government; in fact it was a joint board meeting, two weeks ago, I think, to talk about the challenge of funding care within an ageing population.

**The Chairman:** So they discussed an important aspect of it.

**Shaun Gallagher:** Yes; and it included the link to things like community budgets.

**Q62 Baroness Tyler of Enfield:** In a sense, we have already got very much into this because this whole question is about strategic, long-term planning for an ageing population and the sorts of processes within Government to plan and prepare for this. We have already started to talk about this. You have talked about some of the groups that already exist to try and look at this on a cross-Government basis. Are there some officials or advisers who are really focusing on the longer term—I am thinking about a 15/20/25 year timeframe—and some who are focusing on the short term, say the next five years, or is it the same people who are doing both? If it is the first, how are those two pieces of thinking brought together?

**Trevor Huddleston:** Let me start with the point of view of the Department for Work and Pensions. There are so many elements of what we do that relate to the older people’s question that there are a range of teams doing shorter-term and longer-term pieces of work. For example, for the teams working on pensions policy the natural frame of reference is 40, 50 or 60 years ahead, as well as the transition for how you get there. Obviously there are a whole raft of things legislated for that have not yet been implemented, such as subsequent increases in state pension age and things like that. There are then shorter-term questions around extending working lives. What we can do to improve the employment rates of older workers both before retirement age and after would be a current discussion, whether that involves influencing employers, ensuring people are being signposted and having the right training if they are unemployed and things like that. So naturally there is a range of timescales, with some that fall in the middle concerning incapacity benefit policy and things like that.

**Baroness Tyler of Enfield:** I recognise that this is pushing you a bit but we have had a discussion about what the existing processes are across Government and we recognise it is complex and difficult to join up these sorts of issues. What scope do you think there is for Government to improve the way it looks at these big issues in the round? In an ideal world, what would you like to see happening in Government to enable Government as a whole to have a more joined-up approach to this?

**Trevor Huddleston:** Let me have a techie answer and then others can correct me. What was transformative in thinking about pension policy was the creation of a model we call Pensim2, which simulates a whole raft of changes in society. Effectively it models people
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entering the labour force, ageing, getting married, having kids, divorcing, becoming disabled, buying a house, retiring, saving, earning or whatever it happens to be. It models the life course. In order to do that you need to have the right data and we did have the right data and the right computer power.

What made the Turner Commission very influential was that the evidence base was very strong. What we started to explore with colleagues from the Department of Health was how we can build social care issues into that. That is an area that is not well served by some of our survey data sets. Having an integrated tool that can put all these things together becomes an enabler to that sort of policy making. It has to be said that these tools are incredibly complex and covering that many different aspects is a real challenge. We would describe our analytical tools in this area as the best in class, probably in the world, or as good as anyone has in the world. The more you try and do these models the more complex they get and, in some senses, the more at risk you are of losing the ability to look in detail at a specific area.

**Baroness Tyler of Enfield:** Thanks, that is really interesting. Could I just press you on that point? How much time do you or any of your colleagues in Government spend looking at how other countries are approaching this whole issue of preparing and planning for an ageing population?

**Trevor Huddleston:** We are in regular contact with countries around the world to try and learn lessons for pensions design, auto-enrolment, extending working lives and active labour market policies. Then on things like simulation tools we have had a lot of contact with colleagues in Australia, Canada, the USA and throughout the EU to try and work out the best way of bringing the evidence to life in these areas.

**James Richardson:** It is a regular topic of conversation in fiscal fora, not just bilaterally with other countries, but the IMF and the OECD are very focused on these long-term issues. They are regular visitors to this country. We had the OECD here this week; we had the IMF the week before last; there is a constant dialogue. It is very useful talking to those organisations because they can give you a broad picture over a number of other countries without the expense of visiting far-flung countries. You can pick up a broad sense of what is happening. The long-term fiscal challenges are there for a whole range of countries. In fact, they are much steeper for some other countries than they are for the UK. They are very high up the priorities of bodies like that.

Other bodies, like credit rating agencies and so on, that one interacts with in a fiscal role are also concerned about these issues so there are a series of fora and discussions that naturally keep these issues on the agenda. That is always very helpful because underlying the original question is that there is a natural difficulty in thinking of issues that are in the long term. A political cycle of four to five years makes that a challenge. Some of these fora, bodies like the OBR, and things like the Fiscal Sustainability Report and the Pensim model, are ways of continually bringing your attention back to these long-term challenges and saying you cannot just not worry about these things; they are there on the horizon. Having outside bodies, in the OBR’s case as a creation of the Government, and the IMF and OECD as bodies that we are members of, and raising those is part of the answer to how you keep it in people’s gaze.

**Q63 Baroness Blackstone:** I want to ask how we make health and social care systems more effective and more sustainable in the context of a rising elderly population. This is a very big question but it is pretty central to what this Committee needs to look at, just
because of the cost of these services. I would find it very helpful if I could hear first from the Department of Health but then from the other three Departments as to how they perceive the problems here and what contribution they can make to it.

Shaun Gallagher: Thank you very much. It is a very big question, so if I go on for too long do feel free to cut in. The first point I should say is that, regardless of the detail of the projections and what view you may take of them, it is very clear that the health and care system has to respond to a growing number of older people, both in the relatively short term and in the further future. That is not just about supporting greater numbers of people but we are also conscious that we need to change the pattern of care and how it is provided to support people in the most effective ways. It is not just a fiscal or affordability issue; this is actually about responding to the needs of people and how they might be best served. It is certainly one of the issues that has been at the top of the agenda.

I would just point out that our new Secretary of State, Jeremy Hunt, who at this moment is giving his speech to his party conference, is going to be identifying how we respond to the challenges of an ageing population as one of his very top priorities as he comes into the role. In his early discussions with us it has been at the top of his list. His thinking is very much in tune with that of this Committee. There may be more that we will be talking to him about as we go on.

To summarise, the key elements that have to be in place across the whole system are, first of all, that there needs to be a broader objective not just to treat people when they face a crisis or a need for health and social care, but to support older people to stay healthy and well, stay in their own homes and stay as independent for as long as possible. Some of that is about some pretty long-term work on improving public health and wellbeing, to reduce the risk factors that people may face with growing numbers of conditions like diabetes or obesity that cause problems as you get into old age. So the public health reforms we have in place will, over time, be aiming to make a difference to that. Then, in the shorter term, there needs to be a focus on preventive support to people when they are old but not necessarily needing a great deal of support and care. This links with what my colleague Jon Bright was talking about earlier on. When the Government was working to develop its plans for care and support last year, and talking about how we might take a more preventive approach to support people to stay well and stay out of hospitals and care homes, the importance of housing came out as one of the most critical elements. That is one of the things that supported the joint work that Jon Bright talked about, which has led to the use of Department of Health money to support the boosting of more specialist housing for older people and a range of other steps to support better housing options to help people stay independent.

There are other things like voluntary and community engagement to support people to stay connected in their communities, because social isolation and loneliness is one of the biggest risk factors for people needing care and support. It is critical to take steps to support informal care—which is often the first line of support for older people—through specific services that local authorities and the NHS can offer, as well as the voluntary sector, but also steps in other parts of policy, such as flexible working to support people with caring responsibilities. All of that is about the preventative side of things.

Then there needs to be a focus, which has been increasing in recent years, when somebody does face a care need, that there are appropriate services focused on getting them back to independence and helping them regain their previous abilities. The Committee may have heard the word “re-ablement”, which has been a strong focus of services in recent years.
That can actually shift the way in which services see older people's capabilities. So you are actually helping them to recover from a fall or some other crisis and get back home, whereas previously they might have ended up going into residential care. There are other services like telecare and technology-supported care, which can make a big difference to that. Often that needs to be across health and social care working together.

One of the things we have put in place in the last couple of years to try and support that is specific funding from the NHS into social care, with the view that that should be targeted at these sorts of areas. It has allowed investment in re-ablement, telecare and other services around falls prevention and hospital discharge.

Finally, the broader issue is that across the whole health and care system, local leadership of services as they plan ahead needs to move the entire focus of support into communities and away from hospital acute care for older people and residential care, where there can be steps taken to reduce the use of those. That is a whole-system approach that needs to be led locally by health, care and public health partners, working together. I can say a bit about how we think that might happen but perhaps I could leave it there and allow any follow up.

**Jon Bright:** I would endorse the very strong point Shaun Gallagher was making about the importance of preventative work. One example is the work undertaken by Home Improvement Agencies, which are largely unsung, quite small, not-for-profit bodies. We have 85 per cent coverage across the country but these organisations have built up a very strong trusting relationship with older people and support about 250,000 elder households a year. They help carry out small, minor repairs, sometimes bigger repairs, and do the things an older or disabled person may need to have done to their home to enable them to stay there independently.

I think there is probably scope for those bodies to do quite a lot more in thinking about their business models and how they are going to expand, cope and diversify their services, so they can meet some of the more social needs of older people, addressing issues of loneliness and so on. There is great scope for the voluntary sector to do more in this area and some of them are already starting to do it. I was in Bristol recently and the Home Improvement Agency that covers the four West of England unitary authorities is a model for developing new business models, thinking about how to address a wide range of needs and generally planning to meet the diversity of needs of a growing older population in that area.

**James Richardson:** From a Treasury perspective, obviously the Treasury does not design services, we fund them, but this is one of those areas where the thing that works best from an individual's point of view also works best from the Treasury's point of view. The points my colleagues are making about public health, around prevention and re-ablement, are what individuals want to get a better service but are also ways of improving the efficiency of the health and social care system. It is one of those areas where the issue looks the same from both sides of the spending negotiation. When we ran the Spending Review in this area we looked at health and social care together and what the opportunities were for funding within the Department of Health to support some of these agendas and the extent to which the health service could integrate better with social care. Health and social care settlements are run out of the same team within the Treasury. Social care is not considered centrally with the rest of local government. Obviously it has to join up very closely because it is such a large element of local government funding but, because of these links, we have put the responsibility for social care spending alongside health spending, rather than alongside the rest of local government, and made the link that way. That also links through to some of
these broader issues, such as the Disabled Facilities Grants. That was one of the things we looked at very carefully when doing capital settlements; it scored very highly in our processes because of its read-across to social care and health.

Trevor Huddleston: There are three areas to highlight from a work and pensions perspective. One is disability benefits themselves and the role they play in making a contribution to the additional cost of a disability. Enabling people to live at home is clearly a massive link with the whole social care area.

On the prevention side, it is about enabling people to stay at work, not drop out of the labour market, and making sure that occupational health systems are best in class. A really important part of the joint work between DWP and the Department of Health at the moment is about how to incentivise and enable employers to have best-in-class systems like that. We know the links between working and wellbeing are well established.

The third one, which is another really good element of the Universal Credit system, is the link with informal care. How do you enable people to have informal care as opposed to formal care? At the moment we know in the current Carer’s Allowance system there are some quite significant cliff edges where, once you start earning above a certain level, you lose your entire benefit. What Universal Credit does, not for everybody but for a significant number, is enable people to combine different patterns of caring with part time work in a way that has not been as obvious or smooth before. Universal Credit gives us interesting opportunities to think about how we marry up informal care and part time working.

Q64 Baroness Blackstone: One of the common themes in what you have been saying is prevention. This has been a buzzword for 30 years. People have been saying, particularly in relation to the NHS but also more generally, that we must have more prevention. Yet it does not really seem to happen in terms of expenditure being channelled at it. You said that there was some transfer of NHS funds into social care. How are we really going to make prevention at the top of the agenda rather than always looking down, when acute services need money and we have all kinds of targets that relate to acute services, such as waiting list times? Secondly, in a context where NHS funding will be under a lot of pressure—that is what most people in the NHS believe and it is probably true—how are you going to make sure the funding you mentioned coming from the NHS into social care is actually going to be sustained whilst hospitals, general practitioners and suppliers of acute provision are under the cosh?

Shaun Gallagher: I will try to pick up those points. You are absolutely right, and many of the members of this Committee have seen this from the sharp end as Ministers and with other responsibilities. The history of the Health Service has a dominant focus on the acute sector and it is difficult to shift away from that. You mentioned the transfer of NHS funding into social care; that is certainly an important part of how we can try to get a preventive approach in the interface between acute care and community support.

The other thing worth mentioning is the approach to public health funding. The reforms that were taken through Parliament last year included a transfer of public health responsibility and a ring-fenced budget for public health from Primary Care Trusts into local government and with directors of public health as statutory officers of local authorities. One of the purposes of that was to try to protect that focus on preventive investment and spending, through the ring-fenced budget. It is our hope that that would help to achieve that aim.
One of the other things we hope that change will offer is that the focus of public health can be a slightly broader approach. So, rather than just a narrow medical definition of what public health is about, it fits into the broader local community focus on support and wellbeing in the population, so it can actually link very well into local authority responsibilities for community development, leisure services and other responsibilities that they have. That is one change that should hopefully make a difference.

The way the investment across into social care has been constructed means there is a requirement on NHS and local authority partners to agree between themselves what that money will be used to invest in. Central Government gives a certain direction as to the sorts of support that we expect to see there, but we deliberately do not prescribe. And that local partnership, in a sense, is the way in which people can agree how that gets used. The evidence so far is that, even in times when the NHS is absolutely feeling that funding is challenging into the future—the budget has been protected, but that nevertheless is some way short of what the NHS has been used to in terms of budget increases—there is pretty strong NHS support for the case for investing in social care, in order to have a joint benefit from that, because the risk from a shortfall in adequate social care support is that there will be a knock-on for the health services themselves.

So at national level, people like the NHS Confederation have been very strongly supportive of that work, and often at a local level, you will find that general practitioners and others recognise the validity of it. In some areas, there is actually money added to that, so the Health Service offers more than was transferred at national level.

Q65  The Chairman: Could I just add a supplementary on that, rather than come back to it? But what you are describing—and the King’s Fund put it clearly a couple of weeks or so ago—is almost a major shift in the delivery and focus system of the health and care social model. Put cruder than it ought to be, we have probably got more hospitals than we need. We have to do something about that spend there to get more funding into community care, given how we all are faced. I have not heard—tell me if I am wrong—a Minister make the argument as to why, because our health and care needs have changed, which they undoubtedly have, we need to change the structure of our health and social care system, and some of the consequences of that. I can imagine why they have not, because if you say “Fewer hospitals” or “Close a hospital”, you have a row on your hands.

But unless there is some articulation to the public about the need for these very, very big systemic changes in the way our health and care system works, people will incrementalise and fudge—let alone the understandable resistance there will be from professions, because they like their budgets and their practice, or existing institutions like hospitals. I am putting it too crudely, but it is a massive systemic change.

Baroness Morgan of Huyton: Can I add another supplementary, which follows on from the Chairman? Can you describe to us more clearly where the incentives are in the system for the change that you are talking about, because I am sure we all agree with the grand policy outline? We have all heard it for a long time; we have all probably made the same speeches, in a sense. But where are the levers that are going to make that start to happen? If you are sitting upon a foundation hospital trust board, if you are being paid per day to keep people in the beds, what is going to make you operate differently than you do now? In what you are describing, what is going to change that means there is not an incentive to keep people in those beds, but be encouraged to get them out into the community? How is that process going to happen?
Shaun Gallagher: I will try to pick up all of that. Chairman, regarding your point about “You have not heard it from Ministers”, Ministers have made the point about the shift in the nature of provision that is needed. But in a sense, what is more important is that there are voices from, for instance, the clinical leadership of the key professions to make that case as well.

The Chairman: Would you give us references for all of that, because we did not get any of that in our evidence at all?

Shaun Gallagher: I will see what we can put together in terms of where that set of statements had been made.

The Chairman: It is good news you are telling me. It would be nice to see it.

Shaun Gallagher: So the idea that there needs to be a shift from acute settings into community-based support, and that that requires a shift in the model of care locally, is pretty well rehearsed. Although you are absolutely right that it is never a politically easy thing to undertake service changes of that kind, it is also not true that they are always difficult. There are a range of changes that have taken place, for instance as a result of specialist services for stroke care with support for people in the community and the appropriate type of support, which have gained clinical buy-in and understanding in a local area. It has seen through changes of that kind to move investment into the community. It is not always an impossible thing that can never be addressed, although I quite recognise that it is difficult.

We have been saying for a number of years “How might it actually happen?” and “What are the incentives?” The first thing is that it is challenging, and it requires that shared local leadership, with a clear national approach that supports it. One of the changes that will come into place next April, from the Health and Social Care Act 2012, is the creation at local level everywhere in the country of what are called health and wellbeing boards. Those organisations are specifically designed to bring together clinical commissioning groups, in a way that has not quite been seen before, which hold: the purchasing responsibility for all healthcare; social care responsibilities within a local authority; public health responsibilities, which I mentioned before; and others, such as children’s services and housing. They will be under a statutory duty to undertake a needs assessment of the broad health and care needs of their local population, looking into the future, and to agree a joint health and wellbeing strategy as to what is needed to deliver that. The commissioning plans that the clinical commissioning groups undertake need to be in line with that.

Baroness Morgan of Huyton: When you say, “They need to be in line with that”, is that statutory? I know they have been set up, but I can imagine them being, with the best will in the world, very large talking shops. I am trying to understand how the money is going to flow in the direction that you are describing.

Shaun Gallagher: The important thing is that those health and wellbeing boards do actually act as a strategic local leader of services to support need. It would be a failure if they were simply a talking shop, and indeed the entire effort is to try and ensure they do offer much more than that. It is only at that local level that you can have a strategic plan for how services may need to change, if you can bring those voices together with a plan that is based on the needs of the local population, where there are clearly deficits in, for instance, support for older people in communities. This may include some politically controversial questions of particular services and buildings and so on. The only way in which you can really see through that sort of change, with community buy-in and engagement, including
local political buy-in, is through that shared leadership from the start. In some ways, that
sounds like a structural answer, when actually it needs to be much more than that. But I
think what we are putting in place is that set of structures that enables that local leadership
to take place.

Baroness Morgan of Huyton: They will not hold the joint budgets, will they? That board
does not hold the joint budgets across all the services.

Shaun Gallagher: They will oversee the overall strategy that is supported by the
commissioning budgets from the different parts of the system. They will also be under an
obligation, under the law, to promote integrated care across their services and to consider
joint commissioning and joint budgets if that is something that can support it. We have shied
away from prescribing that there must be joint budgets, partly because the evidence of
integrated working is that the more top-down it is, the less effective it is in generating that
local ownership. The incentives in the system are intended to support that set of changes
that I have talked about. There are elements within that that will need further work, such as
what you were talking about, which is clearly the tariff system for how hospital care is paid
for. But there is work going on to try to ensure that we do that, too.

Baroness Shephard of Northwold: Are these new boards going to be per strategic
health authority, or what?

Shaun Gallagher: They are per upper tier local authority. So if it is a county with districts,
it is for the county, but with the involvement of the districts and everywhere else it will be
around the unitary authority.

Baroness Shephard of Northwold: To whom are they accountable?

Shaun Gallagher: They are accountable, essentially, to their local population. The local
authority is accountable, locally, to those who elect the local authorities. They bring
together organisations with a range of different formal accountability structures, so the
clinical commissioning groups are accountable to the NHS Commissioning Board. There is a
shared local and national accountability for the work that they undertake.

Baroness Shephard of Northwold: So if I am an individual and I want something done, I
write to them. And if they do not do it, I cannot elect them?

Shaun Gallagher: As a local citizen, you would have an ability to influence the work that
that health and wellbeing board undertakes.

Baroness Shephard of Northwold: Yes, but there is no electoral accountability.

Shaun Gallagher: There is on the boards. The elected membership of the local authority is
a statutory part of the boards.

Baroness Shephard of Northwold: So, really, the accountability is via the local authority.

Shaun Gallagher: For the board as a whole, it is to the local population.

Baroness Shephard of Northwold: No, I am asking about the local authority. The local
population is something different. The local population is powerless unless it is electing the
people who are doing this work.

Shaun Gallagher: It is. So there is an elected membership on the board. They are not all
elected, so, for instance, there is membership of the clinical commissioning groups on the
board. There is also a local citizen consumer representative, under local Healthwatch.
Q66 Lord Mawhinney: Forgive me, but I would like to take you back to Baroness Morgan’s question, because I do not think you answered it. Some of us spent many a happy hour in the Chamber, listening to all this health and wellbeing board stuff, and indeed all the rest of it. The question is: what is fundamentally different that is actually going to change? Even when I was Health Minister in a previous generation, for God’s sake, we talked about hospitals and GPs and local authorities and social care. And it was one big happy family, and they were all working together, and the people in Peterborough had never had it so good in terms of healthcare, blah, blah, blah.

It did not work. Part of the evidence for the fact it did not work is that you felt the need to produce a whole new restructuring of the Health Service. That is as good evidence that it did not work as any. Whatever happens under a different title with different words on the top of the notepaper, we have got all of the same people allegedly working together again. Baroness Morgan asked, “What is going to make the difference, that this time it is actually going to work and change something?”, as opposed to the local authority saying, “No, we are not going to give you any of our money,” the hospital falling out with the GP and the commissioning people, and mental health not getting a look in. Her question was very specific: what is the key in this new organisation that is fundamentally going to change what has, thus far, been in policy and structural terms a failure, and make it into a big, resounding success?

Shaun Gallagher: I will do my best to answer that. There are a number of things that are different, one of which is that the leadership of the clinical commissioning groups, who essentially hold the budget for NHS services, is more clinically led. This, in some ways, of course, harks back to the earlier moves to give GPs a greater say over the use of budgets. The evidence was that it did have some impact around the configuration of hospital services.

Lord Mawhinney: Excuse me for interrupting, but GP fundholding probably was the single greatest change of primary care in our combined memory. Clinical commissioning was supposed to be a return to the old days. By the time the legislation got through, clinical commissioning groups had got about six, or eight, or 10, or 12 or 14 other people on them, as well as the GPs. In other words, you started out with a GP foundation, and by the time you finished and sent it to the Queen, it was just a new district health authority with a different name. So forgive us if we do not buy into the “Clinical commissioning stuff is the key” that Baroness Morgan asked about, because Government watered it down and watered it down under political pressure to the point where it is now just a district health authority by another name.

Baroness Morgan of Huyton: But it does not have the same boundaries, necessarily, as the local authority that is dealing with the social care budget.

The Chairman: Have a go at this question, because we have then got to have other questions.

Baroness Morgan of Huyton: It is fairly fundamental, though, to a lot of what we are talking about. I am happy to drop my later question.

The Chairman: I am not hearing an answer.

Shaun Gallagher: On the boundary question, there was a clear drive to offer clinical commissioning groups freedom to determine how they defined themselves. There is a clear match between clinical commissioning groups and the health and wellbeing boards that they sit on and serve. I am not sure how the boundaries have come out in terms of a match with
local government boundaries. In many cases, they are pretty aligned. I could give you the
detail on that.

Baroness Tyler of Enfield: It would be useful to see that.

Shaun Gallagher: I was saying that clinical commissioning groups offer something of a
difference in the local clinical leadership influence on how health services are designed, and
the tilt of the balance in the system towards a community-based and a demand-led
approach, rather than the dominance of the acute sector. I quite take the challenge that this
has been tried before, and this is not a guaranteed success. But that is one of the elements
that is different.

The other thing that is different is that the health and wellbeing boards are genuinely a
bringing together of all the partners in a stronger and clearer form than has been the case in
past arrangements, and with incentives and duties to work together across health and care.
The Government has not taken the step of a major structural merger between the services,
because it has always been felt that that would be a huge shift and change, not something to
be taken lightly. Nevertheless, the aim of the boards has been to get the strongest
partnership within those different statutory frameworks. I am not going to sit here and
pretend it is guaranteed to have the success that we would like to see, but our job is to try
to support those local boards in undertaking that leadership and taking it forward.

Q67 Lord Bichard: Sitting and listening to you this morning, and having been on the
other side of the table on occasions, I have been struck by the fact that you are well-
informed, helpful and well-intentioned. I am not, however, left with a sense that there is—
and I am sorry to come back to this issue, but it is so important to what we are looking
at—a Government approach to the challenges of the elderly, and of an ageing population.
Some people have suggested to us—I am not actually recommending this—that we should
have a Minister, but we do not have a Minister taking responsibility.

James Richardson: Can I try and offer an answer to that? I suspect it will not satisfy you
one way or the other, but let me try. The first thing I would say is that arrangements are
never perfect. There are always improvements, and I am sure the Committee will make
recommendations that will help us. We have tried a number of things in the past. We used
to have a Minister; we used to have lots of committees; we used to have strategies. Lord
Mawhinney’s test is a good one: did all these things that we have tried in the past actually
succeed in addressing the problems better than we are addressing them now?

I am not sure that all of that infrastructure necessarily meant that the critical policy issues
were being addressed more successfully than they are now. There is always a choice
between lots of top-down architecture and addressing issues with a slightly more bottom-up
approach. It would be fair to say that the current Government quite clearly is not a fan of,
for example, the kind of PSA architecture that you may have been alluding to a second ago.
It has adopted different approaches. All of these issues are being addressed within the
approach on pensions; the approach on health; the approach on social care; and the
approach on housing. People do talk to each other. Maybe it is more informal than it was under some past structures, but I do not think that is necessarily a criticism of it. It is a different approach. It is perfectly reasonable to ask the question of “Is it working better than it was in the past?” and we will welcome your views on that. But I think the fact that the system is different, and perhaps more bottom-up and more reliant on informal approaches, does not necessarily make it worse. In many ways, those kind of approaches can work much better than top-down architectures of the sort that we have seen in the past.

**Lord Bichard:** Let me rise to the challenge, then, and look at it from the bottom up. Many of the discussions that we have already had in the Committee, and much of the evidence that we have received from others, have alluded to some excellent examples of local practice. I remember Baroness Shephard, at the very first discussion we had, saying “There is a fantastic thing in Norfolk. Why is it not happening across the country?” The reality is that it does not happen across the country. No-one seems to be identifying the really good practice and trying to ensure that it is replicated. If I look at health, we have a National Institute for Health and Clinical Excellence now. In order to achieve the bottom-up—because I do not think it is happening at the moment—do we need a National Institute of Ageing Excellence? Do we need someone who is actually looking out for the good practice, and making sure it is replicated? Because it is not consistent or uniform at the moment, is it?

**Jon Bright:** We are doing that very thing. There is an initiative led by the Cabinet Secretary at the moment to explore opportunities for creating “what works” institutes, and one of the early adopters is going to be on ageing. The aim is to get this moving quite quickly. It will, in time, develop an evidence base so that local commissioners could draw on evidence of what has worked in Norfolk, or wherever else, to tackle a particular—

**Lord Bichard:** Who are these local commissioners?

**Jon Bright:** We are operating in a more localist philosophy than we did under the last Government. So Health and Wellbeing Boards, local authorities and others who are commissioning services to address the needs of an ageing population, will better be able to draw on an evidence base of what is most likely to work in that particular situation and with that particular group.

**Lord Bichard:** This is very interesting, but let us just think about how it is going to work. This “what works” group is going to come up with a really good practice in Norfolk, and it is going to say, “We ought to be doing this nationally.” How is it going to ensure that happens, if, for example, that good practice in Norfolk challenges some of the professional boundaries that exist—let us be honest—in health? How are we going to ensure this has some clout behind it?

**Jon Bright:** It does not exist yet. We are in the process of designing it, and it is a cooperative venture between the Department of Health, the Department for Work and Pensions, and the Department for Communities and Local Government, with Cabinet Office coordination. We are still scoping it out. It is unlikely to mandate that a particular approach that works in one place should be adopted in another, because in this particular policy area the evidence is not always as strong as it is for example, in the medicinal arena. But promoting approaches that have been shown to work in some areas will encourage in others to think about applying that particular intervention, rather than something else for which the evidence may not be as strong.

**Baroness Morgan of Huyton:** Is the problem not that you are back to your health and wellbeing board, but that, as a group, is not held accountable by anybody? To whom is that
group really accountable? Again, I am back to levers of influence, I suppose. If this is best practice, who is going to make sure that that group takes any notice at all?

Jon Bright: That one is not for my Department, I am afraid.

Q68 The Chairman: We would be interested in seeing the narrative you have described about the centre of excellence. None of us are saying that is not useful. The debate is about whether that is going to be sufficient, so please let us have that. It would also be interesting, because we have a session on it, to look at where there is evidence about more prevention, how it works, and whether it might be cost-effective. We would welcome a note on that as well, so we are informed of the Government’s position on that before we have our evidence session.

We are still back to the fundamental question of this session, which is whether changes to the commissioning structure and good practice are really going to overcome—put crudely—the vested interests and the inertia of the system to change fast enough according to public needs. I do not think you have got us with you on that, so far.

Lord Bichard: I do not want to be unkind, but “not for my Department” encapsulates my concerns.

Jon Bright: Sorry, I was commenting specifically on the accountability question of health and wellbeing boards.

Baroness Morgan of Huyton: Except that local government is represented on those. So if they are going to work at all, they are not the responsibility of the Department of Health, are they? Otherwise, we are exactly where we are: because they were in the health Bill, they are the responsibility of the Department of Health.

The Chairman: We have got your question to ask at the end, Baroness Morgan.

Baroness Morgan of Huyton: I am not worried about that one, actually. They can write in.

Q69 Lord Bichard: My final question is a much simpler one. I would be interested in hearing, particularly but not just from the Department of Health, about the role that you think technology has in tackling the issues that we are talking about. For some of us, looking at the possibilities of telemedicine and telecare, these are very considerable. I sense that maybe we are not moving forward quickly enough. They are also about addressing this balance between state provision and individual capacity. So could you just maybe give us a brief outline of what your position is on that?

Shaun Gallagher: You are absolutely right. Technology, and innovation more generally, is absolutely critical to improving the way in which public services and beyond respond to these sorts of needs. There has been quite a lot of work on things like telecare. There is a risk with telecare that people think that something that was cutting-edge technology maybe five or 10 years ago, is the answer, and that what you need to do is keep putting that into people’s homes. Actually, it may now be a great big clunky box, and the world has moved on.

What we need to do is to have an approach to how these sorts of services work that is much more responsive to innovation. A lot of it will probably be things like mobile applications. There are a lot of advantages that can come from the information agenda, because one of the deficits that people often feel is that they do not know where to go,
what to do, or how to make choices between different approaches. So innovation in information provision is one key part: it does not have to be machinery. But it is a central point, and I could offer to give the Committee a note that would talk about some of the things that we think may help to do that.

Q70 Baroness Morgan of Huyton: I have a final question on communication, which goes back again to the big argument with the public. If we think about the discussion we have been having about the difficult decisions within health and social care, and indeed wider issues about the ageing population, have you any thoughts or suggestions or evidence for us about how the Government is planning to take those issues out to public debate? Are there any cross-Government discussions about how to have those large public conversations? The public buy-in for any of this, obviously, is essential.

Trevor Huddleston: On the communications side, things are pretty well joined up on the Directgov websites and so forth. There is some really good stuff around retirement planning and preparing for retirement, and some really good materials and signposting there. It is a one-stop shop for advice. There has been a massive campaign going on over the last two or three weeks on things like opportunities for saving, auto-enrolment into workplace pensions, and stuff like that. There is a range of initiatives. Whether that is quite getting at where you are coming from, I am not sure.

Baroness Morgan of Huyton: Arguably, it is a question for Ministers when we see them. It is about leading public debate.

Q71 The Chairman: You can hear our argument that the evidence suggests some very big shifts as a consequence of a progressively ageing society, which challenges the affordability and the efficacy of current service models. It is barmy to think Government is responsible itself for solving all of that; it cannot be. Therefore, if you kick Dilnot, understandably, and the SPA into the next Spending Review—if you just deal with it as a zero-sum game between Departments, rather than try to articulate why we as a society, let alone we as a Government, have some choices to make about how we value our older people and care for them, and how we fund those issues and what should be the right balance between what is done through tax and the individual and how the state focuses its limited resources—it will just be the usual dog fight, will it not? It will be the usual dog fight, come what may, but there should surely be an argument that Government ought to try to set out those issues more clearly and more holistically for public debate, without thinking that Government is responsible for it all.

James Richardson: You raised the Spending Review, and how we did it in the last Spending Review. I cannot say that it will be done the same way in the next Spending Review; the Government have made no decisions on that yet. But we did have far more public engagement and debate in the last Spending Review than in any previous Spending Review. That is not to say that we could not do more.

The Chairman: That reinforces my point, does it not?

James Richardson: One of the things that we learned from doing that is how we might do it better in future. We did engage the public, generically, through websites and invitations to send in comments. We had over 100,000 submissions from members of the public in terms of the last Spending Review, but then also through expert roundtables around a series of themes. I am afraid that I cannot remember precisely what they were on. We set up a challenge group where we got people from outside the relevant Department to come along
and probe what they were doing. These were all new innovations in the last Spending Review. Because it was done over a short-ish period of time, I am sure they could be improved, but that kind of approach does create the opportunity for people to have these kinds of discussions. It certainly was designed precisely to avoid it becoming a purely bilateral discussion between the Treasury and a single Department.

**The Chairman:** Let us have your thoughts when you can about how you might better address the issues we have talked about as part of the next Spending Review. Could I ask Mr Huddleston, because clearly you have a bit of an overarching role on all of this, have you not? What is your response to our suggestion?

**Trevor Huddleston:** I was reflecting on the debate that was started by the Turner Commission, and I do not think that debate has actually ended. I think it is ongoing. Almost every day, there are things going on that are a consequence of decisions that have been taken by a range of Governments in the past. The fact that we are equalising the state pension age as we speak was a decision taken 17 or 18 years ago, having profound impacts on the labour market and some remarkable increases in employment levels amongst older workers at the moment. In the last week or two, we have had auto-enrolment into private pensions. It is the start of a massive journey, but it is once you start getting these things live that the debate then becomes something that is no longer theoretical stuff on a piece of paper.

The issue about saving in pensions, the issues about working longer, the links with later retirement for public servants—it seems to me that this is quite a mature debate that is now being had. It has almost become the DNA of discourse: rather than a set piece, let us have a look at the trade-off between working longer, saving more, and higher taxes. It seems to me that that is the stuff of what is happening at the moment.

**The Chairman:** It is happening in part. The question, essentially, is whether you think that we should be doing more of that, and there are mechanisms to better feed and inform that debate over the next few years.

**Trevor Huddleston:** For me, the plan to bring forward a simplification of the basic state pension will itself create a further debate. There is a question about whether all of these issues together are insufficient, or whether when one then reflects on it, one says “Well, actually, there is a need to do something more.” For me, rather than to say, “We need to plan now to do a significant consultation”, there would be a question of whether there is a need, or whether we have stuff in place that is provoking that debate.

**The Chairman:** I have heard it. We are over time now, and on behalf of the whole Committee I would like to thank you. It has been extremely interesting. There is lots of interest and lots of worries there, as you understood. We asked for quite a lot of information; we would like that through to us. We look forward to exploring some of these issues: both with you, if we need a further follow-up, and certainly with relevant Ministers at the end of our process. Thank you very much indeed.
Central Government (Department of Health) – Supplementary Written Evidence

PREVENTION IN ADULT SOCIAL CARE

Purpose

1. The purpose of this note is to set out the Department of Health’s position on prevention within adult social care including the cost-effectiveness of spending money to prevent older people from having accidents or having to go in to hospital.

Context

2. Prevention and early intervention is one of the key principles, which lies at the heart of the White Paper ‘Caring for our Future: Reforming Care and Support’. The White Paper confirms that we should do everything we can – as individuals, as communities and as a Government – to prevent, postpone and minimise people’s need for formal care and support. The system should be built around the simple notion of promoting people’s independence and wellbeing.

Defining prevention

3. Prevention can be concisely defined as “services that prevent or delay future intensive interventions”. It is useful to consider three different types of prevention. Primary - people with no symptoms of illness to maintain good health, delay significant disability or prevent reoccurrence of an illness. Secondary - identify people at risk or those who have existing low level needs. Tertiary - minimising disability or deterioration from established diseases and maximising rehabilitation.

4. It can be difficult to distinguish Social Care based prevention from NHS or public health prevention, and the benefits of either delivery mechanism can be felt in either sector.

The evidence base

5. A health and social care system that intervenes at crisis points rather than in a preventative manner is likely to deliver poorer outcomes. For example, too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place. There is however a scarcity of evidence on the cost-effectiveness of prevention. The evidence that exists suggests that it is cost-neutral at best rather than cost-saving.

6. There are a number of barriers to implementing preventive measures locally. These include risk aversion and pressure on resources (with immediate needs taking priority over lower needs), identifying and targeting potential recipients and difficulties in measuring success.

174 Department of Health, Shaping the future NHS: Long term planning for hospitals and related services consultation document on the findings of the national beds inquiry, 2000
7. The evidence on the potential for net cost savings from prevention is inconclusive and could suggest that there are at best only marginal net cost benefits. However, there are pockets of evidence that we can highlight which suggest that there can be the potential for net savings in health and social care usage, examples include: the national telecare initiative in Scotland and the Whole Systems Demonstrator programme for telehealth and telecare in England, and the Partnerships for Older People Projects (POPP) programme.

8. The findings of the national evaluation of the POPP programme indicate that the projects as a whole had a potential to improve the quality of life for participants and the potential for considerable savings, as well as better local working relationships. For example:

- for every £1.00 spent on the POPP services, there was a marginal cash saving of £1.20 on emergency bed days (confidence interval £0.80 to £1.60). In addition, there were estimated to be savings in use of community services and reported improved quality of life which have not been monetised
- overnight hospital stays were reduced by 47 percent and use of accident and emergency departments by 29 percent
- reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total average cost reduction of £2,166 per person
- efficiency gains in health service use appeared to have been achieved without any adverse impact on the use of social care resources
- the quality of life of those using services were reported as improved, to varying degrees depending on the nature of individual projects
- 79 per cent of respondents agreed that partnership working between the local authority and voluntary and community sector providers had been improved.

9. Recent DH modelling of reablement suggests that although it leads to substantial savings in home care, over the course of the first 12 months it is broadly cost neutral because of the cost of the reablement package. However, there is potential for savings over a longer time period.

10. The picture is more positive with regards to Quality Adjusted Life Year (QALY) gains from social care prevention – including some of the community based support initiatives identified within PoPP. Evidence suggests that adding these gains to cash releasing savings can often make preventative interventions cost effective.

**Prevention of falls in older people**

11. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. In 2010-11, 348,115 people were admitted to hospital as a result of a fall, and fall injuries accounted for more bed days than stroke and heart attack admissions combined. Resulting injuries in older people, i.e. hip fractures, can lead to loss of mobility and independence – requiring a subsequent move into a care home for many. Older people also have the highest rate of deaths due to falls – with 30 per cent of those suffering a hip fracture dying within a year.
12. Falls in older people can be reduced through public health interventions. There is a concerted programme of activity underway with regard to falls prevention – with leadership from local clinicians and managers, charities and advocacy groups, expert researchers and clinicians, colleges and specialist societies. The work is supported by a range policy levers and resources from central Government including:

- A falls and bone health commissioning toolkit (first published in 2009);
- A ‘Blue Book’ produced by clinical leaders to show best practice;
- National audits and databases to share information;
- Best practice tariffs for hip fractures; and
- A NICE Quality Standard on falls (published in 2004), which will be expanded in due course.

13. In recognition of the scale of the problem, the Department will be including two indicators in the Public Health Outcomes Framework (falls and injuries, and hip fractures in the over 65s), which will come online from April 2013.

Other levers and enablers to support prevention and early intervention

14. Shifting emphasis towards prevention and away from crisis response, demands a whole systems response with health, public health, housing, care and other services working together to help maintain older people to maintain their independence.

15. An example of this approach is the “Hospital2Home resource pack” launched by Care and Support Minister, Norman Lamb on 26 October 2012. The resource is designed to make it easier for health and social care professionals involved in hospital discharge to support older patients in returning home safely after a hospital stay and reduce the risk of readmission to hospital.

16. The Outcomes Frameworks for the NHS, Adult Social Care and Public Health have been designed so that indicators relevant to older people feature in each of the frameworks to promote prevention, support for wellbeing and recovery from illness, across the whole system.

Supporting greater investment in prevention

17. To improve the current evidence base and to promote greater investment in preventative care, as part of the White Paper *Caring for our Future: Reforming Care and Support* we are establishing a library of evidence in 2013 and are making funding available in 2013 for a Social Impact Bond Trailblazer Programme to encourage innovative new forms of investment in preventative interventions.

18. Under SIBs care commissioners pay providers by results for the provision of preventative services. On the promise of these payments, care providers are able to attract social investors to pay for the upfront capital costs of the intervention. As a payment by results tool, the bonds ensure that taxpayer funding is used only if services are successful. Social investors weigh the social and financial returns they expect from an investment in different ways. They will often accept lower financial returns in order to generate greater social impact.
Central Government (Department of Health and Department for Work and Pensions) – Further supplementary written evidence

**Central Government (Department of Health and Department for Work and Pensions) – Further supplementary written evidence**

**DWP’s answers to the questions posed to the Department by the House of Lords Select Committee on Public Services and Demographic Change**

**Consideration of fiscal projections**

**What might the Government have done differently 10 or 20 years ago if they had had access to good long-term fiscal projections?**

In the pensions landscape the implications an ageing society would have upon pensions adequacy and public finances has long been recognised. In December 2002 the then Government set up the independent Pensions Commission to review the longer-term challenges faced by the pensions system and make recommendations for reform.

The current Government took the view that as life expectancy was rising faster than it was predicted to do at the time of the Pensions Commission’s 2nd report, it was necessary to bring forward increases in State Pension age in order to maintain the stability of the pensions system [and is now looking at a mechanism to update regularly]

The 2011 Pensions Green paper consulted on the mechanism for regular reviews, and Budget 2012 committed to ensuring that the State Pension age is increased in future to take into account increases in longevity.

Also successive Governments have had access to good long term projections of expenditure on state pensions. Initially from GAD and now from DWP. These long term projections were important in informing decisions in the 1980s to curtail the likely growth in SERPs and the decision in the 1990s to equalise SPA at 65.

A dynamic microsimulation model, Pensim2, was created in early 2000s to provide distributional analysis of trends to complement the aggregate analysis that has been available for many decades. The Pensions Commission used Pensim2 to underpin its final recommendations and the model has also underpinned the current government’s decisions to accelerate the speed at which the SPA will increase.

**Employment**

**What steps are the Government taking to foster the employment of older people? What followed from the Social Exclusion Unit’s review of education and skills policy as it affected older people?**

OECD looked at older workers employment across countries and in 2006 they published a number of recommendations for the UK[^175]. Included were:

Further pension reform to simplify the system and make incentives to work clearer, a higher universal basic State Pension and increases in State Pension Age. Single Tier — and other pension policy - will meet this recommendation.

Take further steps to prevent disability related benefits being used as a defacto early retirement scheme — the move from Incapacity Benefit to Employment Support Allowance will do this.

Measures to increase the willingness of employers to hire and retain older workers. Including abolishing mandatory retirement age, which the Government has done with the abolition of the Default Retirement Age, including a significant programme of engagement with employers to help them adjust to the new legislation. (We worked through the Age Positive Initiative which worked with Sector Lead bodies such as the Federation of Master Builders and the British Retail Consortium.)

Strengthening older workers employability. (The OECD recommended building on the New Deal for 50+.)

On supporting older claimants

We recently published research on how ready jobcentre plus is for older claimants.

Jobcentre Plus has been delivering the new flexible support model for claimants since April 2011. The new flexible model has three elements: a core regime of regular face-to-face meetings, flexible adviser support and a flexible menu of support options, these include

- skills provision and job search help using a Support Contract which includes improving job search and getting ready for work core modules that are nationally available;
- Get Britain Working measures and provision funded through the Flexible Support Fund and European Social Fund.

A number of Jobcentre Plus districts are using their flexibilities to provide tailored support to older claimants — building on the research that has been published — which can include specialised advisors, and training tailored at older claimants etc.

The need for this varies depending on the demographics of the area.

On financial incentives to work longer

Research carried out for the OECD identified two areas where financial incentives to work longer in the UK were weak:

- Around disability related benefits, which changes to ESA are tackling.

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Central Government (Department of Health and Department for Work and Pensions) – Further supplementary written evidence

- Around traditional DB pensions which often have rules which prevent accrual after a given number of years service, or don’t allow for increased payout if the pension is deferred:
  - For public sector pensions this is being addressed through public sector pension reform.
  - In the private sector this is a declining issue. Accounting standards have reduced companies’ willingness to use DB schemes as a way of getting rid of people.

**UC and making work pay**

Universal Credit will make work pay. A single taper rate and simple system of earnings disregards will mean people in work can clearly see how much support they can get and how increasing their earnings will benefit them. It will also mean that people considering a job will understand the clear financial advantages of work.

By removing the distinction between in-work and out-of-work support, Universal Credit will reduce the risks and complexity associated with moves into employment that exist in the current system. This will promote a more dynamic labour market.

**Saving**

**What actions are the Government taking to encourage the public to save more for both their pensions and their social care?**

- Mandatory automatic enrolment is intended to overcome the barriers to saving by harnessing inertia, rather having to make an active decision to save in a workplace pension, an employee has to make an active decision not to save.
- Evidence shows automatic enrolment leads to increased participation. In the United States, case studies show automatic enrolment increased membership of similar schemes among new employees from around 20-40 per cent to around 90 per cent.
- Automatic enrolment will transform our savings culture by encouraging and supporting millions, who would otherwise face a poorer retirement, to take personal responsibility and save for their future.
- The Government expects 6 to 9 million people to be newly saving or to save more, generating £11 billion a year more (in steady state) in pension saving.
- Automatic enrolment began on time and all employers remain in scope. However, small businesses will be given additional time to prepare for the implementation of automatic enrolment. The timetable has been adjusted so that no small employers will be affected by the reforms before the end of this Parliament.
- By the end of December 2012 around 600,000 workers will be newly saving in a workplace pension scheme.
- Around 4.3 million workers will enrolled by the end of the parliament.
- Employers will be “staged in” over the next six years. Minimum contributions build to 8 per cent of a band of earnings by October 2018.
- National communications campaign launched on 17 September, using TV, national press, radio, trade press, digital media and partnerships with third parties.
Central Government (Department of Health and Department for Work and Pensions) –
Further supplementary written evidence

- TV adverts which ran from 17 September to 21 October were intended to raise
  awareness quickly amongst target audience - those not yet saving in a pension. (NB:
  None of the employers or workers featured was paid to appear.)
  - 75% of all adults who watch commercial TV should have seen the advert 5
    times.
  - 63% of adults will have had 9 opportunities to hear the radio advert.
- The communication campaign will help individuals find out about automatic
  enrolment and understand the benefits of saving and remind employers of their
  responsibilities
- DWP is working in partnership with others to make sure that we gain the attention
  of people who wouldn’t otherwise hear our messages. These include Sky Sports
  (digital), Mediaforce (84 regional press titles), Real and Smooth (radio). More
  partnerships will follow in the New Year

UC and pension saving

Money paid into a work place or personal pension will not be taken into account when
calculating entitlement to Universal Credit.

Currently, only 50% of pension contributions are disregarded through the benefits system,
meaning that people who are doing the right thing by putting money aside for their
retirement can find their benefit reduced as a result.

There are around seven million people in the United Kingdom who are not saving enough
for their retirement – putting them at risk of poverty in later life.

However the changes under Universal Credit will incentivise more people on a low income
to put money aside to save for their later lives, complementing wider pension reforms.

Department of Health’s answers to the questions posed to the Department by
the House of Lords Select Committee on Public Services and Demographic
Change

Shaun Gallagher promised to write to the committee with examples of when
Ministers and others have talked publicly about the shift that is needed from
hospitals to community care, to address the issue of demographic change and an
ageing society.

Ministers

Paul Burstow, Minister of States for Care Services, King’s Fund 18 July 2012
“Different Councils are responding to the pressures in different ways. Some are being
smart, others are resorting to easy, short-sighted cuts.

The smart ones are working with service users, carers and providers to innovate and
redesign services. Using the investment in reablement. Looking to integrate. Sharing back
office functions.
Central Government (Department of Health and Department for Work and Pensions) –
Further supplementary written evidence

Such as in Greenwich where they have redesigned their care management system, creating
integrated teams with the local NHS Community Health partners, care managers,
occupational therapists, district nurses and others. They manage the care pathways around
hospital admissions, reducing emergency admissions, and delivering better discharge planning
into intermediate care and reablement. The service has not only created £800,000 of
efficiency savings but has also won the HSJ Award for Staff Engagement for 2012.”

Sir David Nicholson, NHS Confederation Conference, 22 June 2012
“No matter how compassionate, how brilliant our nursing staff are – and the vast majority
really are – it is really difficult to give frail elderly people with dementia the care they need
on an acute medical ward. The answer is about transforming services.”

Health Minister, Simon Burns, May 2012
"The health and social care act will make shifting care out of hospitals and closer to people's
homes simpler. No one should stay in hospital longer than they need to and we are already
investing £300m to help people return to their homes with the support that they need
more quickly after a spell in hospital."

Earl Howe's key note speech at QIPP summit, July 2010
“It is not only hospitals leading the way. There are many excellent examples of community
services significantly improving patient care and reducing costs. In Sandwell, the PCT has re-
designed its approach to managing dysphagia, an inability to swallow. For many people
approaching the end of their lives – those with conditions such as dementia, Parkinson’s or
stroke – dysphagia can mean a revolving door in and out of hospital. Sadly, it also means that
more people die in hospital rather than in their nursing home. This is not good for patients,
for carers or for the NHS. So, in Sandwell, they decided to do something about it. First,
they developed a Rapid Response Unit to assess patients within four hours rather than the
recommended two days, reducing hospital admissions. And second, they developed an
extensive training programme for nursing home staff to help them manage dysphagia in their
patients. This made hospital admission one option, not the only option. The effect has been
dramatic. In the six months between April and September last year, 75 people avoided being
admitted to hospital. Not only does this improve the quality of patients’ lives, it saved the
PCT almost a quarter of a million pounds [£225,000]

Other Public Statements
Peter Carter, CEO of the RCN, 19 July 2012
"Far too many patients arrive at our accident and emergency departments when, in reality,
they really do not need to be there. For our older patients, the problem is often more
serious. Often alone, with little or no support at home, they spend extended stays in our
acute settings because the systems are just not in place to care for them closer to home.
The sad reality is that we know they would often rather be in their own home receiving
care where they feel comfortable.”
The Royal College of Physicians has set up the Future Hospital Commission
(http://www.rcplondon.ac.uk/projects/future-hospital-commission) which has promoted
debate on the redesign of services to improve patient care.
Details of the boundaries that are used for CCGs

The boundaries of Clinical Commissioning Groups (CCGs) will be in alignment with the boundaries of local authorities. The Government accepted the NHS Future Forum’s recommendation that the boundaries of local CCGs should not normally cross those of local authorities.

If an applicant CCG wishes to depart from this guideline, it will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefits for patients: for example, if it would reflect local patient flows or enable the group to take on practices where, overall, this would secure a better service for patients.

As part of the authorisation process, the NHS Commissioning Board will be looking for evidence that CCGs have engaged local authorities in establishing their geographic area. More than one CCG can sit on a Health and Wellbeing Board. A HWB can invite other CCGs to attend or be represented when they have large numbers of registered patients within the local authority area.

The use of technology and innovation in dealing with the issue of demographic change and an ageing society

Purpose
The purpose of this note is to provide information about use of technology and innovation in dealing with the issue of demographic change and an ageing society.

Context
The White Paper ‘Caring for our Future: Reforming Care and Support” recognises the important role of technology and innovation in supporting people to live independently and have greater control over their health and wellbeing, improving the quality of life for both those using it and their carers. For example supporting people with a range of long term conditions including dementia avoid emergency admissions to hospital or care homes. The technology and innovation ranges from telecare such as personal pendent alarms and fall detectors to telehealth devices to monitor vital health signs remotely for those living at home with long-term conditions, to innovative projects to reduce levels of loneliness and isolation in older age.

Accelerating the roll-out of assistive technology
We know that telecare and telehealth is not yet being used to its full potential to promote people’s independence. It is estimated that are no more that 5,000 users of telehealth and probably no more than 1.5m pieces of telecare equipment in use in England. The barriers to higher uptake have been the high unit cost of the equipment, lack of understanding amongst professionals, lack of awareness amongst the workforce, lack of interoperability and principally the lack of evaluated evidence.

In May 2008, the Department of Health launched the Whole System Demonstrator (WSD) programme. It was the largest randomised control trial in the world of telecare and telehealth involving over 6,000 people across 3 sites in England (PCT/LA partnerships in Cornwall/Kent and Newham) and 138 GP practices. The headline findings from the national evaluation of the WSD programme published by the Department of Health on 5 December 2011 showed:

- a 15% reduction in A&E visits;
- a 20% reduction in emergency admissions;
Central Government (Department of Health and Department for Work and Pensions) – Further supplementary written evidence

- a 14% reduction in elective admissions;
- a 14% reduction in bed days;
- an 8% reduction in tariff costs;

More strikingly, the findings also demonstrated a 45% reduction in mortality rates.

Now that the Whole System Demonstrator program has provided evidence of the benefits of telehealth, the Department is focused on ensuring that these technologies can be adopted by and integrated into the NHS and social care at scale and pace.

To achieve this level of change the Department of Health is working with UK industry, the NHS, social care and professional partners to achieve the ‘3 million lives’ campaign. The aim of the campaign, which was launched on 19 January 2012 with the signing of a concordat between the Department of Health and UK telehealth and telecare industries, is to improve the lives of 3 million people with long-term conditions by rolling out telehealth and telecare across the country. The campaign is one of the six high impact innovation changes for the NHS set out in the report *Innovation Health and Wealth*.

This is a new approach to rolling out a proven innovation. It builds delivery through those with the skills and knowledge of the innovation. The role of the Government is to create the right macro environment to support this innovation and industry (with the NHS, social care and other stakeholders) are creating the right micro-environment to help spread awareness and knowledge.

There has been considerable progress in the way industry are working together to deliver at scale and an outline of the new business model has been prepared. This will be used to go out to the service to push for the first 100,000 installations this year.

**Supporting innovation**

**Improving dementia care**

In August 2011 the Design Council in partnership with the Department of Health launched a national innovation challenge titled; *Living well with dementia*, which aimed to develop innovative solutions for those diagnosed with dementia to live a better quality of life. The Department invested £600,000 and the Design Council £200,000. The project’s overarching aim was to turn the challenge of rising costs associated with dementia care in an ageing population into an opportunity to stimulate improvements through opening up the market for business and third sector innovation. The launch of the project prototypes took place on the 26th April 2012. The five successful projects are as listed below and they are now securing investment partners to take their product to market.

**Dementia Dogs**
Providing assistance dogs for people with early stage dementia by developing a service that explores the potential of trained dogs in a dementia situation to help maintain independence, dignity, companionship and joy.
(Alzheimer Scotland, Glasgow School of Art, Dogs for the Disabled, Guide Dogs)

**BUDDI**
A permanently worn discreet wristband to aid people with dementia. The product will provide user identification, personal monitoring and emergency alert functionalities via 3D
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| accelerometers and RFID, and will offer GPS location tracking alongside the current buddi telecare system.  
(Buddi + Sebastian Conran Associates) |
| **Trading Times**  
A web and mobile-based service for carers of people with dementia to help them find work that can be delivered on a time and location flexible basis. This will enable carers to supplement their income and protect their savings, as well as offering the chance to stay within the world of work.  
(CREO Strategic Solutions, A+B Studio, FeedHenry, David Reinhardt) |
| **The Scent Clock**  
A home scent-device to stimulate appetite and enhance nutritional status in people with dementia. The device will look to increase the likelihood of eating, reducing the issues of weight loss, dehydration, fatigue and malnutrition that people with dementia experience.  
| ‘Grouple’  
A collaborative caring and sharing tool which enable the family to support their relative through easier, accessible communication. Applicable from the point of diagnosis, Grouple will provide online and physical tools to facilitate co-ordinated support.  
(Studiohead, BT Innovate & Design, Louise Wilson, Ifung Lu, Meike Walcha + Jewish Care) |

Innovation is a key theme in the Prime Minister’s Challenge on Dementia launched on 26 March 2012. The challenge sets out a renewed ambition to go further and faster, building on progress made through the National Dementia Strategy, to secure greater improvements in dementia care and research so that people with dementia, their carers and families get the services and support they need. As part of the challenge, on 25 June 2012, the Department launched an Innovation Challenge Prize of £1m for NHS organisations to develop ideas for transforming dementia care.

**Tackling loneliness and isolation in older age**

The Department is working with the charity Nesta – and a number of other partners – on a Challenge Prize on Ageing Well. The Challenge Prizes were developed in conjunction with the Cabinet Office to encourage new ways of giving time, skills and resources for specific social change.

Earlier in the year, Nesta opened the Ageing Well Challenge Prize – which offers a prize for the innovation that can reduce levels of loneliness and social isolation and/or increase the mobility of vulnerable older people. Nesta received over 200 ideas, and is currently in the process of shortlisting 25 semi-finalists to go through to the next stage. The winner – and recipient of the £50,000 prize – will be announced in October 2013.

Using Section 64 funding, the Department commissioned the Campaign to End Loneliness to produce a digital toolkit for health and wellbeing boards to support them in understanding, mapping and commissioning for loneliness and social isolation in their communities. For more information on the toolkit, see: [http://www.campaigntoendloneliness.org.uk/toolkit/](http://www.campaigntoendloneliness.org.uk/toolkit/)
This note has set out a range of ways in which the Department of Health working with partners is supporting a greater use of technology and innovation as a key part of addressing the challenge posed by an ageing population, with the aim of ensuring that people get the highest quality care and support.

**The Department of Health’s position on prevention in adult social care**

**Purpose**
The purpose of this note is to set out the Department of Health’s position on prevention within adult social care including the cost-effectiveness of spending money to prevent older people from having accidents or having to go in to hospital.

**Context**
Prevention and early intervention is one of the key principles, which lies at the heart of the White Paper ‘Caring for our Future: Reforming Care and Support’. The White Paper confirms that we should do everything we can – as individuals, as communities and as a Government – to prevent, postpone and minimise people’s need for formal care and support. The system should be built around the simple notion of promoting people’s independence and wellbeing.

**Defining prevention**
Prevention can be concisely defined as “services that prevent or delay future intensive interventions”. It is useful to consider three different types of prevention. *Primary* - people with no symptoms of illness to maintain good health, delay significant disability or prevent reoccurrence of an illness. *Secondary* - identify people at risk or those who have existing low level needs. *Tertiary* - minimising disability or deterioration from established diseases and maximising rehabilitation.

Preventive services will often span across social care, healthcare and public health, and this is one of the areas where joint working across local services – linked with housing and other community and voluntary support – is needed.

**The evidence base**
A health and social care system that intervenes at crisis points rather than in a preventative manner is likely to deliver poorer outcomes. For example, too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place. There is however a scarcity of evidence on the cost-effectiveness of prevention. The evidence that exists suggests that it is cost-neutral at best rather than cost-saving.

There are a number of barriers to implementing preventive measures locally. These include risk aversion and pressure on resources (with immediate needs taking priority over lower needs), identifying and targeting potential recipients and difficulties in measuring success. The evidence on the potential for net cost savings from prevention is inconclusive and could suggest that there are at best only marginal net cost benefits. However, there are pockets of evidence that we can highlight which suggest that there can be the potential for net savings in health and social care usage, examples include: the national telecare initiative in

177 Department of Health, *Shaping the future NHS: Long term planning for hospitals and related services consultation document on the findings of the national beds inquiry*, 2000
Scotland and the Whole Systems Demonstrator programme for telehealth and telecare in England, and the Partnerships for Older People Projects (POPP) programme.

The findings of the national evaluation of the POPP programme indicate that the projects as a whole had a potential to improve the quality of life for participants and the potential for considerable savings, as well as better local working relationships. For example:

- for every £1.00 spent on the POPP services, there was a marginal cash saving of £1.20 on emergency bed days (confidence interval £0.80 to £1.60). In addition, there were estimated to be savings in use of community services and reported improved quality of life which have not been monetised
- overnight hospital stays were reduced by 47 percent and use of accident and emergency departments by 29 percent
- reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total average cost reduction of £2,166 per person
- efficiency gains in health service use appeared to have been achieved without any adverse impact on the use of social care resources
- the quality of life of those using services were reported as improved, to varying degrees depending on the nature of individual projects
- 79 per cent of respondents agreed that partnership working between the local authority and voluntary and community sector providers had been improved.

Recent DH modelling of reablement suggests that although it leads to substantial savings in home care, over the course of the first 12 months it is broadly cost neutral because of the cost of the reablement package. However, there is potential for savings over a longer time period.

The picture is more positive with regards to Quality Adjusted Life Year (QALY) gains from social care prevention – including some of the community based support initiatives identified within PoPP. Evidence suggests that adding these gains to cash releasing savings can often make preventative interventions cost effective.

**Prevention of falls in older people**

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. In 2010-11, 348,115 people were admitted to hospital as a result of a fall, and fall injuries accounted for more bed days than stroke and heart attack admissions combined. Resulting injuries in older people, i.e. hip fractures, can lead to loss of mobility and independence – requiring a subsequent move into a care home for many. Older people also have the highest rate of deaths due to falls – with 30% of those suffering a hip fracture dying within a year.

Falls in older people can be reduced through public health interventions. There is a concerted programme of activity underway with regard to falls prevention – with leadership from local clinicians and managers, charities and advocacy groups, expert researchers and clinicians, colleges and specialist societies. The work is supported by a range policy levers and resources from central Government including:

- A falls and bone health commissioning toolkit (first published in 2009);
- A ‘Blue Book’ produced by clinical leaders to show best practice;
- National audits and databases to share information;
Central Government (Department of Health and Department for Work and Pensions) –
Further supplementary written evidence

- Best practice tariffs for hip fractures; and
- A NICE Quality Standard on falls (published in 2004), which will be expanded in
due course.

In recognition of the scale of the problem, the Department will be including two indicators
in the Public Health Outcomes Framework (falls and injuries, and hip fractures in the over
65s), which will come online from April 2013.

Other levers and enablers to support prevention and early intervention
Shifting emphasis towards prevention and away from crisis response, demands a whole
systems response with health, public health, housing, care and other services working
together to help maintain older people to maintain their independence.

An example of this approach is the “Hospital2Home resource pack” launched by Care and
Support Minister, Norman Lamb on 26 October 2012. The resource is designed to make it
easier for health and social care professionals involved in hospital discharge to support older
patients in returning home safely after a hospital stay and reduce the risk of readmission to
hospital.

The Outcomes Frameworks for the NHS, Adult Social Care and Public Health have been
designed so that indicators relevant to older people feature in each of the frameworks to
promote prevention, support for wellbeing and recovery from illness, across the whole
system.

Supporting greater investment in prevention
To improve the current evidence base and to promote greater investment in preventative
care, as part of the White Paper Caring for our Future: Reforming Care and Support” we are
establishing a library of evidence in 2013 and are making funding available in 2013 for a Social
Impact Bond Trailblazer Programme to encourage innovative new forms of investment in
preventative interventions.

Under SIBs care commissioners pay providers by results for the provision of preventative
services. On the promise of these payments, care providers are able to attract social
investors to pay for the upfront capital costs of the intervention. As a payment by results
tool, the bonds ensure that taxpayer funding is used only if services are successful. Social
investors weigh the social and financial returns they expect from an investment in different
ways. They will often accept lower financial returns in order to generate greater social
impact.

December 2012
Overview

Housing should enable people to live independent lives and help them to be active members of their communities. It should also help to prevent people experiencing crises in their lives that impact on their health or wellbeing. This means homes which support these aims, and for some older, vulnerable or disadvantaged people, it means providing housing support to help people lead full and active lives.

The Coalition Agreement includes the commitment:

“We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.”

The Government is committed to ensuring that housing and planning policies positively reflect the wide range of circumstances and lifestyles of older people. Laying the foundations: a housing strategy for England (November 2011) set out what we are doing to meet this commitment.

Over the Spending Review period, we will make £6.5bn available for Supporting People Services to enable vulnerable people to live independently. For the elderly, we have set out a new deal on older people’s housing, with a better offer to support older people to live independently for long. We are also supporting a series of pilots exploring Payment by Results which will help commissioning services for vulnerable people identify better outcomes and value for money.

The timetable for the look they are taking at the disincentives in the market for building new housing for older people

This is on-going work to inform our thinking for the next SR

When an older person wants to move into more suitable housing they often have to take out a loan to cover their costs before they can get the money from their house sale. The committee asked whether DCLG had been in touch with lenders about this and Jon Bright promised to write on that.

Generally, lending is a commercial decision for lenders and not something that Government can direct. However, two organisations that DCLG funds to provide help and advice to older people, Foundations and FirstStop

FirstStop enables older people, their families and carers to make informed choices about their housing, care and finances in later life and to access local services which can help them to repair and adapt their homes, or support them to move to more appropriate accommodation.
Central Government (Department of Communities and Local Government) – Supplementary written evidence

Foundations is the national body for home improvement agency and handypersons services, providing support to the home improvement agency sector through:

- developing and expanding home improvement agency services
- providing advice, training and support to home improvement agency staff and service commissioners, and
- representing the sector in discussions with government and other stakeholders.

Both organisations have provided an outline of how they work with financial services which the Select Committee may find useful and are attached at Annexes A and B.

Jon Bright mentioned that DCLG were working with DWP and DH on a project that will look at different approaches that have been taken around the country, and what can be learned from them. The committee asked for more information on this joint project, as well as further information on the 'centre of excellence'.

This was a reference to thoughts about creating bodies similar to NICE or the Early Intervention Foundation which can assess what works in major policy areas. DWP has covered this in the follow up evidence they have already sent to the Committee, which said:

Civil Service Reform plan set out an aim to review the value of creating bodies similar to NICE or the Early Intervention Foundation which can assess what works in major policy areas so that commissioners in central and local Government do not waste time and money on programmes that are unlikely to be value for money.

Feedback from Local Authority Commissioners and service providers is that they often find it difficult to know where to go to find good quality advice around interventions on issues related to ageing.

Following the Social Care White Paper DH will be commissioning an evidence library to ensure that there is a single bank of evidence for preventative interventions in care and support.

DH, CLG and DWP have been working to scope whether there is a role for a wider institute looking at issues related to ageing, which cuts across housing, transport, leisure and other services.

At the same time The Big Lottery Fund has been looking at funding a Centre of Excellence on Ageing, which would both bring together existing evidence, and generating new evidence for key interventions. The three Departments are working closely with Big Lottery to help scope the centre and map out a clear proposition, to ensure it meets the needs of as many potential users as possible.
Q. What happens to people who want to move home? What does DCLG do to help?
A. It funds the FirstStop information and advice service for older people and their families, whose remit spans housing, care and related financial matters. This is run by the charity Elderly Accommodation Counsel (EAC) in partnership with a number of local not-for-profit organisations and older people’s groups.

Specifically, FirstStop offers:
Comprehensive information and discussion around how best to achieve what the customer wants to achieve. Financial issues are raised frequently, or crop up in discussion. FirstStop Advisors can offer help with:

Grounding and orientating clients in unfamiliar territory
By and large, FirstStop clients present in one of three ways:
- “This is what I want to do – tell me how”;
- “This is the situation I’m responding to – where do I start?”
- “I feel on my own – how do I cope?”

Initial discussion helps identify how much they know, what if any pressure they feel under, what information they may be lacking and what kind of dialogue might help them clarify their priorities and gain confidence to pursue them.

Overview of the range of later life housing options
What the market looks like, including types of developments (schemes) and associated services, tenures, eligibility, capital costs, service charges, leases.
This is a particularly important starting point in discussion with many clients, a large minority of whom have the impression that retirement housing is broadly similar to residential care.

Detailed information on individual housing schemes
Accommodation provided, shared facilities, services provided, management and support arrangements, EAC resident-led quality ratings.
EAC’s National Directory of Housing for Older People’ covers 26,000 housing schemes, and aims to present very detailed information about each.

Benefits
Preliminary assessment of likely eligibility for all key state benefits relevant to older people. This is important not only for those with very low income. Many clients are unaware of benefits that could help substantially improve their lives; and those considering equity release or other financial products often need alerting to their possible impact on benefit already received.
Central Government (Department of Communities and Local Government) –
Supplementary written evidence

Financial products and services
Introduction to product and service types including equity release, insurances, investments.
Explanation of regulated financial advice (IFA) services, industry specialisms and
accreditations; guidance on how to choose a suitable IFA including questions to ask;
introduction to local specialist IFAs accredited with Society of Later Life Advisers (SOLLA);
introduction to Just Retirement equity release.

FirstStop has no financial connection at all with IFAs or with SOLLA. It neither seeks nor received
any commission or other income from either in return for introducing clients to them.

FirstStop was set up on the promise of an integrated approach to housing, care and finance,
and this is what we have sought to achieve over the last four years. The main challenge has
been dovetailing knowledgeable and comprehensive ‘front end’ information about financial
matters with the specialist and tightly regulated services provided by IFAs.
Four new local ‘money advice’ services launched recently with FirstStop as co-ordinator and
Comic Relief as funder.

Few clients specifically ask for financial advice in a general sense; more often they have heard
about products that might be relevant to them, for example in relation to funding care, and
ask to be talked through what they are / what they mean. Otherwise it is our Advisors who
raise financial questions in the course of conversation, and then offer information and/or
suggest the client considers accessing more specific/personal financial advice.

Moving home service
Introduction to FirstStop Moving Home Service (a commercial service provided in
partnership with 3 regional enterprises) that helps with the practicalities of moving – from
finding a new home to packing to settling in).

Legal services
Information about legal aspects of property, particularly transferring or sharing ownership,
understanding leases, releasing equity – and introduction to FirstStop fixed price legal
services negotiated by EAC with QualitySolicitors Truemans.

Information about lower cost tenure options
Introduction to shared ownership (part buy, part rent) and renting (temporary or
permanent) options, both of which are becoming more commonly available through major
housing associations and of interest to a surprising number of older movers. Several major
housing associations now let substantial number of properties to ex-owner-occupiers;
Girlings Retirement Options offer private retirement rentals, including a bespoke “find a
property” service; A majority of new extra care and some assisted living developments offer
multiple tenure options.

We are continually surprised at how many clients show an interest in tenure options once
we raise the question. Widowed older women often feel uncertain about taking on the
responsibility of property ownership, but across all owner-occupying clients there is a
surprising level of interest in options that both reduce responsibilities and release equity in a
‘simple’ way.
Bridging finance
Introduction to products and services available, e.g. Bridgefast: “a Personal Adviser to deal with your individual needs and interests and co-ordinate the entire selling and moving process” [quote from Bridgefast website].

Package deals offered by retirement housing developers and estate agents
Part exchange as offered on new properties by Churchill Retirement Living, Retirement Security Ltd and others. All-in packages such as McCarthy & Stone “Move for Free” [quote from McCarthy & Stone website] service encompassing removals, estate agency fee, solicitor fee, and stamp duty.

Integrated discussion of options
Moving home is rarely a quickly achieved solution, so where matters are pressing we offer a review of alternatives and of interim solutions. These might include improvements / adaptations to the home, or bringing in support services. We refer or signpost frequently to local agencies such as Home Improvement Agencies and Age UKs, and to other local services providing domestic help, gardening, befriending, day centres, etc.

Local initiatives and incentives
Information about local authority schemes that incentivise and/or support tenants and/or owner-occupiers to downsize. We maintain an increasingly comprehensive directory of simple cash incentive schemes and have a less well-developed knowledge of innovative schemes such as Redbridge FreeSpace (see FirstStop publication ‘Helping older people choose the right home for them’).

ANNEX B - Foundations
DCLG funds Foundations, the national body for home improvement agencies in England. Foundations supports the HIA sector to help older and vulnerable people remain living independently – and that includes helping them to access appropriate financing solutions.

Foundations is currently working with private sector finance provider Just Retirement Solutions (JRS) to pilot equity release advice tailored to the HIA client group.

Foundations has provided the following information on the pilot scheme for the Select Committee:

- Foundations are six months into a national pilot to introduce equity release products and services. It is the introduction of a panel service of ER products and services representing selected providers designed to meet the vast majority of client needs. Amongst the panel of providers is Just Retirement Limited who also provide products tailored to more vulnerable clients including, for example lower levels of financing thresholds and top-ups than this market has typically entertained in the past and is now very well regulated compared to the situation which prevailed with first generation ER products of the 1980s. That increased confidence is now underpinned for example by market wide guarantees of no negative equity. Conduct within the sector is now overseen by the recent emergence of a strengthened trade body in the re-named Equity Release Council.
The work led by Foundations has been taken forward with one of the leading providers of equity release advice – Just Retirement Solutions (Age UK also have a formal partnering agreement with JRS).

Just Retirement Limited (JRL) a sister company of JRS have committed significant resources in research and development activity to introduce product developments which better address the needs of vulnerable clients.

JRS recognise that this is a “long term play” and this development is a reflection of their professional assessment of the impact of economic and demographic changes as well as a by-product of their market analysis, aided by Age UK and ourselves.

JRS in partnership with Foundations completed an orientation training programme earlier this year with some 200 HIA caseworkers drawn from some 40% of providers in the HIA sector.

Previous efforts by equity release providers to engage this market with equity release solutions have faltered partly because of the absence of either formal or informal advisers and partly because the products were not attuned sufficiently to their needs. This pilot service has addressed that by establishing referral roles for locally-based case workers and “advice” roles for JRS staff handling in-bound requests for follow up alongside changes to the product and service offer themselves. In our view, these changes make for a very high level of assurance for the client.

JRS have ability to look outside panel of providers if needed.

Ensuring the client gets the most appropriate ER solution as well as a benefits check. This is overlaid by HIA involvement which draws in wider local intelligence on housing options, charitable funding and so on.

In practice only about 1 in 10 of all enquiries are ever expected to result in an equity release transaction and this national pilot is proving no different. Early results indicate an encouraging but not spectacular flow of referrals especially from some of those HIAs impacted most acutely by the cessation of the £300m Private Sector Renewal (PSR) funding – that includes the 20 plus local authority districts who had utilised PSR funding to underpin the West Midlands Kickstart Scheme (which is now winding down). The pilot scheme was always going to take time to build.

Currently HIA are generating in a typical month around 10 or so referrals and unsurprisingly these are concentrated among a small number of providers. Lead time to completion is necessarily quite lengthy because of the protections in place for the consumer.

Foundations receives no commissions on transactions. The model however provides for the individual to receive independent financial advice and legal advice. Moreover within the model being piloted the HIAs also retain no commission in the event an enquiry progresses to a completion.

In terms of next steps we are now shaping plans to broaden the number of active agencies engaged in the programme so that a meaningful level of activity can be evaluated and interpreted at the end of an initial 12 month pilot period.

December 2012
Central Government, Sir Bob Kerslake

Evidence Session No. 19
Heard in Public
Questions 639 - 667

TUESDAY 18 DECEMBER 2012

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope
Baroness Tyler of Enfield

Examination of Witness

Sir Bob Kerslake, Permanent Secretary, Department for Communities and Local Government, and Head of the Civil Service

Q639 The Chairman: You probably know or have heard of most of us. Thank you very much for coming. You were going to be one of a panel of about four but your colleagues were not able to come. We would like to address two questions to you, one in your role as Head of the Civil Service and a little bit also about CLG. How are you for time, can I just ask? How long do you have?

Sir Bob Kerslake: I have a meeting at about 12.30 pm.

The Chairman: So you need to finish by 12.25 pm.

Sir Bob Kerslake: If we can, yes.

The Chairman: One or two have to go slightly before that, but I think that gives us 50 minutes. Let me kick straight off. You know essentially what we are addressing, which is asking the question, “Are we ready for ageing?” We all know society is ageing and the question is essentially are we as a society, as individuals, in public policy and in public services ready for what is coming quite clearly down the track? That is the question. To start off, could you give us your view, as Head of the Civil Service, as to what the significance of an ageing population is in public policy and public services?

Sir Bob Kerslake: Yes, I will say a few words about that. First of all, I think we have pretty good data and pretty good forecasts about what is happening here, so this is not something where we cannot reasonably understand what is likely to come down the track. This is
really quite an important point. The second point I want to make is—and I am sure others have said it but I think this is critical—the issue is not in itself ageing. It is perfectly possible that people are going to live longer and life expectancy getting greater is a good thing that we should celebrate. So the fact that we live longer, will work longer, and probably study longer as well, of itself it is not an issue.

The issue really is what I would call health expectancy: to what extent is people’s ability to carry on in a self-reliant and self-sustaining way matching the pace with which life expectancy is moving? The evidence suggests that it is not, that life expectancy is moving faster ahead than health expectancy is and therein lies the key issue that it seems to me we have to address. So it is not in itself ageing that is the issue, and I worry about that being presented as the issue because it suggests being old is a bad thing. It is not. Being old and being ill, either mentally or physically, is a bad thing. Being old and being alone is a bad thing. These are the things that we have to think about rather than the issue of ageing per se.

The third point I would make is that this issue is not just about people’s health; it is also about people being in active employment. It is absolutely clear that we will have to work longer. There is no question about that. To that extent, I think the Government have faced up to that issue. There is no question about that. The only three things you can do about pensions. One is to pay more when you are in work, the second is to work longer and the third is to live with less when you retire, and probably all three are going to have to come into play here. Unless as a country we face up to that issue, then we are in danger of just deluding ourselves about the challenge. So are we ready? I think in one sense we understand the issues. Have we had an honest debate with the people in this country about those issues? I think not, truthfully.

The Chairman: That is remarkably clear. There is also quite a large part of our report that you have written for us already on that, which is comforting. Let us move on into some of the Government’s planning processes and how it is addressing this.

Q640 Lord Bichard: We have heard a lot of evidence from a lot of people who tell us that one of the problems here with this issue is it is fragmented—the provision is fragmented, the policy planning is fragmented. There is a lack of collaboration. There is not enough emphasis on prevention. We do not design services around clients. There are separate budgets. In talking to some of the people who are responsible for good initiatives out there, a lot of this comes back to what is happening at the centre—what is happening in Whitehall. Some of these problems derive from the way in which departments do not work well together, they say. There are two questions. One is, as you have just said, this is one of the biggest issues facing us, so could you describe to us how the Permanent Secretaries as a group address this issue? How do they go about as a group planning the policy? How do they go about as a group monitoring what is happening and measuring success? Just describe that to us. The second question is: how are your reforms going to improve on what we currently have at the moment?

Sir Bob Kerslake: They are two important questions, Lord Bichard. I think it is fair to say that both of us come from a local and a central perspective on this. This is for me quite important. You cannot decouple this. Much of what we are going to have to do is to change the way things are delivered at a local level to people as well as at a central government level, but let me stick with the central government question first. The starting point for me is the way that we are addressing this issue matches the way in which the government typically addresses cost-cutting issues, and some aspects of that are very good and some frankly are not. Naturally the Civil Service is a federal model. Each department provides sees
itself as self-reliant and what it tends to do, therefore, is develop policy and then test it across the Whitehall group rather than necessarily develop policy in a collaborative way. That is a direct and honest description of how things, by and large, get done. I am sure you will recognise it and it works extraordinarily well on specific issues. It works less well when you are trying to cover a broad-based demographic or societal issue.

I think the way it is being handled in government is through a combination of things. One is a director level group co-ordinating work on ageing, led by a director in the Department for Work and Pensions, so there is a cross-cutting Whitehall group that is looking at issues of ageing and what flows from that. Secondly, the work is being handled I would say more around what might be called consequential issues. For example, we have had a joint board meeting between the Department for Communities and Local Government and the Department of Health specifically to look at the issues of health and care and how they fit together. As I said earlier, that is a critical issue here.

Q641 Lord Bichard: Is that a regular meeting?
Sir Bob Kerslake: It is not a regular meeting, but we have had one of those and we will have another one in the new year.

Lord Bichard: Should it not be a regular meeting?
Sir Bob Kerslake: I think it is a fair challenge. I am not in any sense saying what we have now is perfect, but what I am describing to you is that there is a director level co-ordination and there is a higher level co-ordination of specific consequential issues for an ageing population, whether that is related to health and care or to working and encouraging people to work longer where they want to. That is the way we are intending to tackle it.

The third thing we are doing, which I think you have heard about, is seeking to improve our coherence at the centre on horizon scanning. How good is our analysis of the scenarios that are likely to flow and our evidence-based analysis of what works in terms of policy in action? That is the What Works Institute that we have developed around ageing will look at. That gives you a summary and I hope an honest description of what is going on. Are Permanent Secretaries meeting on a regular basis to discuss ageing?

Q642 Lord Bichard: Before we go on to the report, let me just pick up on some of that. We have had evidence that the Australians, for example, have a vision for ageing—living longer, living better. They have a budget. They have a Minister for ageing. They have just launched all of this publicly. Has the directors group that you talked about been seeking to develop a cross-governmental strategy vision for an ageing population and will that be signed off by Permanent Secretaries?

Sir Bob Kerslake: That is not what they have been doing. They are ensuring that, as I said earlier, there is a cross-Whitehall co-ordination of issues. It is not endeavouring to produce what might be called a vision. There has been work, as you know, that has been done by organisations outside of government—voluntary community sector organisations that are developing a vision for ageing. I very much think there is a lot to be said for them looking to develop a vision rather than us trying to do it for people. So that has not been part of the work they have done.
Q643 Lord Bichard: The trouble is that Whitehall departments can make it very difficult for people outside, whether they are voluntary sector or local authorities, to work in an integrated sensible way, can they not?

Sir Bob Kerslake: They can indeed, which is why I was going to come on to Civil Service reform. But just before I do, if I am absolutely frank I am not wholly convinced yet about a grand vision for ageing. I think I need some persuading that that of itself is going to be helpful and it risks becoming a very all-singing, all-dancing kind of document. I am personally much more interested in focusing in, as I said, on what the key consequential issues are that flow from the match between life expectancy and health expectancy, and what we are going to do by way of action both by the state and by the community in order to address those issues. I am nervous about producing a grand vision that tries to tell people—

Lord Bichard: So would I be but would it not be useful if the others who were working within this system had some idea of the framework within which they were working, perhaps to at least articulate what the framework should look like?

Sir Bob Kerslake: That is something I would be more comfortable with and I think there is a provision there—

Lord Bichard: But it is not happening.

Sir Bob Kerslake: No, it is not happening. I am being very direct about that. There is a lot of work going on, as I said earlier, on specific issues, but where you can reasonably challenge is by asking, “Have we pulled those issues together into a framework that oversees the range of issues in one place?” That is the reasonable challenge.

Q644 Lord Griffiths of Fforestfach: Can I ask a question? Are you saying, Sir Bob, that the Australian model is defective?

Sir Bob Kerslake: No, I am making perhaps a slightly different point. I am saying: where do we direct our efforts and is it about government producing a big vision or is it about us working collaboratively with others in the community to hear their vision of what needs to happen and then how respond to it? So it is about the approach to the task and whether that is likely to produce results better than we might do in a different way, which is not to contradict the central point that Lord Bichard is making that there is a case for saying we need a more coherent framework for the actions that we are going to take.

Q645 Lord Bichard: I have been away a long time, but from what you have described, what is happening is that the directors group are getting together every now and then to try to ensure that there is not too much of a misfit between what they are doing, rather than trying to create a framework within which government and the rest of the country can work. That is what you mean by co-ordination, is it not?

Sir Bob Kerslake: I am being very direct. Yes, that is what they do. They meet regularly but their focus is on effective government co-ordination of issues related to ageing rather than a commission to produce a grand vision. That is the honest answer.

Q646 Lord Bichard: How are the reforms going to change all of that? I think you are being very honest and accepting that this is not really good enough.

Sir Bob Kerslake: I am saying that some individual work on specific issues is very strong. I am saying: does it add up to a coherent framework? I think that is a fair challenge. They are two different points. On the question of how will reform change things, the most direct
thing I would say is how we change the way in which the Civil Service works. As I said, it is a collection of departments. The default is federal, individual; it is not unified and it is not cross-government and we have to fundamentally change the way we work to become a more unified Civil Service.

Q647 The Chairman: It is short term and it is fiscally focused.

Sir Bob Kerslake: Both of those are absolutely correct as well, so we need to have longer-game thinking and we need to work more as a unified Civil Service on cross-cutting issues. If you read the reform plan, it picks out very clearly those as key priorities.

The Chairman: Would ageing be one of the things that you would expect to see?

Sir Bob Kerslake: It is one of the things we said would be a priority for the What Works Institute.

The Chairman: It is different.

Sir Bob Kerslake: It is one part of it. It is a really important part of it as well, because it is trying to create a centre of expertise to form evidence to develop evidence-based policy or advise on evidence-based policy. So it is trying to garner where things work and what works.

The Chairman: Jolly good, but why would not this be one of the things that you had as a priority for the medium-term planning?

Sir Bob Kerslake: It is one of the priorities and it is in the plan as something we are going to do. Secondly in the plan is to completely overhaul our arrangements for horizon scanning so we have a more joined-up approach to that. The third thing we have talked about in the Civil Service reform plan is having a much more fluid approach to the way in which policy is developed, so that we look at having policy capacity that is available cross-government and so that we do not assume that it all has to be located in departments. We are working on that issue as well. My point is that in order to do justice to this, it is not simply about dictating that we will produce a grand strategy that will take ages to write and then will gather dust. We have to fundamentally change the way we work as a Civil Service in order to do justice to issues like ageing.

Q648 Baroness Morgan of Huyton: This is a minor supplementary. It is a bit unfair to ask you this perhaps, since you are the one person who has turned up, but were you aware that all your colleagues have found themselves too busy to come and join us today? It has been very marked that we have taken a great deal of evidence and people have changed meetings—they have even changed holidays in order to come and take part in evidence sessions. To have a situation where DWP are too busy, effectively, to be here when it is a pretty fundamental part of our work is rather depressing, and I would just like your comment on that. Secondly, to what extent do you think the Treasury will be involved in the reform plans and the detailed work you are talking about going forward? When we have had other evidence, we have had a concern about the short-term nature of fiscal planning and, unless the Treasury are fully involved in policy discussions, they are, at times, esoteric but do not necessarily go forward.

Sir Bob Kerslake: The Treasury has to be involved in any discussions that we have, whether they are short term or medium term, and they are closely involved in discussions around Dilnot, for example, and how that is taken forward. So you cannot have any of these conversations without Treasury being in the room. On your first question, I was aware they
were unable to make it today. It has turned out for me personally to be quite a difficult day and I apologise for that. It is an unusual—

**Baroness Morgan of Huyton:** It is very unusual, once every century.

**Sir Bob Kerslake:** It does not happen that often, but I do have a good excuse.

**The Chairman:** I have been told off by the Committee staff that we offered your colleagues only one date, so that—

**Sir Bob Kerslake:** I am sure they will come back and join you in a meeting. In the ideal, we would have had all three of us here and I did suggest that we might rearrange the date for all three of us to come, but I understood that because of your timetable for the work it needed to be now or never.

**Q649 Lord Bichard:** I think other Members of the Committee would agree with me that when we had a group of senior civil servants here very early on giving evidence to us, we did not get the impression that this was an issue that was being addressed across departments in any meaningful sense. It contrasted hugely with the evidence we had last week from front-line staff, who were working with huge enthusiasm, very innovatively, to get different organisations and professionals to work together.

On your point about the Treasury—this is my specific question—one of the questions that we asked was about equity release, which we think is a really quite important issue. We did not get any sense that that was something that the Treasury or the rest of the Civil Service was even focusing on at the moment and that, in a way, Dilnot had hijacked the debate, in that this was an issue to which Whitehall had to respond. It was responding to Dilnot but, as a result of that, a number of other issues were just getting swept under the carpet.

**Sir Bob Kerslake:** I think that is an overly harsh description of it. What I was trying to say earlier, perhaps not very well, is that on specific issues, such as how we integrate more effectively health and care, how we prevent emergency admissions to hospitals, how we prevent that pattern, that cycle that often happens that leads to people losing independent living and going into care or into nursing care, there is a lot of work going on at both national and local level.

If I just cite one example from my own department, CLG, we have run a project called the community budgets initiative. It is working in four parts of the country. It has been an intensive effort with over 30 civil servants, including Treasury civil servants, being outposted to work with these four areas in order to help them develop new models for delivery of services that can improve services at lower costs. A large part of that, not all of it, has been around agendas that relate to older people and particularly to do with health and care. So there are some really tangible examples of practical work being done around key issues that link in with the ageing society.

Responding to your question—do we have a grand strategy and do we have people working on it?—the honest answer was no, but I was not saying there is no good work going on. There is good work going on, both on health and care, on housing issues and quite a lot of changes have happened in the employment area to provide greater incentives for people to carry on working. So the evidence is there on the specifics but it is not there on the framework and that is the point I am making.

**Q650 Baroness Shephard of Northwold:** Sir Bob, I apologise for my late arrival, for dental reasons—therefore, what I say may be a touch blurred. Also this question may have
been asked. I was most interested in your four areas where pilot work is going on, that you have just spoken of. Can you tell us where they are? Can you tell us if one of the messages coming out of those areas is the message we got last week from all of the four areas we were looking at and that was that the way the funding is arranged is a positive disincentive to working together rather than an incentive? The third part of my question is: what other hurdles are there coming out of your four study areas that are being thrown up?

Sir Bob Kerslake: Yes, I can come on to all those questions. The first of the four areas that we have worked with is Greater Manchester. The second one is the so-called tri boroughs: Westminster, Kensington and Chelsea, and Hammersmith and Fulham. The third one is in Cheshire and the fourth one is Essex. They have looked at a range of issues, not just health and care, but I think health and care has been probably the most significant in scale and interest.

What they have been trying to do is to say that, if you take an area, let us say Greater Manchester, and you look at how the system and the healthcare system work, are we using the resources in a way that would deliver the best outcomes or can we secure those outcomes for less cost? The reports came in about a month ago. They are intensive, evidence-based pieces of work and they suggest that there is real potential for reconfiguring the services to deliver both better outcomes and savings, and most of that comes from trying to break down the cycle of dependency that leads to the high costs in the first place.

The tricky bit we have, and it goes to your question about funding, is the way it is often described in Manchester is the fruits of one person’s labour land in another person’s garden. Essentially what you need is a model—I call it a flow of funds in an area—that if you invest in preventive care, if you invest in the things that cause emergency admissions, in housing, for example, reducing trips and falls and so on, then you can, in the whole system, secure that return of cost back within the system to share the benefit back to the place that made the investment.

What we found interesting with the community budget models is that many of the things can be done within the existing framework. It is not the case that there is some single deal-breaker barrier that gets in the way of this. I have to be honest with you: my frustration comes from hoping they would find this one thing that would unlock it, but it does not look like that. A big part of it is about empowering the managers and the people Lord Bichard talked about at local level being able to make these decisions and move resources around. That needs to include the primary care and obviously the clinical commissioning groups. It needs to include the hospitals. It needs to include the local authorities so that they can make the whole of those budgets work in a better way. A lot of this is about empowering them. It does not need legislative change or anything like that. It just needs an ability to trust at local level that they can get on with it.

One thought that has come through is whether you have a line in the budget for one area, so in government you might have a budget line there for Greater Manchester or whatever that would symbolise a sense of, “We have got one resource here”. The frustration but also the opportunity here is that much of this can be done if we can free up and change the way things work on the ground. That is the key thing we have learnt from it.

Q651 Baroness Shephard of Northwold: Do you mind if I ask a supplementary? We had evidence from North East Essex last week and in the recesses of my mind is a memory that there used to be a scheme where the chief executive of the health authority was also the chairman or director of social services in Barking or Dagenham. Does that ring a bell with anybody or with you?
Sir Bob Kerslake: Hammersmith and Fulham?

Baroness Shephard of Northwold: No it was not. It was definitely Barking or urban Essex some time ago.

The Chairman: Make a general point wherever the geography was.

Sir Bob Kerslake: The point I think you may be alluding to, and apologies if I have this wrong, is that quite a lot of places have moved to a model where they have either brought together public health and care or, alternatively, they have brought together the roles of managing adult services in the local authority and health as well, covering a similar area. I think the creation of the Health and Well-being Partnerships, the transfer of public health to local authorities' responsibility, which is a big change only just getting off the ground—

Baroness Shephard of Northwold: But is back to pre-1974, of course.

Sir Bob Kerslake: Pre-1974. It has taken us back, yes.

Baroness Shephard of Northwold: Some of us are old enough to remember.

Sir Bob Kerslake: Indeed. Nothing is ever new in this world. But I think those two things, plus clinical commissioning groups that connect with the areas and the boundaries that the local authorities do, open up the opportunity for this sort of collaborative working on this key agenda. They do not guarantee it will happen but they do provide the opportunity for it to happen. I would say that unless we find ways of transforming how service is delivered, we are going to have some very serious challenges in relation to funding the services required. So, for me, this is an absolute top priority issue both for government and for my own department, CLG.

When I referred earlier to the question whether there is any serious work going on at Permanent Secretary level, both Una, if she was here today, and I would say this is a shared top priority for us. It is worth saying it applies irrespective of Dilnot. Dilnot answers a particular question, as I am sure you are very much aware. It answers the question about the personal choice and risk around cost. It does not answer the question of how we fund the public care and how we make that system work. We have to answer both questions and the second question is crucially about how we make health and care integrate.

Q652 The Chairman: Could we just hijack for a second, because we have clearly taken lots of evidence. We were exploring that with our previous witnesses. Where the Committee is is that we think that the model whereby there is shared responsibility between the individual, the family and the state for social care is fundamentally right, because otherwise the cost drift is too mad. Yet with the problems with the current system, it looks as if local government is going to face a wreckage if it stays where it is, by which I mean social care is such a significant point of their discretionary budget and is phenomenally underfunded, therefore you distort what the local authority can do in very, very significant ways.

The second question is, because it is through local government, does that not inhibit, given where we have all been, the ability to win arguments for increasing substantially the funding that most of us think is blindingly obvious you need both now and in five and 10 years’ time into social care? There is a tension. Local government is a good vehicle to harness community involvement and apply the means test and a bad vehicle for getting more funding.

Sir Bob Kerslake: I would just test back with you why you think it is a bad vehicle for more funding.
The Chairman: It is a crude argument: there is no transparency, there is no ring-fencing, therefore it is hard to win an argument. If we give it to Wigan, they will go and spend it on football pitches or something rather than—

Sir Bob Kerslake: Let us deal with your first question, and this is a challenge that I have talked a lot about at a number of places. Fundamentally, local government spends a very high proportion of its budget on a relatively small number of people and a relatively small part of its budget on a relatively large number of people. It has been that way for some time. The challenge that local government is facing is, as we reduce the spending through the austerity programme, that the aggregate budget is coming down but the pressures on the care budgets are going up.

The Chairman: They are going to go up, yes.

Sir Bob Kerslake: You face a challenge there that you and I might say we are paying our council tax to keep the streets clean but in reality it does not look like that at all. So there is undoubtedly an issue here. I do not go as far as to say we will reach the doomsday scenarios of care squeezing out the whole of the budget, because all sorts of things can happen from this point on on that.

But there is a genuine issue here. The question is what we do about it. It has to be a combination of discussion around funding for care at the time of spending reviews, which is a key issue. Secondly, we have to look at the things I talked about earlier, the relationship between health and care and whether that can achieve more effective outcomes for less cost and, as I say, there is some evidence that it can. Thirdly, we need to do things through public health and make it a priority for public health to increase the likelihood that most of us will stay active and stay healthy for longer. Those are the three core areas that I think we have to work on. Not one of those alone is going to see us through this issue.

As for your challenge about local government, I see the point you make and there is clearly a risk that people think when they are cutting local authority budgets they are cutting chief executive salaries. That is a risk at a, let us call it, high political level. But when we come to discussions about spending review and resources, it is absolutely vital we do know the consequences of these two things together. So you might argue in a political sense it is easier, but it will come back and bite you if you do not deal with it, in my view. We are very alert to that point in government, which is why, as I said earlier, I am working hand in glove with Una on the issue of how her priorities on care sit with my agenda on local government. The two have to be considered in tandem.

Q653 Baroness Tyler of Enfield: We have zigzagged around a bit, but I would like to return briefly to the issue that Lord Bichard opened up. How is the way the Civil Service is structured and currently works assisting really good-quality strategic planning, medium-term planning and preparation for an ageing population? First of all, just in factual terms, could you tell us which government department leads, or it may be a bit of, “I do not know”, on the overall co-ordination of preparation for an ageing society?

Sir Bob Kerslake: It has essentially been a shared leadership between Work and Pensions and the Department of Health. If you look at who co-chairs the group working with the cross-ministerial group, it is the two Ministers from those two departments. If you see who are the prime leaders that I talked about at official level, it is those two departments. So it is not one of those departments but a combination of the two.

Baroness Tyler of Enfield: So it is a formal Cabinet subcommittee, is it, which is doing that co-ordination level at ministerial level?
**Sir Bob Kerslake:** No, there is a Cabinet group, but there is also a group working with the voluntary community sector as well on these issues and that is co-chaired by the two Ministers.

**Baroness Tyler of Enfield:** Would I be right in saying, because I know this has come up in earlier conversations we have had, that there is not at the moment one Cabinet Minister who is Minister responsible for this sitting round the Cabinet table?

**Sir Bob Kerslake:** No, there is not one Minister who has been given, as far as I can establish anyway, the responsibility. Indeed, there are mixed views about this, as you know, including some of the voluntary and community sector organisations who wonder whether giving one person the role will prove terribly effective. There is mixed evidence about the—

**The Chairman:** There is. We struggle with it though, because we thought: who is in charge of medium-term financial planning? Danny Alexander. Who is in charge of blue-skies medium-term policy thinking? Oliver Letwin. We asked both of them and both of them refused to come. It was not a diary issue, so they were signalling really that this was not an issue that was on their agenda—well, I will not take it any further. They did not come.

**Sir Bob Kerslake:** Yes. It is on everybody’s agenda but it is not one person’s agenda.

**Q654 Baroness Tyler of Enfield:** I think we all know that sometimes when that is the case you do not get the degree of either focus or priority that is needed. It is absolutely great to hear that it is a really top priority for you and for Una, bringing together what is happening between CLG and Health in terms of social care, but could you say what priority you think the Government as a whole is giving to this? Obviously government has many challenges to address but this whole issue of preparing for an ageing society, is it up there with the top three to five priorities or what?

**Sir Bob Kerslake:** It is clearly a very important priority for government and it is top priority in some of its aspects. That is what I would say. Getting people into work is a key aspect and creating flexibility and changes around retirement age and so on have been a key area where government has taken action. Issues around whether we have appropriate housing, issues around whether we have the care and health agenda sorted out, all of these are key priorities for government. So the agenda is important and elements within it are extremely important.

**Q655 Baroness Tyler of Enfield:** Just to finish off this bit of questioning, in terms of the future, if you were asked in your role as Permanent Secretary to advise possibly a new Government after 2015 or whatever how they should best structure themselves in order to deal with this issue, what sort of advice would you want to give? I think you have been commendably honest about how the current set of co-ordination arrangements co-ordinate but do not necessarily lend themselves to doing some of the big-picture strategic planning.

**Sir Bob Kerslake:** Yes. What I would say is, first of all, I would resist grand strategies and big teams, which then try to pull the issue out of government departments. This is an issue that is in the web and weft of the departments, so trying to pull it out seems to me unwise. I would focus on the framework that we talked about with Lord Bichard and, within that, the key consequential issues from ageing rather than ageing per se. That is really what I am trying to say. There is nothing that absolutely flows from ageing. It is things that are consequential—the match between health expectancy and life expectancy, work and so on. I would concentrate on having a framework of that sort where you would link it in with the longer-term planning we are doing on horizon scanning—powerful evidence-based
intelligence on what works by way of government interventions. That is how I would guide it. I would advise very strongly that we do not do this as simply big government; we do it collaboratively with voluntary and community sectors, so we listen as much to them about what the right issues are as we try to deduce our own conclusions.

Q656 Baroness Tyler of Enfield: Thanks. That is clear. My final point here is if, as part of this preparation, we need to look at big shifts of money—it might be health into social care, it might be to do with housing, it might be to do with pensions, those big and difficult shifts of expenditure—how will that get addressed? Would the framework you set out be sufficient to do that or would that still have to be done through Treasury-led spending review processes?

Sir Bob Kerslake: That is a good point. The framework would be sufficient to inform that work but I do not think it would do it. I guess the interesting challenge we face is that we tend to have our conversations around the spending review, which is relatively short-term, but we also need to have a conversation—and I do not think we yet have the mechanisms to do this terribly well in government—about what the long-term liabilities are.

The Chairman: Exactly.

Baroness Tyler of Enfield: Yes.

Sir Bob Kerslake: The report that has had much less profile from the OBR is their long-term liabilities report because that, in many ways, should inform thinking as well as the immediate spending review discussions. At the moment, the weight of government is on one but less on the other.

Q657 The Chairman: Perhaps it should not just be couched in long-term liabilities because that tends to position it as a fiscal problem for the Government rather than addressing the questions about what is it government needs to do with citizens given this issue.

Sir Bob Kerslake: I think that is fair. You would expect the OBR to focus on the fiscal problem for the Government. That is their job.

The Chairman: True, but because the Treasury dominates, both in the short term and what medium term there is, which is not a lot, it is still defined as a cost. The work we have seen so far on this has been that the Government has moved when it wants to close down its cost exposure. It has not moved much at all when it wants to look at the fact that some of these risks are going to be dumped on to the system. So it is an essentially selfish view of the world, the Government thinking about itself rather than thinking about its citizens.

Sir Bob Kerslake: I see the point you are making. The framework approach that I described earlier ought to not just be about the here and now challenges but about some of the longer-term challenges as well. You get the caution I have here and part of this is driven by having previously, albeit on a much smaller scale, tried to develop ageing population plans when I was in local government and, in truth, you ended up trying to cover every issue from every direction and much of it really did not have a lot of relevance to people getting old. It made assumptions about them, which were frankly patronising, and did not get to the core of the small number of really big issues that do flow from—

The Chairman: We will come back to those two in a second.

Q658 Baroness Morgan of Huyton: I wanted to pick up on the political involvement. I take your point that there is a real debate about whether one lead Minister is a good idea
or not. It is absolutely clear that there is not a clear answer on that. Do you think it would be helpful going forward to having a serious Cabinet committee trying to pull together some of the issues? We have had really powerful evidence this morning, completely consensual across the range of people—all the people you would expect in a way, a very clear catalogue of measures, particularly on the health and social care agenda they felt would move things forward. Yet, bluntly, there is no evidence in government, whether this one or any other, that those medium-term to long-term issues are seriously seized. For example, if we know that there has to be a movement from the acute into community, then that means reconfiguration has to be seriously seized. I wonder whether getting wider Cabinet colleague buy-in into those sort of issues helps to move the agenda forward. Otherwise, in a sense, if it is contained within the walls of the Department of Health, they are fighting local battles all the time.

**Sir Bob Kerslake:** I see your point. I think if you were to do what you are suggesting, it might not be a standing committee but a task and finish one that drew together the set of issues that we are talking about here.

**Q659 The Chairman:** Can I close on this before coming over to Baroness Blackstone about local government and housing? I just want to try to give an illustration, because sometimes this feels as if it is a nonsense medium-term discussion. Look at what had happened. DWP addressed, essentially, government's cost exposure to pensions with longevity and the Treasury, no doubt, would seriously reinforce them to do that. What government did was perfectly sensible. It raised the pension age and most of us say that was sensible. But DWP defined the issue about how do we stop government's exposure to the cost of pensions. It did not address the question of what do we, as a Government or a society, do for individuals who are going to live longer in terms of their funding. By defining it as a pensions question, rather than an income question, it ignored issues about funding social care. There is quite clear evidence on that. So it defined that out of the question. Secondly, although it has done something about employability, it has not done much about employability. Right to request is excellent but flexible policy for older workers is absolutely nowhere. So government, by the way in which its silos are short-term fiscally focused, defines these questions, gets the answers that are good enough for that but are the wrong answers if you take a wider, more medium-term view. If you take that picture together it is not very pretty, is it?

**Sir Bob Kerslake:** I think your challenge is a good one, which is that you say we define the issues by our organisational structure and functions and we define it by the time horizons that we are currently working to. Both are things that we struggle to break out of in government, not just on ageing, I have to say, but on other issues as well. What we are grappling with here is what are the best techniques that help us break out of that. I would say some of them are things such as Cabinet committees can do at their best but they can do—

**The Chairman:** I have been to too many, so I am not so sure.

**Sir Bob Kerslake:** Personally, I would go further and say—and you may think this is counsel of perfection—we need to change the underlying way of working of the Civil Service and how we deal with some of these issues. There is nothing on earth stopping us from creating collaborative policy teams, for example, but we do not.
Q660 Baroness Blackstone: I am going to turn to an area where you have a lot of experience and a lot of expertise, and that is housing. What can both central and local government do to stimulate more appropriate provision in housing for older people?

Sir Bob Kerslake: Part of it is work that I did at the HCA, which is understanding who has made good progress on this. We did a study, the so-called “HAPPI Study”, that went across Europe to understand where others had got on this agenda and learning from the best, I guess is the way of describing it. I think that learning is not just for government but it is also for the private sector as well. We are in a world where a significant part of the new housing supply comes from the private sector and they need to be persuaded that there is a market opportunity here. I think an important part of our role in government is to learn from the best and seek to persuade, encourage and incentivise the private sector to create the kind of products that people would want to live in. That has a double benefit because, if they move in, there is a chance that they will free up a house that would be useful for somebody else, basically. That is one part of the argument.

The second thing we have to do is work across the boundaries between what we are doing in housing and with health and invest funding in improving the quality of existing housing stock and its appropriateness for the needs of older people. Money has been put in. I think £300 million was put in to support that. It is a relatively small sum. I am not going to suggest that sorts the problem out completely.

Baroness Blackstone: It is a drop in the ocean really, is it not?

Sir Bob Kerslake: It is a small amount. I would not suggest it is a full amount but it is the territory we need to be in, which is ensuring that because we cannot build purpose-built housing for everybody, we make the best we can of what stock we have and that means investing in that stock to make it better for people who are ageing. The third thing, and we have done a lot of work on this, is how we made the planning system work so that when local authorities are developing their local plans they have taken account of the needs of their area, including whether it is an ageing population. So, there are three key things for me. One is about best practice and signalling. The second is that it requires funding to adapt existing stock. The third is that the planning system at local level should build into it the needs of older people.

Q661 Baroness Blackstone: Tell us a little bit more about what you found from the international comparisons and whether there is a role model country or two or three countries where we ought to be trying to implement what they have done.

Sir Bob Kerslake: It was called the “HAPPI Report” but it was, I am afraid, slightly depressing for us on one level because it showed how far ahead some other countries are. The Scandinavian countries have done the most here. They have consciously created housing that works for older people, where they choose to live in it as opposed to what they have to live in. The suggestion there is that if you provide that kind of product, people will buy it and will take it up. So it is the way you design the housing, it is the form of housing and so on.

Baroness Blackstone: Why do we fail to do this? What is wrong with us?

Sir Bob Kerslake: Well, it is a good question. I have pondered it many times, because there is so obviously a business opportunity here. If I am very direct, probably more direct than I should be, I think we have a particular house building model that finds it hard to move beyond its current stock of products. Most house builders have five standard products and
they are very reluctant to move beyond this, if I am honest. Somehow or other we have to create critical mass. We took along one of the more forward-looking house builders, Tony Pidgley from Berkeleys, and he came back absolutely convinced that there was a market opportunity here. But we need more of them to see that and see—

**The Chairman:** McCarthy & Stone, who you will know, gave evidence to us and essentially said there was an enormous problem about getting planning permission for sites. That implied, if one takes it at face value—and I am sure there is a little bit added on—that most local authorities do not seem to have what one would say was a clear housing strategy that recognised this was one of the big issues they face. It does not require state spending because a large proportion of older people are capital rich. The funding is more complicated, because you have care to provide as well, so your point is right, but even McCarthy & Stone were tearing their hair out to try to get access to sites to build what one would have thought in the right places would have substantial demand. So that said—at least to me, I do not know about the rest of the Committee—that most local authorities were just not waking up to this issue.

**Baroness Shephard of Northwold:** I do not think it is that. Sir Bob will, of course, answer, but the fact is they are very stretched and I think if you asked many local authorities they would say homelessness and single parents and the general demand—

**The Chairman:** They do not need to spend on this, Gillian. This is just about planning policies.

**Sir Bob Kerslake:** Personally I think it is both, to be frank.

**Q662 Baroness Shephard of Northwold:** But then it has a knock-on effect on their services. If they have a big conglomeration of housing for the elderly, what they see is big bucks were spent so that they have to shell out to support that housing.

**The Chairman:** No, that is true.

**Baroness Shephard of Northwold:** That is what my local authority is saying.

**Sir Bob Kerslake:** There may be some of that. I am sure that there are some who think that way. I do think it is a combination of both. I do not think there are enough players in the market like McCarthy & Stone, who tailor themselves towards the market, and there are some authorities who do not get the point either. I think both are true.

**The Chairman:** So what do we do?

**Sir Bob Kerslake:** We have to work on both levels, which is why I am saying we need to work with house builders. That is why we did the exercise we did at the Homes and Communities Agency. We have to persuade them that there is a market opportunity here, get the market leaders to bring the others with them. That is one part of it. The other bit is we have to get local authorities, in their five-year supply, to address the issue of an ageing population and the type of housing they are producing. You are quite right. They will face enormous pressures because we are simply not building enough houses. So in any one place, there will not be enough housing for people who are first-time buyers, as well as older people, but in the end we have responsibilities at a local level to deliver the needs of the whole community. So I do think it is both, but it is not entirely a story of gloom. There is some good evidence of very imaginative schemes around extra care, for example, across the country that have really been quite—
Q663 Baroness Blackstone: You have not mentioned housing associations.

Sir Bob Kerslake: I was going to come on to that as the last bit. You have moved on to a different issue. The housing associations are critical providers. They are the main providers of new affordable housing. Some specialise in this area and have done some very, very good schemes. They are certainly encouraged to bring forward schemes through the affordable housing programme that we have. I see them as key players. In fact they were part and parcel of this study we did for the HCA as well, so I think they are critical to the future. Frankly, they are often quite forward-looking on this, not least because many of their tenants themselves have changing needs, so I think they are critical. But we have to work on all of those levels.

Q664 The Chairman: Can I bounce off that to the question that is the local government equivalent of the questions that we were asking you as Head of the Civil Service? Again you know something of this from your Sheffield days. I agree with you that we do not want lots of policy wonks spending years doing an enormously complicated set of policies, which you will never do anything about because you do not have any money. But you would expect, would you not, that local authorities, every local authority, had a look at what was coming down the track—as you say, we know it. How many old people will they have and how many older old in 2020 and 2030? These are easy questions to answer. What does that then say about how they work with health and their social care? What does that say they do about their planning policies and their housing policies? Just do those things and you would have been a long way forward. We have no evidence at all from local government that they are doing it. I am sure some are doing it but there does not seem to be much sight that many are doing it. You may know better. Tell us what is going on and we do not need to worry.

Sir Bob Kerslake: I think there are some authorities who are doing some really good work on this and I will voluntarily bring some more back to you on this.

The Chairman: Please. A landscape view: we think that this about 10 per cent of the total or 50 per cent of the total?

Sir Bob Kerslake: I will see if we can work out a sense of where—we do not keep that sort of data.

The Chairman: No, I know.

Sir Bob Kerslake: So it would be hard to judge it, but I will try to give you some examples of where we think there is some real evidence.

The Chairman: You hear where I am coming from. What do we do to encourage those who we think are asleep to address it without thinking it is too difficult or too complicated?

Sir Bob Kerslake: Yes, therein lies the challenge of how much we are going to direct local government or empower them.

The Chairman: Indeed, and we know where you are at on that.

Sir Bob Kerslake: On the balance of that, we will be more on the empowering side than the directing side, as you know.

The Chairman: I do.

Q665 Baroness Morgan of Huyton: Can I come in at the end point on that about equity release, which in a sense is the flipside of making the whole market develop more for
elderly people? When we had the official from the Treasury he just said, point blank, that no work was happening in the Treasury on this, which is why, perhaps, we felt fairly fed up about the response that we have had. First, is that your understanding but, secondly, is that an area that government seriously are going to look at in terms of trying to help stimulate the market to make that work?

Sir Bob Kerslake: I think it is right to say that we have looked very much to the private sector in terms of products and that sort of thing.

Baroness Morgan of Huyton: Sure. I am not suggesting government products, no.

Sir Bob Kerslake: We fund, through CLG, some advisory resources on equity release and I am happy to provide you with information on that, so there are organisations who can give advice on this issue and we fund them, and they are taking forward some quite interesting work. So it has been less on, “Do we run a scheme?” and more on, “How does it happen?” I missed one point out, which is a really important point, on the local government side and I should mention this. It is that the Local Government Association have been working with quite a wide range of authorities on how they plan better for an ageing population.

The Chairman: It would have been nice if they had told us, would it not?

Sir Bob Kerslake: It would. I will get you a note on that.

The Chairman: I wrote to every single local authority in the country asking. I urged the LGA and all the LGA said was, “Social care funding”.

Sir Bob Kerslake: They probably undersold what they are doing and I will give you some information on that.

Q666 The Chairman: Could I pick up on Sally’s question though, because one of the simplest ways in which an owner-occupier with lots of equity can fund their social care costs would be if the local authority itself effectively kept a tab and rolled up the cost and put a charge on the property for when they died. Technically that is relatively simple. Am I right in thinking the Treasury would oppose that because it would score? Would it score significantly?

Sir Bob Kerslake: Local authorities can prudentially borrow, so they make their own decisions on these things. They have an ability to prudentially borrow.

The Chairman: It does not use up fiscal space, to use the phrase a Treasury official used to me, or does it?

Sir Bob Kerslake: Well, it clearly does. If they are borrowing, then that counts against the overall borrowing requirement of the Government.

The Chairman: It is relatively small beer, is it? I do not know.

Sir Bob Kerslake: It is. At the moment, there is very little of it going on but it is clearly an option for local authorities to help provided they can secure—it is by voluntary agreement.

Q667 Baroness Morgan of Huyton: I think it is both equity release for social care but also equity release to move into more suitable property while their property is being sold. We have had clear evidence that that is a problem at the moment.

Sir Bob Kerslake: It is, yes.

Baroness Morgan of Huyton: It makes it more difficult for people to live independently.
Sir Bob Kerslake: What I do not know is the extent it is happening or whether authorities are exploring it. Again, I will come back to you on that point.

The Chairman: Thank you very much indeed. Thank you for shuffling a busy diary and particularly a busy morning. We would be grateful for where you have signalled you would provide—

Sir Bob Kerslake: I will come back. Do you need it this side of Christmas?

The Chairman: No, it will do if it is first week back in January if things are pressed.

Sir Bob Kerslake: I will get people working over the Christmas break.

The Chairman: We are as well. Thank you very much indeed.
DWP Ageing Well Programme

Ageing Well Programme was commissioned by DWP and launched in July 2010, by Steve Webb. Ageing Well was a programme funded (£4 million) over 2 years, ended March 2012, to support local authorities to develop good places to grow older.

Ageing Well was a programme of free support, available to single-tier local authorities to understand the issues of an ageing society and develop good places to grow old. It provided sector-led support to help local authorities to meet this challenging agenda. Ageing Well’s focus was to go beyond the traditional boundaries of health and social care.

The programme was delivered in partnership with the Local Government Association (LGA) and has four main themes:

- **Leadership** – enabling leaders and decision makers in local government to set the vision and direction of what it means to create ‘a good place to grow older.’
- **Strategic approach** – the agenda is so important and wide ranging, affecting local government as a whole, that it will not be tackled by piecemeal or fragmented responses.
- **Involving older people** – as principal ‘customers’, a failure to effectively involve older people is likely to result in poor and inefficient services. Older people also have a huge contribution to make, which can be increased significantly through strategic but low cost support from the council.
- **Joined-up approach** – greater productivity and customer focus is more likely where commissioning and service delivery are properly coordinated and where a place-based focus is adopted.

The programme delivered intensive bespoke support to over 60 councils and other on-site support to around 100 councils, with around 1,000 senior officers and elected members attending Ageing Well Seminars. Key areas of support focused upon a number of subject areas:

- Support for councils to adopt a place based approach
- Support for councils to integrate the ageing agenda and engagement with older people into their Health and Wellbeing Boards
- Work with councils on an Intergenerational Programme to develop a peer support approach
- Ground breaking work to develop an approach for creating Dementia Friendly Communities
- Support to Scrutiny Committees to incorporate the ageing agenda into their work
Support for workforce initiatives Ageing Studies Certificate (the first academic qualification of its kind) and the development of a Leadership Programme with the Association of Directors of Adult Social Services

DWP are keen to take forward the learning and experiences from the programme. To:

- Disseminate the findings and learning from the Ageing well programme across local government, other government departments and stakeholder organisations
- Work with other Government Departments and partner organisations to deliver support to local authorities, that will embed the legacy of Ageing Well in terms of good practice and learning
- Influence and encourage local authorities, their partners and stakeholders to use the legacy tools and products

Maintain contact with, and encouraging advocacy, from those councils who received bespoke support to be champions for the learning, tools and products form the programme.

Deferred Payment Agreements

1. Annex B of the evidence submitted by DCLG on 17 December discussed equity release products supported by Foundations (the national body for home improvement agencies in England). This paper discusses Deferred Payment Agreements offered by local authorities to enable people to fund their social care needs.

2. Estimates suggest that around 30,000 to 40,000 people sell their homes to pay for residential care each year. The majority of sales involve people with insufficient income and savings to fund their care without using housing assets.

3. Selling the home can be difficult when entering residential care and is something people may wish to delay doing for a range of practical, financial or emotional reasons. For example they may simply need more time to adjust and to arrange a sale, or they may wish to rent out the home or keep it in the family.

4. Authorities can offer people who face selling their homes to pay for a care a deferred payment agreement (DPA). A DPA is an agreement between a local authority and a care user who is due to pay an authority care charges. The authority may defer the charges allowing the care user to pay at a later, convenient time. The authority secures repayment by placing a legal charge on the person’s home, allowing it to recover the charges when the home is sold, or from the estate.

5. Authorities have powers (not duties) to offer DPAs, i.e. they are discretionary. Surveys suggest that availability of deferred payments is variable across the country. Some authorities do not offer them or do so in exceptional or limited circumstances. However some authorities do offer them on a more significant scale and a few may have hundreds of agreements in force.

6. The Dilnot Commission concluded that availability is ‘patchy’ and recommended that DPAs should be available in all local authorities. The Government agrees with this and
thinks it is important that people have the option of a deferred payment to provide them with breathing space and greater choice when they go into residential care.

7. The Government has made the following commitment:

- From April 2015, all local authorities will offer deferred payments.

- No-one will have to sell their home in their lifetime to pay for residential care. People that cannot afford reasonable residential care charges without selling their home will have the choice to defer the fees until they are ready to pay, or from their estate.

- We agree with the Dilnot Commission that interest or charges should apply to help authorities recover their costs (interest is not currently chargeable), AND

- We will fund local authorities to help them offer the deferred payments.

8. This will have a range of benefits, making it easier for people to pay for care and reducing the problem of ‘distressed’ housing sales.

9. The Department of Health will consult with the care sector in 2013 on how the scheme should work. This will include: who is eligible for a DPA; what fees the scheme should cover; and what interest and charges should apply.

10. The Care and Support Bill will set out the legal framework for the universal deferred payments scheme.

January 2013
WEDNESDAY 9 JANUARY 2013

2.05 pm

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope

Examination of Witnesses

The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health, and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions.

Q668 The Chairman: Good afternoon again; welcome again, Secretary of State and Ministers. I am very glad you could come with us to help us. You know essentially what the Committee is about; it is asking the simple question, “Are we ready for ageing? Are we ready as individuals? Are our public policies and services ready?” That is it. I will not introduce the Committee. I think you probably know a fair number of them. Apologies from Baroness Shephard; she has an official duty and hopes to be with us if she can towards
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 1)

the end of the session. Apologies from Brian Mawhinney, who will be with us for the first question or so, but again has to leave as well. You will be used to it from your own Select Committees, this process of change. That is where we are at. Can I just check that you do not want particularly want to make any opening statements and are comfortable for us to go straight into the business? Will that be all right? Excellent.

Let me start off by asking the Secretary of State, but in your role as a Cabinet Minister: what has the Cabinet done so far to look at the issues of an ageing society collectively? Clearly, individual departments have looked at issues, but what has the Cabinet done collectively? Has it had a process for doing so, and has it developed out of it any coherent vision or strategy as to what we should be doing in public policy terms?

Jeremy Hunt MP: I think we have made good first steps but, to answer the broader question “Is there much more we can do?”, I think there certainly is. The way I would characterise the Cabinet’s approach to this issue is that we believe that one of the things that unites the coalition is an attempt to try and make big decisions for the long term. When you start thinking about the big decisions that you face in public services, it does not take very long before you come up against the ageing population as one of the big nettles that you have to grasp. There has certainly been a recognition of the importance of the protection of older people’s benefit, the triple lock on the pension, and the protection of the NHS budget, for which the overwhelming benefit goes to older people.

The two departments that you have here are the ones that have been engaging most actively in that agenda. Certainly, since Norman and I have been at the Department of Health, we have identified a number of key priorities, the majority of which relate to the challenges of an ageing population—the big debate over improving standards of care; the big focus on dementia and long term conditions. I think there is an understanding in the NHS, which is not yet reflected in actual change in terms of what is happening on the ground, of the need for change, because older people have very different health needs from the needs that the NHS was set up to cater for. It was set up to cater, and by and large caters extremely well, for people who have a discrete, curable health condition—need a new hip, a new knee or whatever it is. But most older people, particularly the over-85s, will have a set of long-term conditions which are not likely to be curable and will need constant interaction with the NHS.

The Chairman: You are absolutely right; we will come to that in some detail. Could I just stay for a minute with the Cabinet and the collective process by which the Government, at senior level, has looked at this issue in the round, as a medium-term issue? Where we are, we do not particularly see that there is much sign that that has happened as yet; you admitted as much yourself. There has been good work done in terms of looking at cost exposure to pensions, for example, but there has not yet been a process to look at what it is going to be like in 2020 and 2030, and what that implies for public services and public policy in the generality.

Jeremy Hunt MP: I would like to respond to that, if I may, but I think that Steve wanted to say something.

Steve Webb MP: If I may, just briefly: one of the Cabinet committees that is chaired by my Secretary of State, Iain Duncan Smith, is the social justice Cabinet committee. That had a session specifically on ageing, and from that came an organisation called the Age Action Alliance. Is that something that has come up? That stimulated that process. It was not so much that it is on every agenda to discuss this issue, but that it got that process going, and
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q that it has been a really good means of bringing together of a lot of external organisations with Government, to look jointly. This Committee is within the Cabinet structure, so while it has not necessarily been on a formal Cabinet agenda it has been looked at at that level.

The Chairman: The officials briefed us on that at one of our early meetings. Let me put the question in a different way, then. What do you think ought to happen going forward?

Jeremy Hunt MP: I think that Governments need to be judged on their actions. The fact that we have not had a brainstorming session as a Cabinet—what do we do about an ageing society?—is not the key point here. The two biggest issues we face as an ageing society are the sustainability of the NHS and the sustainability of the pension system, and within the NHS I include the social care system as part of that. We have made very real progress in trying to tackle those issues. We are not there yet. DWP is coming forward with some very ambitious plans for a single-tier state pension, which we now need to deliver. The NHS is embarked on the biggest programme to try and make it sustainable for the long term that it has ever had in its history, which involves annual 4 per cent productivity savings, which we are so far delivering but it is very tough to do so. We are confronting some very difficult questions in the social care system with Dilnot but we are not yet delivering that and need to make sure that we do so. In a two-year period, a lot of good work has happened, but there is a great deal more that needs to.

Q669 The Chairman: That is clear and honest, and thank you for that. Let me ask one final question, or put an assertion to you, and then invite other Members of the Committee to come in on the same topic. The sense we have got from evidence over the past six weeks is that clearly a lot is being done, but it is essentially looking with a fiscal focus, short term and departmentally. Clearly, because we all know the processes, anything that is done departmentally is checked across—that is the way Government works; we all know. But it is not essentially starting from looking at the issues addressing citizens in 10 years’ time—citizens collectively—and what that implies in terms of public policies. That is the impression we have got. Comment if you wish to, but we will come back and test some of that, I think, throughout the course of the next hour or two. Feel free if you want to comment on it, otherwise I shall pass to Lord Mawhinney.

Jeremy Hunt MP: All I would say to that is that I would not accept that, if you do not mind me saying so, with respect to the approach that we have taken to the NHS, which is the one that I can speak most directly to. We have spent a huge amount of time on dementia and long-term conditions. That is not something that is going to pay any political dividend in the short term. We are looking forward to 2020, when there will be a million people who have dementia in this country, and we are recognising that there needs to be a radical transformation of the way that the health and social care system works. So we are very much looking forward. What I would say is that we have made progress, but there is a huge amount to do. When you lift the bonnet up on these problems, you often find that they are a great deal more complex than you originally thought and a small piece of work leads to much bigger pieces of work, and we are in those early stages.

The Chairman: We will look forward to testing the health position in more detail shortly. Later on, I will probably give a couple of illustrations that justify, I think, the assertion that I made, and why one can see the policy flaws in the absence of a process which is looking medium term at a certain change that is facing us. This is not a risk; it is a certain change that we all know is happening. Enough for now, though. Brian?
Lord Mawhinney: Secretary of State, can I go back to one of your two big issues, NHS sustainability? For 20 years, Ministers have been saying that we needed to shift people out of hospitals and into the community. I was doing it 20 years ago; you are doing it today; and it has covered all three Governments in the intervening period. The fact that you still have to do it today is a reflection on the last 20 years. So what direct powers do you—you, the Secretary of State; you, the Government in Richmond House—have to require treatments to be shifted from hospitals to the community?

Jeremy Hunt MP: We are very conscious of the fact that facing up to this challenge has eluded many of our predecessors in the Department of Health. That is the first point that I would make. I think that the heart of Andrew Lansley’s reforms has been greatly misunderstood in this respect. What he was really trying to do with those reforms was to say that the only way that we will actually tackle that issue is by not thinking about the levers that a Secretary of State has, because every single lever that a Secretary of State has has been tried to be pulled over the years, without any success in dealing with that issue and indeed many other issues that the NHS faces; and that the way that we are going to do that is by focusing the NHS on outcomes and getting politicians to set outcome targets for the NHS, and then leaving it to clinicians to deliver those outcomes. The heart of the delivery of the new system is the local GP-led consortia, the clinical commissioning groups, that will be responsible for delivering what is in the NHS mandate, which is better outcomes for older people, which does mean vastly enhanced primary care and keeping people out of hospital as much as possible. It is a rather technical answer to the question but highlighting that what we want out of the £105 billion budget are those outcomes, rather than me trying to be chief executive of the NHS, is going to lead us to have a much greater chance of success.

Let me just prolong the dialogue a moment longer. That was certainly where Mr Lansley started off. As you know, Parliament required him to assume responsibility with the national commissioning body. The idea that Secretaries of State did not have to have any responsibility did not fly in Parliament—it certainly did not fly at this end of the corridor—so that was changed. Over the last 20 years—I—I keep saying “me”, not for ego reasons, because I do not want you to feel like I am having a go at you; I mean all of us—have been saying much the same thing. We call them primary care trusts; we call them SHAs. For two years there was genuine change under GP fundholding, but by and large the words change but the rhetoric has remained the same. That is a fairly good indicator that something is really not functioning the way any of us would want it to function. All of the evidence—which you will not have read, and I do not blame you, but someone should read it for you—overwhelmingly is that, when all the dust settles on these new proposals, the fundamental issue of shifting people from hospitals to the community is not going to change very much. I would not presume, Chairman, to second guess what this Committee is going to say, but I think it is probably fair to say that we are pretty sceptical as well. Would you answer my question again? If you want to answer it in terms of “Here are the targets we are going to set, and I, the Secretary of State, have power to do that with the national Commissioning Board”, give us some idea of what the outcome levers are that would satisfy you that there was a genuine shift from hospitals to community care. Of course, this is particularly important for the elderly.

Jeremy Hunt MP: There is quite a lot to unpack in that question, so let me do my best and then I want to hand over to Norman Lamb, who wants to add something, if you are happy for me to do that, Chair. First, I want to clarify one very important point. In the passage of the health Bill, which is now the health Act, Andrew Lansley and I always believed—and the Government has always believed—that the Health Secretary and the Government are
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 155) responsible for making the NHS better. We remain responsible, and we were happy to put it in the legislation that we retain that responsibility. The debate was about how you achieve that and whether you are more likely to achieve it with the Health Secretary effectively sitting as chief executive of 247 Foundation and NHS trusts and 8,000 GP surgeries and the rest of it, or whether actually you are more likely to achieve that if the politicians try and set the outcomes for the system but give much more operational autonomy to the hospitals, the GPs and the other parts of the system. I think you are right to say that there was very real change under GP fundholding, but that only applied to a very small part of the NHS budget and a very narrow subset of the kind of conditions that people needed to be referred for. We are hoping, with clinical commissioning groups, to achieve the same innovation, enterprise and local empowerment, but for a much broader range of conditions. So we are very much going in the same direction as those GP fundholding reforms, but for the whole service, not just for a part of it.

If I may say, if the Committee concludes that clinical commissioning groups are not working and are not going to achieve this important shift, it would be somewhat premature, because they only actually come into force on 1 April. I believe the evidence on the ground. If you talk to the leaders of the clinical commissioning groups, who have been operating in shadow form for a year, the vast majority of them are practising GPs and they are absolutely talking about the most incredibly impressive innovation in terms of how to keep the frail elderly out of hospital by better integrated, more joined-up care, and I think some of the innovation that is happening is going to be ground-breaking. But I do not think you should make the benchmark of success whether fewer people go to hospital because, broadly speaking, demand across the NHS is going up by 4 per cent a year. What we are actually trying to do is to control growth in demand, but I do not think that even with the most successful implementation of the reforms we will see massively less people because the background picture is of ever rising demand. What we want to do is to cope with that demand better by treating people outside hospital who are able to be treated outside hospital.

Norman Lamb MP: Better management of people with chronic conditions is key to this. Certainly, we want to stop the crisis admissions to hospital that cost the system so much and are so totally disruptive of someone’s care. If we think about where the money has gone over the past decade, the big increase in investment, it has all gone at the acute end, the repair end, rather than at the prevention end. If we ask whether we are using the money that we have available to us optimally, the answer is clearly no.

Are the financial incentives within the system right? I do not think they are always right. Payment by results is a good system for elective care, when you need a hip joint replaced or whatever, but to deal with long-term chronic conditions, we need to be more sophisticated than that and create incentives to manage people’s care much better out of hospital. Things happen as a result of financial incentives, and we have to get the incentives right so that we are addressing the new need which, as Jeremy has said, is all about the acute problem of an ageing society and people living for many years with often a number of different chronic conditions. I am a great advocate of integrated care, and we have to make sure that that the financial incentives allow that to happen.

You asked about the direct levers. We have the mandate which sets the Government’s priorities to the Commissioning Board. It was very clear that we want clear progress on developing systems that deliver integrated care at scale and pace. That is the phraseology that we used. There are mechanisms, but the new architecture is much more about collaboration than diktat from Whitehall.
Q672 Baroness Morgan of Huyton: I want to ask you about incentives. We have had quite a lot of evidence about the incentives—the disincentives in the system in a sense—the false incentives that mean that if people need out-of-hours care, the only option they tend to have is 999, and then there is an incentive on the hospital, bluntly, to keep them in. I am interested in the nitty-gritty because you have sketched out the broad description, which I would agree with, in terms of what you are trying to do, but can you be a bit more concrete for us about how you are going to change the incentive system so that there will be opportunities for people not to have only the option of going into hospital because that is what is available out of hours, seven days a week and free at the point of use?

Norman Lamb MP: We want to encourage experimentation. I am bringing in a whole load of people within the NHS who are working at a local level on changing the incentives. One of the great potential values of the reform is that it potentially allows much more experimentation at local level rather than the one-size-fits-all blueprint imposed from on high. There are some quite exciting things going on. I visited Heartlands Hospital in Birmingham recently which has now collaborated with the primary care trust so that it is incentivised to keep people out of hospital and to maintain their conditions better, rather than just getting more pay for every extra patient that comes into the hospital.

You do not get this right immediately. This is work in progress, but all of the most successful health systems around the world are moving towards this different model. Rather bizarrely, the United States, which overall has a completely dysfunctional system, has within it examples of great practice. Kaiser Permanente and Geisinger are using capitated budgets to give incentives to the whole system to manage care better, and there is a lot we can learn and we can allow it to be applied where there is clear evidence that they can make it work.

Baroness Morgan of Huyton: Does that include a move to looking at a whole budget rather than at fragmented budgets? In a situation where part of it is totally free at the point of use and the other part is not at all, there is a very clear incentive for the user to end up in the health service rather than in the social care system, if they can get into it, and the only way into it is to call an ambulance, so the whole thing moves on that way.

Jeremy Hunt MP: Somewhere where that is happening is Oxford. It would be worth having a look at what the clinical commissioning group in Oxford is doing. It is paying for a year of care for its elderly, the people who have complex, long-term conditions. There are a handful of clinical commissioning groups that are coming out with very revolutionary plans that could go a long way to cracking this.

Q673 The Chairman: I wonder whether I can focus on what we are about as a Committee because what is happening now and in the next year or two is interesting and relevant, but it is not really our focus. Our focus is looking to 2020 and 2030. Why we are looking at this is because we know from the department’s data that by 2030 we will have 50 per cent more people in our society aged 65-plus and by 2030 we will have 100 per cent more 85 year-olds. Those are massive strategic shifts of population and demand that we have to serve. There are fundamental issues that affect demand. You know it much better than we do because you are sitting on top of it. I am certain that the essential thrust of what you are saying is that you are not going to address these massive systemic changes by incremental bits of change and improvement.
Let me just bore you with a few more bits of data because they may at least be relevant to those who read Hansard, if not to you. We have not been able to get data from the department itself on what forecasts you have of the level of disability you think there will be in 2020 and 2030. If you have got it, we would like it. The academics said that they are not aware that it exists. We would like data on your estimates of the level of morbidities and comorbidities by 2020 and 2030 because they are fundamental to anybody looking at this issue seriously and strategically. We have had to rely on academics, and we have had some excellent academics. The sort of data I have is that if you look just at 2020, 2020 is virtually now. It is not 2050. 2020 is what we should be planning for now. They forecast that we will have between 30 per cent and 50 per cent more disabled people, depending on the definitions used. Between 30 per cent and 50 per cent more disabled people by 2020 is a totally game-changing set of demands on the system. If you look at five key chronic conditions, they are all plus or minus 5 per cent, but it does not matter, the figures are so big that they will be game changers. On chronic conditions, it is 24 per cent. On multiple morbidities, the department’s own data is that there will be 1 million people more with multiple morbidities by 2020. You have any number of other data.

All this is driven by the big population changes. Ageing is highly correlated with long-term conditions, as you know, and long-term conditions drive 70 per cent of your costs. Put that lot together, and you get reports from Nuffield that tell us that on its best estimates by 2022 the increase cost needed by the NHS is between £40 billion and £50 billion, unless you make remarkable efficiency savings, in which case it will drop to about £30 billion. I do not need to underline that. You know how utterly these are strategic shifts of demand requiring a strategic rethinking of everything from the funding model and the entitlement model to the delivery model. That is our mindset at this stage. Can I invite you to respond to that?

Jeremy Hunt MP: I agree with you. I think that the picture you are painting is very bleak and challenging and is one that we have to face up to. I do not disagree with your sense of urgency. I would disagree with you if you were suggesting that the pace of change within the NHS and the social care system is not fast enough, because if you talk to anyone inside the NHS, they would tend to say the opposite. They would tend to say that the pace of change is very fast indeed.

The pace of change is substantial. The new structures are designed to do that, but if you look at the efficiency savings, we now think that we have saved about £11 billion of the £20 billion identified from the Nicholson challenge. The NHS has never had to make those kinds of productivity savings before, and it is accustoming itself to the idea that it will have to continue making those changes, and that is going to be extremely challenging.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 449)

The Chairman: We are not saying as a Committee that nothing is happening. We are aware that an enormous amount of good work is going on. I think we are doubtful that the scale of efficiency changes—it is great news if you have made 11 of the 20—by themselves will address the scale of the changes that are needed. Let me stay where Lord Mawhinney was. He was essentially on the question that was extremely clearly put to us by the King’s Fund and Nuffield. The NHS’s needs have changed, as you put it very clearly, from dealing with infection and acute crisis towards the management of long-term conditions. That is too black and white, but the weight has shifted quite clearly and dramatically. That requires much better primary, much better out-of-hours, much better community, much better local integration of all those functions and a minimisation of admission into acute whenever possible. Those to us seem like very significant strategic changes, and the question was not whether are CCGs hopeless. It is far too early to say that. CCGs by themselves—200 of them—are not going to drive those sorts of structural changes. The policy of the department appears to be: “Let the mushrooms grow. Stand back. We have given them the resources; it will happen”. That defies most of our diverse experience of managing and making change happen at a strategic level, as opposed to incremental improvements.

Baroness Blackstone: It was great to hear about local autonomy. I am all in favour of local autonomy, and I do not want to sound Stalinist, but the scope for local autonomy is incredibly limited if the national framework and the way in which it is structured is wrong in terms of the needs we now face. That is the view that the Committee now takes. We have a structure and a system that is no longer fit for purpose. Large numbers of old people end up either in hospital or neglected in some way in the community because we have not worked out what the relationship should be between social care, care in the community and the NHS. It is so much easier, as Lady Morgan was implying, to end up in a hospital where there is seven-day-a-week care than it is to stay where you probably should be, which is either in your home or in some other kind of more appropriate and cheaper community facility. Given all the other pressures that the NHS is under in terms of increasing demand as a result of growing knowledge, new technology and so on, we are going to be in quite a big mess unless we can do something nationally rather than sitting and waiting for good initiatives.

Lord Bichard: It may be easier for you to roll up the answer.

The Chairman: Let us have three or four questions. You will love it as a politician as you can then pick and chose which ones you answer.

Q675 Lord Bichard: I want to come back to the issue of fragmentation, but not just fragmentation within the health and social care sector. Secretary of State, not surprisingly you have been talking from that perspective. We have had people here from the front line, if you want to use that term, who have come up with inspirational stories similar to those you have come up with from Heartlands and Oxford. We have been inspired by that. The thing that saddened us was that they nearly always said, “We have achieved this in spite of the system and in spite of the way in which national government organises it”. I have to tell you, Secretary of State, that when we have had senior civil servants before this Committee, we have not been convinced that the kind of approach that you articulated at the beginning, the joined-up approach that you would like to see, was actually happening. Frankly, we did not sense that they had ever met before, let alone to talk about ageing.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q The reason I say that is not just about the Department of Health is because to get this right it needs to be about employment policy and the way in which employers are dealing with older people, and it needs to be about planning. We have heard how difficult it is to get planning permission for housing for the elderly. It is easier to get it for a supermarket than it is to get it for housing for the elderly. It is about housing, it is about the way in which we are devolving local administration. This is why the Chairman started at the beginning by asking what the Cabinet has done and whether there is a strategy—I know strategies and visions are out of fashion at the moment. Is there a sense that all of this is somehow being brought together? We do not necessarily want to suggest what the Australians have—a Minister for Ageing—but it is a different approach. Are you happy with the way in which the centre is facilitating and will facilitate action on the ground?

The Chairman: Let us pause there and then Ilora can come in after this; otherwise we will get so many different questions. You have two sets of questions there. Lord Bichard has taken you back to the Cabinet processes and then Baroness Blackstone asked about the system change.

Jeremy Hunt MP: We have to be very careful here. I understand that it would be immensely comforting for people who are alarmed about the challenge of an ageing population, as I am. That was what I talked about in the first speech I gave as Health Secretary. Pretty much every speech I have given has been around the theme of an ageing population and how we need to wake up to it. I think I have said more about it than perhaps any of my predecessors in the past decade. I completely share your alarm, but we have to be careful not to draw false comfort. Had the Government produced a wonderful strategy, a document that said, “This is how we are going to achieve X, Y and Z, and we have thought it all out and it is all joined up”, it is my belief that Governments should judged by what they do, not what they say.

I think this Government have been doing a lot. If you look at the NHS, I know the reforms were controversial, but for the first time—and this was something that was put in place by the previous Labour Government at the very end of their tenure, so it is not entirely of this Government’s making—the NHS is making 4 per cent efficiency savings every year, year in, year out. It has never had to do that in its history before. That is a huge change in the whole mentality throughout the NHS. That is about sustainability. That is not about short-term fiscal balances because the budget is flat, broadly speaking. In real terms, it is going up slightly, but we are getting a 4 per cent increase in demand every year, so we have to make 4 per cent efficiency savings. That is a huge change for the system, and that is a decision that has not been ducked. That is happening.

How you make a change is perhaps where there is a difference between me and some Members of the Committee because my experience and belief is that we will be more likely to get radical transformative change if we increase local autonomy rather than trying to direct it from the centre.

Q676 The Chairman: Most of the evidence we got did not necessarily disagree with some form of local commissioning. People may have doubted whether they would have chosen 200 as opposed to 50, but put that to one side. Most of the questions were essentially about what else you needed. To give you an example, people felt that if you looked at the recipe that the King’s Fund put out about improving primary, improving out-of-hours services to reduce unnecessary admissions into acute and recognising fewer, much better acutes with much higher standards, it thought that politicians had to be painting a
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q picture of why a restructured health service along those lines was necessary to deliver what older people, and others, will want in 10 years’ time. I do not think people have heard that.

Jeremy Hunt MP: With respect, I think 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 because the structures we have at the moment are such that you have very entrenched support for local hospitals, and you have a Minister in the Department of Health, SHAs and PCTs that come up with strategies that talk about rationalisation, and they have failed to gain public support.

The Chairman: We totally agree. It is a political truism and clearly addressing it as, “We've got to close hospitals to save money” is the wrong question. Seeking to get funding from acute into community with perhaps better acute services is a different way of putting it.

Jeremy Hunt MP: What you are asking me to do is to come up with a grand national strategy that I then impose on every part of the system. Respectfully, what I am saying is that that approach has been tried to death and has failed. What we are trying to do is something very different. If you look at what we have charged clinical commissioning groups with doing, we have said that care of the elderly and dealing with long-term conditions are an absolute priority. It is one of the key things they have to deliver. These are local GPs who have very strong links with local hospitals, and we are starting to see some very interesting models develop.

When I was in my previous job, I was responsible for superfast broadband. Without any money from the Treasury, I said, “I want Britain to have the best superfast broadband in Europe”. Much to the surprise of my department, I took the small amount of money that I had, carved it up, gave it to local authorities and said, “You get on with it”. We will have the best superfast broadband in Europe by 2015 because of that sense of ownership at a local level of the changes that needed to happen. That is really what we are trying to achieve with these new changes in the NHS.

Q677 The Chairman: Broadly, I am sure that the Committee does not disagree with that. The question was whether the power of those commissioning bodies is sufficient to make those sorts of changes when they require above all sorting out out-of-hours and emergency. Why do the public love their hospital? It is because it is the only damn thing that is open on Saturday. You would be mad to want to close your hospital when you cannot get anything in service terms apart from a call centre. I am being crude, but you know what I mean. Unless we have the diversionary services and systems that mean that people do not need to go to hospitals, people will always want to defend their hospitals, until they understand that they are more likely to live if they go to a centre of excellence rather than a crap local hospital. Of course they are going to fight closures.

Jeremy Hunt MP: I think the Committee is right to ask whether we need to remove more obstacles to that local empowerment. That is a central question. These bodies are starting in April. A central part of what we have to do as Ministers is to look at the things that prevent that local empowerment and local innovation happening. Seven-day working is a key thing. When it comes to hospital reconfigurations, they come to my desk as Secretary of State and I need to make the case for change as well as making the case that local people’s concerns should be listened to. I am completely with you on that. What I am nervous about is the suggestion that the only way that we will achieve this kind of
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q fundamental, radical change is by unveiling something called a strategy and then imposing it on every corner of the system.

The Chairman: I think you are misunderstanding us. We accept that that is old-fashioned speak and not the way we make complex systems change, but it requires some sense of making an argument about why a world like this would be better than the world we have and trying to support people in bringing that new world about.

Norman Lamb MP: I completely accept that we have got to go out and make that case. To give a quick insight, at the first meeting we had around the table—we both arrived in the department back in September—the first question posed was: how do we achieve a sustainable health and care system with an ageing population? We were posing this very question. With the priorities that Jeremy has set and my acute interest in changing the model of care to address this new challenge, we get it. It is about creating a shared vision rather than a centrally imposed blueprint.

Lord Bichard, you struck a chord when you talked about great things happening despite the system. I find it constantly when I talk to people around the country. You get real pioneers out there who are doing brilliant things, but it is always a slog to get there. What I want us to have is a culture that facilitates that experimentation within that vision that we create about the system that we need to create to meet the needs that you have so clearly articulated. We absolutely understand that a pretty fundamental shift has to be undertaken.

The Chairman: That is very helpful. Ilora, do you want to have a go at question 3 or have we largely done it?

Baroness Finlay of Llandaff: There is whole tranche that I would like to cover that leads into this.

Lord Griffiths of Fforestfach: Is that the end of this session of what we have been doing?

The Chairman: I omitted you, Brian. Would you like to come in, and then we will come on?

Q678 Lord Griffiths of Fforestfach: Yes. I am very sympathetic to the approach that the Secretary of State and the Minister set out. From my experience back in the 1980s in No. 10 and the reforms we started in education, if you look at what is happening in education, there is tremendous potential for enterprise, pilots, new ideas, creativity and so on. I am not sure how much of some overall framework you really need. I have to say, Chairman, in some of the sessions we have had—I think I mentioned it to you privately—the reform of the NHS has been on the table for 30 or 40 years, and it has never been done. The question we have to ask is: why has it never been done? Is there not something here that is at the heart of us not being able to do it? I think I said to you that in some of these sessions I felt I was probably in the early 1970s in the Ministry of Planning in Moscow trying to sort out what should be done. Instinctively, because of what I have seen in education, I am very sympathetic to let not mushrooms, as you suggest, but a thousand flowers bloom. The question I would really like to put is: if this is where you think you are going, and I go back to my experience in education, what would be the key elements in convincing some of the sceptics around the table here and certainly the wider public? What would be the key elements that you would make in making that case?
Jeremy Hunt MP: I think the education parallel is a very good one because although it does not have the specific issue of the ageing population, for obvious reasons, it has gone a lot further than we have in health in dealing with the quality issue. Someone who was an adviser to Tony Blair said to me yesterday that the most significant moment in education reform in the past 20 years was in 1991 or 1992 when the Government of the time had the courage to allow Ofsted to declare some schools as failing. That process—and I would add to that the decision by the incoming Labour Government in 1997 to keep Chris Woodhead as chief inspector of schools at Ofsted—sett in train a process whereby driving up standards in education became part of the DNA of what the education system has to be about.

We have only just started on that journey, but if you ask me what has to happen, first, we have to have the courage to talk about where there is failure in our healthcare system. That has to be the start of the process. For that, the reforms are very important because they remove the Secretary of State and Ministers from operational responsibility for the NHS, which means it is much easier for us to talk about where there is failure. That is a very important part of it.

Another thing we can learn from the education system is that the system is also very good at recognising excellence. As well as those failing schools, it recognised outstanding schools, and the superheads who have been at the heart of the transformation of the education system were recognised as people who Ofsted said were running outstanding schools.

One of the problems we have at the moment is an element of demoralisation inside the NHS because the people who run great hospitals do not get the recognition that they might get, and they are exactly the cadre of people who could turn around some of the failing hospitals.

With respect to an ageing population, I would add that the further thing we need to do is to allow local flexibility but to combine that with complete rigour about the assessment of whether people are hitting the mark and to be public when they are not. For me, the one Stalinist piece, if you like, in the new equation is very thorough, very public independent inspection. It is really important. This morning I had a meeting. I was questioning why of 8,355 GP practices across the country the public do not really know which ones are good and which ones are poor. We do not really know that about our hospitals. In terms of the abuse of the elderly in some parts of the system, one of the reasons that that continued for much longer than it should be is because we do not have the knowledge of where things are going wrong. It is not there. In terms of delivering the standard of care that we want, that is very important.

With the NHS, we have a problem that the education system does not face so much, which is the financial sustainability of the system. That is why I want to make one final point—I am sorry this is a long answer. One thing we have not mentioned so far in this debate, which will be critical, is the use of technology. We have to recognise that. Banks have reduced the cost of retail banking by one-third because so many people now bank exclusively online. The airline industry has massively reduced its costs because people book their tickets online. The NHS has barely started that journey, and there is massive potential in terms of making the system sustainable financially and offering a better service to the public if we embrace that revolution wholeheartedly.

Baroness Finlay of Llandaff: Secretary of State, there were several things I was really glad to hear. One of them was that you were talking about your role in the centre in driving up standards. You mentioned seven-day working in passing, but disease respects
Jeremy Hunt MP: Let me ask Norman to comment on the social care bit of that question because he has been particularly thinking about that. What you said is music to my ears. I completely agree with the thrust. On things such as seven-day working and the working time directive, there is a central role. Government has a role. Those are centrally imposed blockers that we have to do everything we can to try to mitigate or remove. I accept that we have to do that. The debate has started on seven-day working. Professor Bruce Keogh is looking at that now, and I know the NHS Commissioning Board is very focused on it. You are absolutely right; we have to have a 24/7 NHS. There is a very clear link between financial sustainability and making sure that we do not end up with the outrageous fact that you are more likely to die if you are admitted to the hospital at the weekend than if you are admitted midweek. We have to sort that out.

On technology, you are absolutely right. What can we do from the centre? First, very much part of what we are trying to achieve is a system that is transparent so that we expose parts of the country where the clinical commissioning groups and GPs fail to deliver a high or adequate level of care for older people with chronic long-term conditions. The first thing that we want to do, we cannot do at the moment. Michael Gove can go into work on a Monday morning and know that there are around 2,000 primary schools that are not meeting minimum standards. He does not have to worry about the other 18,000; he can focus his effort on the 2,000. We do not know where the 2,000 or whatever the number is pockets of population are where these standards are not being properly dealt
On technology with respect to older people, I think it is absolutely crazy in this day and age that an ambulance can answer a 999 call and arrive at someone’s home not having been able to use an iPad on the way to their house to look up their medical history and find out that the person who they are going to pick up has mild dementia, was admitted last year with a stroke and has diabetes, which are facts that could be critical in the care those paramedics give to that person and which could determine the hospital they are taken to and all sorts of things. We do not have that information at people’s fingertips. Of course that would deliver massively better care, even if that person never touches an iPad in their life. It would also be a big money saver for the NHS because we are far more likely to get them back healthy quickly.

Q680 Baroness Finlay of Llandaff: I was not talking specifically about computer IT and data IT. That is part of it—rapid data transfer and rapid access to results—but the other part is the ability, for instance, to put a pacemaker in an elderly person whose rhythm could be transformed by doing it rapidly. If you can do a rapid MRI within a few hours on somebody who has developed leg weakness when they have got malignancy, it will make all the difference between them losing their legs and being paraplegic and heavily dependent and being potentially treated. That is irrespective of age, but the numbers are going up because the number of people living with long-term malignancy, for example, is going up.

It is also the medical technology that we already have being available on a 24/7 basis to appropriately intervene and to be able to get bloods done rapidly. In the community, some people are waiting three weeks before somebody will come out to take their blood. It seems ludicrous when a GP can visit and take blood. We have almost compartmentalised even clinical care right down so that the GP says, “Oh no, the nurse phlebotomist will come and do it”. In the days when I was a GP, we just took the blood and dropped it off on the way back. There are some things where in so-called streamlining we have created duplication in the system, and it is the same with aspects of social care. We have tried to define healthcare and social care, partly because of the budgetary split, yet we are now leaving people stuck in compartments, and there are delays and duplication because of multiple assessments where the more skilled person could be doing the lot when they are on site and pulling people in. Their framework for working needs to be changed, and I do not see how that happens at a local level because it is all tied up with national contracts.

Norman Lamb MP: We have got what I would describe as institutionalised fragmentation. We have managed to divide mental health from physical health, primary care from secondary care, healthcare from social care, and it is not very rational from the patient’s point of view. I shall give you an example. Judith Wood is an inspiring practice manager from a rural GP practice in Norfolk—North Elmham; Baroness Shephard will know it. I met her last week, and she talked to me about how, despite the system, she has brought together the dementia nurse from the mental health trust, the social care people from the local authority and the district nurses and is starting to build a collaboration with the acute trust to manage the condition of people with chronic conditions much better. They meet regularly, they monitor the condition and they are even doing something rather revolutionary: they are getting a GP to go proactively into care homes to work with the care home staff to manage conditions. At the moment, they just go in when there is a crisis.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 32)

This is crazy. They have demonstrated what is possible. We have to facilitate that mainstream across the system.

Baroness Finlay of Llandaff: We are trying to ask you what Government needs to do centrally and where those long-term levers are. We have lots of these examples, but we need to be saying nationally, “This changes”. Where are your levers?

Norman Lamb MP: That is why I said that we have got to facilitate experimentation and remove barriers, which are often the payment systems that cut against that good practice. We have to allow the local area collaboratively—it might be based on the GP practice as the lead provider—to do things in a much more rational way rather than it happening despite all the levers working in the opposite direction.

The Chairman: We will be coming back to this issue of the local delivery of integrated health and care as our fourth big topic. Let us move to funding social care, a favourite topic.

Q681 Baroness Morgan of Huyton: It is no surprise that this is on our agenda. Secretary of State, you talked earlier about making big decisions for the long term. Obviously this is one that you as a Government seem to be, from what we can tell in the papers, about to take. We have had extensive evidence of the crisis and the uncertainty around funding for social care and the provision of high-quality social care. One of the things that we have become perhaps more conscious of than we were at the beginning as a Committee is that if you reach a decision on Dilnot, that will be a step forward, but not the entirety. It would be very nice if you were to give us the figure today, but we are not expecting that. First, what do you think a decision on Dilnot brings to the table? What else has to be done? What are the other decisions that have to be taken for the long term to improve the quality and provision of social care?

Norman Lamb MP: I think Dilnot is an essential part of the solution, but it is not a panacea, and I think everybody understands that. It is a legitimate and important role of government to protect people against catastrophic loss, which in a way is what Dilnot focused on. There is real potential for Dilnot, once implemented, to drive some behaviour changes which would be beneficial. At the moment, someone who starts to have care needs will be panicking about how on earth they can fund them, so their instinct would be to hoard their money and not to spend it on good prevention early on. If people can relax a little bit about the fact that they will be protected against catastrophic loss, it will encourage people to start spending sensibly. Alongside that—and this is where the Care and Support Bill comes in—we can encourage people to engage as soon as possible when they start to have care needs. At the moment, we have this crazy situation where self-funders are literally on their own. There is no access to support or help that is readily available. Things are starting to change here and there, but we need to have a system that encourages people to come forward to have a conversation about how they can build resilience, how their family can help support them, how neighbours can help and how they can self care. Self care has got to be a critical element of this in future. So many people with chronic conditions do not know how to manage their condition well, and so the crises occur. That early conversation with the local authority that the Care and Support Bill will provide for can be really beneficial in helping to prevent deterioration.

The other point I would make is that there is hope—nothing can be guaranteed—that financial services will respond by offering top-ups once there is some certainty. One option that Andrew Dilnot talked to me specifically about is the possibility that pension schemes
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence

Q might start to offer a care option so that instead of receiving the full lump sum on retirement, you might take a lower lump sum with a care option if the need arises. Any financial institution that offers that package has an interest in maintaining your health, and so we start to change the environment in which we are trying to make good things happen.

Alongside that, the Care and Support Bill does some other useful things. The universal entitlement to defer paying for care so that you do not have to sell your home at a moment of crisis is a very sensible reform, and portability, so that you can move nearer a relative without the care package collapsing straightaway, is a positive thing as well.

Q682 The Chairman: What does it not address?

Norman Lamb MP: It does not deal with the fact that there are immense financial pressures on the base line, on the existing care system. I am acutely aware—

The Chairman: Can we agree with you on that? We might debate where the cap should be and whether this is a total priority, but nobody on this Committee is going to say, “Throw Dilnot away”. However, the debate has been hijacked by Dilnot, and I think the public probably think that if the Government say, “Yes, Dilnot’s done”, the job is done, and that is a disaster because quite clearly the funding crisis now in social care is appalling. You know it better than I do. Let me put what has been put to us pretty crudely: in the next spending round, the Treasury is not going to give the Department of Health more money. That is a fairly crude assumption, but it is not going to give much more money, given the consequences to other services, so if we are going to address the social care funding crisis, you have got to take money from the NHS and put it into social care.

Norman Lamb MP: Which we are already doing.

The Chairman: Indeed, commendably, and much more than has been done so far.

Norman Lamb MP: I met with county council leaders and some unitary authority leaders this morning to talk about these subjects. There is no escape from the financial pressures. Public finances are in a difficult position whatever one’s politics, so it all comes down to how we can use the money optimally and how we can encourage other behaviours. I talked about much more sensible integration between health and social care. I also think that unleashing the power of community is critical here. I have heard of some fascinating projects in Leeds and Sandwell where local authorities are working together with the voluntary sector.

The Chairman: We took evidence and were very impressed. It is totally right, is it not?

Norman Lamb MP: It is fantastic. There is a danger that we all think of old age as just a bad thing and a whole load of problems. Actually, there are great aspects to this, and we must not forget that. People in retirement so often want to give, want to help, want to give back, but often do not know how to. We can unleash the power of people in their communities—neighbours. I made this point over Christmas and got attacked on Twitter for doing so, which is something that we are all familiar with these days. As the extended family has dispersed, sometimes internationally, there is a great danger of people being very lonely, on their own, not having any companionship and of their physical and mental health deteriorating. 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.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q683)

Baroness Morgan of Huyton: Can I just ask something, just as a supplementary? I do not think any of us around here would disagree with what you have said—in a sense we have all got personal experience of those things as well—but I am interested in pushing a little further. While recognising the arguments you have made about innovation and local autonomy and Brian’s comments, which I sympathise with from my period as—

Jeremy Hunt MP: Scars on the back.

Baroness Morgan of Huyton: Scars on the back—and indeed, a real belief that inspection should be used to drive improvement, I am really interested in what you said about that. However, I am also interested in knowing to what extent you are willing to push where you need to and to really take strong action from the centre where that is needed. I would like to go back to the 24-hour point that Baroness Finlay raised because I, too, heard Sir Bruce make those comments and I thought “Hooray! Good luck! You are pushing hard on this”, but I thought he put his head above the parapet and took it down again immediately. It seems to me that there is a series of issues that are fundamental to get any of the innovation and the change to happen on the ground. There are some issues that you need to identify very clearly at the centre and be prepared to make them happen.

The other point in a sense relates to what you just said about being close to family. We heard a lack of evidence on it, although we tried. It is around equity release and getting products in the market moving that enable people to move from an overlarge home into a small home nearer family and so on. To be blunt, the evidence that we had from the Treasury and a couple of other departments was hopeless on that, like, “No, we’re not looking at it”. It seems to me that there is an important role for you to identify some issues that are necessary for you to sort, to be brave about and to take on in order for local change to happen.

Norman Lamb MP: I think we are willing to do that. I had to take on responsibility for the Government’s response on Winterbourne View, and I regarded it as a national scandal that people with learning disabilities were being treated as second-class citizens. I posed the question, “Would we ever allow someone with cancer to be given inappropriate treatment or care?”. Of course we would not, yet that is what has been happening. There are moments when you have to set a national imperative for change, but you do not have to impose a blueprint about the one single way it is done. You create a shared vision about the type of service we need to meet the extraordinary challenges you talk about, but then you allow the flourishing of local experimentation to find the answers. This is the way innovation will happen, not by Whitehall dictating the answer.

The Chairman: You are articulating our report for us, but the first point is the bit we are labouring on about articulating the vision and making the case for that vision. Let us move on. Let me link it with a final cheerful comment. The forecast we have seen is that the amount of disability we will be facing in 10 years’ time is 30 per cent greater than that we are facing now. Therefore, the funding and the funding model both for disabled and healthcare are not sorted quickly like this but require some very serious thinking by government. You know that, but we will labour the point.

Let me move to another cheerful topic: pensions.

Q684 Lord Griffiths of Fforestfach: In the evidence we have taken, two issues have come up. One, following the Turner commission was the inadequacy, almost the lottery in some ways, of the present system with major risk being taken by the individual with defined
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q contribution. One thing that really concerns me is that if we had inflation, we have a massive overhang of debt in this country and in other countries, and we also have quantitative easing. There is an awful lot of money out there. If there was unexpected inflation, which could easily take off, we could see people severely damaged. The question is: as you look at the future of pensions, how do you see changes that could be introduced to strengthen people’s sense of what they will have and to have some sort of permanence in what they might be offered?

The second issue is state pension age. I can speak only personally, but I think it is true to say that there is a lot of evidence that says that the present system is unsustainable. We do not want to be apocalyptic, and we want to have a level playing field between incentives to work after 65 and incentives before 65 or 60. We may even want greater incentives for people who would otherwise be retired to work. I wonder how you see that shaping up.

Steve Webb MP: The first thing I would say is that I think the Turner commission and the contributions to that by Jeannie Drake and John Hill have been hugely valuable and have stood the test of time. The commission started 10 years ago, and what it said then is still broadly true today. Since then, three major areas of reform have happened. One is automatic enrolment into workplace pensions, which was initiated by the previous Government. One is the state pension age increases, which were begun in the 1990s, and which we are accelerating, and I will just briefly say a word about that. The third is state pension reform, on which we will publish a White Paper very shortly and which will be implemented in the next Parliament. There are three strands.

Just briefly on how each of those addresses the points you made, clearly, on state pension age, we took the view that to get to 65 for men and women only by 2020, which was the plan we inherited, was extraordinarily pedestrian. It would leave you with a male state pension age in 2020 that was roughly the same as it was a century earlier. Indeed, the last time the male state pension age changed, it went down. We felt that was too slow; we accelerated it—there was some controversy about the speed with which we did that—so that we are already looking at 66 by 2020 and 67 by the mid-2020s, and then there is a mechanism, the crucial thing, for being systematic about this.

Coming back to Lord Filkin’s point about short-termism, I sort of smiled a wry smile because when I look at the analysis and charts I get given in the department, I had to stop them putting 2100 on one of them because I thought that was a bit speculative.

Along with the state pension reform in the White Paper we will have a section on the mechanism for responding to longevity and the state pension age. We have already indicated that broadly what we will do is say, “Where there are growths in longevity, they will be shared between your working life and your retired life”. Some countries are saying that the whole of that goes on your working life. I went to Denmark, and they told me when the state pension age would reach 74. They already have a blueprint all the way to 74. We felt that that is too draconian, but that if you have a broad proportion of adult life in work and retirement, then improvements in longevity would mainly go on working life, but partly on retirement. We will set out in the White Paper shortly a mechanism and a process with the flexibility to say that the stats tell us this, but we know that in the north of England longevity has not improved or we know that it has or has not improved in manual workers, just to give a bit of flex on that. There will be a minimum notice period so that you are not changing people’s pension ages five years ahead but are not locked into 25 years ahead. If someone tells a 30 year-old what their state pension age is going to be, they are
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q lying, so you have to get that balance right. That will be more automatic and semi-independent—it is sort of independent but it is ultimately responsible to the Government—and that is the first strand.

The second strand is state pension reform. The White Paper is almost imminent. In a world where pension outcomes are much more uncertain and inflation is becoming much more volatile, we think the role of the state is to get someone who has a lifetime of working or caring contributions to that basic minimum that the current basic state pension does not do. Even today, we, the DWP, do not think that the £107-a-week basic state pension is enough to live on and we will top you up with another £35 of pension credit. How can it be right to let many people retire poor and then try to catch them through a means-tested safety net? We do not think that is right, and it does not work in a world of auto-enrolment where we want even small savers to save.

What we think the state should do is what Beveridge said: a single, simple, decent, flat-rate contributory pension that just gets you to the minimum. That is then earnings-linked, so even the people at the bottom of the pile are protected against the volatility of the future. They will not be on a king’s ransom. If you are on average earnings, a £7,000 state pension is not going to make you very happy, but it means that the people at the bottom part of the pile who are least able to cope with the volatile world we are going into will be protected. That is the second strand; I shall come back to that.

The third crucial strand is automatic enrolment into workplace pensions. Again, one in four of the people who we automatically enrol are in their 20s. Auto-enrolment is not going to change pension outcomes in the next five to 10 years, but it certainly will in the next 30 years. The goal there is to say that the state does what the state does best: universal provision at a minimum level but dealing fairly with women, carers, low earners and people who the pensions market is not interested in. Then there is universal workplace provision, with a mandatory employer contribution and a taxpayer contribution, which is opt-out but in which people see clearly what the state guarantee is and is not in order to make informed choices about how far they want to make sacrifices to go beyond. That is our long-term strategy that tries to address some of the points that you raised.

Q685 The Chairman: Can I just pick up one point, Brian? I think that is clear and, by and large, I would guess that we thought that was good, but again, we would say that it is not sufficient. The elephant in the room is that over the past 10 years, for reasons that you know better than we do, there has been a shift from defined benefit to defined contribution, and defined contribution is a dreadful product for two reasons: it shunts all the risk to the individual—the investment risk and the longevity risk—and as a consequence, the individual—I am grateful to colleagues for this one—has no understanding of what pension they will get for the sacrifice we are asking them to make now. In a situation where 20 and 30 year-olds are stretched, they are not going to make a sacrifice to save £10 a week for a product when they have not got a clue whether it will deliver anything. So our hypothesis is that defined contribution is a completely bust product and government and the industry have urgently got to work to at least remove some of those appalling characteristics so that you effectively know within certain parameters what you will get. Otherwise you will never incentivise people to save. Would you broadly accept that?

Steve Webb MP: No. I absolutely accept that there are issues with defined contribution pensions, and I will say a word about how we are going to try to address them. If you are a low earner working for a firm that currently has no pension provision, I am never going to force it to have a defined benefit pension—
The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q)

**The Chairman**: Defined contribution.

**Steve Webb MP**: No. I am never going to be able to force it to have a defined benefit pension. They just will not do it. The only pension provision that firm is going to make is to put some money into a pot. That is the world we are in, so the challenge to us is to make defined contribution good for those people.

**The Chairman**: That is my question. It was not going back to DB.

**Steve Webb MP**: Quite. What I am saying is that the bulk of future pension provision is going to be DC going forward. People sometimes ask, “Why should I save into a pension under auto-enrolment?” The difference between that and sticking it in an ISA or under a mattress is the employer contribution. In terms of pensions, clearly the first thing that matters is how much is going in. 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. Can you find another investment that turns four into eight overnight? 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. That is the first thing.

**The Chairman**: We are not knocking auto-enrolment. We have got to go beyond auto-enrolment.

**Steve Webb MP**: Indeed we do. That is the first thing. The second thing is not to underestimate the role of NEST in all this. NEST will be the pension provider of default for people who have never had pensions before: the small firm and the low paid. That is who people will chose: the Government set up, low-cost, good-value-for-money scheme. Precisely because it has had to focus on the end of the market that we are all worried about, it has had to innovate, and it has been very good. Other providers are doing it as well, but it has been very good on pensions language for people who do not speak pensions, communication and on giving people an idea of what they will get and how much they need to save. There is a huge amount that can be done on all that.

It is not just NEST. For example, Morrisons, the supermarket, has done a huge amount of communication with its employees—road shows, gurus off the telly and all that—and it has had massive opt-ins to its workplace pension just through creative communications. DC is not an awful product. It is a pot of money. The challenge to us is: (a) to get as much money in as we can; (b) to get maximum value for that money—charges, governance, scale and all that; and, (c) to make sure that we get the maximum pension out at the other end, which is shopping around, open-market options and all that.

Can I just say a brief word on risk sharing?

**The Chairman**: I agree with all you say, but on the third one, it is a question about whether there needs to be more work done by the industry and government working together to increase the level of certainty about what is going to be the value yielded from the sacrifice you are making and what you are putting in. That is the area we are looking at.

**Steve Webb MP**: Let me come to this if I may. I have posited this thing in the middle. Pure defined benefit on final salary, guaranteed and index-linked, is wonderful, but incredibly expensive and volatile for the employer. Pure DC, as you say, puts the risk on the individual and the firm walks away. It just puts the money in and walks away. Is there a space in the middle? I have called it DA: defined ambition. It gives some element of certainty.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q Malcolm Mclean put it very well recently. He said: “Good pensions may have gone away, but good employers haven’t”. There are employers out there who are willing to do more than basic DC. My job is to give them a regulatory regime that helps and encourages them to do that. Let me give you a simple example. If I am an employer and I want to provide a workplace pension linked to what people used to earn, I cannot just provide half your final salary; I have to provide, by law, index-linked half your final salary. It is illegal for an employer to offer half your final salary without indexation. Why? Well, because workplace pensions used to replace state pensions. Now that we are abolishing contracting out, it is additional. We should be embracing employers who want to offer some element of certainty and guarantee, so that is our defined ambition space. We produced a document just before Christmas on this with a range of options which are all about addressing the limitations of pure DC for people who work for firms that are willing to do it. Many people do not, so we have to make sure that pure DC is a good product as well.

Q686 The Chairman: We will look at that. Before we come to Baroness Blackstone and the related issue of work, which is fundamental, can I just press you on an illustration that we gave to Bob Kerslake? It was of the absence of government looking at this issue holistically. DWP addressed quite vigorously the question about pensions, either by minimising the state’s exposure to state pensions—putting it negatively—or by trying to get a better pension system, which you have just articulated. It did not address the question of how older people amass, or have access to, sufficient funding to meet the risks they are going to cope with. It was put very clearly to us by a very senior official that it did not address the issue of funding social care, for example. Norman will be well aware of that. Saving for social care is not even on the policy agenda in any real sense, not in the public debate, yet it ought to be an issue, if not as big an issue. I am not asking you to comment on that, but do comment on what seems to us to be a bit that is largely ignored, except in a negative way.

Given the impossible pressures coming on to public finances in 10 years’ time, not because of the fiscal challenge we are in but because of the shifts we are talking about, we have got to do something to make it easier for people to use the very substantial accumulated wealth they have locked up in their properties—where they have them—to support them either in income, in getting appropriate housing, in funding some of their social care costs, or at least in making life a bit easier. In other words, we have this enormous amount of assets—obviously lumpily distributed, but at least it is there—and it is potentially one of the most creative solutions to the great conundrums that we all face as a society. That is not being debated. When we asked officials about it, it was stuck somewhere in a cupboard at CLG, and they were not quite sure who had the key to it. It was not being thought about creatively, pan-government.

Steve Webb MP: Let me just comment on the pension/social care interaction because I think we may be about to see a big step forward there. You are right that we need to save for a retirement income, but it feels to me that the risk of catastrophic social care costs is a kind of insurance-y sort of thing. If we had done a Dilnot, as it were, and therefore the tail risk had been capped, I think insurance products would start to become feasible. That links to what Norman said a minute ago. Funnily enough, I think it is easier in a DC world. We create a generation of people through auto-enrolment and other mechanisms who build a cash pot. I have strategies to enable people to have fragmented cash pots brought into one which I call a big fat pot, to use a technical term. At the point of annuitisation or similar, if I give the Pru £X,000 out of my pension, a relatively modest capital sum, I do not sacrifice
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 1 much annual income, and if it has 20 years before it turns into care costs for a percentage of people, (a) that is pretty good value, and, (b) as Norman says, it gives all the right incentives to encourage people to look after their customers. This has not happened because there has not been an insurance market because of the tail risk. I think this could start to move quite quickly.

I had two sessions with Andrew Dilnot—my first boss—in the course of doing his review, and he was joining up between departments in the way that you would like to see. I think that could happen and is happening.

I take your point about housing, actually. As you imply, housing equity is unfortunately pretty well correlated with pension wealth, so there is a certain extent to which, on average, people with lots of money in a property also tend to be quite well pensioned as well, but clearly there is a set of people in the middle. I think there is a lot more that could be done on trading down, although this is incredibly sensitive territory. I represent an area with lots of rural communities. Saying to someone that they have all that housing wealth and the best way to release it is to trade down and move to a flat, but they have to move out of the community they have been living in, is very difficult, but I take your point that that is something that has been a bit siloed.

The Chairman: That goes back to one of our points that local authorities are not having appropriate house-building strategies to have the right houses with the right products to make the switch possible, but leave it for now.

Q687 Baroness Blackstone: I want to take a step back from pensions to work. Some of our earlier discussion about health and social care implied that most people who have reached old age are either physically frail, partly ill or seriously demented. That is obviously nonsense. There are hundreds of thousands of people in their late 60s and right into their 70s who are physically fit, very well and full of energy. Surely it would be helpful if far more of those people were working, not necessarily full-time, but certainly part-time, some of them possibly volunteering. Norman Lamb referred to putting something back in terms of companions for the very old and frail, but it is much more than that, because there are large numbers of people who probably would enjoy working and would like to work. They would be less lonely, less poor and happier. What are the Government doing to make that happen?

Steve Webb MP: First of all, I entirely agree with the propositions. One of the most dramatic changes we made, which will take time to come through, is abolishing forced retirement: the default retirement age and all that. How could we have a situation where we are raising state pension age to 66 and beyond, but people could still be sacked for turning 65? That was a nonsense, so we got rid of that. The biggest cultural, social shift will be the day when the male pension age ceases to be 65. Sixty-five is such a powerful thing in the psyche, but on the day, which will be some time in 2018 or something like that, when even men do not get a pension at 65, it will suddenly be, “Oh, hang on—my pension age isn’t fixed”. There is not a day when you retire. It is a much more fluid process. That is partly a cultural shift, but having the state pension age the same for men and women will also be a cultural shift from women retiring several years earlier. That is important.

In terms of what we are doing, one of the biggest reasons is that people drop out of the labour market. For example, for men in their early 50s it is incapacity benefit, ill health or that kind of thing. Rather than essentially just parking people on long-term sickness benefits, which is a terrible waste of their talents, we are intervening early through workplace
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q 395)

recipients, sitting down with them and asking whether there are any jobs they could do, what are the barriers and what is the support they need. The Work Programme incentivises providers to help people by re-energising a whole set of people who have dropped out of the active labour market and will go on sickness benefits until they reach pension age and then have a lousy pension, which is crazy.

The third thing we observe is that people sometimes write to me who are aggrieved at our raising state pension ages and say, “Why are you making me work when there are all these unemployed 20 year-olds?” But of course the evidence, as you well know, is that these two are complementary—harnessing the skills of older workers is good news for young people on average as well. So we have to communicate the fact that we want to retain and harness the skills of older workers and not write people off.

One thing that I have talked to the Minister for Employment about is whether the Work Programme is doing enough for older workers. The Work Programme will prioritise the long-term unemployed and people who have had past sickness absence, but it does not have any special support for providers to get older workers back into work. If you have got someone who has dropped out of work—perhaps IT would be the obvious example—it would not take much to get them back as a credible member of the active labour market, but they have just dropped out. The danger is that the Work Programme provider does not have any incentive to prioritise them over all the other groups that they are prioritising.

What we need to look at is whether the initiatives we are taking in the labour market are doing enough for older workers who have dropped out. We do have initiatives in jobcentres and so on focused on older workers, CV skills, IT skills and so on, but that there is an awful lot more to do, I would entirely accept. For us, if people are going to live on average to late 80s and beyond, retiring in late 50s is just never going to make the sums add up. One final observation: I had a police officer who came to me the other day, who complained that we had stopped him retiring at 52. We just cannot do this any longer.

Q688 Baroness Blackstone: Can I just come back? Looking at the elderly unemployed is only one tiny segment—

Steve Webb MP: Yes, it is the inactive—

Baroness Blackstone: —of this great big market of potentially employable people. What we need to do, do we not, is to consider—of course it is partly cultural change in terms of attitudes—how we support those who already want to, and encourage those who do not want to, to continue in employment much longer than they currently do; and, when they stop their main career or job, whatever it may be, to then find other employment? That is really what my question is about, not dealing with those who are defined as unemployed and are turning up at jobcentres.

Norman Lamb MP: There is also a job to do in changing attitudes among employers. I was an employment lawyer in a past life. There are some great exemplar employers.

Baroness Blackstone: I was about to ask you—that was going to be my next supplementary: what about employers? What kind of discussions and conversations are you having with employers’ organisations?

Steve Webb MP: We do have various employer forums that we work with. If I say, “It is great to employ older people”, it is said, “You would say that”, but what if other employers
The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q say it? The classic example is that the McDonald’s branches that employ older workers have higher profits than the McDonald’s ones that only employ teenagers. So there is plenty of evidence that it makes good commercial sense, but there is still all the prejudice and so on.

The Chairman: And the CBI and others have been hopeless on this agenda so far, have they not? You could not possibly comment, but they have been dragging their feet massively. Our perspective is that this is a real wake-up for industry.

Q689 Lord Bichard: This is such an important point it should not just be a footnote, should it? I was going to say that all of your answer ignored the employer. You have now talked about the odd forum, but actually we have heard one or two inspiring examples of employers who employ older people. B&Q’s oldest employee is, I think, 89. We have all heard the same examples. Why did they do it? Because it was good for their business. Most employers see it as corporate social responsibility. This is something surely in which Government, with organisations like CBI, could make a big contribution to changing attitudes and culture in our employment market.

The Chairman: And start with your own employees—make part-time employment work possible.

Baroness Finlay of Llandaff: You look at the NHS, which is one of the largest employers in the country and yet has very few people over a relatively low age limit. It has very few people over the age of 65 working in there, and is remarkably inflexible to using the talent in those that it has got so they leave because they either do that job or they have to go, instead of developing much more flexible approaches.

Steve Webb MP: That has partly been driven by public sector pension scheme ages, so that if you can have a full pension at 60 why would you work to 65? That will change over time, but it will take a very long time to work through.

Norman Lamb MP: In terms of the culture change you talk about, the fact that the Government has actually legislated to remove the automatic retirement age of 65 is the most significant thing of all, because it suddenly opens up the discussion and the moves to introduce age discrimination laws as well. It also includes the way in which you are treated by the NHS, which is an incredibly important shift that has happened, implemented from 1 October last year I think. We have made quite a big shift in culture change. Now there needs to be a constant encouragement for employers to embrace that.

Q690 The Chairman: And, to really be extremely difficult, the Government should review, should it not, all of the incentives and disincentives that encourage people to stop working by looking at a whole suite of policies that automatically mean that you get to a certain age and you either pick up certain benefits or you get certain dispensations from tax?

These seem to be products of a world that we have lost. They are terribly difficult politics, you know better than we do. Nevertheless, they have to be part of any serious looking over the next 10 years, have they not?

Jeremy Hunt MP: I would just add that if we are going to have this fundamental rethink, I would like to put education into the mix, because I think it is totally wrong that we have got into this pattern where you do full-time education for your first 21 or 22 years if you go to university, and then it is full-time work, and then it is full-time retirement. All the evidence is
The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence

Q that people who carry on learning throughout their lives are much happier and much more fulfilled. You might vary the proportions during your life, but actually people who retire to boost up their learning, do a little bit of work and have a portfolio of things that they do are generally the most fulfilled people. So I think we should look at attitudes there as well.

The Chairman: Sounds good to us. I think we are positing as a hypothesis a world whereby people do not retire suddenly if they do not want to—that they can partially retire, that they can do partial work—and that they do not automatically pick up all sorts of benefits that encourage them to stop working, because that is not in anybody’s interests apart perhaps from policemen’s in the short term. Then you have a much different attitude to this view about cliff-edge retirement—retirement suddenly being the perfect life. I am speaking very crudely, and it is much more difficult than that, but that is what we have got to be having a debate about with the public, is it not?

Steve Webb MP: That is another example where the much maligned DC pension actually has the flexibility, because it is not a fixed age that you draw on this day and that is it. You have got much more choice when you take a DC pension when you turn it into an annuity, and because you can defer state pension with quite generous accrual if you do you can take different bits of your income, do a bit of part-time work, and those flexibilities will become more rather than less.

Q691 The Chairman: Liberal delivery of health and social care—Gillian?

Baroness Shephard of Northwold: I have a question for Norman Lamb. He mentioned good practice that he found at a GP surgery in Norfolk. I would also like to refer to a point made by the Secretary of State—I was late, but it was just as I came in—which was that it would be a very great help if ambulances had access to the health status of those whom they are going to see. We have had extraordinary evidence about the local delivery of health and social care. We have heard that it is underfunded and confusing for the recipient. There are perverse incentives for the working together of the various agencies but notably health and social care. We have heard that it is underfunded and confusing for the recipient. There are perverse incentives for the working together of the various agencies but notably health and social services. Most of all, the arrangements seem to ignore the existence of the individual—the person—in the care, the process and the system, What never seems to be taken into account is the experience of the individual recipient of the care.

We have also heard some good practice. One of the pieces of good practice that we heard about was Torbay, where every recipient of social care and indeed every patient from a GP surgery has, in his or her house, a yellow folder, which provides details—manually prepared—for the services that they may have, the treatments that they are getting and so on. The ambulance people would pick up the yellow folder—it is rather like a red folder in the education system—and have it in front of them.

We do not want to recommend wholesale reorganisations of anything. There has been far too much of that, and there is a very big one going on right at the moment. But what are you doing to share good practice across the country? We have been struck by marvellous practice in places. Do they know about yellow folders in Norfolk, Mr Lamb? If not, why not? If you think it is good practice, what are you doing about that? It would be one way forward.

Norman Lamb MP: I spend my life talking about Torbay, and they do a lot of things very well there. They have integrated teams of health and care workers that monitor the health of all of those people at the top of the pyramid who are most likely to go in and out of hospital, and clearly they provide information for anyone arriving in an ambulance to collect someone and take them to hospital.
Beyond that there is, as Jeremy indicated, a big project to ensure that all of the elements of the local health system are joined up electronically. It is crazy in this day and age that the local GP practice, the hospital, the social care people and, critically, the patient are not all linked up, sharing the same information. If we are to get integration to work—as you were absolutely rightly saying, services shaped around the needs of the individual not the institution—that is facilitated by the technology. There can be an enormous advance, I think, with smart use of technology. You look at it in systems like Kaiser Permanente in California, where they are really smart at identifying people who are at risk, with early intervention to stop conditions deteriorating. Also, there is the sending of messages about how you can maintain your health better—the aids to self-care.

**Q692 Baroness Shephard of Northwold:** That is fine, but what is happening here? That is my question.

**Norman Lamb MP:** I think it might have been before you came in. What I want to see is for us to encourage and facilitate that local experimentation, and for that best practice to spread as quickly as possible. We cannot, I do not think, impose a single blueprint from the centre. That would fail. We have tried it in the past. A point we were discussing earlier was that too often these great things happen despite the system, and if the system can facilitate really effective joint working then we can effect real change at scale and pace.

The King’s Fund are really up for this, and I am working very closely with Chris Ham. I am going there on 16 January to meet with these local innovators that you talk about who are doing great things. We can use the national organisations—whether it is the Department of Health, the Commissioning Board, or the Local Government Association—both to drive that best practice and really encourage it, and also to remove barriers where they exist. One of the barriers that does exist is the financial incentive that encourages acute hospitals to do more and more activity—payment by results. For people with long-term chronic conditions, that payment system is not fit for purpose and discourages that really good innovation at the local level. We have got to facilitate it, not block it.

**Baroness Shephard of Northwold:** You are right that I was late. Did anybody tell you that Chris Ham, when asked what a good system would look like, said, “The reverse of what we’ve got”?

**Norman Lamb MP:** Yeah. I have had a long collaboration with Chris Ham for years now. He has got a lot of this right, and we should be working closely with him.

**Q693 Baroness Finlay of Llandaff:** Nobody is asking or expecting you to impose some kind of rigid targets or whatever, but unless there is a standard set and an expectation of that mushrooming or development locally to meet a gap—so unless there is an expectation that healthcare systems at a local level will be fully integrated—we do not see where the pressure is, where the driver is, to make that happen if at a local level it is being put in the “too difficult” box. While we have regulators and people like CQC and so on now in place, are you asking them to set those as definitive standards that should apply across the whole country, so that patients’ care is timely, that they feel that they are treated with dignity and respect, that they do feel that they are listened to, and that they do feel that their concerns and needs have been addressed and they understand what is happening to them? Those are some very fundamental things, but unless things are joined up you cannot do the timely care.

**Jeremy Hunt MP:** Could I possibly just respond to that, because we believe that we have put a lot of things in place to make sure that we deliver that? To go back to the Chris Ham
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q point, we agree: there are a lot of things in the way that the system works at the moment that are totally not fit for purpose and need to be changed, and that is what we are seeking to do.

Could I just give you three things that I think will make a difference? First of all, we have made it very clear in our mandate to the NHS Commissioning Board that better integrated care is something that we are expecting to see delivered. In terms of their accountability for the £95 billion that we are giving them, that is one of the key things that we will be looking at. That is important. The second thing that is important, which is a real change from what has happened previously, is that every part of the NHS is having to save about 4 per cent in productivity every year, so hospitals are getting 4 per cent less in their tariffs, GPs are having to do more for less, and community services are having to do more for less. That process means that everyone is asking the fundamental questions and, time after time, they come back to me and Norman and say, “The way that we can do this and deliver services more efficiently is by delivering more integrated care”, so that we avoid this awful business of people being pushed around the system from pillar to post, getting terrible treatment, with one half of the system not knowing what the other half is doing, and people becoming much more ill than they need to be as a result.

The third element, which I think will also be equally important, is a very rigorous programme to expose bad practice, which I do not think has been part of the NHS before. Put those together, and I think that we have a chance. I do not want to be overoptimistic, because I am sure that you have seen lots of Ministers talking about their grand plans before, and this is all going to be about the implementation, but I do think we have the bones of a structure that could have real impact in that area.

Q694 Lord Bichard: First, I have a footnote to Baroness Shephard’s question, really, because since I chaired the Soham inquiry it has always been clear to me that whenever we talk about child protection, social care, collaboration and integrated working, the elephant in the room is data and information. We have not talked about it at all today and a lot of people—I know you would not—regard it as a rather boring subject. It was interesting that when we had the local providers here, including Torbay, unprompted every one of them said, “A major problem that we experience is sharing information. Can Government do something to help us?”

Baroness Morgan of Huyton: To allow it, actually.

Lord Bichard: To allow it. Torbay said, “We went to 23,000 patient clients and asked them if we could share information”, and most of them said, “We thought you already did”, and 300 said “We don’t want you to”, but they had to go through that process with every individual. Is there not something that Government could do to facilitate that and take away that gap?

Jeremy Hunt MP: I completely agree with that. I do not have very many Stalinist drops of blood in my system—

Lord Bichard: Yet. You are very young.

Baroness Morgan of Huyton: Come back in a year.

Jeremy Hunt MP: —but I do think that is one of the areas where you have to do things from the centre as well as let a thousand flowers bloom locally. For example, we are looking
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q towards in the next few weeks making an announcement about a paperless NHS, and part of the meat of that announcement will be a date when hospitals will be ready to share the information they hold electronically with GPs on everything they do to a patient, as an expectation of being commissioned to do that work. So that will be a pretty top-down moment where hospitals will be required to make fully—I see Baroness Blackstone looking a bit shocked, because it will affect all hospitals. They will all have to make sure, for the first time, that their data systems can talk to anyone else.

The Chairman: And across the social care divide?

Norman Lamb MP: Absolutely, social care has got to be part of this.

Jeremy Hunt MP: Yes.

Baroness Finlay of Llandaff: Will GPs be required to inform the hospitals of what has happened to the patient in the community? You cannot have that revolving door unless the communication is both ways.

Jeremy Hunt MP: It is not a requirement to inform; what will happen is that all the data will have to be sharable. It will be done with very careful consents and very careful protections for patients, but the heart will be your GP record, and through that you will be able to see what has happened to you in the social care system and what has happened to you in the acute sector, the tertiary sector or wherever it is. That is going to be a very big moment, and I hope that will happen while Norman and I are Ministers, because it is absolutely essential. To burnish my Stalinist credentials, that is the only part of our programme for the NHS where I have focused on something that you could loosely describe as process rather than outcome, because I just think that it is such a crucial change that needs to happen throughout the NHS, this embracing of technologies. It has happened in every other sector of the economy.

The Chairman: Well, you cannot get outcomes unless you liberate the input controls, can you?

Norman Lamb MP: We know from other systems that when the patients get used to having control of their records as well, that can be revolutionary, so they must be a critical part of the sharing of this information.

Q695 Lord Bichard: My last word on that would be that we have a culture in this country which is so committed to protecting data that getting practitioners to understand and to feel comfortable with sharing it is almost as big a problem as the one that you have outlined. The two need to go hand in hand.

The question that I wanted to come back to, Minister, was more about standards. I think there are at least five of us round this table who have been very pleased at your positive comments about education in the 1990s.

Baroness Blackstone: One of us had responsibility for lifelong learning.

Lord Bichard: Absolutely. However, the question is: are you confident and happy that regulation and assessment in the form that we have had it, whether it is in education or with CQC, is sufficient? We are all concerned about Winterbourne View, and it is not a single example of an institution that has failed, notwithstanding the system that we have in place. Are there other ways that we need to use to ensure that care homes in particular are of a
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence

Q: Is it possible to assess the quality? Let me float one particular idea that I have been very interested in. Schools have got governors. I hesitate to use the example of prisons, but they have visitors. Is there a way in which we could use third-age citizens to be more involved in care homes, which frankly sometimes do appear to be very detached from their local communities, on a regular basis so that we are not so dependent on a one-off inspection every now and then? Would that be a way of giving people greater confidence in the quality of all of our care homes?

Norman Lamb MP: I am very interested in that idea, and we should be very open-minded about exploring all these options. The new HealthWatch will have powers to go in and look at any health setting where there is funding from the NHS or local authority. That in itself could be used potentially quite effectively. Awful things happen behind closed doors, away from the public gaze, and that is what happened with Winterbourne View and, as you say, across many other similar units around the country. I would certainly be very willing to look at that option.

Good regulation is a critical element—it is not a solution in itself. You do not always change culture by just regulation alone. Jeremy will want to talk, I am sure, about the work that he is leading in starting to look at whether we can have ratings again. We have to be very sure that we do not end up with unintended consequences; they have to be evidence-based and they have to be trusted. I mean having a system that encourages care homes and other institutions to reach up to the next level—to become excellent—or GP practices or whatever it might be, and actually being able to celebrate the excellent places. There is a local care provider for people with learning disabilities in Norfolk that I was talking to the other day. It so happened that his report from CQC had said very positive things about their setting, so he went out and celebrated it and was telling everyone about it. Well, that is great, but let us have a rating that allows all the excellent places to do that. If you just focus on minimum standards, we do not necessarily achieve the best results.

The other element I would just add, very quickly, is training and skills of the workforce. It is clear that, although there is great quality care in many places, there are also other places where the care is not of a good enough standard. Part of that is about raising the skill level of the workforce. This is work that is under way; I addressed it in the Winterbourne View response, but we have got to improve the standards of care in some of the places where problems are happening at the moment.

Jeremy Hunt MP: Chairman, can I just add a very brief point to that, which I think is something else that we can learn while we are on the education theme from Ofsted? Ofsted is able to inspect a school and come to an objective assessment of something as woolly and intangible as a culture of a school, and it works. Parents do not say, “That is totally subjective”; they recognise that it is possible for inspectors to go in and make a judgment about the culture of a school. Nor do Ofsted inspect every single subject in every single school they go to. We need to think about that when we look at NHS institutions and care homes as well, because some of these problems in terms of care, when we have really seen the most appalling abuse of older people that has just shocked people to the core when they read about it in the papers, are things that in the end we are only going to deal with if we make sure that places have the right culture. We can all smell the coffee. We all know the difference between wonderful institutions and ones where you feel something is wrong, and the public do not know that when it comes to the NHS at the moment. That is one of the key things that we need to look at.

The Chairman: That links back to Graham’s question about visibility.
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q697

Lord Tope: Before I ask that, Chair, while we have been up here questioning you, London Councils have been downstairs launching their report into A Case for Sustainable Funding for Adult Social Care, and I promised them that you would not leave without a copy of it, so I need to give you that before we finish in a minute.

The Chairman: No guesses as to what it says.

Lord Tope: Well, I have not read it either yet, but I suspect that the title gives a fairly good indication of what it is saying.

Really I follow on from the theme that we have been talking about. Norman, you said much earlier on that for self-funders in the social care system there is really nowhere to go for information. As the Chairman has just said, do you have plans for increasing the visibility of information about social care providers? You have rightly said that people who get an excellent report, if they have any sense, will go out and make massive publicity about it. If they do not get an excellent report, they just might not do that. How are people—self-funders—going to be better able to assess what is realistically available to them and what that quality is?

Jeremy Hunt MP: I would like to introduce Ofsted-style ratings across the care home sector, across hospitals, across GP surgeries, the works, but we need to do very careful work to make sure that if we do that it is done in a way that is academically and clinically rigorous, so that those ratings hold the respect that Ofsted-style ratings have. The last Government had those ratings, and then unfortunately the Healthcare Commission got rid of them. The mistake was not the principle of ratings. The mistake was that what the ratings tended to do, particularly for hospitals, was measure access, because the big priority at the time was waiting time targets. Then you got a distorted picture of a hospital, because you could get an extra star by getting more people to meet the 18-week waiting time target but it might not have actually been doing particularly great things inside the hospital in order to meet that target, so the system became discredited.

We now have much more information about what happens inside hospitals and, in terms of care homes, it is a more straightforward process anyway. If we can do it for a complex secondary school, we can definitely do it for a care home. So I think it is time to recognise that the principle was right, learn from the mistakes that happened, and make sure that we do then get that information. The key point is that, if we are going to drive up standards throughout the whole system, everyone needs to feel that they are on a quality escalator where their organisation is striving to do better. The ones that are outstanding are striving to remain outstanding and at the top of the pack, but the ones that are good think, “What do we need to do to become outstanding?” and the ones that are below par feel real pressure to start delivering more satisfactory standards. That is a very key part of how we can make the NHS deliver better for older people.

Norman Lamb MP: You asked about visibility. Since July last year we have started to create a quality profile of individual care homes. The idea is that anybody with a loved one who may be thinking about a care home can find information about the home. That will include the CQC rating, and in the future it is hoped that it will include the quality rating that Jeremy has just articulated. It could include user reviews by people who have actually experienced care in these places. We have to be careful since we know that concerns have been raised about TripAdvisor, but do we want to prevent that voice being heard? I think not. If awful things happen in care homes, the public has to know about them. When you are thinking about selecting a care home for a loved one, you want information to be
Central Government – The Rt Hon Jeremy Hunt MP, Secretary of State for Health, Norman Lamb MP, Minister of State for Care and Support, Department of Health and Steve Webb MP, Minister of State for Pensions, Department for Work and Pensions—Oral evidence (Q available at the click of a button so that you can find out exactly what people are saying about it. That could be an incredibly powerful driver towards improving standards because information is power. The Care Quality Commission has introduced a widget, as they call it, so that any care provider can make a direct link from their website through to the CQC rating of that particular home. The good places will have it while the poorer places will not. Should we require everyone to maintain a direct link?

Q697 Lord Bichard: I am slightly confused about this. Recently I looked at the website for the Social Care Institute for Excellence which seems to have all that in what looks like a TripAdvisor system. It has the CQC report and, while it does not have much in the way of client feedback yet, it has a space for it. It sets out everything it knows about a home, and it is doing the same for providers in people’s own homes. You did not refer to that, so does that mean that we are dealing with two separate systems?

Norman Lamb MP: No, and we must not have that. The truth is that very few people know about it yet; you have uncovered it.

Lord Bichard: It is quite new.

Norman Lamb MP: The principle is a good one and we have to make sure that there is one place that everyone knows to go to in order to find information. Critically and ideally, if you go to the website of a particular care home, you ought to be able to click straight through to find this information about it.

The Chairman: We have gone almost 10 minutes over our time. I thank you very much indeed. If we have been robust with you—I am sure that this has been nothing in comparison with a Commons Committee—it is essentially because we are saying that this is not just about the hearing now, it is about the issues in 10 years’ time. Our challenge to Government and to all parties is this: what is the thinking about these issues in 10 years’ time rather than just getting through a difficult hearing today? I am sure you got that sense from us. Thank you again. If you have any further thoughts, please do send us a note. Otherwise, we are very grateful to you.
Monitoring
Information on employer attitudes and practices on age and employment is reported and monitored regularly by DWP. A comprehensive assessment was undertaken in 2010 when DWP published the ‘Second Survey of Employers’ Policies, Practices and Preferences Relating to Age’, the ‘Default Retirement Age – Employer Qualitative Research’ and ‘Pathways to Retirement: The Influence of Employer Policy and Practice on Retirement Decisions’.

Progress on the key issues identified in these reports is being monitored by DWP working with The Pensions Regulator (since 2011) to include questions on employing older people in their annual employer tracker survey (last report July 2012, next due summer 2013). This covers employer attitudes on employing older workers, retirement and support for opportunities to work longer. The Department also includes questions on older worker employment in the context of its wider employer surveys on the labour market and workplace pensions reform as appropriate.

Alongside this, the DWP publicly monitors trends and characteristics of 50+ employment in comparison with other age groups, through its annual Older Workers Statistical Information Booklet. A supplementary analysis of 50+ employment by main business sector will also be published January 2013.

Engagement
The DWP’s Age Positive Initiative works with key business organisations, trusted by employers to:

- encourage employers to realise the business benefits of employing and retaining older workers;
- to address employer issues about employing older workers as part of a multi-generational workforce;
- to tackle the cultural shift needed to open up widespread opportunities for older people to work longer and phase their retirement; and
- capture intelligence and feedback around employer practice.

Age Positive guidance is drawn from existing employer good practice and is backed by research evidence. In 2011 and 2012 the guidance and accompanying case studies provided practical support to employers in removing the default retirement age and adopting more flexible approaches to work and retirement. That guidance was widely promoted by business organisations to their employer networks: DWP and the Chartered Institute of Personnel and Development (CIPD) also produced a tailored product for HR managers ‘Performance and Retirement Practices - Get it right!’; and for small employers our ‘Two Minute Toolkit – Working Longer’ was promoted by organisations such as the Federation of
Central Government (Department for Work and Pensions)—Further supplementary evidence

Small Businesses to their employer members and by the British Chambers of Commerce to local Chambers.

We have continued to work with employer organisations and employers to update the guidance and case studies to focus on: phasing retirement; and effective succession management – getting the most from experienced older workers whilst bringing on younger workers. It addresses myths about older worker performance, health and training and sets out how to realise the business benefits of managing an ageing workforce.

It is backed by a new collection of over 30 employer case studies showing how employers of various sectors and sizes have effectively managed the issues and opportunities presented by an ageing workforce. They offer practical examples and transferrable experience across the public and private sectors, from heavy industry to the service sectors, including: care homes; Clugston’s (construction); ABM University Health Board’s mid-wifery service; Falkirk Council; Ronseal and Allevard Springs (manufacturing); AT Coaches; ASDA, McDonalds, and Centrica.

This updated Age Positive resource will be published and widely disseminated by March 2013, to employer organisations and business advisers for their wider promotion to employers.

**Through our Age Positive Sector Initiative** we gave expert support from 2010 to December 2011, to over 80 business lead organisations in the nine largest occupational sectors to help them provide information and guidance on employing older workers to over 800,000 employers. The sectors covered were: manufacturing, transport, construction, health & social care, retail, hospitality, local authorities, education and financial services. Trade bodies and Sector Skills Councils such as the Federation of Master Builders, Skills for Care, the Financial Skills Partnership, the Institute of Hospitality, the Local Government Association, the British Retail Consortium and Skills for Logistics, actively promoted Acas and Age Positive guidance to help employers with removal of the default retirement age and to highlight the important role of older workers within their sectors. They produced features and articles in their employer newsletters, web guidance, sector presentations, sector surveys, employer guides and toolkits.

We are continuing to keep sector stakeholders updated with information and tools through regular sector specific newsletters. This aims to support their on-going work on tackling attitudes to age and encouraging the employment of both younger and older workers.

**Age Action Alliance:** The DWP and leading business and age expert organisations are working together through the Age Action Alliance’s Healthy Workplaces Group to develop practical resources for employers on effectively managing the health and productivity of an ageing workforce. Members of the Group which will next meet in February, include leading employer organisations such as CIPD, NHS Employers, the Financial Skills Partnership, ABI, and age expert organisations including Employers Network for Equality & Inclusion (chair), The Age and Employment Network, Age UK and Carers UK, with active support from the DWP and Dept for Health. The Group is developing a business case for employers and a resource pack that brings together key tools for employers in managing an ageing workforce, flexible working/phased retirement and health and well-being. These will be ready for launch from spring 2013 and will be freely available from the Age Action Alliance website for all employers and business organisations. Members of the group will be
Central Government (Department for Work and Pensions)—Further supplementary evidence

promoting the resource to other employer organisations and through their own employer networks.

**Wider Government policies will also support an ageing workforce.**

We are joining up with the Government’s wider employer focused developments on extending the right to request flexible working to all employees and the new occupational health advice service: both proposed for 2014. These developments are key enablers towards fostering employment opportunities and a culture that better meet the needs of older workers who want to work longer and phase their retirement. Many older workers currently face barriers to remaining in work or returning to work due to caring responsibilities, ill health or disability. Flexible working can help them manage these pressures.

January 2013
Transcript to be found under BT
Cheshire Fire and Rescue Service—Written evidence

1 Does our culture about age and its onset need to change, and if so, how?

We need to present the future of an aged population as an opportunity and a positive challenge and make older people part of the solution. At the current rate of population growth, by 2020 we will not be able to afford the health and social care spending of local authorities. The prevention agenda around maintaining independence and older people health safety and welfare is imperative. The Fire and Rescue Service has significant capacity and ability to add to this agenda.

2 Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

Most definitely the culture needs to shift. We have created a dependency culture. We need to build community capacity and resilience and incentivise independence through taxation making the looking after of an elderly relative easier. This can be achieved through flexible working if you have a dependant relative and using council tax breaks to encourage people to accommodate relatives. Older life is seen as a huge negative the whole depiction needs transforming. Age UK have done some good work around active ageing which should become national strategy. Early retirement should not be seen as a positive. Contributing to the nation by extending working life is positive in maintaining mental health and activeness. We need to constantly reinforce positive role models in this area and there are many. Develop a B and Q culture they can teach us a lot. We need to lose the patronising approach used by many who engage with the elderly.

3 Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

Public services need transforming and a lot can be learned from the current Local Community Budgets pilots being run in the UK. The really big money is in health and social care and these services are being integrated. The vast majority of the money is spent in dealing with crisis and mitigation. Very little is spent on "prevention". Sustainable funding models need to be developed. More community involvement and workers with generic and holistic skills. We need to make assistive technology available to a broader market to keep people independent. Younger people would buy it for parents as it will keep them independent and out of care. This would protect the family asset of the home because if they go into care the house will have to pay for it. Far greater use of ethical equity release programmes.. Co-location of community assets and redesigning of services in consultation with older people is a must. Have services that people need as opposed to what we think they want. Do it with them and not to them. No one wants to end up in care or hospital. Develop the strategy that prevents many falling into that cycle.
4 Do we need to redesign and transform public services for these challenges? If so, how?

Funding models need to change. The current model of payment by results (PBR) for the health service is perverse as it actually pays more for the more beds you fill. Incentivised models such as "Capitation" can pay for developing strategy that helps people to avoid critical services and reinvest in prevention which is where huge savings can be made.

5 What should be done now and what practical actions are needed?

Our approach needs to be intelligence led and initially go after the low hanging fruit. One of the biggest costs is around excess winter deaths, do we all have cold weather plans? PCTs-Foundation Trusts hold significant capacity based on the inevitability that older people will require beds in the winter. For many the route from here will be into long term residential care. Last year 40million bed days were taken up by over 65s who had suffered slips trips and falls at a cost of £2billion to the NHS. Where is the prevention strategy? The other major cost impacts are incontinence and strokes and dementia. Learn from mental health trusts and revisit Care in the Community. Remember that people thought that closing mental hospitals and care facilities was madness. In fact it has resulted in people having a quality of life and dignity who would previously have been branded outcasts.

6 How can we stimulate national debate about these issues?

Work with the third sector and the Age Action Alliance to stimulate the debate to start presenting positives as opposed to using terminology such as "Demographic Ageing Time Bomb" Nominate some older peoples champions and involve the private sector in strategy development such as Band Q. Work with agencies who have been very successful in prevention such as Age UK, FRSs, mental health trusts, they know how to do it. The biggest problem is we have institutionalised organisations who are comfortable with existing models and thinking.

8 August 2012
The Chief Fire Officers Association (CFOA) is a professional membership association and a registered charity. CFOA members are drawn from all UK Fire & Rescue Services (FRSs) representing the senior executives and managers of the Service. Through the work of its members the Association supports the Fire and Rescue Services of the UK in its aspiration to protect the communities they serve and to continue to improve the overall performance of the fire sector. CFOA provides professional and technical advice to inform national fire policy.

The issues raised in this call for evidence are relevant to each of CFOA’s Directorates: Corporate Services and Sector Improvement (CSSI), People and Organisational Development (POD), Prevention, Protection and Road Safety (PPRS) and Operations. Comments from representatives from each of the Directorates have been incorporated into this response which is submitted on behalf of Dave Curry, Director of Prevention, Protection and Road Safety and approved by Peter Dartford, Lead for Prevention and incoming Vice-President Elect of CFOA.

1. Does our culture about age and its onset need to change, and if so, how?

If the nature of care is going to change with an increased number of older people living in their own home, rather in care accommodation, then we need to change the culture to one where it is to support those people.

The Fire and Rescue Service is well placed to assist with this change in culture, with it’s current role in supporting communities. CFOA believes that greater emphasis needs to be placed on community resilience to ensure older people are supported by their local community, again the Fire and Rescue service is engaged in developing community resilience to support this cultural change.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change? If so, how?

The likelihood of these expectations is that older people will work longer, be less well off and lead more independent lives. Therefore the impact on Fire and Rescue Service would be that older people would become more vulnerable than they are now and therefore will be in greater risk of death and injury due to fire. Therefore consideration will need to be given to resources to ensure the Fire and Rescue Service is capable of meeting this increasing demand.

3. Do the extent and nature of public services need to change? If so, how and how should they be paid for?

Public service’s will always need to change to meet the demands of the communities they serve, with the varying degree of resources available. Public service’s are currently reactional to the needs of the community. A more prevention focus would help public service’s to reduce risk and the resources needed to respond. As public service resources are reduced, all public services need to work in partnership to ensure a synergy is achieved.
This means that individual public services will need to change their role to support a more collaborative environment.

The fire and rescue service has a positive track record of introducing preventative activity which has reduced deaths from fire by half in the last 10 years, this expertise should be used by other public services to ensure they can achieve the same success.

4. **Do we need to redesign and transform public services for these challenges?**

Currently public services are designed to support responsive activity. They should be transformed to allow greater collaborative resources towards prevention. An important first step in targeted prevention activity is intelligence, in order to achieve this, greater cross sector resources need to be established to ensure community intelligence is available allowing targeted collaborative activity.

5. **What should be done now and what practical actions are needed?**

We need to develop the intelligence lead approach to ensure we fully understand what the implications are going to be of an older population. Once this has been established, each public service needs to undertake an impact assessment of the effect this will have on their area. Public service’s will then need to be able to demonstrate that they are making the necessary changes before each of the impacts identified arises. Some good examples of where this has worked well in recent years would be the equalities agenda and currently the environmental agenda. Public services have experience of the adaptive change process, and proven that they are able to undertake change.

6. **How can we stimulate national debate about these issues?**

Clearly to influence this culture we will need to engage the media. In order to achieve this, public services and Government will need to make it a priority.

CFOA has an established strategic debating forum called Fire Future Forum, which provides an opportunity for strategic partners to debate key issues. This consultation has prompted us to arrange a Fire Future Forum on the impacts of an ageing population to ensure our public service is continuing to show leadership of this important issue. CFOA recently lead a consultation to develop older persons strategy called Ageing Safety, this strategy is informing Fire and Rescue Services across the UK in how to support this agenda. Ageing safely is copied as an attachment for your reference.

1 September 2012
The Compression of Mortality and Morbidity

I report on the development of age-specific mortality rates between 1950 and 2000 in Germany, the United Kingdom, Spain and Switzerland. The data stem from the Human Mortality Database published by the Max Planck Institute, Rostock, and the University of California, Berkeley. The evaluation of the development of morbidity will be based on general literature and an extended version can be found in Breyer et al (2010). Oxford Review of Economic Policy.

Table 1 shows the change in life expectancy between 1950 and 2000 for the four countries. In 1950, the Swiss and the British had a substantially higher life expectancy than the Germans and the Spanish. Yet, starting off from a lower point, the population in Germany and Spain experienced larger gains in longevity since 1950. Spanish men’s life expectancy, for instance, increased by 18.5 years, whereas British men gained only half as much. In all countries, men’s life expectancy is about 5 years shorter than women’s. Furthermore, the gender gap in longevity has shortened somewhat over time, except in Germany where it has increased by 1.5 years over the last 50 years. Overall, patterns of life expectancy reflect changes in dietary condition, health technology improvements along with other factors which are very much country specific.

Table 1: Life expectancy at birth in years, 1950, 1975, 2000

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>Germany</td>
<td>61.20</td>
<td>68.38</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>65.75</td>
<td>71.68</td>
</tr>
<tr>
<td>Spain</td>
<td>58.86</td>
<td>64.18</td>
</tr>
<tr>
<td>Switzerland</td>
<td>66.16</td>
<td>71.62</td>
</tr>
</tbody>
</table>

Sources: Human Mortality Database

Similarly, Tables 2 and 3 present the age distribution of the gains in life expectancy between 1950 and 2000. During the first 25 years, the largest contribution to the increase in life expectancy came from reduced mortality among newborns. Improvements in neonatology and paediatrics contributed between 41 percent (Switzerland) and 56 percent (Germany) to the increase in life expectancy of men before 1975. In the following 25 years, the decrease in mortality of newborns and children slowed down – the corresponding contribution to the increase in men’s life expectancy ranged between 13.6 percent (Switzerland) and 26.3 percent (Spain), pointing to diminishing marginal returns at an already very low level of mortality. However, these results were again country specific.
Table 2: Age distribution of the gain in life expectancy in years, men, 1950-2000

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<tbody>
<tr>
<td></td>
<td>Germany</td>
<td>UK</td>
<td>Spain</td>
<td>CH</td>
</tr>
<tr>
<td>&lt;1</td>
<td>2.91</td>
<td>1.09</td>
<td>3.52</td>
<td>1.52</td>
</tr>
<tr>
<td>1-14</td>
<td>0.63</td>
<td>0.39</td>
<td>2.27</td>
<td>0.47</td>
</tr>
<tr>
<td>15-34</td>
<td>0.69</td>
<td>0.42</td>
<td>1.91</td>
<td>0.26</td>
</tr>
<tr>
<td>35-54</td>
<td>0.66</td>
<td>0.51</td>
<td>1.45</td>
<td>0.72</td>
</tr>
<tr>
<td>55-74</td>
<td>0.67</td>
<td>0.38</td>
<td>1.23</td>
<td>0.91</td>
</tr>
<tr>
<td>&gt;75</td>
<td>0.82</td>
<td>0.47</td>
<td>0.73</td>
<td>0.94</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6.37</td>
<td>3.26</td>
<td>11.10</td>
<td>4.83</td>
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</table>

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<tbody>
<tr>
<td></td>
<td>Germany</td>
<td>UK</td>
<td>Spain</td>
<td>CH</td>
</tr>
<tr>
<td>&lt;1</td>
<td>2.57</td>
<td>0.84</td>
<td>3.44</td>
<td>1.23</td>
</tr>
<tr>
<td>1-14</td>
<td>0.48</td>
<td>0.37</td>
<td>2.42</td>
<td>0.46</td>
</tr>
<tr>
<td>15-34</td>
<td>0.35</td>
<td>0.72</td>
<td>1.92</td>
<td>0.43</td>
</tr>
<tr>
<td>35-54</td>
<td>0.48</td>
<td>0.48</td>
<td>1.35</td>
<td>0.86</td>
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<tr>
<td>55-74</td>
<td>0.72</td>
<td>0.82</td>
<td>1.92</td>
<td>1.85</td>
</tr>
<tr>
<td>&gt;75</td>
<td>1.04</td>
<td>1.55</td>
<td>1.02</td>
<td>2.07</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5.63</td>
<td>4.78</td>
<td>12.07</td>
<td>6.90</td>
</tr>
</tbody>
</table>

Importantly, the development of mortality in the last fifty years has been markedly different for older individuals. The advancement of medical technology for the treatment of individuals older than 55 years can be argued to have contributed between 17.7 percent (Spain) and 38.3 percent (Switzerland) to the increase of men’s life expectancy between 1950 and 1975. In the last quarter of the last century, the gains in life-years of older men contributed between 60 percent (Germany) and 72 percent (United Kingdom) to the total increase. In all countries, and most accentuated for the very old, life year gains were largest in the last quarter. The latter appears to qualify as a stylised fact.

The empirical developments observed correspond to a compression of mortality. Indeed, mortality has been compressed to ever higher ages, resulting in a rectangularization of the survival curve. For a newborn, the probability to survive the next year lies close to one up to the age of 60, then decreases slowly before falling steeply around the age of 80. By taking fifty years ago as a benchmark, we can conclude that the survival curve has decreased steadily from the age of 50.

To better understand the determinants of life expectancy it is important to understand the main sources of mortality in each country under examination. In doing so, we find a shift in the age distribution of rising life expectancy reflecting a clear-cut differential progress against life-threatening ailments as displayed in Table 3 for the two decades 1980-1990 and 1990-2000. The largest single contributor to life expectancy expansion is reduced mortality from heart disease and stroke, which added between 1 and 3 years to life expectancy, with even higher gains for men and occurring in the nineties as compared to the previous decade. The
large life year gains of the very old, reported in Table 2, are to a great extent due to advancements in treating heart attacks and strokes. Hence, highlight the importance of health treatment and new technologies in bringing gains in life expectancy.

**Table 3: Gain in life expectancy in years by death causes, men, 1980-2000**

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</thead>
<tbody>
<tr>
<td></td>
<td>Germany</td>
<td>UK</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>0.42</td>
<td>0.31</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>0.87</td>
<td>1.50</td>
</tr>
<tr>
<td>diseases</td>
<td>Cancer</td>
<td>0.45</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>Accidents</td>
<td>0.35</td>
</tr>
<tr>
<td>Residuum</td>
<td>0.60</td>
<td>0.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.73</strong></td>
<td><strong>2.33</strong></td>
</tr>
</tbody>
</table>

**Women**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>0.40</td>
<td>0.30</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>-0.25</td>
<td>1.25</td>
</tr>
<tr>
<td>diseases</td>
<td>Cancer</td>
<td>1.11</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>0.09</td>
</tr>
<tr>
<td></td>
<td>Accidents</td>
<td>0.19</td>
</tr>
<tr>
<td>Residuum</td>
<td>0.78</td>
<td>0.35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.33</strong></td>
<td><strong>1.93</strong></td>
</tr>
</tbody>
</table>

Sources: European Mortality Database, WHO (Germany, Spain), federal offices of statistics (Germany and Switzerland)

In addition to the compression of mortality, a second important assumption to test is that of the compression of morbidity. Particulally, the later hypothesis generally states that cumulative lifetime disability could be reduced if primary prevention measures postponed the onset of chronic illness and increased average age at death which results in turn in lower lifetime disability (Fries, 1980). Recent studies find that although disability measures often show improvement, an expansion of other health problems may accompany the compression of disability (Parker and Thorslund, 2007). Similarly, Lafortune et al. (2007) cast some doubts on Fries’ findings by examining trends in activities of daily living (ADL) disability at age 65 and over in 12 OECD countries during the 1990s. Paradoxically, a disability decline was identified among elderly people in only five countries, namely Denmark, Finland, Italy, the Netherlands, and the United States. Three countries (Belgium, Japan and Sweden) report an increasing disability rate and two countries (Australia, Canada) report a stable rate. Studies that examine individuals before retirement find evidence of poorer health status (Soldo et al., 2006).

Explanations of the existing heterogeneity in findings are far from evident. One the one hand, it can be argued that the expansion of education should expectedly lead to better prevention. Similarly, health technologies might have given rise to improvements in
diagnosis, which make an expansion of (measured) health problems compatible with a compression of (true) disability. Recent studies looking at life expectancy without disability (e.g. Manton et al., 2006) reveal a significant compression of disability, namely an expansion of life free of disability, which is projected to increase from 74 percent in 1935 to above 85 percent in 2080.

Altogether, evidence points towards a compression of mortality, especially in older ages. The latter is associated with improvements in medical technologies. Disability, although country specific and sensitive to retirement effects, appears to suggest evidence of an expansion of life free of disability.

The are life expectancy gains, though ageing affects health expenditures through a number of different channels, some of which we manage to highlight. We argue that causality is limited by the fact that ageing itself is partly the result of rising health expenditures in the past. As Section 3 has made clear, with growing per-capita income the willingness to pay for greater longevity and thus the demand for health services in old age has increased. This has also resulted in a higher probability of using new technologies and accordingly an expansion of health care expenditures. Our estimates in Section 2 manage to show that gains in (healthy) life expectancy that have been achieved in the last three decades have mainly accrued to the already old, and there are clear indications of a compression of both morbidity and mortality to ever higher age brackets. Unlike the backdrop that ageing on the whole is a factor that will moderate the growth of health care expenditures via technological progress in medicine, we find that the rise in longevity leads to a further demand for life-prolonging medical care. Moreover, as ever more people reach a very high age (beyond 85 or 90), the percentage needing long term care in their last years of life increases (Costa-Font et al, 2008). On the whole, there is thus a small positive effect of ageing on per-capita health expenditures, which is estimated by several studies to be in the order of an annual growth rate of one-half percent, as evidenced in Section 4. All in all, the debate on the `red herring’ might be summarized as follows: whilst ageing can not be acquitted altogether of causing a rise in health expenditures, it is far from clear that this should be considered a crime.

REFERENCES


Costa-Font, J; et al. 'Projecting long-term care expenditure in four European Union member states: the influence of demographic scenarios.' Social Indicators Research 86, No. 2 (2008), p. 303-321


Do People exhibit Optimistic Perceptions of Disability and Longevity

The progressive lengthening of human life increases the likelihood of exposure to certain risks to life and health, including those related to longevity and disability in old age. For instance, when one considers some protective actions such as insurance purchase, or lifestyle changes, it is apparent that they depend on individual’s perception of risk of both survival and old age disability. How individuals perceive the effects of disability in old age is an important feature given that it takes place cumulatively upon an individual’s survival into old age.

Empirical evidence from comparisons of perceived and objective risks offer fundamental insights into people’s views and reactions in the context of risks, some examples are as follows. Benjamin and Dougan (1997) find evidence that people form their perceptions of population death rates from privately held information, and in particular age-specific death rates, which determine individual’s perceptions regarding their own longevity. Interestingly, they find that individuals compare themselves to other individuals of a similar age. Furthermore, Hakes and Viscusi (1997 identify other relevant sources of information such as discounted life expectancy. Previous studies reveal that risk perceptions vary with an individual’s age as with personal characteristics associated with the time preference (Viscusi, 1990).

A well-known bias holds when individuals exhibit a tendency to view themselves as invulnerable as (or less vulnerable than others) to experiencing negative life events, leading to what is termed an ‘optimistic bias’. This is particularly the case of those risks that show an increased level of perceived controllability. Therefore, the risk-learning process systematically differs across risks (e.g., subjective probabilities). Therefore, population risk is often preferred when compared to individual-specific risks, which suggest evidence of an ‘optimistic bias’.

One key feature to examine is the extent to which information influences both perceptions of survival and disability in old age. The rational individual’s expectations of longevity are sensitive to individual information channels; mainly those that are fundamentally age dependent (for example, experience), gender dependent or education dependent, which would be expected to affect the understanding of those risks determined by educational status. Finally, healthy individuals may exhibit optimism over their future health, which might in turn have an ambiguous effect on risk perceptions with regard to disability in old age. Indeed, one might hypothesise that the healthier an individual is the more likely they are to perceive the risks of greater longevity and the less likely they are to perceive the risks of disability in old age.

2.

In a study examining general population I find that women tend to exhibit a relatively accurate perception of their own life expectancy (and less so is the case in men), they conversely ‘overestimate’ the risks of disability to the general population. Besides existing cognitive biases at the individual’s level, we find that risks perceptions with regard to both life expectancy and disability are influenced by different information channels, both when examined at either the individual or the population level. However, the only variable that was significant, irrespective of...
of the questions examined, was self-perceived health indicating some evidence of a “status quo” or state dependent risks perceptions. Indeed, the healthier individuals see themselves at the time of the interview affects how they perceived themselves to be in old age. Another explanation might be that healthier individuals might be less likely to imagine themselves disabled in old age and are more likely to see themselves as living longer. This is consistent with the findings of McGarry (2003), suggesting that risk perceptions convey a specific source of private information that influences individual perception on health. However, an alternative explanation might be that optimism simultaneously affects both risk perceptions and self-reported health status.

Next, we found that age has no significant influence on individual perceptions of disability in old age (at the population level), while conversely, the older the individual becomes, the more likely it is that one will expect to live longer as compared to a reference group, which is unknown but likely to be other individuals of similar age cohorts. One potential explanation for this effect may be the existence of a differential perception depending on the proximity of the risk, whereby risks turn from abstract to concrete.

A somewhat striking result is that no evidence was found to suggest a gender effect in explaining life expectancy perceptions or the probability of survival until the age of 80. This would generally be seen as inconsistent with the evidence that women tend to live longer, which could imply that respondents do not take their gender into account when reporting perceived life expectancy estimates. An alternative explanation would be that compared to disability risks, longevity risks are more familiar due to the publicity with regard to the aging process.

Interestingly, education had a greater influence on perceptions with regard to an individual risk of disability than on the perceptions of risks to the general population. Indeed, it was found to be a significant predictor of the perceptions of the risk of disability in old age. Following the predictions from the Bayesian learning model (explained before) whereby individuals update their prior beliefs with new information (here measured in the constant term). On the other hand, education might contain information on the individual reference group so that people’s reference groups with less education perceive higher rates of disability. Furthermore, it is likely that insofar as it conveys information, education should have an effect although arguably relevant information sources, such as personal contacts remain unobservable to researchers. For instance, the recent death of a relative or a spouse might affect an individual’s subjective probability (Hurd and McGarry, 2002). However, in explaining disability risks one might argue that a perceived risk of early death might lessen the perceived risk of suffering from disability in old age. Therefore, in dealing with issues of self-protection and insurance to cover such risks, other relevant factors may need to be taken into account.

Taken together, this study suggests that individuals are reasonably aware of their future risks with regard to disability in old age and longevity, although affected by optimism over their own risks of disability in old age — compared to those they believe are faced by others— which appear to be a systematic feature, depending on education and current health status. The perception of risk with regard to disability in old age might be relatively unfamiliar and subject to significant uncertainty insofar as the aging process is a relatively recent

179 Given that women tend to live longer, the findings suggesting no gender difference indicate once again that women might even be underestimating their life expectancy, since they may not be taking their age specific life expectancy as a reference point, but rather other forms of information from their own social network or experience.
phenomenon. Finally, it is important to stress that perceptions of life expectancy and disability in old age are not necessarily a pleasant experience and, therefore, it might well be the case that a certain proportion of the population have no clear cut view on such matters, especially at younger ages. Finally, it is important to note that part if the biases between statistical and individual risks is due to the existence of some private information. For example if health is evenly distributed across people, very healthy individuals may have a 25 per cent chance of disability by age 80 while a very sick individuals may have a 75 per cent chance, leading to a population average of about 50 per cent. If this is the case then only the sick are underestimating their risk if everyone says that their own risk is 25 per cent. Therefore, the extent and nature of the risks over(under) estimation is likely to depend on the distribution of the true risk across the population.

References

Family ties crowding out long-term care insurance
In most European countries, insurance for long-term care (LTC), i.e. coverage for the costs of personal care for elderly dependent individuals is regarded by scholars as insufficient LTC due to dependency is a high-cost but low-probability event that should expect meet the required insurability conditions, perhaps with some level of uncertainty regarding the future costs of needing LTC However, private insurance continues to play a relatively modest role in financing LTC. Similarly, the development of public insurance for LTC is less hasty than that of other social programs. The puzzling question is, then, why is insurance for LTC still underdeveloped in Europe in contrast to other welfare programs?

Part of the answer lies in the fact that the provision of care for elderly dependants has traditionally been a family duty in most European countries. Only recently has it become a policy reform priority, after public subsidization sprang up in the last quarter of the last century amidst a set of reforms in different European countries, which has led to a process, which is still ongoing. In the main, LTC programmes have not typically aimed at entirely replacing individuals in activities for which they normally take financial responsibility, but instead have focused primarily on correcting the failures of private insurance markets in providing coverage, and, to an extent, pursuing equity and redistributive goals. However, designing LTC insurance schemes becomes an intricate endeavour that encompasses widespread policy discussion on the role of the state in its finance.

A contentious question for the development of a market for insurance is the role of the family in insuring LTC. Family duties are conceptualised as intergenerational care giving contracts that aim at preserving household wealth with a view to bequest in exchange for care. Hence, with this view in mind, the purchase of LTC insurance can give rise to some
forms of ex ante moral hazard by discouraging caregivers to providing care informally. Hence, on the development of different forms of self-insurance instruments (annuities, housing assets, etc.) to pay for LTC might be explained by a preference for informal care giving, which does not compromise traditional family structures. However, all these explanations still fail to explain why, relative to other programmes, both public and private insurance manifest limited development.

Costa-Font (2010) offers a cultural explanation for the limited development of LTC insurance that is consistent with evidence from previous studies. I argue that embeddedness in a family’s social norms (family ties), which I refer to here as ‘familism culture’ or simply ‘familism’, operates as an informal constraint on the demand for insurance (both social and individual) and inhibits an individual’s search for solutions to the LTC financing problem. In other words, familism crowds out expectations of LTC insurance coverage. I show empirical evidence consistent with a positive effect of family ties on the expectation of public and total insurance coverage. Furthermore, such empirical evidence is robust to controls and sub-sample analysis. This result is interpreted as suggesting that family ties act as prior beliefs that prompt individuals into not insuring their future LTC costs, and to rely instead on self-insurance.

Figure 1 shows a negative association between ‘familism’ and LTC expenditure as a percentage of the GDP in a set of European countries

![Figure 1: Familism and LTC expenditure](image)

**Question:** % agreeing that the family is important in life.

**Source:** World Values Survey (2000); OECD data, 2007.

That is, I suggest that the strength of family ties inhibits expectations of LTC insurance coverage. Regression analysis suggests that familism reduces the likelihood of individuals expecting both their public and, although less robustly, it doe influence their expectation of private insurance coverage of LTC-related costs. These results remain after the inclusion of different controls along with sub-sample analysis of first- and second-generation migrants, which in turn adds to the causal interpretation of the result. Furthermore, results remain significant after the inclusion of country fixed effects, hence capturing differences across individuals of the same country. This calls for a need to follow up how family ties evolve over time, as the weakening of familism is likely to cause an increase in demand for insurance coverage for LTC.
References

2 August 2012
You request a submission concerning **demographic change**, this deals with the obvious increase in qualified professional pensioners who as VOLUNTEERS are penalised by paying their professional fees without any tax relief.

Under the heading of:

**ATTITUDE TO WORK:**

**TAX IS TAXING WHEN IT PENALISES VOLUNTEERS**

I recently discovered from the HMRC that Tax relief on professional fees are only tax deductible if used for **PAID** employment i.e. NOT APPLICABLE to our great army of Olympic volunteers !!!

My case is that in order to keep my H&S professional qualifications (Chartered status), I have to not only pay fees but complete continuous professional development (CPD) i.e. keep up-to-date with the legislation. My voluntary work has been as H&S governor for a primary school and as H&S officer & author of H&S documents for the Hop Festival (now resigned)

Also, I assume this applies to Security & first aid volunteers !!! i.e. those not connected to an organisation such as St. John / Red Cross.

So how do I appeal to change this legislation that penalises **retired** H&S officers; Security & first aid volunteers?

The tax system is in favour of high profit sponsors like Samsung; Coke-Cola; McDonalds and even Google but not us volunteers that have to pay to give our professional services for **FREE** !!!

24 August 2012
English Community Care Association, Laing & Buisson (Consultancy) Ltd, Wiltshire Council and WRVS – Oral evidence (QQ 373-462)

Evidence Session No. 11  Heard in Public  Questions 373 - 462

TUESDAY 20 NOVEMBER 2012

Members present
Lord Filkin (Chairman)
Lord Bichard
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Hutton of Furness
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Martin Green, Chief Executive, English Community Care Association, William Laing, Chief Executive, Laing & Buisson (Consultancy) Ltd, Sue Redmond, Corporate Director, Director of Adult Social Services, Wiltshire Council, and Steve Smith, Public Affairs Manager for England, WRVS, gave evidence.

Q698 The Chairman: Good morning. Welcome. Thank you very much for coming to assist us. You know broadly what we are about. Put very simply, we are really asking questions about are we ready as a society, in public policy terms, as a Government, to cope with the great opportunity and challenge of an ageing society? And this session is focusing, as we have had a number of them, on elements of the social care system and we are very grateful to you for coming. Steve Smith, thank you. You are replacing Angela Geer, are you not, who is unwell?

Steve Smith: Yes.

Q699 The Chairman: Before we kick off, would you just like to run along the row and say hello, remind us of your roles? Then we will go straight into the questioning, if we might.
Sue Redmond: I am Sue Redmond. I am a Corporate Director of Wiltshire Council. We do not have a chief executive, so three of us manage the organisation. I manage, amongst a number of services, social care, but that is my background and passion.

Martin Green: I am Martin Green. I am the Chief Executive of the English Community Care Association. We are a representative body for care providers and we have about 6,500 members. I am also the Department of Health’s independent sector dementia champion.

William Laing: I am William Laing, with Laing & Buisson and we describe ourselves as a market intelligence company and we are independent.

Steve Smith: I am Steve Smith. I am the Public Affairs Manager for England for WRVS. We are a voluntary organisation providing social care for older people with our 40,000 volunteers in England, Scotland and Wales.

The Chairman: Excellent. I will not introduce the Committee; you can see who we are. You have probably heard rumours about some of us, so I will leave it at that for now. Let me start off, if I might, with what are the main quality problems with both residential and domiciliary care and do you think that the current regulatory system will resolve them? Who would like to kick off?

Martin Green: I am happy to kick off. There are some issues about quality in both residential and domiciliary care services. One of the challenges is that there is currently no way of differentiating quality since the regulator stopped having star ratings. So 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. There are also some particular issues around domiciliary care and there have been some recent reports from the UK Home Care Association about some of the issues around commissioning for process, not commissioning for outcome—so the 15-minute visit—or, indeed, some of the challenges around how different client groups are treated within the system. So, for example, older people are often commissioned for process things, like to get them up, get them washed, get them dressed and younger adults are commissioned for things like engagement with education, society, and leisure, etc. So there are some challenges in the system and also some challenges about how we know what good looks like and what is a good service compared to an adequate service.

The Chairman: It is a massively diverse market, is it not? Even if you just talked about residential there are quite a lot of supply points, but if you take domiciliary there must be thousands of individual supply points.

Martin Green: About 26,000.

The Chairman: Do we have any real understanding of whether it is good or bad, how much of it is bad and whether it is getting better or worse or are we largely blind on the quality?

Sue Redmond: Shall I come in? As a commissioner, every local authority is responsible for commissioning in their whole local authority area, so my responsibility is to understand the quality. The question about the regulator is one aspect, but a regulator cannot really monitor quality or engage staff, people who work in the services and commissioners, on commissioning for the right thing. Martin was talking about commissioning for outcomes. We have done a huge project with our home care service, transformed it—it has just been
rolled out for March—where we are not doing 15-minute calls. We are not paying domiciliary care agents by the hour. We are paying them by outcomes for people and those outcomes are things like “I want to get on with my life”; “I want to be able to go and see my daughter”; “I want to be able to go and cook myself a meal.” They are not by the hour, so the provider is incentivised to meet those outcomes, not forcing their staff to run around from house to house, spending 15 minutes doing functional tasks for people and not engaging with those individuals. So we can do things differently.

Q703 The Chairman: That is good, but are you seeking to have any understanding or leverage on the quality of stuff that you do not commission? Because an enormous amount of social care is bought by individuals privately, is it not?

Sue Redmond: It is.

Q704 The Chairman: What do you know about that?

Sue Redmond: Certainly in Wiltshire there is 70 per cent that people buy themselves and there is 30 per cent that comes through the local authority. But as a commissioner for the whole sector, what we have done by this huge piece of work is engage four providers to work in Wiltshire. It is a seven-year contract, and as part of that they are incentivised to do outcomes. The carrot for them was, we want them to sell to the self-funding community in Wiltshire. We monitored them on their quality and their price and the quality was about how their managers manage, salaried staff, not zero hours, not travelling between things. There are lots of things we can put in the specification that they can then sell to people who buy their own care in Wiltshire and that is our responsibility for everyone in Wiltshire.

Q705 The Chairman: So buying through an intermediate layer of market managers and quality managers: is that what you are doing, if I have understood it?

Sue Redmond: No. We make sure, as commissioners, that in the sector, in the county, there is a really good service that self-funders can buy into. So they can go direct to that, if they want to, or they can go through us, but they can go direct and that is what we want them to be able to do.

Q706 The Chairman: But that layer tries to assure some quality.

Sue Redmond: We, through the commissioning and the specification working with those providers, ensure the quality.

Q707 Lord Griffiths of Fforestfach: Are there some people who provide who are not part of your system?

Sue Redmond: Yes.

Q708 Lord Griffiths of Fforestfach: Do you monitor them in any way or is there just a free market?

Sue Redmond: People who have money can go anywhere and buy anything, so in that respect there is a free market. But what we need to do more and more and what we are all trying to do is give advice and information to everyone out there to say, “This is what you need to look for, this is what you want”. We also have financial planning advisors giving people advice. We, as commissioners, are trying to do that for everyone in Wiltshire.
Lord Bichard: We are told in the paper that your colleagues produced, before you tell me it is rubbish, that the CQC record a registration of 12,500 adult social care providers in 25,000 locations, but fewer than half of these have been inspected. Is that right?

William Laing: I do not think it is, no. I think a lot more of them are now being inspected.

Martin Green: But this idea of doing the inspections is relatively new and the CQC has now got a bit more organised about inspections, but I think that report, Lord Bichard, probably refers to the time when the CQC was not doing inspections and that was a worry. Sue is right on some levels, but my issue is that we have a national regulator. Her authority is leading the way in this, but there are lots of authorities who are not, and there will be lots of people who go and they will not know how to differentiate quality. The provider in front of them will be registered, but they will not know whether it is above registration standard or whether or not it is a high-quality service. Because of the move towards people having their own budgets, for example, and the way in which the sector is changing, we need some absolute consistency across the system and my view is that is what a regulator is there to do. For example, I can go to any airline and I can make a choice based on quality, but I know that that service is safe, because it has been registered and it has been taken account of. But there are quality standards that I can choose, because I know quality in certain airlines is better and I will pay more for them.

Lord Bichard: We had a conversation with a previous set of witnesses when I was suggesting that we could involve not just the regulator, but maybe younger old people themselves in visiting care providers, in other words, a kind of mystery shopping, if you want to use the current trend. What do you think of that idea? Because it seemed to me that it did two things: it widened the regulation or the inspection process; and it involved younger old people in something that was really worthwhile.

Martin Green: It is a great idea and, in fact, it is done through the Experts by Experience programme, which the CQC has developed. But I think it needs to get more traction and needs to be part of, perhaps, every inspection. I have to say, Lord Bichard, it is not only about younger older people; there are lots of older older people out there who could also make a contribution.

The Chairman: I think it would be good to allow the whole panel to make their initial statement about quality before we dive in to too many supplementaries. So can we allow them to do that, so each has made some statement about the big question about the quality problems of the sector, and then we will go down the list of Committee members afterwards? William Laing, would you like to give your perspective on the quality?

William Laing: I agree with much, if not all, of what Martin Green has just said, so I will not reiterate that, but let me just give you one or two numbers on this. We do have the essential standards of quality and safety—the CQC at the moment. I was doing some work on that last night and what we have found is that of about 11,000 care homes for older people, most of them have been inspected now and about 72 per cent of them are fully compliant. So that is one measure. All these are, in a sense, fairly superficial. So that is one measure of reasonable quality.

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180 Towards excellence in adult social care: Progress with adult social care priorities England 2011/12; Local Government Association; Directors of Adult Social Services; Social Care Institute for Excellence; SOLACE; Think Local, Act Personal.
If you go back to the old star ratings, the normal measure we use for that is the percentage of homes or services that are either two or three star rated, and that started off around about 75 per cent and rose to around about 80 per cent by the time it was abandoned.

Another of the measures we have is the Information Centre for Health and Social Care; they run a quite extensive survey every year and they get about 50,000 respondents. Now, admittedly, these are all people whose care has been purchased by local authorities, so it does not take into account self-payers, but you find really quite high satisfaction ratings in those. And again, I was looking at that last night. The most recent figures show that in the case of residential care, 71 per cent of respondents were either very or extremely satisfied with their care in a residential care home. This went down for nursing homes and went further down for home care. With home care, it was about 55 per cent either very or extremely satisfied. So that points up something, I think, perhaps.

Q712 The Chairman: Without making sweeping generalisations, many, if not all, older people would tend to be slightly more deferential, particularly when they are in an institutional setting and frightened of saying anything critical.

William Laing: I think there is an element of low aspirations here and an unwillingness, perhaps, but on the other hand, the people who did the survey were very careful to speak to the individual themselves and it was anonymised as well. So I think it is more a low aspirations thing.

Q713 The Chairman: Let me put the case against. Many of the public, having seen some television programmes of appalling situations of neglect or worse in residential settings, would seriously worry about the quality of the sector. With an annual inspection, particularly when it is for a home that is not effectively utilised by the local authority, how can we have much confidence that this is a sector that is of high standard and improving standards?

William Laing: The media, by their nature, will look for situations of difficulty and distress.

Q714 The Chairman: They found them, did they not?

William Laing: That is the nature of the media, to be honest.

Q715 The Chairman: It does not mean it is not true, does it?

William Laing: It means it is not necessarily representative.

Q716 The Chairman: Let me push you. What percentage, then, are as bad as we have seen on some of these horror stories? Nobody has a clue, do they?

William Laing: If we again look to the last survey for the Information Centre for Health and Social Care, they found that about 3 per cent or 4 per cent of people are extremely or very dissatisfied with their services. Now, it is possible that the media could be focusing on these 3 per cent or 4 per cent. I do not know.

Q717 The Chairman: Okay. I will stop beating you up, but you are painting a picture that it is not as bad as the media says and it is worse in domiciliary than it is in residential.

William Laing: Yes.

Q718 The Chairman: I can speculate on that, but I will not. Steve, do you want to come in?
Steve Smith: Thank you. I do not have very much to say on this one. We are not engaged formally in the regulated sector, but we do deliver some services, such as books on wheels, into residential care home settings. One of the things, anecdotally, you will pick up through those is that the person who is delivering that care is not always the same person. There is a lot of fluctuation there. The time element is often poor as well. So I think often the high-level things people want are some consistency and some time. We do quite a lot on loneliness and isolation and it has now been identified by Government, as the White Paper clearly shows, that it does have a very harmful effect on physical and mental well-being. It is as dangerous as smoking 15 cigarettes a day and this is where our volunteers can come in and help out on those befriending aspects.

Baroness Morgan of Huyton: I just want to push a bit more, if I could, on the measurement of quality. I confess that I chair Ofsted, therefore, in a sense, I come from a position of hating the idea of minimum standards really and a pass or fail; I cannot stand it. So I confess that at the start anyway. I am interested in what Sue was talking about, because clearly you are trying to move to a different way of assessing quality and delivering a quality service. What about all the people who you do not provide for? One of my big concerns is the majority of people, broadly speaking, across the country are now self-paying. How on earth, in a situation where CQC effectively do a minimum standards form of regulation, can we assist them in making decisions, whether they are funding it themselves, whether their families are; some of them may be getting personal budgets, whatever. How can we help them make that decision sensibly? Because my impression at the moment is that there is very little information out there and several local authorities I have spoken to have said, “We cannot say whether people are good or not. We really cannot do that. You will have to try and talk to some people locally and see how you can pick that information up.” Are you cracking that in any way? Can people who are not getting the service through you they phone a helpline and get advice on who to use or who not? How can we start to provide that quality information to people?

Sue Redmond: I am going to take a few steps back. Yes, they can phone a helpline, they can ring social services and ask, but we are not allowed to, because it is about jeopardising other people’s businesses. Since the quality ratings have gone that is more difficult, but it comes to some things that colleagues are saying. We cannot leave that to the regulator. There is no way we can regulate everybody. There is no way we can possibly do that unless you give local authorities and the regulator a lot more money. People talk about over-55; I am in that age group; we are all there. When we have a society that does deal with older people as separate entities and we are having this conversation about old people as though they were separate entities, local authorities and communities should be looking at resilient communities and it is a bigger area than social care. Social care should deal with the end. It should be resilience within communities, engagement, older people contributing to their communities. In the case of residential care homes, we talk about regulating them and most people in this room might say, “That is the last place you want to be when you might need some help”. So we do not need some residential care homes in the future; we need communities that are accepting and engaging with older people and that is what we need to focus on: public health, engaging older people and then information and advice, financial planning and accepting that we are going to get older unless we die before and that it is an okay thing unless we have a health problem.
If we have a health problem, we need to face it now. We need to start planning now. That is what we need to be doing with people, so that we do not have to put everyone through a social services or a social care funnel in order to get some help.

**Q720 Baroness Morgan of Huyton:** That is fine and I agree with all of that, but if somebody wants to buy domiciliary care for themselves at the moment, where do they go to get the information about quality?

**Sue Redmond:** Coming back to your point, we have older people assessing all our care agencies. They are going out and doing it. It is not quite mystery shopping, because what we want them to do is go with training and support and what to look for. So we have people trained to do that and that is the beginnings of those sorts of things. Local communities befriending their care homes, word of mouth: that sort of thing we have to develop more.

**Q721 Lord Bichard:** Do you train and pay them to do that? Is this general across the country or are you in the leading cohort?

**Sue Redmond:** It has happened for years in quite a few authorities. It is beginning to happen more and more and, yes, we do pay their expenses.

**Q722 Baroness Tyler of Enfield:** This is very much a follow up point to Baroness Morgan. The same report that we quoted from earlier told us—and I think you have referred to it, Sue—that councils are not required to publish assessments of local service quality. You seemed to be implying that it was not possible to do that, unless I misunderstood you, because of the whole procurement and tendering process. It just struck me that surely there must be ways in which some sort of assessment of quality could be given that does not obstruct the tendering process, because in these sorts of areas transparency can be so important, I feel, in terms of the information available. Can you imagine ways in which local authorities, in terms of their role in shaping the local market, could do more on the transparency and publishing information about quality standards?

**Sue Redmond:** They are beginning to. Everyone is looking at a portal at the front about information and advice for people. We are all doing our own versions of TripAdvisor. Older people, people who use the services, rating them themselves is the best advice you can get, so everyone is starting to do those things more and more.

**Martin Green:** Just on that, Lady Tyler, there is now an initiative that has been developed by some larger care groups and some of my larger members, where they have got Ipsos MORI to standardise their user experience questionnaire. They have done an initial pilot. What they intend to do is make that questionnaire freely available to any care service, so that when the information comes in, it can be benchmarked, so people can see, a bit like the TripAdvisor, how people rate the service. One of the issues for me is that the sector needs to take some responsibility for this.

On the point Sue made about the issue about residential care, there is a bit of a myth around, perpetrated, I have to say, by lots of local authorities, that nobody wants to go into residential care. Well, the bottom line is when people have the opportunity to make their own decisions, lots of people do go into residential care. What we need to move away from is dogma that says either you should or you should not be. It is about choice and it is about individuals looking at what services support them most appropriately.
On the point Steve made about loneliness and isolation, I have spoken to people who said they were in their own homes, they were getting small amounts of domiciliary care and they were absolutely isolated. Their front door was not their route to independence. It was the thing that closed them down from contact.

So we should be a little bit wary of saying one or other service is the right service. That should be about individuals making choices about what is appropriate for them and the system should enable them to have the information to know what services are right, what quality is the most appropriate for them, so that they can make an informed choice.

Q723 The Chairman: And it does not at present, from what I have understood.

Martin Green: Well, it does in some places. The problem, Lord Chairman, is that some places do it quite well, and obviously Sue is in the very vanguard of some of this, but other places do not. And we cannot have a system where it is geographically based and it is just pot luck whether or not you can make an informed choice.

Q724 Lord Bichard: I am, again, beginning to feel like a permanent secretary, because when you ask a question, Sue, with respect, you are telling me, “Oh well, it is beginning to happen” and it is quite difficult. We are here to try and help you, because we want to make some recommendations that are going to move things on. What I am searching for is a best practice model. What would you like to see in the future that we do not have at the moment? Although it may be happening in one or two places, do we need some greater consistency around transparency? Would it be useful to have people from the community going in—whatever we call them—and reporting? Do you want a TripAdvisor kind of system? What is it that we could recommend that would help? Or are you really saying to us “Oh, no, no, just leave it, because it is naturally going to get better”?

Sue Redmond: I am not saying that at all. I am saying all those things you have mentioned are things that we have been recommending for a long time should happen. But the other thing we need is the status of the staff, the workforce who work in those industries. They have the lowest status. They are doing the most intimate and the most amazing work for people and their status and their pay is very low. I think one of the most important things we could do is value what they do. Paying by outcomes is not asking people to go in for 15 minutes and leave someone in their home isolated. It is saying, “Part of your job as a care worker coming into someone’s house is to engage that person with their community”. So part of the outcome is to take that person out; not to do everything with them and befriend them, but introduce them to their local voluntary organisation, take them to the library, introduce them to groups. Get them out of their house if they can. That is paying by outcomes. That is as well as doing home care personal tasks. We need to value the workforce. We need to get the managers inspired and motivated and valued by society and then we will have a culture and behaviour that is different, as well as the rest of society owning that they live next door to a care home or owning they live next door to someone who may need care, but also can contribute a lot back to them. Now, okay, that might sound woolly and I am not giving you specifics, but that is something about awareness-raising in our communities that is different from what we do now.

Q725 The Chairman: Does anyone else want to make a specific set of responses to Lord Bichard’s question about what needs to happen to raise quality?

Martin Green: Lord Bichard’s question I thought was very sound and all the things that you mentioned, Lord Bichard, need to happen. But there also needs to be some monitoring of
the commissioning quality, because we now have a system where nobody monitors the way commissioning is done, because that role was taken away from the CQC. The level of commissioning is very important in relation to some of those outcomes. So, for example, Sue talked about the staff. Adult services directors some time ago were given responsibility for their entire workforce in social care in their locality. I see little evidence that any of them are coming up and saying, “Okay, independent sector services can access our training”. How do we engage in a position where we have pay and conditions that are equalised across the system? Because there is a conflict. I understand the enormous pressures on adult services directors, because they have great pressure in terms of need and very few resources to deliver on them. But the reality is we have some of those structures in place, but nobody is monitoring whether or not they are being delivered. So I do think there needs to be some emphasis on the role of the local authority not only in terms of its commissioning role but also, as Sue mentioned, around its market-shaping role, because we have to have enough good quality services and localities for people to be able to buy in and get the services that are appropriate to them.

Q726 Lord Hutton of Furness: I just want to pursue this issue in one further direction, because this really is probably the hub of it. In various ways you have all described, as you see it, some of the problems that you are experiencing in helping to improve the quality of local social care services. You, Sue, have talked about the role of local authorities in shaping the local market, particularly for domiciliary care services. You, very intriguingly, referred earlier to what I took to be some of the competition law barriers to you providing more of an active role in this field. You talked, Martin, about problems with the CQC, and others have talked about funding obliquely and so on, but are there any further barriers that stand in your way to improving the quality of social care services in your areas? I would particularly like to pursue your reservation about competition law and the barriers that imposes upon you.

Sue Redmond: When we had the star rating, all we could do is produce a care directory that gave everyone information about every care home. We could not recommend a care home. That was not allowed, because that is competition. Is there another barrier? Well, it is all the things I have mentioned. We need to pay people a bit more. We need to value people a bit more. The regulator looks certain things. Is there a choice of meals? How many visits a day do people get? It is not saying, “What is the outcome of that intervention in that person’s life?” And sometimes what we do, and we do it all across the sector, is we take people into our sector and we make them dependent; they are in the sector and they are in our sector for good. If you put someone in a social services and you give them an assessment, we will assess them for something and once they are in our service they stay there, because we do not incentivise our providers—good providers do it anyway—to keep reabling, to keep looking at outcomes, to keep asking that person what is the next goal they want to achieve. All that would mean that person lives a different life and it would cost less.

Q727 Lord Hutton of Furness: But do you want to be able to recommend local providers or not? You say you cannot, but do you want to?

Sue Redmond: There are lots of really good providers out there and it is very subjective, in terms of care homes, what a person likes. So you need to be able to say to people, “There are lots of good providers out there” and tell them the good providers. I would like to be able to do that.

Q728 Lord Hutton of Furness: But you cannot.
Sue Redmond: I cannot do that. I could say the ones I like, but I am not allowed to say the ones I like, no.

Martin Green: But I think we just cut out the middle man there and what we do is we have people’s experience framing the quality. The TripAdvisor model or the model that Ipsos MORI are developing will be about the experience of people who use the service. I could tell you that I think X service is good. Well, it might be good for me, but it might be totally inappropriate for Sue, because she might have different measures of good. So if we see how people have experienced a service and they have an opportunity to say why they thought it was good, that will help people make informed choices.

The Chairman: William, you were nodding at that, were you not?

William Laing: Yes, I am. I think the problem at the moment is that these things are only just starting and what you need is scale and what you need is a reasonable expectation that if you do go onto a website you will see three relevant comments or be able to draw down some figures. That does not exist at the moment.

Q729 The Chairman: Who should make it happen, if you are all agreed it should happen?

William Laing: I think the private sector is best placed to do this. In fact, we are looking at it ourselves, but I will not go any further than that.

The Chairman: Well, if it can happen, it will be good.

That was very interesting and fascinating. We could spend two hours just on that topic alone. We are now going to turn to questions about informal care and the use of volunteers.

Q730 Baroness Finlay of Llandaff: That was very interesting, but we are aware that there is going to be an increasing pressure on families to provide care for an increasing number of disabled elderly people and the difficulty there is that demand will go up. How much do you think that this demand is going to be there and be desirable, and how are we going to cope with the vulnerable elderly who may not be getting the care that they need? You are talking about inspection, you are talking about ways of monitoring, but how will we be able to make sure that we do not have vulnerable people, in a way, locked behind those closed doors and not even saying what is really happening to them? Linked to that is how we make sure that any informal carers access the training that they need for some very simple things, even like helping people move, getting up out of a chair and so on, as well as accessing equipment that will be appropriate and make the caring easier and be able to monitor as needs change, so that the equipment supply changes when they themselves have had no background.

Sue Redmond: There are huge things there. Informal caring: just because we have an ageing demographic does not mean that we are naturally going to have lots more people coming to us because of that demographic increasing. Certainly in Sweden they have the oldest population and they are spending less, because we are healthier, we are more engaged as we get older. So, hopefully, there might be a generational thing going on now that we have to stop happening gradually. So we have to start doing something differently now for the 55-pluses, etc, and that is all of the things I was talking about: keeping healthy, taking some responsibility for planning your future, etc.
But carers who care—and we have always had caring, as well; we have always had informal caring, have we not?—do need the support, and certainly in the new Bill local authorities have a duty to assess all carers, and we will be. That is going to be a huge pressure, by the way. So we need to understand how we will do that and what the consequences of assessing them will be. But certainly there are lots of carers’ organisations out there, funded by local authorities in the main, who deal with carers, who train and support and ask them. I talk about this a lot, because I am in this world: I and my sister are going to plan our lives, and I think the next generation coming through will. We want everything to make our lives easier. We do not want to resist anything, whereas my dad will not accept anything. So I am hoping we can start educating differently. For the group we have now, who are not accepting of care and really reluctant to have care, we need to make sure we look after these carers. Now, that is not easy and, again, I think it is not about saying social services have to do this. It is communities and people who live in their communities. It is the voluntary sector, it is local people. We have a huge number of volunteers in this country who do everything. We are rich with volunteers, but how much are we really going to ask them to do that is too onerous? If you just befriend a care home and if you are just in your community, it is easier. You are asking impossible questions in some ways, but there are some ideas as to how we answer them.

Martin Green: I absolutely agree with Sue, because this has to be a community response, but also it has to be a response about how the system supports those communities or, indeed, those families. So, for example, there is a lot of emphasis now on childcare. There are tax breaks for people, there are benefits for people, there are flexible working approaches. We have not wised up to the fact that the 21st century is about older people, the notion of this sandwich generation and the notion also of how many very elderly people are caring for partners or people who are very dependent. How do we make sure that we support them? How do we make sure that their children or loved ones have the opportunity to support them a bit as well? We should look at the model that is used around children and think how we can replicate that for caring needs. And perhaps we should stop focusing on whether it is a child or a person with dementia and start thinking about how we support people to still engage in their economic role, to have a life of their own, but also enable them to support their families and loved ones in communities.

Q731 Lord Bichard: That is a really interesting point. I think it is one that needs to be developed. Has anyone developed this possibility of doing some of the things that we have done over the last 15 years around children, around older adults. For example, as we said at a previous meeting, we set up businesses to care for young children and therefore we began to develop an economic benefit from focusing on that particular group. You could do the same for older people at the moment, but I am not sure that we are. We are not commissioning for that purpose. Has anyone looked at this in some detail?

Martin Green: Not to my knowledge, Lord Bichard, but the point you make about business it is very interesting as well. When we look at the care sector, we always see it as this economic drain. Look at local communities. I have just been home to the north east of England where caring is probably one of the biggest employments in that locality and those people are also spending money in their local areas, in their local shops; they are sustaining businesses. Yet it is very interesting, when we talk about things like approaches across the system, you get lots of compartmentalising of things. So, for example, we do not have Economic Development Units thinking about this. Interestingly, I was talking recently to so-called strategic commissioners in London. I asked them what they thought strategic commissioning was and what they said was, “Well, we look at the demographics and we just
produce more of the same to deal with those numbers”. Now, in that area there are people who are cash and asset rich in Hampstead and four stops down the Tube there are women, particularly, who need flexible working. Why are the Economic Development Unit and the training budget not training those people to be the workforce? And of course, when those people buy in that high-cost service that these people will be employed to deliver, they are not a burden on the state, because they are quite happy to buy that service to be a low-level prevention service for them. So we have to get a much more holistic approach to the whole issue of care and looking at it from different perspectives. Economics and the support people can give is a very important part of that.

**Sue Redmond:** I agree entirely with that.

**Q732 The Chairman:** William, do you want to add anything on that? It is about market-making and shaping, is it not?

**William Laing:** I agree that we do need a lot of new thinking and I am sure there is a lot of potential there. I would say, though, that I think that Sue was being slightly optimistic on the expectation that we will become a less dependent older society in the future. I would love to think that, but I am not sure that I believe it, especially when you look at the figures on healthy life expectation and non-healthy life expectation; that does not support that view.

The positive thing I would say is that there was at least a fear that the number of informal carers was going to run out as people become more mobile and as there are smaller families and so on, and there is no evidence that that is the case. People still are committed to informal caring.

**Q733 Baroness Finlay of Llandaff:** Can I just pursue a little bit more your statement about volunteers? They are a different cohort to the person’s own contacts, family and very close friends who might be providing care, particularly intimate care. How can we use that group of volunteers better? They often seem to be used to do relatively small tasks rather than take over responsibility, so we get armies of volunteer drivers and so on, but they are not undertaking the whole care of the person. Often whoever they are volunteering with puts boundaries around what they are so-called covered and trained to do and can and cannot do. How can we change that culture, perhaps, to match more of the philosophy that Sue is outlining?

**Sue Redmond:** The phrase “health and safety” comes to mind. There is only so much volunteers might want to do and certainly one of the things I would like to see is someone can look after my dad in Liverpool and I will look after their mum in Wiltshire. We can try and do something like that. So we befriend people. There are all sorts of things happening in other countries—you mentioned other countries—about swapping and time-sharing and doing all sorts of things. You can do things differently with volunteers, but there is only so much you can ask volunteers to do.

**Q734 Baroness Finlay of Llandaff:** Steve, it is your field really, is it not?

**Steve Smith:** Yes. One of the things we do is to focus on the person and not the condition. That is the first thing about WRVS. So we do not look at any particular condition, but the older person as a whole.

Also, this has probably been covered previously, but there is a lot of negative attitude towards older people. We did some work a couple of years ago when we looked at the contribution that older people made to the economy. I think we estimated that in 2010
over-65s made a net contribution to the economy of around £40 billion. We expect that to go up to £77 billion by 2030. The value of older people’s provision of social care was worth about £34 billion in 2010. So there are quite a lot of older people looking after older people; they are doing things for their grandchildren, lending money and doing lots of other things that are socially good. A lot of our volunteers are older people as well.

**Q735 The Chairman:** I accept that and celebrate it and we are well sighted on it, but in a sense the question is that we know from the demographics there are going to be a lot more older people and a proportion of those are going to need some form of care support. Obviously, the local state, particularly on current funding, cannot possibly do it all, so it is critical we think about ways that we increase the contribution of civil society locally, volunteers and informal care. That is the question we are after: what should be done to maximise that potential resource?

**Steve Smith:** There is a great opportunity. After the Olympics and the Paralympics, there is a big spirit out there for volunteering. We see now people coming through who are enquiring about volunteering and it has gone up many, many fold.

**Q736 The Chairman:** But what should be done to accelerate it more?

**Steve Smith:** We are looking at, obviously, CRB checks. I have a number of them. I do not know why I need so many. I have one with my local authority. I have one with WRVS. I do some work with school governors. How many do I need?

**Q737 Lord Bichard:** Do volunteers have to pay for that themselves?

**Steve Smith:** I do not know. I am just the recipient of having to apply for these things.

**Sue Redmond:** We pay an organisation to do it much more cheaply and it is free for volunteers.

**Q738 Lord Bichard:** I have heard complaints from some older people that they are paying for their CRB checks, which seemed to me to be quite outrageous.

**Sue Redmond:** Some do, yes.

**Q739 Baroness Finlay of Llandaff:** You mentioned CRB checks, but what are the other barriers to volunteers really engaging in a much more holistic way with the person who they are in contact with and being empowered to take responsibility for whatever they are doing with the person, including being able to take risks that that person might want to take? Because older people sometimes say, “Well, I know that there is a chance of A, B or C”, but they do not want to be paralysed by fear. The risk averse culture paralyses them by fear of what might happen, when it probably will not and if it does, it does.

**Martin Green:** I was talking to some people in volunteer bureaux. I was talking about it in relation to older people who might want to share a meal and somebody going into somebody’s house to have lunch, like we all do. Suddenly there was this great list: you must be worried about salmonella and you must make sure that you have boiled the soup for 25 minutes and a whole load of complete nonsense. We have to somehow change people’s mindsets away from that. If I come to your house, I do not know whether you have boiled the soup for 25 minutes, but I will take the risk. So I think it is absolutely the point, Lady Finlay; we have to enable people to take reasonable risks and to be in control of taking those risks. We also need, though, to get the organisations that are empowered supposedly to help and support them out of the barriers to delivery culture and into the facilitation and,
The Chairman: If I can push any of the panel, I do not know what the numbers are, but I would be surprised if we did not really need a doubling of the amount of informal care and volunteering to support older people; or it would be good if we could get it. Take that as a theory. What should we do and what needs to be done to make that happen over the next five to 10 years?

Q740 Baroness Morgan of Huyton: Can I just add to that, Chairman, because that is very much where I wanted to come in? Particularly to Steve, are there areas of the country where, frankly, this is much more difficult than others? Do you have much stronger WRVSs in Wiltshire than you have in Liverpool or is it everywhere? And what does it take for you to get it running? I am always interested in the little bit that has to be put in the system to make a lot happen? Can you describe for us how a successful WRVS network operates, what it takes, what bits of funding it takes to then get a wider involvement?

The Chairman: Can you take that as two questions, otherwise we will lose the first one, which is about making systemic change and then address the one about the WRVS model in practice?

Steve Smith: You are right, we have different services in different parts of the country. One of the things we are doing at the moment is modernising our whole offer. We are creating a number of hubs. We have 67 hubs we are rolling out this year, which will try and pull together and integrate our services much better, so we respond to the needs of the older people much better. But our funding comes sometimes from local authorities, for example, Meals on Wheels, the befriending schemes and community transport, where we will get contributions from the local authorities, but there will be some maybe small payment as well from the recipient of that particular service. So, as I say, local authorities are very important in this, because if we do not have the contact with the local authority we cannot really run the service. We do hospital to home schemes. If we do not get the referrals when people are coming out of hospital, if we do not know they are coming out and they have a need, we cannot really get involved. So there is that joined-up-ness that needs taking care of and that does not always work particularly well. So it is joining up, more integration with ourselves and the public sector and the private sector. I think it is a three-way thing there.

Q741 The Chairman: Can I encourage your push? Because I am still not getting three big things that ought to be done, either by local government or the central state, to make a really big difference to the amount of volunteering and informal care, because we are going to need it, are we not? The numbers demonstrate if this does not happen a lot of older people are going to have less good lives than they might do. So if that is true as a premise, what should be done to significantly increase the amount of volunteering, social care and community support for older people?

Steve Smith: Can I just follow up on care banks, which I think is another important aspect? We are piloting in Windsor and Maidenhead a Care Bank scheme that started in March this year and over the last seven months I think we have recruited 60 volunteers and that is now providing services for an additional 132 older people. They get, obviously, vouchers and bits and pieces they can use on their local facilities. That seems to be working and obviously we are monitoring that.
Q742 **The Chairman:** Does WRVS have a manifesto about what should be done to address this? If you do, please send it in to us, because at present I am not getting the picture about what WRVS or British Red Cross or others think should be done to transform the amount of volunteering and informal care and we need that from you. Any other comments?

**Martin Green:** The other comment I would make, Lord Chairman, is that also lots of people, particularly who offer mutual support that we might describe as volunteering, would be horrified if it was categorised as such. I was talking to my mother recently, and she gives a lift to two ladies in the village who cannot drive to the supermarket. I made a flippant comment about “It is really nice that you volunteer to do that, because what would they do if they could not get to the supermarket?” and she was horrified. She said, “These are friends of mine and they help me and I help them”. So there is another issue about how we label things. The point Sue made about how we develop communities and mutuality is perhaps a much more important way of seeing it, rather than just ticking in the box that “I am a volunteer”. It might be about people help me, I help people, so it is about how we harness that.

Q743 **The Chairman:** And how do we?

**Martin Green:** I think we have to get much more community activities. For example, one of the things that I am very anxious to push is I want care homes to get much more into their communities. We are developing a care homes open day on 21 June and the whole rationale for that is to get the local community into the care home, doing activities. Now, once people start to do that, they will go into the care home to do something. They will meet their next door neighbour or they will meet somebody who lives down the road and suddenly they might say, “Well, I go into Lincoln three times a weeks, do you want a lift?” So it is about how we just get contact with people, which could then develop into informal contact, which might not necessarily be styled volunteering.

Q744 **Baroness Finlay of Llandaff:** Just building on your comment about your mum and helping people locally, how do we get the local, perhaps, nursing home, the local care provider of some sort, to provide open access to training on different aspects that might be helpful? I am thinking about one of the things, which is getting people in and out of cars. There is a technique to get people easily in and out of cars, and most old people try to get in and out of cars in the most difficult way and the most likely way to fall on the pavement as they get in and out. It takes 10 minutes to demonstrate it, but the majority of people lifting have no idea that they could get any kind of guidance. How do we free up that possessiveness of those who are training and stop it being a domain where you have to be a trained trainer in order to be able to demonstrate to somebody what you can do, because the diktat comes back “But I am not covered”?

**Martin Green:** Absolutely and what we have to do is break down some of those silly bureaucratic issues about the fact that you cannot tell somebody something that is about helping them. So, for example, I would really like to see care homes getting much more open to their local communities. For instance, they might have activities where, if people who are living in communities with their families are coming into the care home, the care home staff are there to receive them and are able to then show them how they can easily get somebody out of a car. So it has to be done in a reasonable way that is not about a session on something or whatever. It is just about trying to enshrine that when people have advice that could be helpful it should be transferable wherever and whenever it is useful.
The way I have been pushing and selling it to care homes is about the fact that they could be the centres of support for people in communities who are looking after people with dementia, etc. But I am also saying to them, “It is a good way of growing your next tranche of market. If you engage with people, if they understand what you do, if they start being comfortable in that setting and they see good quality care, they are far more likely, when their husband or wife needs a service or their mother needs to be looked after, to go to a service that they are already familiar with.”

What we do in the current system is we wait until people have a crisis and then there is a no-choice scenario, whereas if we open services out and we engage people who are not needing them at that particular time—it might be that you engage them as a volunteer, it might be that you engage them to give information—we will then start to get people much more able to engage with each other and get useful information.

Q745 The Chairman: Thank you for that. We have pushed you a bit, but I think it must be a very important issue for us, given what is going to happen. So if you do have further thoughts or know of others, please let us have something in writing on this.

Q746 Lord Griffiths of Fforestfach: I would like to direct my question in the first instance to Mr Laing, who clearly knows a lot about the private sector. I take it here that the private sector is a for-profit sector and I would just like to ask you what you think the potential of the private sector going forward is, because it has had some bad publicity. I should declare an interest: I used to be chairman of Westminster Health Care for a number of years. I just wonder what you think of the potential capital coming into this sector. Given the need for regulation, in the end, within the private sector, other than at the very high end and particularly looking at the lower quartile, can you really make private provision pay and attract capital into it where it is competing with all other potential investments and so on? I would very much like to hear your thoughts.

William Laing: Over the past 30 or 40 years capital has flowed into the care sector. It has done so because it is attractive; because there have been returns. However, we all know what the issue is at the moment: there are periodic squeezes on prices that the public payers are willing to pay. It happened at the turn of the century; it is happening again now and that does threaten the flow of capital. There is certainly a lower appetite amongst private equity companies for investing in asset-based care services at the moment. Partly it is because of profitability; partly it is because of the bad press that the private sector has had in recent years, particularly Southern Cross and Castlebeck. But nevertheless, I think that you will see capital flowing in, because the reality of the situation at the moment throughout the country as a whole is that although local authorities are unwilling to pay reasonable fees, nevertheless in most areas of the country care home operators are able to survive and, indeed, in many cases prosper, because of private payers. And, in effect, private payers are simply cross-subsidising public payers and that is what is keeping the whole thing alive. So I think we will continue to see capital flowing into the sector under those circumstances.

Q747 Lord Griffiths of Fforestfach: Rather than the upper end or professional people who are in retirement and so on and who do have some sort of financing, if you take the lower end, to me the question has been do you need a greater state funding to supplement whatever resources they may have in order to make that viable for the private sector to provide?

William Laing: In order to make it viable obviously you need to have sufficient income coming to the provider. The provider will get adequate income from private payers, as I
say, combined with the local authority payers. If there is a reasonable balance of private and public payers—and I think Martin may well disagree with me here—there is no huge issue as far as the viability of care homes in areas with large private pay populations. The fact is that the people who are supported at inadequate fee levels at the lower end of the income scale by local authorities are able to piggyback on the willingness to pay of private payers and that is just how it is. Care homes are not divided into those that are pure private pay and those that are pure public pay. Nearly all of them do a mixture of both.

**Martin Green:** I agree with what William has said. The difficulty comes in areas like the north east, for example, where I was yesterday, where the ratio is so much higher for the public pay. And if we are not careful, what we will start to see is a two-tier system and people will decide that they have to have high levels of public pay because of the geographical location they are in; the south east, for example, will have much more thriving businesses. One of the things we have to do is make sure that we do not have that very clear differentiation between public pay and private pay, because we want to have quality for everybody.

**Q748 Lord Griffiths of Fforestfach:** What is the answer to that?

**Martin Green:** The answer to that is a cost of care exercise and William does a brilliant one, which identifies the true costs of care.

**Q749 Lord Griffiths of Fforestfach:** We are talking about residential care.

**Martin Green:** Yes, residential care, but you could roll that into domiciliary care as well. I do get very irritated sometimes when I am sat across the table from public sector officers who tell me things like, “Well, why do people need to make a profit out of care?” and I remind them that their public sector pension is taking whatever it is, 13 per cent out of the system, which is not directly delivered to care. So we need some clear benchmarks and my view is we should focus not on this notion of private, public or voluntary, we should think about this in a sector-neutral way. We should think about the outcomes we require, the quality we want, and we should work back on what a reasonable price is. And a reasonable price has to include making it attractive for capital investment, because we know the public sector has no money for capital investment or, indeed, for innovation and creativity in the system. And the only way we will drive both is by having a system that is healthy and having a sector that delivers proper returns.

**Q750 The Chairman:** Do we have that currently?

**Martin Green:** I think we have it in some areas but not others.

**Q751 The Chairman:** For the cross-subsidy reason.

**Martin Green:** Yes, and the cross-subsidy issue is a very big one, because in effect it is a levying of another tax on people who are already paying.

**Sue Redmond:** I do not think any longer local authorities can justify not paying the right money, but I do not need to tell you the situation. I do not need to tell you that, also, we have to be cognisant of the self-funding market, because just in my own authority last year, £4 million of our spend was taken on people who had funded themselves and then run out of funds in their home that we have to pick up. That is happening more and more as people live longer in those homes or as their equity in their property gets less. So we have to take notice of what is happening in the market, and I am not going on and on about funding, but when you put that into a finite pot and you say this is the end of a whole stream of health
and social care that has gone into people—we have not mentioned the health service—the majority of funding for older people is spent on an inefficient health service. 6 per cent of the total funding of older people goes on social care, 35 per cent goes on health, the rest goes on benefits. Talking about the private sector, I think there is a huge market for the private sector to invest in something like social impact bonds, on outcomes for people. If the health service invested in six issues—stroke recovery, hydration, continence, foot care, dentistry, dementia—the social care costs would be far less. So we need to look at the whole system and then we can fund care when people need it properly and we can do the right thing. If you want to do anything, please unlock the separation of health and social care budgets and please ask health to deliver on some outcomes, not the targets they have, which is four hours in A&E, although that might have been helpful, or delayed transfers of care, which we talk about, which are horrendous, but the other real outcome that will impact on older people and would really help social care. That would really help.

**Q752 Lord Griffiths of Fforestfach:** One final question: I have always thought the case for the private sector is that you expect to see innovation in the private sector. As you look at the provision, particularly of residential care, do you feel that the private sector has provided innovation?

**William Laing:** Yes, I think it has. If we go back quite a long time and imagine how residential care used to be delivered, it used to be delivered in Nightingale wards, no single rooms, no en-suite facilities. This is minimal-level innovation, but nevertheless it has been important and the investors have been important as well. There are quite a lot of examples I can think of: boutique care homes, or care homes where they have different staffing models. So I think quite a lot is going on, although you do not hear very much about it in the press.

**Martin Green:** The innovation could also be really enhanced if, for example, health started to commission things in. So, for example, I went to a really brilliant care home where they were doing a night sitting service for people with very severe dementia and challenging behaviour. And previous to that, I was talking to a carer and she said to me, “My only point of getting some support in the middle of the night, if I got to the point where I could not cope anymore, was I rang 999”. Now, if we had a system where she could ring that service and somebody would be blue-lighted to that service, not to an A&E department, which is bad for the patient and bad for the system, we could get much more innovation. But I absolutely agree with Sue: the budget issue is a really big and difficult issue. If we could get health to start commissioning a range of things that are going to deliver better outcomes in social care, we could make much better use of the money. But I am so depressed as I go round and I talk to these new groups. I was in the north east yesterday and what is happening is the personnel are changing and are going from one job to another, but the mindset is not changing. And the challenge that I gave them was: how are you going to look at the delivery of outcomes and how are you going to look across your system to say, “How can we get those outcomes?” It might be that it is a social care service, it might be a leisure service. For example, one of the things that irritates me tremendously is a lot of adult services directors have taken over roles in managing libraries and leisure care, but they still manage them in silos. So they do not say, “What can leisure services do for people with dementia?”, for example.

**Q753 The Chairman:** Let us stay with the point that you have made, which is reinforcing what Sue said. It is one of the central issues for us, because clearly the King’s Fund diagnostic is that the health service is designed for, effectively, a past set of circumstances
and is not well-prepared in terms of its excessive concentration on hospital-based rather than community-based and joined-up. We have had sessions on integrated commissioning and we are still struggling with that. So I would really welcome, and I think we would find very helpful, a note from either of you about what it is specifically you think that health should be, probably with adult care services, commissioning in localities, which is obviously relevant to the cost drivers in health, so they have an incentive, but would start to shift the system. That is on the money, as far as we are concerned, in part.

Q754 Lord Bichard: We need to be very specific about this. Martin, your last contribution: I could not have said it any better and I agree absolutely with you. But we will be told that there is a concordat between the Local Government Association and the NHS Commissioning Board, which is going to resolve all of this. We will be told that Health and Wellbeing Boards have changed the landscape completely. What we need to do is to get behind the words. I cannot understand some of the words, frankly. I think we should be saying what you are saying, which is that there is not a lot of evidence that things are changing and what we want to change.

Q755 The Chairman: There are two questions. Do not answer them now, we do not have time. What should happen locally on the point that both of you were making, and what are the ways in which we are going to make what should be happening come about, as opposed to just concordance? Can I leave that with you? It is important for us, so it would be welcome. Either do it separately or do it as a collective, we do not mind. Good. We are struggling for time and, Baroness Tyler, you wanted to ask about where it is done better elsewhere.

Q756 Baroness Tyler of Enfield: Yes. I am particularly interested in international experience and what we can learn from that and, in our sessions so far, we have heard of various other countries. We have heard something about Australia and a rather holistic approach they have been taking to an ageing society. We have heard a little bit about Scandinavia and, Sue, you mentioned Sweden. We have also heard about countries like France and Belgium, where the generation of a really vibrant care market is seen as part of an economic growth strategy—so very much picking up your points, Martin. My question is: which country should we really be focusing on, first of all, in terms of the split they have of roles, as between the state, the individual, and the private sector—so those who are operating an effective mixed economy—and secondly, how much focus they put on the whole issue of community resilience, reciprocity, social relations and networks, picking up the questions that we had earlier from Baroness Finlay.

The Chairman: Who can we learn from and what can we learn?

Martin Green: I have to say, Lady Tyler, part of my somewhat irritation sometimes about the international comparators is that we can all pick out the best bits of particular systems. What would be useful is if somebody would do a cross-western society analysis of what works in particular areas and then pull it all together and say, “Okay, we need to take that from France, we need to take that from Japan”. We can look at what those societies do; for example, the Swedish example is very heavily weighted towards communities. They have lots of things that we do not have, like they have a very small population, they have much more focus on particular areas, they have rural communities that are good at supporting each other. But I have to say, if you go to rural communities—I come from rural Northumberland—they are very good at supporting each other as well. And I think one of the things we do is we seduce ourselves into a situation where we look at our big urban
centres and say things are not going well there, so they are not going well everywhere. And so I think one of things we could usefully do is look at some of the things that work here and try and replicate them in different bits of the system. It is not to negate your point and I guess what I am saying is I do not have the answer.

**Q757 Baroness Tyler of Enfield:** I am obviously particularly interested in systems where there is sufficient comparability that transferring things would work, as opposed to countries where the whole system is so different it is interesting, but not really going to help us.

**Sue Redmond:** I will volunteer to go.

**The Chairman:** Any other comments across the panel?

**William Laing:** It is impossible to give a comprehensive answer, but I suppose I would point to Australia and New Zealand dementia care and also, particularly, extra care. They have developed larger scale extra care quite a lot. That is where you have independent living units, but with a care infrastructure. It is a halfway house between domiciliary care and residential care and they have developed quite substantial large-scale developments where people can make a choice to continue to live.

**Q758 Lord Hutton of Furness:** Is that not happening here in the UK?

**William Laing:** It is, but it is very limited and one of the big problems, of course, in the UK is the planning laws.

**Steve Smith:** WRVS did a study with Demos, which we published earlier this year. It was based on a literature search and the European Social Survey and we looked at the UK, Germany, Netherlands and Sweden. It looks like there are a number of issues. We did not come out particularly well against any of them, under any of the parameters, but it looks like it is a cross-section of income, health and social issues that directly impact on that. We did circulate the study to the Clerk beforehand.

**The Chairman:** We have it, have we? Okay, good.

**Q759 Baroness Finlay of Llandaff:** What I wanted to ask follows on from that and your comments about health and social care and the interface. In the Netherlands, they have dealt with some of that by creating a specialty of nursing home medicine. There are very large nursing homes for people with very complex, chronic conditions, but where they are living independently and they are living much more as if they were in a residential home. So it is a cross between a nursing home in terms of care provision, but residential in terms of outward-looking social activities for people and the ethos of the place and of mutual support within them. I wondered if you knew of anywhere in the UK that has picked up that kind of model, perhaps linking it with geriatric medicine.

**Martin Green:** In fact, I was in Newcastle yesterday and they have done some stuff up there. There is some work done by Eileen Burns in Darlington; she has been doing some of that. There was some absolutely brilliant work that had been done on that by Amanda Thompsell in Southwark, but unfortunately that team got dismantled, because it was a good opportunity to see that health input that was then enabling people to manage their long-term conditions, and that meant that they could engage in those social activities and societal engagement. So there is some good work going on, but one of the things that is unfortunate is that often when things get tough financially people who have done this...
great work, which is about the systems supporting each other, retreat back into their silos because they have a budget problem. Some of the stuff that is seen as a bit peripheral, which is actually essential to that engagement and wellbeing agenda, gets lost. When I was talking in Newcastle, they were very fearful that that might happen there. What we are very short on, though, is the research that says this makes a difference and the research that says the cost-benefit analysis of this and the wellbeing benefits of this are significant. It is a challenge for us to get better research into that, because that will then be the basis for being able to continue it into the future and replicate it across the system.

Q760 Baroness Finlay of Llandaff: Or even just straightforward evaluation. It does not have to be high-quality research, but even some metrics to demonstrate whether it has had any impact at all on the cost.

Martin Green: Yes. A quality of life matrix with people themselves would be a really good way to start, I think.

Q761 Lord Hutton of Furness: Inevitably, the discussion has reached the issue about resources, because you have all hinted at this being a very chronic problem. Could I ask all of you what your assessment is of the current funding arrangements for older people’s care and whether local authority funding for adult social care services might be better served if it was ring-fenced?

William Laing: The argument against ring-fencing is always that, if you ring-fence one, then what about the other things, and I must say I have always rejected the idea of ring-fencing. But if I can make a point about funding in general, we hear comments that there is a crisis in funding and we cannot go on with the present system. In part I think that is true, but in part I just totally reject that. If we divide up the funding into private and public, I think the real problem is in public funding. We know that there are going to be more older people, there will be a greater demand on taxpayers’ money in order to fund care for the people who cannot look after themselves or who do not have the resources themselves. That is a real issue. Dilnot does not address this, of course, because that is simply a transfer of money from the taxpayer into middle class families or lower middle class families. But as far as the private funding goes, remember that, on our figures, about 45 per cent of residents of care homes are purely private funded. If you add in the quasi-public funded—that is, the people who top up, local authorities—that takes it up to 55 per cent. We would expect that in 10 years’ time that might reach about 60 per cent, because of the growth of owner occupation amongst the very old population. This is actually the largest segment of funding. Now, in one way or another, the way in which people privately fund their care homes is basically through the equity of their owner-occupied house.

Now, looking forward into the distance, 10, 20, 30 years, I can imagine that there is no problem, basically, with people funding care services at the end of their lives out of the proceeds of formerly owner-occupied properties or out of some other financial product that will be based on that. So I see that there is no fundamental problem that needs a fix in private funding. The thing that needs the fix is how to get more money into the public side.

Q762 The Chairman: That implies that Dilnot, for political reasons, has been focused on where all the noise is, that people like to pass their wealth on to their children or their children would like them to pass their wealth on to them, and has missed the real issue, which is the poverty of funding for those who do not have assets.

William Laing: His solution is a very elegant solution for a political problem, yes.
Q763 The Chairman: Yes, and it does not really address the problem of where the funding needs are in social care.

William Laing: No.

Q764 Lord Hutton of Furness: What then is the way to address that problem?

William Laing: More money from you and me and the taxpayer. Ultimately, that is it.

Q765 Lord Hutton of Furness: Can we go on justifying, do you think, local authorities directly providing care homes when we know the cost is so significantly higher than the private sector?

William Laing: I would say it is very difficult to justify it, indeed. There is only a residue of about 20,000 to 25,000 care places in local authority hands out of a total of about 450,000 all told, so it is going down but it is still there and there are certain local authorities. But yes, absolutely, they could save a lot of money by outsourcing.

Q766 Lord Hutton of Furness: The issue, really, is about Dilnot, is it not? I accept there is a political decision that governments have to make about the overall level of funding for social services and that is a political thought for ministers. But Dilnot has been posited as the solution to the problem. Is it also the view of the others that it is not, in fact? It is an answer to part of the problem and quite a significant part, because the majority of people are self-payers, but it does not address this other very significant cohort that we ought to be worried about.

Martin Green: One of the things that gets lost in the Dilnot debate is the fact that he said we need £2 billion in social care immediately as a cash injection. People want to talk about the long term, but there were some elements of Dilnot that were about the immediate. But I think William is right, it solves a problem for some part of the system, but it does not solve the problem in terms of the funding that the public sector delivers.

On the point about ring-fencing, my view, Lord Hutton, is you either have it for specific things or you take it all off. So, for example, if a local authority could raid their education budget, then they might be able to make ends meet in different ways. Because at the moment what happens is the only bit of budget that they can raid to deal with difficulties in other parts of their responsibilities is the social care budget, because it is the largest bit of non-ring-fenced expenditure. So I think if we are going to go down the route of ring-fencing or not ring-fencing, it should be applied right across the system and that would enable local authorities to make decisions about how they use the money and how, for example, a lot of education money goes swishing into local education services that could easily make some efficiencies or savings to be transferred to other areas.

Q767 Lord Hutton of Furness: But individual departments patrol their boundaries very rigorously, do they not, and it might be quite difficult, would you not think, for some departments to give up the whole concept of ring-fencing altogether?

Martin Green: Well, yes, it would be difficult, but then that is what requires leadership, is it not? Somebody needs to say if it is in the best interests of the system your fiefdom might have to be attacked.

Sue Redmond: Going through the budget round now and having the biggest budget in social care, as you quite rightly say, that is not ring-fenced, everyone has to look at their budgets. The only way we are going to solve it is not ring-fencing; it is to open it out and look at
community budgets or something else, so we share. We look at, across the piece, people live in this community, what is being spent on the public services? And I come back to health again and I come back to the police and I come back to other services and the voluntary sector. What is being spent in that community on those people? What is the health and social care and other outcomes those people want? What roads do they want mended? Every year we have the dilemma of people saying potholes and roads are their biggest priority and yet we have this demand. So we look in a community, you put the money together in a pot and you work out what outcomes that community want and you spend it. And that is the only way we are going to solve the problem, because we cannot keep going on. We cannot keep putting more money in the system when there are quite a lot of efficiencies still to be found in the system, but only if we join up and we have a pathway, for want of a better word, of outcomes for people. And then we say, as Martin says, “We are taking that money off you for the greater good”.

Q768 **The Chairman:** Can I just go back to the Dilnot issue, first, because it is an incredibly important issue and I am not seeking to, in any way, criticise Dilnot or the brief that they were given. But the brief they were given I think, by and large, was focused on the noise around people who did have assets having to use those assets to fund their own care. If I look at what Dilnot shows, it shows, I think, the three top quintiles get the majority of the extra funding that Dilnot will cost. So the money is going in to the relatively well off rather than to the poor; it is what figure 11 shows. And secondly, I do not know what the figure is, but is much of the additional funding that Dilnot will cost going in to increasing the funding into social care or is it basically a transfer payment to relieve those who have assets from the obligation to use them? Two difficult questions.

**William Laing:** It is mainly a transfer payment. What Dilnot does is to create a model in which he hopes that new insurance funding will come into existence. I would, myself, think that that is fairly limited. As to who is the beneficiary of the Dilnot transfers, of course, quite a lot of it will go to the relatively poorly off: those people who are caught by the £25,000 asset limit at the moment, which will go up to £100,000.

Q769 **Baroness Finlay of Llandaff:** Returning to the question of joint budgets, what happened in the past was that the social care budget ended up being raided for health. That was one of the arguments for keeping the social care budget ring-fenced and there is a fundamentally different philosophy: health is free at the point of delivery and social care delivery is effectively means tested, assessed one way or the other. How do you reconcile those two different approaches and where do you put the boundary line, then, of what is going to be provided free at the point of delivery versus what is going to be subsidised by the person receiving that input once you get into really, truly merged budgets?

**Martin Green:** I think it is a really tough question, Lady Finlay, and I also think there needs to be a debate about what is free in health. And we need to have redefinitions of what a health service is and what is free, because, for example, a lot of people with long-term conditions have things that are absolutely about their long-term condition, but that triggers it suddenly becoming a social care service. Well, why is somebody who needs support because of their dementia getting a social care service when for somebody who might have a cancer with similar levels of support that is defined as a medical need? So I think we need to have a debate about that and we need to redefine the boundaries, but it is going to be very tough, because the moment you start redefining the boundaries the political pressure will start to get very difficult and then politicians, particularly those who have to face
elections, are often then thinking about the interests of other things rather than the best interests of the system.

**Q770 Baroness Finlay of Llandaff:** Is it already happening by stealth with the changes that are occurring?

**Martin Green:** I think in some areas, it probably is.

**Q771 Lord Hutton of Furness:** But being redefined in a negative way. Presumably you are not saying it is being redefined in a more generous way to provide more taxpayer funding. So the criteria are narrowing rather than being extended. So you are all saying that the only solution to the problem of those who are not caught by Dilnot is, potentially, quite significant extra sums of money for the taxpayer.

**Sue Redmond:** Or use the money differently, I am saying.

**Q772 Lord Hutton of Furness:** By getting rid of all the ring-fencing.

**Sue Redmond:** By looking at outcomes and what really matters and what really does work in the system. Even if you do not join it all up, which, okay, might be beyond my lifetime, it is what health can do to save spend on older people.

**Q773 Lord Hutton of Furness:** The way the system currently works, effectively, you have told us, is that the self-payers are funding and subsidising those who are not and, of course, Dilnot is designed essentially to increase the revenue flow into the sector from those who are self-paying, through the insurance model and so on. Is that not going to have a similar effect going forward to the current effect of the system? In other words, if you get more resource coming in for those who are currently self-paying, could that extra resource itself be used to lift the funding model for the whole system up and the care and quality standard?

**William Laing:** Potentially, I suppose, that has slightly more potential for more and more cross-subsidising.

**Q774 Lord Hutton of Furness:** That would not be a good thing, in your view.

**William Laing:** Well, it worries me, I must say. I will take the example of Devon at the moment. There, there is a battle between the county council and the providers about fees, as usual. Devon has produced a very sophisticated model in which it is effectively saying that “we, as a local authority purchaser, even though we are not going to give any block contracts for anything, think that we should not pay the full average costs of care”. So that is a deliberate policy decision to rely on cross-subsidisation.

I will bring up another point that might be relevant, again about Dilnot. Of course, the way in which I think the public has read it is that care will be paid for and then people read “care” for “all care services”, which of course is not the case at all. I am conscious of John Redwood’s analysis, I think it was, of this and how much people would have to pay out of the typical care home fees. We have done some work ourselves on a fair price for care and what we find is that if the average reasonable cost for residential care throughout England as a whole would be about £600, only about £200 of that would be care costs. The other £400 people are going to have to pay for themselves.

**Q775 The Chairman:** Could you let us have that?
William Laing: Yes, of course.

Q776 Baroness Morgan of Huyton: Can I just push a bit more on that? I do not completely agree with your analysis on Dilnot, because I think the thing that Dilnot potentially brings to the party is a security that enables people to plan looking forward. Thinking about the conversation earlier about planning for older age, it is fear at the moment that is preventing and, on the one hand, a sort of assumption that people are not going to need the care, but then a kind of total panic about an inability to plan both financially, but also plan a care pattern looking forward. I think, at the very least, the thing that Dilnot brings is honesty about the fact that people have to plan and that there is going to be a known level beyond which they are not going to get help. At the moment people really do not have that understanding.

William Laing: Right. But the reality of it is, though, that under Dilnot, if it were applied, people would have the knowledge that after a certain amount of spending of their own money to pay for the totality of the bills, at a particular point help will kick in whereby they will get a £200 grant in aid for a £600 service. So that helps to a certain extent, but it is not the whole solution.

Steve Smith: As far as Dilnot is concerned, I would agree with Baroness Morgan; having a cap does, we think, does provide some degree of certainty on how you can plan and maybe bring forward some new types of financial services into the market. Also, going back to what he said about the eligibility criteria and the regional variations, that was very good.

Coming back onto the funding issue, I think people out there want the right care at the right time in the right place. They do not see health here and social care here. It is all healthcare for them and this is why we need better integration. Most of our money is going into acute and where we could be making savings—and I am sure you have heard this from previous sessions—and invest to save almost, in those prevention and early intervention exercises, does not happen. I think the NHS has been transferring money across in tranches, £648 million last year for reablement, whatever that might mean—for some authorities it might mean gritting the road. So there is money that is almost ring-fenced and whether that is there to provide new services, be innovative about prevention or just propping up what is already there, that is a concern.

Q777 The Chairman: It clearly is one of the hopes for the future that there will be a recognition in the NHS that it is carrying a lot of inefficient costs at present by having older people in wards who do not want to be there, where it is highly expensive and if there were more appropriate care support outside hospitals there would be benefits both to the system and themselves. That is the argument that is made, is it not? Is it true? Does the numbers add up? Does it demonstrate that if you could shift 50 per cent of those it would make a significant difference? Has anybody done the modelling on that?

Sue Redmond: There has been a lot of evidence that health in the community costs less, but of course you cannot just do it by stealth, by closing a bed in a hospital or stopping a few people going into hospital. You need to do it on a bigger scale. You need to do a whole ward, a few wards and that then causes lots of political outcries. There is also lots of protectionism around services, which are very separate. The consultants in a hospital are separate from the GPs in the communities. Hopefully, that might change. Something might come out of the changes around that, maybe, but you need to do it in a systematic way, not piecemeal and we need to do whole systems to make it work.
The Chairman: Will CCGs drive that change or not?

Sue Redmond: Well, I am an optimist, so I am hoping that something will come out, but at the moment it is not happening.

The Chairman: This is one of the questions, potentially, to the Secretary of State. This is quite a significant change to the NHS that arguably is required and just hoping it will happen organically is a big hope.

Sue Redmond: It will not.

Martin Green: But also, the public sector is not very good at decommissioning strategies. They love commissioning strategies and they love commissioning and overlaying one service on another, but this is the point when we need to radically, as Sue says, reconfigure. We need to look at community budgets and it is going to mean, sadly, blood on the carpet in lots of areas. And it is about how we get to a point where people take reasonable and strategic decisions and shift resources and reconfigure services, rather than just piecemeal putting bits of different services into the existing system.

The Chairman: I think we have heard a lot of evidence supporting that, but I do not see who is making that case for change or who is going to have the courage to argue. Do you? No.

William Laing: One of the few areas where I think we can be reasonably confident or optimistic that it will happen is that of health and social care community-based services, because there, in a sense, you can separate off a segment. I personally think that what you need, as well as integration of health and social care commissioning, is integration of the provision of services themselves. Personally, I think that is best done through a degree of outsourcing, whether outsourcing to the public sector or the private sector does not matter. There is quite a lot going on there, with work by Virgin and Serco, etc, which essentially is just taking these services anew and looking again at how they might be provided in totality. So I think there are some real possibilities of progress in community-based services.

Baroness Finlay of Llandaff: How are you going to have leverage on the health and wellbeing boards and with the clinical commissioning groups for exactly that type of integration to happen?

Martin Green: That is going to be very different in some areas. Some Health and Wellbeing Boards will get it. But the next point is, we have seen so often that there are good policies coming from those strategic levels and then, when it filters down the system and it gets to the delivery point, it is more difficult to see the change. So I think in some areas there will be great leadership. I am also quite interested in the role of public health within the local authority now where as Sue said, there is a real potential to look at some of those prevention and public health and support strategies and then feed some of those issues into the Health and Wellbeing Boards. But the jury is out, for me, on whether or not they will make as big a difference as people think they will.

Sue Redmond: Certainly local authorities are very keen on Health and Wellbeing Boards in the hope that they could get closer to health and have more influence over health. Coming back to the comment that was made about one of the ways of integration, I agree with integration in community services and community health and social care. But where you have a structure that foundation hospitals are built on people coming into them, that is how
they get their payment, they are not incentivised to close wards and then to put that money into the community. So we can have Serco and other private organisations. That is a structural change and some of the services that are going on now with health and social care are really working well in the communities, but we need the pathway and the whole system to change so that money flows to the person that comes out and we stop people going into hospitals. Older people should not be going into hospitals.

**Q782 The Chairman:** Can I just draw your attention to this, which I read, *Towards excellence in adult social care*, which came out recently by the Local Government Association, ADASS, etc, and the Social Care Institute for Excellence? It describes it as progress with adult care priorities and, of course, it is completely the reverse of that. It is describing what I find quite shocking: how the entry thresholds to getting access to local authority care, even if you did not have enough money, were inevitably rising, so that only those people who had severe needs were likely to get any sort of local authority care. It says other things as well in terms of how we are shrinking down. So this appears to illustrate exactly what William was talking about and you would say, that as budgets get pressurised, even before we have been hit by the real demand, the thresholds will rise and there will be a lot of people left to fend for themselves. Am I misreading it, because that is, I thought, clearly what that said? That is correct, is it?

*William Laing:* Yes.

*Sue Redmond:* And I think the emphasis behind it came back to not everything going through the funnel of social care, so maybe it is a re-shifting of the balance by saying social care in this climate, with the 6 per cent of funding that is spent on older people, can only do so much. Maybe social care, with its expertise, should only intervene when needed. However, evidence does show that the higher you ratchet up the eligibility criteria the more people come to you really in crisis, you spend more money and you should be doing a lot more prevention. But should it be social care who are doing that or should it be, as we come back again, resilient communities, health, health promotion, public health, other people doing it?

**Q783 The Chairman:** The big question for us is whether shifting some funding out of the NHS, and this happy land that I was trying to encourage you to develop of where the community all care for people, are likely to fill the gap given the increase in demand. Has anybody done that assessment and planning and modelling? Otherwise, are we just hoping?

*Sue Redmond:* There has been lots of modelling on how we can do things differently and avoid costs coming in the future. There is lots of that.

**Q784 The Chairman:** Yes, but that is micro level, is it not? I am talking about a macro analysis of it, which basically says you have to close down this number of bed spaces in hospitals to shift the funding there, and you have to increase the number of volunteers at this level to have a chance of dealing with these needs. Has that work been done? No. Okay. There we go. It is all very cheerful, is it not?

**Q785 Lord Bichard:** What Sue and, I think, Martin are espousing, but I think it needs to be explicit, is a very localist agenda.

*Martin Green:* It is a localist agenda, but also some clear expectations about what citizens have a right to expect, because we need people to understand what their expectations are
and then for localities to respond to that in ways that are appropriate for them. But I certainly do not think that a localism free for all is necessarily the best way forward.

**The Chairman:** Baroness Shephard, welcome. Is there anything you would like to throw in on this, because it has been one of your passions, has it not?

**Baroness Shephard of Northwold:** Yes. Of course, I am rather handicapped by having missed the earlier discussion, so I do not think I will. I will not waste the Committee’s time or the time of the panel.

**The Chairman:** Okay. We are only five minutes over, which for us is quite good. Are there any last burning questions that any of the panel would like to put?

**Q786 Lord Bichard:** I would like to ask a question about personal budgets. I have not had a chance to do so and I think we should know where you think personal budgets are. This paper that has been referred to once or twice talks about the drive to implement personal budgets is succeeding, but then it goes on to say, “However, a higher proportion of people now have managed accounts”. In fact, I think the managed accounts have gone up something like 57 per cent in the last year or so, and that may be an expedient action by local authorities to meet the Government’s target, which is now only a few months away; I think the target date is 2013. And as a result of that, it may be that people who are using the service and carers are not getting as much benefit from the change to personal budgets as was originally intended. I find this all quite confusing and everyone I hear talk about personal budgets seems to have an axe to grind. What is your assessment of where we are with personal budgets at the moment?

**William Laing:** Your analysis is absolutely right and it is worrying that nearly all of the increase in personal budgets is managed budgets, but I think the jury is out on whether or not these are effective in allowing people genuinely more choice and we just need to do a bit more work on that.

**Martin Green:** Certainly, because of the headlong rush to reach the target for 2013, a lot of personal budgets have been centrally managed. So, for example, I would much rather look at whether or not the direct payments route is a better route if people are supported and enabled to make informed choices. Though, again, I think there is another element of ageism here, because a lot of people who have direct payments who are younger people get a lot of support to enable them to manage those direct payments.

And the other issue, just finally, if I may Lord Chairman, is to talk about the quality agenda. We are seeing far more personal assistance, but there is no quality assurance of them and that is a challenge for the system, I think.

**Sue Redmond:** Can I say something on that as well, because I have been a bit of a maverick about personal budgets? Personal budgets have been a method for us to say we have told people how much we spend on their care and they know about it and they can choose to spend it themselves or not. And often it has been to get to a target. The whole point of it was to give people choice and control in their lives. We did a huge piece of research in Wiltshire before we implemented our new process and older people said to us, “I want to be able to have what I want. I do not need choice of lots of providers. I do not want the money. I want to live my life.” We can commission services. You can have as many personal budgets as you want and every year we are making cuts and cuts and cuts. We will reduce people’s personal budgets, potentially—how else will we do it? But it is no good
having a personal budget if you do not have the quality of service out there that is commissioned and there is good care and there are good services. We still need to do that. That is why we have gone the route of saying to people, “We will commission this service that gives you choice, because it is about outcomes that you want, not hours of service that you can buy”. So it is a totally different philosophy.

**Q787 The Chairman:** Very helpful. Just a final question: some people have argued for a national care service. That does rather beg the question about what we mean by a national care service association. I think one of the centre-right think tanks have as well. Any comments on that? Clearly, Dilnot moves a bit in that direction, does it not, by setting national eligibility criteria, national pay rates. So there are elements of that, but I suspect what they really mean is integrated funding at the national level rather than the local level. Do any of you think that is a good idea?

**Martin Green:** The history of national services is they get subverted and then we get lots of money spent in bureaucracy and not in outcomes, so I am not necessarily a fan of it. But I think there should be a national framework of expectations that people should absolutely be clear that as a citizen, it is their right to have certain things and then the delivery of that could be for a very plural market to respond to. As Sue said, it is about people having the options and the choices in their localities to be able to respond to services that meet their needs and give them a life, not a service.

**The Chairman:** William, any comment?

**William Laing:** Nothing much. I agree largely with what Martin says. I think it is a bit of an irrelevance.

**The Chairman:** Thank you. We should close now. Thank you all very much indeed for a fascinating session, with some very interesting evidence for us. Could I encourage you, when we have been suggesting we would like a bit more information, that you please do send that in? And you got some pretty clear signals of where it is really hot for us, did you not? So, either by yourselves or soft consortia work, we look forward to receiving that. Thank you very much indeed.
**Equity Release Council—Written evidence**

**About the Equity Release Council**
The Equity Release Council is the industry body for the equity release market, representing every aspect of the equity release sector including providers, qualified advisors, lawyers, surveyors and other key stakeholders. It was born from the success of SHIP Equity Release, which over the course of 20 years represented the providers of equity release products, introduced a strict code of conduct and put in place important safeguards and consumer guarantees.

The Equity Release Council continues to set and maintain safeguards for consumers, ensuring that equity release products are safe and reliable for the people that use them. Each member of the Council that provides equity release products is signed up to the Equity Release Council’s Code of Conduct which puts in place a number of safeguards and guarantees for consumers.

**The role of housing wealth supporting an aging population**
With falling annuity and pension returns and the demographic pressures of an ageing society, it is clear that pensions cannot be viewed as the only savings vehicle for retirement income. Individuals increasingly are looking to other assets to support themselves in retirement, care and older age. Housing wealth can provide a solution to a number of these challenges for many people.

Housing wealth continues to be the biggest asset held by people aged over 65 and more than two thirds of people in this age bracket are homeowners without a mortgage. Prior to the current downturn, the UK enjoyed a sustained period of significantly high house price inflation. Home ownership has also increased dramatically during the post-war period, with the proportion of owner-occupiers increasing from around one in four in 1950 to two-thirds by the mid-1980s. Thus the older generation has on the whole benefitted from unprecedented growth in unmortgaged asset ownership.

Having benefited from the windfall created by this sustained period of high house price inflation windfall, housing equity is now increasingly playing a greater role supporting the baby boomer generation in later life. For many, unlocking the wealth tied up in their property may be a more viable and appropriate option than an annuity or insurance policy.

While the market is currently worth slightly more than £1 billion per annum, analysis from the Pensions Policy Institute estimates that £250 billion of equity could be released into the UK economy immediately, with currently around £900 billion tied up in home equity in the UK as a whole.

Currently, the typical equity release customer releases £48,952 from their home. In light of buoyant levels of housing wealth held by the older generations, equity release has an increasingly important part to play in helping people to support themselves in their retirement and to fund their social care. Indeed, in his independent review of the funding of care and support, Andrew Dilnot recognised that housing wealth has a part to play in the funding of people’s social care and that equity release can help people to access that wealth.
By using an equity release product, a home owner can draw a lump sum or regular smaller sums from the value of their home, while remaining in their home. This equity could be used for a range of purposes, including, but certainly not limited to:

- retirement needs;
- holidays;
- home adaptations;
- social care; and
- support for family members.

With an increasing number of older people owning their own home, the equity release market is growing as more of these older people seek to use their housing wealth to support themselves or their families. Independent research undertaken by the Equity Release Council showed that 73% of people would consider using housing equity as part of their later life finances.

November 2012
Professor Julien Forder, University of Kent, Geoff Alltimes, NHS Future Forum joint lead, Carewatch Care Services and NHS Confederation—Oral evidence (QQ 289-326)

Transcript to be found under Geoff Alltimes, NHS Future Forum joint lead
Professor Peter Goldblatt, University College London (UCL), Professor John Hills, London School of Economics (LSE), Professor Sara Arber, University of Surrey and Fabian Society—Oral Evidence (QQ 537-553)

Transcript to be found under Professor Sara Arber, University of Surrey
TUESDAY 16 OCTOBER 2012

Witnesses: Professor Sarah Harper, Professor Philip Rees FRGS FBA CBE and Simon Ross

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Mawhinney
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Professor Sarah Harper, Professor of Gerontology and Director, Oxford Institute of Population Ageing, Oxford University, Professor Philip Rees FRGS FBA CBE, Emeritus Professor, School of Geography, University of Leeds, and Simon Ross, Chief Executive, Population Matters.

Q94 The Chairman: We are aware of who you all are, so I did not think we would do introductions. You can see who we are; that is probably all you need to know. You are sighted, I think, on the broad question we are looking at in terms of the implications of an ageing population for public services. You will have seen that we have had a previous evidence session on this with ONS. In this session we wanted to go into a little bit more detail to get some hard understanding of the uncertainties around what we are talking about. That is essentially what the focus of the session will be. My apologies if there are slightly fewer of us than there have been, but that is the nature of what happens when there is other parliamentary business going on. Thank you and welcome.
Can I kick it off with a very general question? How much confidence should we have in the projections about the ageing of the UK population? What are the major disagreements among demographers about it?

**Professor Rees:** I think we can have every confidence that the population is going to age. There is virtually nothing anyone can do to stop that process—short of an asteroid hitting the earth. There are questions about how far and how fast it will go. There is a major issue about forecasting each of the components, which will possibly change either the absolute number of the elderly—particularly mortality—or the other components such as fertility and international migration, which will change the rest of the population. In terms of mortality there are a couple of views floating out there in the academic sphere. One is very optimistic; it is represented by James Vaupel of the Max Planck Institute for Demographic Research at Rostock in Germany and his colleague Jim Oeppen from the University of Cambridge, who see the current pace of mortality decline continuing into the future. It has, over the last 25 years, been very respectable in most countries in Europe—and the UK has also been a part of that group. They point to the failure of predictions in the past by demographers that everything would slow down and there would be a limit to longevity; that has been wrong time and time again. They trace it from the 19th Century right through to the 21st Century and point to the limits of life expectancy being broken. Those are the optimists.

On the other side there are the pessimists, represented by Professor S Jay Olshansky from the University of Illinois in Chicago, who say there are lots of threats to our wellbeing and a lot of morbidity epidemics—pointing to, in particular, the effects of obesity and increasing rates of diabetes—and argue that the rates of improvement in survival chances among the old are subject to diminishing returns. We will get on a bit later to a discussion of the impact of obesity. I thought it was going to have an enormous effect about three years ago. When I looked at a prospective cohort study produced by a team led by Sir Richard Peto, of smoking and lung cancer fame, they showed an enormous differential in future mortality according to their very extensive prospective study. But, actually, when you translate that into numbers of people surviving, it does not have a big effect. The Foresight obesity project said that life expectancy by the 2040s would only be at a maximum half a year less than we were predicting it to be. We are predicting it to be six to eight years better. Even S Jay Olshansky predicts a decrease of only one and a half years in life expectancy in the US.

When I did projections a couple of years ago for a big European project, I took a very optimistic view of the future. For the whole of Europe, I measured the rate of decline in a specific mortality across 31 countries. It averaged, over the last 15 years, about -2.7% a year, and I think there are reasons to believe that will continue. That is towards the optimistic end. That is actually more optimistic than ONS are in their principal projection. It is more like their low-mortality projection.

**The Chairman:** That was very helpful. Can I just follow up with two specific points and then throw it open to others as well? If I have understood you rightly, and this is in layman’s terms—our time perspectives are about 10 years ahead and 20 years ahead and not much further than that, for reasons you can guess – taking that time period, it looks as though we can be reasonably confident about the numbers of people in 10 and 20 years’ time who will be 75, 85, 95 and over 100. Is that right?

**Professor Rees:** It does depend on economic conditions: levels of poverty and unemployment. It also depends on expenditure on their health through the
Professor Sarah Harper, University of Oxford, Professor Philip Rees FRGS FBA CBE, University of Leeds and Simon Ross, Chief Executive, Population Matters—Oral Evidence (QQ 94-103)

National Health Service. Those three things will affect the rate of decline of mortality and, therefore, how many of the cohort reach those ages.

The Chairman: That is a sophisticated answer. What I would be interested in—probably not now, but subsequently—is what sort of variation we are talking about. It might be only a percentage or two up or down. For public policy purposes—if you know that now, for example, there are half a million people aged 85 and over and it is going to be 1.5 million in 20 years—the bigger picture is what you want. You are not too fussed about whether it is 1.45 million, if you follow me. Maybe later you could give us a view on that in terms of with what confidence levels one can get an understanding of the raw numbers of people at certain ages for those periods. Have I put that clearly enough?

Professor Rees: Yes, you have. It is a very difficult question to answer.

The Chairman: That is why we are looking to experts.

Professor Rees: What the people from ONS who came along in July pointed you towards was their variant projections. If you regard those as giving a range of possible outcomes, I would guess—I have not done the calculations—it is going to be plus or minus 20% on the size of the older population. Part of it is not subject to much uncertainty, which is the number moving over the old-age threshold—whatever that happens to be in the particular year. That is cohort replacement coming forward. What is uncertain is, again, this rate of decline of mortality.

Q95 The Chairman: We are bound to want to have some understanding of what proportion of people in those populations you have talked about are likely to have chronic conditions. To put it very crudely, when you add them up, we know now half a million people have dementia but it looks pretty likely that in 10 years’ time that will be three-quarters of a million. For our purposes, we need to understand those sorts of trends because they matter in human terms and they are obviously massive drivers of the demands on the system. Do we have such estimates?

Professor Rees: To my knowledge, I do not think we have national statistics projections of the numbers of people with various kinds of disability. We do have some academic projections. People at the Personal Social Services Research Unit at Kent have done projections. My colleagues at Manchester have done projections. I have done my own projections, but what we have all assumed, to a greater or lesser degree, is that the age-specific rates of any particular condition will not change in the future. We have not yet been confident enough in looking at the trends in the various disabilities to do the same things we have been doing with the other components of the projection, like mortality or fertility, and trying to understand those trends.

Now, having looked at your questions on Friday, I did some calculations that looked at the general household survey and the general lifestyle survey, which are the best evidence we have for things like disability and limiting, longstanding illness. There is a definite downward-trend—age-specific rate by age-specific rate—in the last decade and not before then. It fluctuated, but in the last decade it has been coming down quite significantly. I did some back-of-the-envelope modelling of this and it does reduce the rates of disability over time quite significantly. That is a pretty unreliable back-of-the-envelope model, but no one has really done anything better.

The Chairman: That would be good news if it is true. Let me throw the question to others. I was slightly surprised to hear that there were no national estimates of this, because
I would have assumed that the NHS would be highly concerned about the increased demand in 10 years’ time if it was probably going to happen. If they are not doing estimates, they could be a bit in the dark. Maybe I am wrong about that. Do you want to come in on this question, Sarah?

**Professor Harper:** Yes. I agree with most of what Phil has said, but I do think we do have evidence about the way that disability is going to change. There is the ESRC MAP2030 project which Carol Jagger has been working on, looking forward. What is also very clear—is this supported by international data—is that we are delaying the onset of disability. That means that, although we have increased life expectancy, we are also increasing the number of years that we spend with disability. We are pushing them back but we are also lengthening them. From the individual perspective you can say that, although people are having more healthy years, they are also increasing the number of years they will have in disability, but, as a percentage of their life, that is actually going down. They have done some very interesting work where they have looked at when you enter old age, which they take at 65, with or without an existing condition, and whether that has an impact on that general trend. They have found that, regardless of health status when you enter, you will live longer and you are likely to slightly increase the number of months, in fact, that you have a disability, but even if you have an ill condition you are going to decrease the proportion of time for which you have that disability as a percentage of your life. I think there is data out there and we can definitely supply that. At Oxford we are also beginning—because Phil is right; there is not much data—to look at the chronic conditions and to try to map forward the prevalence of chronic conditions and also the disability that is likely to come from each of these conditions.

**The Chairman:** If that is the case, I am absolutely staggered that it is not being done—if I have heard you right.

**Professor Harper:** It is also my understanding that the disease-specific forecasting of future disabilities by disease is still in its very early stages.

**The Chairman:** Can we leave the question with you? You can see what we are after. We are not equipped to do the actual forecasting ourselves; it is not our job. If it looks likely that there will be, in the most optimistic view, a very significant increase in x, y and z chronic conditions or the number of years that people will have those—it obviously increases the demand if they have them for 10 years rather than five—that is a central issue in terms of the cost drivers that are coming on to the system. We need to understand that as far as we can.

**Professor Harper:** I think there is enough information looking at disability per se to be able to build that into models. I think we do have good information—although not conclusive information—around disability from chronic disease per se. Mapping the individual forecasting is what we are now having to work on by disease.

**The Chairman:** Let me not bore you any further, but you have understood the question I have asked? I think you think it is a valid question, do you not?

**Professor Harper:** Yes.

**The Chairman:** Are you happy to talk to each other to see if you can do something for us on it? Would that be possible?

**Professor Rees:** Yes.

**Professor Harper:** Yes.
Q96 Baroness Tyler of Enfield: Just moving to a slightly different area now, I am particularly interested in how the changes in household structure are likely to impact on both policies that we need for an ageing population and specific services. I am particularly interested in two things. One is the growth in single-person households. I may be wrong here, but I thought I read something saying that almost 25% of the population these days are living in a single-person household and sometimes that starts at quite an early age. It is not to do with a partner dying; it is more like a lifestyle choice or whatever. Secondly, I am interested in the impact of intergenerational issues; we often now have families with four and even five generations alive and quite complicated patterns of caring, sometimes both for children and grandparents and so on. It is quite a general question, but your views on what impact that is likely to have would be very much appreciated.

Professor Rees: If you look at the future projected populations in the different ages and you look at the numbers of people who are likely to be caring for the frail elderly, then there is a huge imbalance there. We are talking about 55 to 69; that is the kind of age group that is going to be looking after their parents aged 80, 90 or 95. There simply will not be very much growth, if any, in that population, while that of the people who need the care will grow very substantially.

One of the things I do not know very much about—and I am not sure there is good survey evidence for it—is the extent to which generations in the family are located close enough to provide that kind of care. We have figures about the number of people within the household who are caring for other members of the household, but we do not have a very good idea about the wider circle of the family, who are very important as well.

Professor Harper: I would disagree and say that we now do have a reasonable understanding. We had the fifth wave of ELSA, the English Longitudinal Study of Ageing, launched yesterday, and we also have some excellent work around the household that has come out of Mike Murphy's group. The picture that we are seeing is, yes, an increase in single-person households. Part of that in the future is going to be driven by two things: one is going to be childlessness, which we know is on the increase. The second thing is going to be reducing the number of children available, so we have what we call these long, vertical families. You may only have one child and that is also compounded by the fact that that child may no longer live nearby. We also have very good survey evidence that is saying that, although in practical terms we do not have the availability of childcare in the way that we used to—to do physical care and support—we do still have a very strong behavioural caring attitude of children for parents and that they will then substitute that care. The way they substitute that care, if they can, is through basically arranging to buy in services or to work with public social services to ensure that their parents get the best possible care. I think the evidence that families stop caring is actually not really supported in surveys.

The second thing, of course, is that we have this growth of second families and reconstituted families. Although we have what we call the beanpole families, which are these very vertical families, we then often have "extended beanpole families", because people are then remarrying and you are getting these step-relationships. What we do not understand is whether the kin obligation between children and stepparents and step-grandparents is as strong as that of a biological relationship. There is maybe now a necessity, given that we are moving into a world where we are trying to keep older people independent within the household, that we should consider two things. One is maybe moving to a southern European model, where we allow or encourage households to buy in workers. This is
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where migration comes in. If you look at what the Italians increasingly are doing, they are using almost an au pair system. They are having migrant care workers who are living in the home and doing what the daughter originally used to do. In fact, about 10 years ago Oxford University suggested to the Department of Health, on the basis of some work we had done, that they should look at really trying to consider this and maybe even regulate it. At that time they felt it was too early.

The second thing, however, is that of course, because we have seen life expectancy and healthy life expectancy of older men in the current cohort increase, we have a growth in men in their 70s and 80s who are looking after, for example, disabled wives. They will need a particular kind of support to enable them to stay active and able to care as they themselves get frailer.

Baroness Tyler of Enfield: Thank you, I found that absolutely fascinating. I really did. It pressed lots of very important buttons for me. The one point I just wanted to press you on quickly, if I may, is the very important point you raised about the issue of childlessness, which is not an issue I think this Committee has yet considered. My understanding is that there are a lot of people in their 40s and 50s who do not have children and, chances are, will not have children. They might acquire children in stepparent arrangements but, as you said, we do not know how strong those ties will be. To what extent do you think public policy at the moment is taking sufficient account of the impact of childlessness?

Professor Harper: This is about a point in the future that is obviously beyond the next 10 or even 20 years. A third of women—I believe this is correct—aged 35 in this country are yet to have their first child. Having said that, the 2010 figures showed that for the cohort in their 20s and 30s there was still a downward trend in total fertility rates, but for those in their 40s there was an increasing trend. We are definitely seeing women in their late 30s and 40s having children, but I think, 30 years down the line, it will possibly be a bigger issue to be considered. Within the remit of the next 10 or 20 years, I do not think we are going to see so much of an impact.

Simon Ross: In fact, there has been a bit of a rebound in fertility. It was 1.6 in 2001; it is now about 2 and the ONS and UN projections suggest it will stay about 2. They do not really see that. Based on the behaviour of young women today and, as I say, women having children later, they do not see a collapse in childbearing. I would say one other thing on household structure, which is that the lack of affordable housing is meaning that more and more young people are living with their parents to quite an advanced age—perhaps up to their 30s. I wonder if that will start to impact on the ability of their parents to care for the grandparents—the fact that these younger people are having to be looked after for longer.

Q97  Baroness Morgan of Huyton: In a sense this slightly carries on from that; I want to ask you to give a little bit more insight into the changes in fertility. Although you are right that when we had the ONS here they thought probably, overall, things would stay as they were, they were actually pretty unsure, I thought. It was very much also affected by immigration rates and was very variable around the country. In a sense, any further light you could throw on the issue of fertility—and particularly the ratio of working and non-working parts of the population—would be very helpful. I just wanted to push back a little bit on you, Mr Ross, if you do not mind. Thinking about Professor Harper’s comments, perhaps one of the key issues is not the issue of whether we are back at 2.0 or whatever but whether or not a higher proportion of families have no children. To what extent are we seeing some families having later children—and, perhaps, more children—and a fair proportion of the
population not having any children at all? Obviously, in terms of caring for elderly relatives that has quite a significant effect.

Simon Ross: There has been a long-term trend of increasing childlessness, but the ONS seems to think that will level off at about 17%, ongoing, and it will stabilise at that sort of number. They do not seem to think it will keep on growing as a proportion. I think it did in the 1970s and 1980s as women went into careers, but then there has been a bounce back as women have had children later. I am not sure; I think there will still be the desire to have children. I am not sure there is evidence that there are a lot of women who have decided not to have children.

Professor Harper: I think the really important thing to note is that we need to dissect this 1.98 total fertility rate. My understanding is that the white, British-born population is nearer to 1.6 to 1.7, which is in line with the rest of the northern European group—not the southern Europeans, who have a much lower rate. It is the overseas-born women and British-born women of ethnic minority descent who are having the larger families. In some parts of the country you may well find a dual system, where you will have certain groups that are having large families and then other groups that are having very small families. That is maybe more in rural areas, because that is where the white population tends to be; obviously the ethnic population tends to be more in our large cities.

The relationship between work and fertility is very interesting, because the evidence that came out of Scandinavia was that when they introduced “positive parenting”, the Scandinavian total fertility rate, which had been quite low, started to come back up. I think there is now evidence from other countries as well that, if you make it easier for women to combine children and a career, you are much more likely to encourage them to have the second or even the third child.

One of the reasons people give for why the southern European countries have such low fertility is potentially because of women’s relationship with the labour market—the fact that there is very little state childcare and they are very much reliant on grandparents. Particularly when you consider how many children in Europe are now born out of formal wedlock, in the Catholic countries of the south that is then compounded by traditional Catholic grandparents who are not keen on bringing up children who are born out of wedlock. Women there tend to delay having their first child because it is difficult to combine their careers with this. They also want to get married, which often happens very late because cohabitation tends to continue well into their 30s. It is a complex relationship between work, supporting parents and allowing women to delay sufficiently long to establish their careers but not so long that they then go into secondary infertility, which increases after age 35.

Q98 Lord Mawhinney: It used to be that the fervency of religious belief, particularly within some frameworks, was a factor in the size of a family. These days that fervency appears to have cooled in relation to the church. Is that manifested in the sorts of things we are talking about?

Professor Harper: I think very much so if you are looking at the Catholic southern European countries.

Lord Mawhinney: But what about in this country?

Professor Harper: In this country, I presume that one of the reasons why some of our ethnic populations are having large families is because they are Muslim. I presume that, but
Simon Ross: The birth rate certainly tends to be higher in the Muslim community but it is hard to distinguish between religious and cultural impacts. There are many Muslim countries with very low birth rates—Iran, for example, or some in North Africa—but certainly the Bangladeshi and Pakistani communities tend to want larger families and tend to have larger families than most others.

Lord Mawhinney: Let me attract you slightly closer to home. What is happening in Ireland?

Simon Ross: In Northern Ireland?

Lord Mawhinney: No, the Republic of Ireland. It was a well defined Catholic country 30 or 40 years ago; now there is much less fervency—let me be neutral—towards the church and its teachings. Is that being manifested in this area?

Simon Ross: It has a relatively high birth rate compared with other European countries. It is up there with us and France. It has had a high birth rate and I am sure the religion reasons have had a lot to do with that. There has clearly been a change in culture relatively recently, but I have not seen what impact that has had.

Professor Rees: The differences between Ireland and the UK have narrowed. Ireland used to have a much higher fertility rate but it has converged.

Lord Mawhinney: Do you see those sorts of trends continuing or do you think a step-change has taken place and it will flatten out again?

Professor Harper: I think the UN believes that most countries will come to roughly replacement, which is about 2 to 2.1—some by the middle of the century and others, including Africa, by the end. That seems to be the presumption behind the total fertility rates.

Professor Rees: Can I just reinforce what Sarah said? Fertility is partially determined by the support the society provides. If you have good childcare facilities for preschool children, you have good maternity leave arrangements, you have good ways of compensating women for interrupting their careers, you have extended shopping hours that go to midnight and if you have other basic things, you maintain a current UK fertility rate or a French or Swedish fertility rate. If you go to Germany, where you might say the economy is a shining example for the rest of Europe, they have very low fertility because, although they have good childcare facilities, they do not cover the whole population. Their culture frowns upon the working mother. I speak from the experience of my daughter, who is a working mother in southern Germany. She has enormous difficulty in arranging after-school care. The society is not really designed to support women who need to have that income by working and also want children. That is a crucial ingredient that we should hang on to and improve in the UK.

Q99 Baroness Finlay of Llandaff: One of the great scourges, perhaps, of the modern day has been obesity. We were just wondering what you think the long-term effect of this obese population getting older is going to be, both on life expectancy and on their need for services. I wonder if you think that is going to alter the comorbidity picture as well. I was interested in your comments about tracking individual diseases; of course, we are increasingly seeing multiple comorbidities, so any one person may have three or four of those. That makes such tracking almost a false exercise.
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Professor Harper: I would pick up on what Phil said earlier about obesity, because I think that is a very important story. There was the prospective cohort study. That was between 1979 and 1996, and what was interesting there was that one of the things they looked at was whether we had an increase in expected deaths due to obesity. Following on from that, in the following decade, 1996 to 2006, we had an almost identical study called the Mehta/Chang study. They asked roughly the same question—this was in selected OECD countries—and we know that between 1979 and 2006 we had a significant increase in obesity in the countries they were looking at. In the UK I think a third of women over 50, by certain measures, are obese. But they found that the increase in deaths that one would have expected due to obesity had actually gone down in that second period over the very first study that was done. A lot of academics have tried to tease out why this might be, and one of the arguments is that, while we tackled last century’s epidemic, which was smoking, by public health—we gave up smoking—we are increasingly using drug interventions to cope with rises in obesity. That has two issues going forward. One of them, obviously, is that we are actually increasing our health bill because, instead of suggesting to people that they behave in a certain way, we are actually increasing the cost of reducing not so much deaths from obesity but things like cancer, cardiovascular disease and diabetes, which seem to be related. The cost is going up. The second is that we can keep people alive longer with these obesity-related diseases. I think that comes back to the very early question, which was about the relationship between morbidity and mortality and whether obesity was going to change life expectancy. It does seem, if you like, that which is driving life expectancy is also driving our ability to keep people alive with frailty for longer. When you see the cohorts with obesity coming through, it is not clear that it is going to impact on their total life expectancy but it will impact negatively on their healthy life expectancy.

Baroness Finlay of Llandaff: Can I just go a little bit further on that and look at health costs? Whilst you are right about drugs, and I would not disagree with that at all, I wonder if you could point us to any evidence of the increased cost overall of any intervention. Even doing a scan on somebody who is obese takes more time, needs different equipment and creates a problem. The health intervention cost of anything is increased; just diagnosing, for example, a cancer in an obese person is a much more difficult and expensive procedure. Then, if you operate, it might become quite a nightmare procedure. I wonder if there is some data separating out the cost of health interventions at secondary care level in the obese versus the non-obese, particularly in the older age groups.

Professor Harper: I would be surprised if there was not some evidence, possibly from the United States. I personally do not know of any, but I think that is due to my lack of knowledge. I can look and try to find that out. Phil may know of some.

Baroness Finlay of Llandaff: America is the place one would expect it to be.

Professor Harper: Yes. I would think the American literature probably has looked at it in that detail.

Professor Rees: I cannot answer the question directly, but I do not think that should slow down the drive to introduce preventative measures or early diagnosis. Although you say the diagnosis may be expensive, it is a hell of a lot less expensive than trying to treat the person after they present with a very serious condition.

Baroness Finlay of Llandaff: But they are much more likely not to be diagnosed, because it is much more difficult to diagnose some conditions in those who are obese. The classic is that with malignant disease they present later, because you cannot physically examine them.
Professor Sarah Harper, University of Oxford, Professor Philip Rees FRGS FBA CBE, University of Leeds and Simon Ross, Chief Executive, Population Matters—Oral Evidence (QQ 94-103)

properly and their symptoms are masked. The breast lump, for example, is jolly difficult to find.

Q100 Lord Bichard: I was going to ask about uncertainties around demographic estimates, but we seem to have been talking about that quite a lot. I suppose I will reframe the question. Are there any areas of uncertainty that we have not touched upon that you want to draw to our attention? How should the Government be using this demographic data better? Chairman, you talked about disease-related projections, for example; are there other areas where, as professionals, you look at Government and think, “Why on earth do they not use this data more effectively?”

Professor Harper: I think the huge uncertainty is going to be around migration. When we are looking at ageing populations, we are not just looking at the number of older people. We are actually looking at a fundamental shift in the age structure of our population, which is as much about the way that we will potentially have younger or older dependants and the shift of our working population in order to support that. It is about the way that migration will intervene and the way that, in the past, we have been able to use migration to bring skills into the country to compensate for the decline in our own skills. There is a World Bank report that has recently come out that has said that Europe is not going to be in a good place to attract global skills coming forward because it will have to compete with Asia and Latin America and, eventually, Africa as their populations start to age. That will be, probably, within the next 20 to 30 years. The demographic dividend that is in the south will go through and then they will want to start cherry-picking skills. That means we have to start looking at our own population and those people of productive working life, which of course will very much go back to whether these people are healthy or not. If you are a healthy and active person in your 60s or even 70s, then it is possible going forward you will be very able to contribute to society through economic employment as well as other forms of, say, volunteering and care. If you are not and we keep our working population from, say, 25 to 60, then we are going to have a real demographic deficit going forward. I think it is important we do not just look at the numbers of older people or the percentage of older people but the percentage shift in groups across the whole of our life course and therefore across our population.

Simon Ross: I think there are two areas of uncertainty. One is around behaviour. If we talk about longevity, we are increasingly aware that lifestyle affects longevity. This comprises things like diet and exercise—which feeds into obesity and a whole range of other problems as well—and whether or not people will adopt that good advice and the increasing evidence about the impact of lifestyles. Then migration and fertility, too, are all about behaviour: how many children people choose to have can change quite quickly within a country for various reasons. Whether they stay where they are or come to the UK depends on the economy of their home country and the economy of the UK and so on.

The other area of uncertainty I think is policy. Obviously, demographers cannot really predict that. Will the Government take a policy of encouraging fertility or discouraging it? The last Government arguably encouraged fertility by relatively generous child benefits, child tax credits and other things. It also depends on whether the Government has a policy on migration, whether it enforces it and whether it is effective. It depends on whether we have 600,000 a year coming in year after year or whether it goes back to the levels of the 1970s or 1980s. That is largely due to Government policy. There will be continual pressure from people from poor countries wanting to come to the UK and learn English. I think I would argue that clearly from our point of view we think there are big issues outside this around
population growth in the UK: around resources, around infrastructure, around sustainability and so on. That is the other question. Do you address ageing but not deal with population growth? Do you have to in some way deal with both ageing and all of the problems arising from Britain being a relatively densely populated country?

Professor Rees: There are two areas where I will make some comment. One is on the immigration issue. I think the current Coalition Government is shooting itself in the foot by the draconian restriction on international student migration. We can see the numbers now going down. This is a very important immigration flow: maybe a third of each annual flow of immigrants is overseas students. They bring along a huge amount of money to pay for their fees. They are not the poor and unwashed of the world; they are the elite. We are beginning to turn them away and give them a hard time—making them queue up in the wee hours outside an office in Croydon and so on. That is going to have a direct effect on the university sector; it will reduce the income of all of the universities who recruit foreign students. It is going to prevent those foreign students from contributing to research and postgraduate work. It is going to reduce our capacity for innovation.

The other policy area is to sort out the care of the frail elderly. The Dilnot Commission has done a lot of research but it does not seem to me that Parliament is moving that forward. On the train I printed out for myself the equivalent Australian policy. The Australians came out with a revision of their policy for the care of the frail elderly; it makes very interesting and very good reading. They are investing a lot of money in improving both home-based care and residential and nursing home care in Australia in a very productive way.

The Chairman: Could you send us that?

Professor Rees: Yes. I will send you the link for that. It is interspersed with some remarks from Julia Gillard about their opposition leader as well, which you can ignore.

Q101 The Chairman: Coming towards the close, as a Committee we are clearly thinking about how we all get a better understanding of these changes. Clearly, there is a lot of denial, for all sorts of different reasons. The question about centenarians, I think, was getting towards that, trying to get a picture of what anybody would see is a pretty old cohort of people, those over 100. I came across a figure in one of the too many things I have been reading recently on this that said there are 11 million people living today who will live to 100. Have you heard of this?

Professor Harper: In fact it was 8 million, I think, though maybe someone else has stated 11 million. It came out of the ONS/DWP report at the end of last year. What they say is that we currently have about 12,000 centenarians; by about 2060 they project we will have about half a million; and by the end of the century we will be heading for a million. I know Phil was a little concerned about Vaupel’s projections, but, actually, I think he is probably in line with a lot of other demographers nowadays. For Britain, this is a two-fold issue. If you take the cohort life expectancy, the 2007-birth cohort has probably a real life expectancy of 103. In other words, to put it very simply, you can say that 50% of that cohort will still be alive by the time they are 103. We are seeing a general increase in life expectancy; that is just mapping those trends forward. We also, of course, have the baby-boomer cohort, which is smaller in this country than in some other countries, but in 2060 they will all be coming up to 100. The combination of a bulge in our population taking advantage of increases in life expectancy means that I think 8 million people currently will make it to a century. One of the things we did at Oxford was do some simple modelling to extrapolate it...
Professor Sarah Harper, University of Oxford, Professor Philip Rees FRGS FBA CBE, University of Leeds and Simon Ross, Chief Executive, Population Matters—Oral Evidence (QQ 94-103) to Europe, which said there will be 127 million people who are going to make it to 100 throughout the EU.

The really interesting question then comes back to what Phil was saying right at the beginning: are we going to see this increase in life expectancy? This is where we see the concerns of Thomas Kirkwood and S Jay Olshansky. There are two very clear things. Statistically, if you look at the bell curve moving the mass of the population up to 100, what is happening is that although we are going to have large numbers of people reaching 100, at the moment we are not seeing the extension of what we call super-centenarians—people of 110 or 115. If you like, it is flattening, so people are suggesting that maybe there is something about senescence, the ageing of the body, which means that there is a maximum life expectancy of roughly 120. Therefore, we may be able to push it a few years, but we are not going to have these massive increases in life expectancy of over 150.

Then you have those other people who talk about how we are pushing forward life expectancy in three ways. One is through conquering chronic diseases, and we know we are making a good inroad into at least keeping people alive with chronic diseases, even if we are not stopping people getting them. The second thing is around new advances like stem-cell therapy, and some of the new stem-cell therapy, which is not embryonic stem-cell therapy but where they take skin from an individual, reprogramme it to become a stem cell and then they can put it back in, and my understanding is that they are already beginning to treat heart, eye and some of the tendon conditions of the body like this. Then there is this whole new area of longevity research or age-retardation research, which is in its very early stages, where we are looking at the molecular level and asking, “Is there something we can do to stop the ageing process?” In other words, we would intervene in younger life to stop the actual senescence of the body. Some people argue that, if you put those three together, by the middle of this century you may see us going through this 120/130 barrier.

**Baroness Finlay of Llandaff:** Can I follow up on that in relation to the baby boomers? The healthcare expectations of that population group are changing the way that healthcare behaves; it is becoming increasingly risk-averse. I was wondering if there have been projections done that look at that effect on health and social care expenditure. Comparing, for example, the UK with India, even with private care in India there is much more risk-taking in healthcare because they do not have these risk-averse drivers in the delivery of healthcare across the board. Within the private sector you would expect that there would be, but it is not so extensive. You could say the way that healthcare professionals behave is more efficient because they are able to take a balanced risk rather than practise in what is becoming an increasingly defensive way and one that drives up cost as well.

**Professor Harper:** I am not an expert on risk-aversion in healthcare, but one thing I think is very clear is that the Health Economics Research Centre at Oxford, Alastair Gray’s group, did a very interesting meta-analysis of healthcare costs in OECD countries looking at age as the driver and found in only one country age per se was the driver. The driver was basically the demand that subsequent cohorts had. The baby-boomer cohort, in 2050 to 2060, will be demanding certain types of acute medicines that previous cohorts would never have dreamt of and doctors probably would not have delivered. That, I think, is what is going to drive up healthcare costs.

**The Chairman:** Could you give us the reference for that? It sounds as though it is important for us to look at.

**Professor Harper:** Yes, I will.
Professor Sarah Harper, University of Oxford, Professor Philip Rees FRGS FBA CBE, University of Leeds and Simon Ross, Chief Executive, Population Matters—Oral Evidence (QQ 94-103)

Q102 Baroness Tyler of Enfield: May I just ask a quick question of Professor Harper? I noticed in your biography that you have a forthcoming publication called International Handbook of Ageing and Public Policy. I wondered a) when that will be coming out, and b) how relevant what you are going to say about public policy is likely to be to the interest of this Committee.

Professor Harper: It is probably very relevant. On Thursday we are having our final collection of chapters. All of the chapters are in, so the draft will be given to the publishers at the end of this year and it will be published sometime next year. There will be individual papers within that that will not have been published. I cannot remember when you finish taking evidence.

The Chairman: We stop taking evidence, apart from that of Ministers, by Christmas and then we publish at the beginning of March.

Professor Harper: We will definitely have peer-reviewed, accepted papers, but they will not have been published. They will be in a format because we have to get it to Edward Elgar by December.

The Chairman: We would really like those.

Baroness Tyler of Enfield: Will you be able to share those peer-reviewed papers with us?

Professor Harper: We would be very happy to, but obviously I will have to check with the publishers.

The Chairman: If you just give us the contents initially, we can see what the menu is.

Professor Harper: Yes, of course. I think a lot of it is relevant and it is very international, looking at international examples.

Q103 The Chairman: Professor Rees, in the very interesting evidence you put to us, following our call for evidence, you went off-piste as a demographer towards the end and drew some conclusions, which I enjoyed. One of those was that a public policy goal should be to push ill health to older and older ages for shorter intervals. Who could disagree with that? However, you also went on to say that we need a national health and social care service, not just an NHS. In other words, you were saying that in some way the NHS and social care need to be developed at a national level. What did you mean by that and why?

Professor Rees: At the moment, the NHS will deliver medical care for patients but there is also care that is associated with medical conditions that is called social care; if you are becoming incapable of doing the activities of daily living, you need assistance either in the home, in a residential home or, at the extreme, in a nursing home. There the welfare state—the net—is full of holes, basically, and the amount that individuals are required to contribute to this care is a very large proportion. Budgets for social care departments in local authorities have been squeezed and squeezed.

The Chairman: A lot of evidence on that has been presented to us, and in part it is about Dilnot and in part it is about local authorities being funded—and partly the market-making has lead to some dreadful consequences. Our impression was that your solution was not to make it work better as a local service but in some ways to make it a national service. That was what I was interested in.

Professor Rees: I am not an expert in financial support systems, but it was about seeing whether there was a way in which you could pay an insurance through your life—rather like
the original intention of National Insurance—that would deliver you a guarantee the costs you would face were not above some affordable maximum. That is the fear we all have.

The Chairman: It is what Dilnot hopes will happen, but I was really interested to see whether you were arguing that these functions should come away from local government and be part of national Government. I do not think you were quite arguing that.

Professor Rees: They are partially. There is a transfer from the NHS budget of public health monies from next April, and those public health monies will be administered by the local government in connection with its social care monies. In a sense, that is already happening in part, but the sums of money involved are completely inadequate for the need that is out there.

The Chairman: Thank you. I found that a valuable and fascinating session. My apologies if we were slightly fewer; it is always the way. They go off and have other meetings that they cannot avoid, but they read the evidence, of course. Thank you enormously for that; that was a very rich session. I am also grateful for your agreement, if under pressure, to send us some further papers. You can see why some of those questions are absolutely critical for us, and we look forward to reading the book, as well.
Professor Sarah Harper, University of Oxford – Supplementary written evidence

Centenarians: Projected number of centenarians in the UK, thousands

Source: Department of Work and Pensions, Office of National Statistics
Table 1: Oldest age at which at least 50% of a birth cohort is still alive in eight countries

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Data are ages in years. Baseline data were obtained from the Human Mortality Database and refer to the total population of the respective countries.

Source: Christiansen et al Lancet 2009
Is healthy life expectancy increasing faster or more slowly than life expectancy?

- **Crimmins et al 2010.** The prevalence of disease has increased in the US in recent years, and mobility functioning has deteriorated. Length of life with disease and mobility functioning loss has increased between 1998 and 2008. *Disabled increase*
- **Manton et al 2008.** Chronic disability prevalence decreased in the US between 1982 and 2004. Younger cohorts of elderly persons are living longer in better health, and there is good evidence of a compression of disability. *Disabled decrease*
- **Yong & Saito 2009.** In Japan the gains in life expectancy prior to 1995 were mostly in years of good self-rated health, while the gains thereafter were in years of poor self-rated health. The exception was for women at age 85, among whom there was an almost continuous increase in the number of years in poor health. The data suggest that life expectancy has been increasing faster than healthy life expectancy since 1995. *Disabled increase*
- **Yong, Saito & Chan 2011.** In Singapore between 1995 and 2005, the proportion of life expectancy without mobility limitations declined, at all ages, and for both genders, with women still experiencing a higher proportion with mobility problems compared to men. *Disabled increase*
- **Unger 2006.** In Germany between 1984 and 2003, life expectancy without severe disability increased faster than life expectancy. Gains in life expectancy with more moderate levels of disability are less substantial. *Disabled increase*
High correlation between life expectancy and healthy life expectancy for men in EU25+ countries

Source: Eurostat 2009 data
Three scenarios for changing relationship between life expectancy at 65 and disability-free life expectancy between 2006 and 2026 in the UK. Percentages refer to proportion of remaining life expectancy that is disability-free. It decreases in all scenarios.

Source: C Jagger, R Matthews. 2008 findings from ESRC IMAP 2030 project
Andrew Harrop, Fabian Society—Written evidence

1. Summary

An ageing society will bring gradual change to key dimensions of life in Britain: family relationships; the structure of the lifecourse; the nature of work; experiences of old age; consumer demand; the place of savings and assets; levels of chronic illness; what we want from homes and local environments; social expectations and prejudices. Public services need to consider the implications of all these trends. Most important of all, unless the government acts, the country will grow more unequal as it grows older.

The ageing of society will not undermine the public finances as long as there is very modest, long-term fiscal tightening. Once today’s austerity programme is complete, rising levels of public spending over the next 50 years will be affordable and compatible with sound public finances. Indeed spending should rise in line with population ageing, to maintain the UK’s widely-supported new pension settlement and to safeguard health and social care provision. Planned rises to the state pension up to the 2040s are fair to individuals and fiscally sustainable – faster increases should only be proposed if life expectancy increases unexpectedly. On current trends another increase to the state pension age will be needed in the mid-2050s.

There are significant non-demographic pressures on public spending. We need to ensure that we devote enough resources to the ‘investment state’ rather than just focusing on the ‘insurance state’ which includes most age-related provision. There are also upward pressures on age-related services, due to the inadequacy of today’s social care system and concerns about productivity and public demand for healthcare.

Services to promote health and wellbeing should be fundamentally transformed, drawing on the following principles: prevention and rehabilitation; relationship-based service; control and flexibility; coordination; local strategic accountability; and clear national expectations.

2. What will an ageing society be like – and how should government respond?

The ageing of society is a trend not an event – and a trend that has been with us for over 200 years. So social change needs to be thought of in terms of gradual evolution not rupture. Nevertheless there are countless ways in which British life will change – or at least should change – in future generations. Many will have a bearing on the future of public services and welfare:

Family structures and relationships – there will be many more four or five generation families, often with fewer siblings in each generation. People will tend to be care-givers at older ages, as parents and partners die later. Many people in their 60s will care for parents and grandchildren, although this will come into tension with the growing expectation that people in this age group will work. More very old couples will care for each other, as men live longer. For women, the childbearing years will feel like a briefer and earlier stage of life than for previous cohorts - often coinciding with education or insecure, low paid work. Many will feel that the optimal window for having children is too short, with consequences
Andrew Harrop, Fabian Society—Written evidence

for family wellbeing as well as the nation’s fertility rate. These trends have major implications for public services supporting carers and young families.

The standard lifecourse will be challenged – very long lives will lead many people to challenge the standard conceptualisation of the lifecourse, where education, work and leisure follow sequentially. While some people will have 50 years of working life, followed by 25 years or more of retirement, others will expect to be able to blend leisure, learning and work at every stage of their lives. The overall share of people in work will change less than people think, assuming that the number working after 60 continues to rise at something like its current pace. With state pension age now scheduled to reach 68 in the 2040s this seems plausible. There is likely to be little impact on employee productivity from the changing structure of the workforce, as long as people are able to acquire skills across their lives. The UK’s patchy provision of lifelong learning will need to radically improve.

Reimagining work – we are nowhere near imagining how the world of work needs to change to accommodate 50 year working lives: a majority not a minority will want flexibility in how, when and where they work; the numbers in non-traditional employment relationships may rise; it will no longer be possible to achieve productivity improvements by increasing the intensity of work; and there will need to be radical change in job structures, especially in white collar professions, to accommodate longer careers and mid-life career change. Regulation will be needed to push some of this change, but employers will also face business pressures to adapt as they struggle to recruit and retain young cohorts (of course, for now these effects are masked by the economic crisis). This will have implications for the public services as major employers, as well for public support for employers, workers and jobseekers.

Reimagining old age – old age will be increasingly heterogeneous, with chronological age a poor marker for almost anything. Although people will notice first that ‘80 is the new 70’ they will also recognise that 80 year-olds are a very diverse bunch with respect to their lifestyles, attitudes, health, income and wealth. The traditional association between old age and poverty will rapidly diminish, as a result of successful state pension policies and more affluent cohorts reaching retirement. However this changing perception may mean that people who are struggling in later life get overlooked. Many will still have to get by on extremely modest incomes, as well as experiencing ill-health, physical isolation and exclusion from mainstream British life. This is a particularly risk for single people in very late old age, some 30 years distant from their pre-retirement lives. Public services will no longer be able to use age as a proxy for need or risk, so personalised relationships will become more important and the marketing of provision will need to be more imaginative. In some cases today’s age-specific entitlements or eligibility criteria may not be the best means of achieving policy objectives.

Changing consumer demand – older consumers will make-up a steadily rising share of domestic consumption as a result of ageing, rising prosperity in old age and (perhaps) more effective spending-down of assets. This will mean that more of the economy will be devoted to sectors such as leisure, personal services and healthcare. This could dampen overall productivity growth as these are labour intensive industries. Marketing, media and popular culture may also reflect changing consumption as long as deep-rooted ageism in these sectors is challenged. The Government’s industrial strategy should identify where public support is needed to assist businesses to innovate and respond to new opportunities.
Savings and assets – with longer working lives and longer retirements people will need to be much better at building up assets and spending them down. But there are stiff headwinds, in the shape of squeezed living standards and rising costs for younger cohorts (eg housing and student loans), and levels of pension saving are worsening. It is therefore likely that levels of savings will only reach suitable levels with mounting prescription from government.

Following the launch of auto-enrolment it is possible that pension contribution levels, views on compulsion and scheme fees will all need to be swiftly reviewed. Retirements will be too long for people to expect to hoard assets to pass them on as inheritances. It will be in people’s interests to convert more of their money into regular incomes, although low trust in financial products such as annuities and equity release may put many off. The Government will need to review the private pension system in the late 2010s and should stand ready to intervene if ‘decumulation’ products appear uncompetitive and poor value.

More chronic illness – on current trends healthy life expectancy will continue to increase more slowly than life expectancy, with longer periods of chronic illness in between. We will need to become better at managing and living with illness and disability - with the right care, support and environments to sustain good quality of life. The great unknown, however, is the prognosis for dementia. The numbers with dementia will rapidly rise if its age-specific incidence remains unchanged. On the other hand, growing levels of investment in dementia research might yield major medical breakthroughs in future decades. There is broad consensus on the direction public services will need to take – more preventative, co-ordinated, holistic provision focused on good health and wellbeing, not just moments of crisis. But fragmentation within the NHS, poor coordination between public services and acute spending pressures in local government create barriers to progress.

Housing and place – more people will spend a greater part of their lives in and around their homes and local neighbourhoods. To prevent isolation and maximise social participation the physical and social design of neighbourhoods will need to change to take account of how they are used by the very old. Most people will live in outdated housing stock which will often be unsuitable for their needs as they develop ill-health (although home adaptations will become more common). Newbuild designs will need to be flexible for use by all age-groups. Unless housing supply increases, the size of older people’s homes will be a thorny political issue. However only a small minority of older people will want to trade homes unless the character and diversity of retirement housing changes to make this sector attractive to more people. Planning policies will need to reflect the age profile of future communities. There will also need to be ongoing innovation in retirement housing and new ideas for assisting and incentivising people to down-size.

Expectations and prejudice – people in early life will need to conceive of their lives spanning over 90 to 100 years. This has implications for practical planning with respect to career choice, savings, family etc. But it also suggests a deeper psychological shift so that people conceive of their lives as a marathon not a sprint, with the implications this has for lifestyle and how people conceive their wellbeing. Ageism and age segregation could grow unless institutions become better at bringing people of different ages together (eg workplaces, learning, leisure, neighbourhoods). While people will always wish to socialise with those of their own age, relations will need to be more porous between age groups for a long-living society to feel at ease with itself. For instance while crime is likely to be lower in an older society, older people will not feel safer if they do not feel comfortable around younger generations. Thought needs to be given on how to promote positive interactions between
age-groups in contexts as varied as local parks and housing developments, colleges and workplaces, and the publicly-owned media.

Inequality – many of the implications of an ageing society are positive or neutral. But alongside them sits the spectre of an increasingly unequal society. The prognosis for income inequality and relative poverty is quite positive because of current government policies. But asset inequality will continue to rise without government action, as affluent groups gain more years to save. If asset prices rise faster than earnings, as they have over the past 30 years, this trend will be exacerbated. Rising asset inequality has troubling implications both between and within generations, calling into question the functioning and solidarity of society, especially if large numbers, of all ages, never acquire much wealth at all. The most troubling issue however is rising health inequality (itself linked to wealth inequalities). The gaps between rich and poor for life expectancy and morbidity have both been increasing in recent years. If this trend continues the benefits of ageing will be disproportionately experienced by affluent groups, while changing social norms with regard to working life will penalise lower income groups with high health risks. This could have expensive implications for Government, with the respect to the pace at which the state pension age can rise, lost tax revenues, and costs to the NHS and disability benefits. The Marmot Review of Health Inequalities has set out the required path: for everyone to share in longer healthier lives action is needed to improve life chances, give people more control and respect in their lives, and promote healthy environments and lifestyles. The growth of wealth inequalities, between and within generations, also suggests that some of our taxes should be switched from income to wealth, including property and significant pension saving.

3. Public finances and demographics

There are so many unknowns with regard to the social and economic implications of an ageing society that it is almost impossible to predict the overall impact on the public finances. Even to ask this question is perhaps to place the cart before the horse, since it will be for each generation to make democratic choices about the welfare provision it is prepared to pay for - albeit with the ‘path dependency’ of previous decisions, institutional arrangements and implicit promises.

It is however possible to make projections regarding the impact of the changing population structure – something much narrower than the social and economic implications of ageing. This is the task assumed by the Office of Budget Responsibility in its annual Fiscal Sustainability Report. These projections need to be handled with care because they are designed to assume all other things will be equal, which of course they will not.

The projections have already been subject to perhaps wilful misinterpretation which needs correcting. In particular, it is a misreading of the Fiscal Sustainability Report’s ‘central projection’ to suggest that the long-term prognosis for the UK public finances will be undermined by demographic change. Assuming we are able to close the fiscal deficit towards the end of this decade the long-term outlook is actually surprisingly positive. The consequences of taking no action would not be benign\(^{181}\), but the scale and urgency of the change required is modest:

\(^{181}\) Although by no means without precedent. Figure 1 shows that the average gap between tax receipts and public spending since the early 1960s has been around 7%, which is the gap the OBR expects to open up by the 2060s on the assumption that the deficit is closed during this decade.
The magnitude of required action is small: The OBR reports that the one-off fiscal tightening required to ensure that public debt is below 40% in the 2060s is just 1.1% of GDP (£17 billion). This compares to the tightening of 10% of GDP over seven years contained in the current Government’s spending plans (including fiscal tightening of more than 1.1% in most years over the period). Generally, there has been rapid oscillation in the public finances over the last 50 years (caused both by policy choices and economic conditions). There has been fiscal tightening or loosening of at least 1.1% in over half the years since the 1960s, including 15 years of fiscal tightening (see figure 1). So if the last fifty years are anything to go by, a one-off act of fiscal tightening to control for demographic change would be almost indiscernible within the noise of annual fluctuations in the public finances. Indeed there is a risk in dwelling too much on demographic pressures to the public finances just because they can be predicted, when they are likely to be just one small factor in the sustainability of the UK’s fiscal position.

Taking action is important but not urgent: The impacts of ageing are gradual and predictable, which means a response can be planned, steady and slow. The OBR points out that action need not be taken in one go. It sets out an alternative strategy of fiscal tightening of 0.4% of GDP (£6 billion) each decade up to the 2060s – or in other words roughly 0.04% of GDP (£600 million) per year over the period (an almost imperceptible amount considering that annual public spending exceeds £700 billion). Middle routes are also possible such as gradual action between 2020 and 2040, which might imply annual tightening of around 0.07% of GDP (a little over £1 billion) for twenty years. To illustrate how imperceptible a gradual fiscal tightening might be, it’s worth comparing to the impact of ‘fiscal drag’ on personal taxation revenues. The FSR states that fiscal drag will increase revenue by around 0.17% of GDP each year if continued until 2030, much more than the 0.04-0.07% of annual tax rises that might be needed to achieve fiscal sustainability through to 2060. In other words it would be possible to pay for the costs of ageing simply by allowing some ‘fiscal drag’ to continue, rather than entirely ending the practice (which is the OBR’s long-term assumption). Fiscal tightening is important but not urgent, so action does not need to be taken this decade while the public finances are already under such pressure as a result of the economic crisis. Gradual long-term adjustments could be almost imperceptible to taxpayers.

4. Uncertainties in the fiscal projections

The FSR sets a range of scenarios for future public finances, based on different demographic and economic conditions. These show that the public finances would be under much greater pressure if the structure of the future population was older than predicted as a result of very low net migration, low fertility or high longevity. The first two of these variables are amenable to Government policy, although not completely under its control. In future public policy decisions on migration and family policy should take account of the impact on demographics and the long-term public finances.

Setting policy on migration and fertility may be particularly important because, in the past, official estimates have under-estimated life expectancy gains. It would be advisable to assume this may happen again. Unexpected increases in life expectancy need not be a fiscal threat, if they result in corresponding increases in the duration of working life and state pension age.

182 This approach would eventually cost more but is perhaps more realistic than imagining a single moment of fiscal tightening in the late 2010s and then another big step in the 2060s, with nothing in between.
Recent announcements on the state pension age should be reviewed again if there is a significant rise in projected longevity.

More positively, there are two areas where there is ‘upside’ uncertainty as a result of the FSR taking a very cautious view, both relating to the changing experiences of successive age cohorts:

Morbidity: the FSR assumes that incidence of non-fatal illness at a given age will remain the same in successive cohorts. This is not borne out by past trends. It would be more plausible to base central projections on an increase in healthy life expectancy, but at a slower rate than life expectancy. In future the OBR’s central case should be based on more plausible assumptions about morbidity as life expectancy rises.  

Length of working life: the FSR is extremely cautious on the likelihood of extensions to working life, compared to the trend witnessed since the early 1990s and continuing today despite the economic crisis. Apart from changes to State Pension Age the FSR’s labour market projections assume constant economic participation at any given age in successive cohorts, even though the average age of exit from the labour market has been rapidly rising. This effects assumptions about tax revenues and economic growth. In future years it would be advisable for the FSR to include alternative scenarios for labour market exit to illustrate the extent to which this effects the projections.

5. Fiscal sustainability, spending rises and tax rises

It is intuitive but wrong to think that age-related fiscal sustainability requires that any future spending increase must be fully offset by a corresponding tax rise. If all the fiscal tightening required to secure public debt at 40% of GDP in 2060 only took place through spending restraint, with no tax rises, spending would still be able to rise gradually from the late 2010s to the 2060s, by 3-4 percentage points of GDP (see table 1). This is an important corrective to neo-liberal perspectives, which use demographic arguments in aide of ideological attempts to reduce public spending. Fiscal sustainability, modest spending rises and stable taxes are compatible.

| Table 1: Public spending excluding debt – impact of cuts to deliver fiscal sustainability |
|-----------------------------------------------|--------------------------------------------------|
| Spending excluding debt interest (% GDP)      |                                                  |
| 2011/12                                       | 42.6                                             |
| 2017/18                                       | 35.5                                             |
| 2061/62 – if fiscal tightening achieved by tax rises | 40.8                                           |
| 2061/62 – if fiscal tightening achieved by 1.1% of GDP spending cut in 2017/18 | 39.7                                           |
| 2061/62 – if fiscal tightening achieved by 0.4% of GDP spending cuts each decade | 38.8                                           |

Source: own calculations using FSR data

183 It is also possible that the FSR over-estimates the impact of morbidity on NHS budgets, since some academics argue that the costs of the final year of life are far higher than usually thought. For example see http://www.herc.ox.ac.uk/research/ageing
Since there is no looming fiscal black-hole it is entirely a matter of democratic choice whether age-related spending pressures are absorbed by tax rises or spending restraint: painful spending choices because of demographics are not inevitable. Wider debates about the appropriate size of the state from the perspective of economic growth, social welfare and public service productivity should largely be kept apart from analysis of the modest fiscal impact of demographic change.

6. The case for raising spending in line with demographic pressures

There is a good case for carrying out almost all the required fiscal tightening through modest tax rises rather than spending restraint. On the OBR’s figures this would still leave the UK as a relatively low taxed nation (in the region of 39% of GDP by the 2060s, compared to an average of 35% over the last 50 years). Tax rises should be preferred because there is no evidence that the British public wish to see a contraction in the boundaries of the welfare state184 – and particularly not in respect to age-related social security and public services, which people strongly support.185 Steady imperceptible tax rises to preserve age-related provision at levels comparable to today are therefore likely to be socially acceptable.

There are also important structural reasons for believing that public spending should rise as a share of GDP as life expectancy grows:

The need for lifetime smoothing of income/consumption: the lengthening of retirement (notwithstanding rising state pension age) and the ageing of the post-war ‘bulge’ generation implies that fiscal transfers should make up a greater part of GDP to smooth incomes over people’s whole lives. Failing to increase state pension spending would place a huge burden on the private pension system, which is already struggling to provide long-term security due to low savings rates.

The concentration of age-related services in the public sector: the ageing of the population suggests that consumption should increase in economic sectors geared to older people such as healthcare, social care and retirement housing – and these are all publicly funded to a large extent. Rising public spending can be thought of as a shift of consumption into these sectors rather than a simple transfer from private sector to state activity.

It is also worth reflecting on the implications of constraining the path of spending growth in the main spending areas relevant to older people:

Healthcare: after a period of ‘catch-up’ in the early 2000s British healthcare spending has reached EU norms. Although there was a resultant reduction in the system’s efficiency, several years of real-term freezes to NHS spending are now likely to lead to productivity improvements.186 There is likely to be little further slack by the late 2010s, so over the long-term failure to increase spending in line with demographic change can be expected to affect healthcare outcomes – especially as there are long-term pressures within healthcare irrespective of ageing (discussed below).

184 The Fabian Society will be publishing new research on this topic in September
185 For example see Prospect (March 2012) and Fabian Review (July 2012)
186 Assuming reorganisation of the NHS in England does not distract
Social care: Social care is a small area of public spending but it is the budget projected to grow fastest over the next 50 years, as a result of the huge rise in the number of over-85s. Today’s level of social care spending is widely recognised to be inadequate. The system is tightly rationed with regard to needs and means and even those who are eligible for services often receive inadequate support. Increasing spending in line with demographic pressures merely ‘locks-in’ this woeful state of affairs, rather than offering improvements. It is impossible to countenance spending any less than the OBR projections.

State pensions: After a decade of debate, review and incremental legislation there is now very broad support for the UK state pension architecture. The emerging system incentivises saving, offers adequate income replacement to most people and will be increasingly effective at preventing pensioner poverty. Its key features are an expanding role for universalism and the restoration of earnings indexation, which both act to secure its long-term adequacy. The cost will be a rise of three percentage points in the share of GDP spent on pensions by the 2060s, from 5.3% in the late 2010s to 8.3% by 2061. However the alternative would be for living standards in old age to slip back against other age-groups and relative poverty to rise - especially given today’s dreadful savings rates which will take many years to improve even if auto-enrolment into private pensions is a success.

State pension age: There is one area where extra spending restraint will be appropriate, but it lies many years off. The ONS’s central population projection suggests that the current schedule of state pension age increases through to the 2040s is fair to individuals and fiscally sustainable (see table 2). However the data also suggests it would be appropriate to schedule another increase in state pension age for the mid-2050s. This would lead to planned SPA increases over the next 50 years reflecting two reasonable rules-of-thumb that result in people in different age cohorts being treated similarly:

SPA should rise when the life expectancy of a man reaching pension age is more than 30% of his adult life (ie the 2018 figure, before pension age rises to 66)
SPA should rise to avoid the proportion of adults receiving a pension exceeding 25% (i.e. the 2010 figure, before women’s pension age increased)

| Table 2: Proportion of adult life in receipt of state pension and proportion of adults in receipt in the year of scheduled rises to state pension age |
|------------------|------------------|------------------|------------------|------------------|------------------|
|                  | 2010 (f: 60 to 65) | 2018 (65 to 66) | 2026 (66 to 67) | 2044 (67 to 68) | 2057 ??          |
| Percentage of adult life post SPA (men) | 28%          | 30%          | 30%          | 30%          | 31%          |
| Percentage of adults post SPA | 25%          | 23%          | 24%          | 27%          | 27%          |

7. Non-demographic pressures on public spending

The question of the extent to which taxes and spending should change, irrespective of demographic considerations, is largely beyond the scope of this inquiry. A few points are worth making, however.
The ‘investment state’: age-related spending increases, while affordable in themselves, will leave little ‘head-room’ for other desirable areas of public spending growth, since they will push mid-century public spending close to today’s North European levels. This is likely to cause political frustrations, since British politicians of all persuasions have historically been ambitious to extend public activity in benign economic periods. This matters from the perspective of long-term welfare and economic growth because it may skew public activity away from the ‘investment state’ towards the ‘insurance state’. Both these dimensions of state activity matter hugely, but investment faces the future, while insurance is mainly about the here-and-now. Britain’s long-term prospects would suffer if the share of public spending devoted to future-oriented activity such as education, childcare, science, infrastructure and environmental protection were to diminish as a proportion of GDP (and perhaps they should rise from today’s modest levels).187

Pressures on age-related public services: there are upward pressures within public services used mainly by older people unrelated to ageing. This means that freezing levels of GDP might be considered inadequate to sustain good provision.

Social care: The most obvious pressure-point for extra spending social care. To adequately meet today’s levels of need and also introduce a less tightly means-tested funding system along the lines proposed by the Dilnot Commission requires perhaps £5 billion extra.188

Healthcare: The most important uncertainty in the FSR projections is with respect to the costs of healthcare. The FSR discusses low public service productivity and also whether healthcare is a ‘superior’ good which society will wish to consume more of as it becomes richer. Other things being equal both these would lead to the share of GDP spent on healthcare rising.

It is important however to recognise that the ‘downside’ uncertainties regarding healthcare costs do not mean that public spending on health will inevitably rise out of control. Since NHS budgets are set on a 1-3 year timeframe and are not linked to entitlements, successive parliaments will have total discretion as to how much they wish to spend on health. The OBR’s different scenarios for health spending really relate to uncertainty regarding the quantity and quality of health outcomes that any given level of spending will buy. The upward pressure is more likely to be ‘democratic’ rather than ‘demographic’ – people will not tolerate standards of healthcare falling well below those in other nations. But all countries will face similar constraints on the extent to which healthcare can grow as a share of GDP (not least the USA, despite its partly private healthcare system). Levels of GDP devoted to healthcare will presumably need to level-off everywhere, since developed economies are not going to become just giant health systems.

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187 This is an argument about intergenerational fairness – but not the one that is usually advanced. The ‘standard’ argument suggests it is unfair and unaffordable for younger generations to pay more tax for the welfare of an affluent generation of retirees. We have already seen that any potential tax rises are very modest. But this argument is in any case without foundation so long as today’s young can be confident that the public finances are sufficiently sound that they will receive equivalent support in their own retirements – which are likely to be even longer and more affluent than those of older people today. Younger generations are participating in a lifetime bargain, by transferring more resources to their future selves, in a way that was less necessary in previous generations.

188 Care in crisis: causes and solutions, Age UK, 2011
8. Re-shaping health and wellbeing services

If budgets are to rise only in line with GDP and demographic effects, health and wellbeing outcomes will only improve if we radically change the way we deliver public services. This is not just about tight public finances, but recognising that today’s services are ill-equipped to meet the complex, overlapping needs of the people who rely on them, particular those in late old age. But improving productivity is not straightforward. Health and wellbeing services are rightly labour intensive and dependent on human contact - so incremental improvements in use of employees’ time are likely to be counter-productive (a good example is the organisation of homecare services). Instead the major opportunities lie in the wholesale redeployment of resources and the reorganisation of services.

The key features of service reform need to be:

Prevention, rehabilitation and condition management – including a rebalancing of resources away from acute healthcare; and away from health services to other social support.

A ‘relationship’ ethos – recognition that health and wellbeing outcomes depend on the nature of public service relationships not just the ‘transaction’ or ‘output’; and that the diversity of people’s needs and preferences requires personally tailored service.

Control and flexibility – citizens and frontline staff will only be able to have personal relationships and achieve bottom-up innovation if they have freedom and control. Market choices are only a small part of this empowerment agenda.

Coordination – public services need to work together in eco-systems where support is seamless for the citizen and service boundaries don’t hinder the rational deployment of resources.

Local strategic accountability – the major reconfigurations of services we need can’t be achieved by autonomous units in public service markets. Democratic institutions need to have the freedom and responsiveness to take decisions about the best use of all public budgets in the interests of the whole community.

National expectations – national government still matters. It is right that ministers should specify the key results they want health and wellbeing services to achieve for the money they give - and to ensure broad parity as to ‘what’ people can expect in every part of the country.

These principles imply that the further marketisation of public services is a grave error; that health and social care provision should be commissioned as a single entity; and that local democracy must have accountability over all local public services including the NHS. This is a radical and challenging public service reform agenda, which is some distance from the thinking of either the coalition government or the last Labour administration.
Figure 1: Tax receipts and total public spending over 100 years – historical data and projections
(Source: HM Treasury via Guardian datablog; OBR Fiscal Sustainability Report)

6 September 2012
Home Instead Senior Care—Written evidence

**Q. 1 Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?**

1.0 Whilst the debate about government funding of social care must continue and reach a conclusion I do feel that there is not enough recognition by individuals that they, and their families, will need care in the future. The attitude, currently prevalent, that government should pay for care needs to be addressed.

1.1 Individuals and their families need to take on more responsibility for the funding of their care and in many cases be prepared to make a contribution.

**Q. 4 Do we need to redesign and transform public services for these challenges? If so, how?**

2.0 Yes, we do need to redesign and transform public services to meet the challenges of a rapidly ageing population and in doing this we need to recognise that the largest growth segment of older adults are in the oldest age groups which brings increased, and specialised, care needs.

2.1 Our healthcare systems need to be evolved to support healthy ageing and our systems need to recognise and provide age and stage appropriate prevention and care which is matched to the needs of individuals.

3.0 When looking at public services we also need to recognise that our options have come a long way in recent years. Gone are the days of caring for mum at home for as long as you can, then move her to a nursing or care home. The provision of care services for the elderly now includes a wide spectrum of provision including companionship care, non-medical care and assisted living.

3.1 We should also recognise that keeping an elderly person in their own home as well as being a more desirable option for the majority of people, is a less costly alternative to either nursing/care home care and this is without factoring in the capital cost of these facilities.

4.0 Whilst everything we do should be motivated by a desire to treat our elderly population with dignity and respect we should recognise that there is an added benefit which is that healthy ageing is a key to controlling healthcare costs.

4.1 There are three areas we need to look at with regards to care: prevention, reablement and ongoing care. In order to successfully, and cost effectively, achieve this, we need to develop a partnership between state funded, private and third sector providers.

4.2 We need to move from hospital acute care and institutional care to community-based care. If we are to achieve this we need to make some fundamental changes to how we approach social care and take a holistic approach with care centred on the needs of individuals.
5.0 In order for any redesign of services to be successful we need an enthusiastic and motivated workforce, trained to recognise the various stages of ageing and trained to deal with them. Particular attention should be directed at the various stages and types of dementia.

6.0 Prevention: We need to invest in prevention so that people arrive, and pass through, old age in as healthy a state as possible.

6.1 It has been shown that if we help people as they age, through providing quality care in their own homes; it helps to keep them fit and active, thereby aiding the prevention of some of the most common accidents.

6.2 A good example is falls in the home. According to RoSPA falls in the home represent the most frequent and serious type of accident in the over 65s age group. Between 2000 and 2002 nearly 1 million people aged 65+ suffered a fall at home.

6.3 Through cost effective home improvements and diligent home care and we can prevent a significant percentage of these falls, this will represent a large saving to the NHS.

7.0 Reablement: We need to have a strategy in place to get people home from hospital as soon as they are deemed medically fit and we also need to look at preventing re-admission to hospital.

7.1 I read recently that the NHS spends £208 million a year on “bed blocked” elderly patients because councils fail to set up necessary help for the elderly at home. So we have a situation where elderly people who, despite being declared medically fit cannot be discharged as their local council has not arranged extra home help from a carer.

7.2 If it costs the NHS an average of £255 to keep a patient in a hospital bed overnight then surely we should be looking to put a system put in place to provide at-home care to free up the hospital beds. The cost would be far less than the cost to the NHS of keeping someone in hospital for an extra night. Apart from anything else, getting an elderly person back into their home environment as soon as they are well enough will have psychological and emotional benefits.

7.3 Some NHS trusts have such a system in place and this could be rolled out nationally with patients having their needs assessed before they go in to hospital and a post-operative care plan built around their individual needs.

8.0 Ongoing care: The current system for social care is widely accepted as being broken and inadequate. Last year’s Equality and Human Rights Commission review of home care, the more recent Which? and Unison reports on social care all paint a disturbing picture of the lack of care being provided to our elderly citizens.

8.1 We believe that the failings stem from local authorities working to a ‘one size fits all’ system, driven by block contracts and short-term cost savings which are compromising the dignity of our seniors and putting their lives at risk.

8.2 When personalisation was introduced the vision was to recognise that the types of support people need may not be confined to personal care and could include a much wider
range of tasks. Systems and training were to enable staff to expand their skills and to work in creative and person-centred ways. Home care services were to be focused on achieving outcomes. Local authorities and providers were to work together so that home care providers had the freedom to innovate and use budgets flexibly as agreed with the person using the services. Recognition that personalisation had the potential to give home care providers the opportunity to make work more interesting and rewarding, thus assisting with recruitment and retention.

8.3 When you look at the care being provided by local authorities, this vision has not become a reality, largely due to the one size fits all mentality I refer to above. The way in which we commission care needs to fundamentally change and we need to get away from the mentality of a one size fits all approach.

8.4 There is currently a disconnect between national and local government. Nationally the government supports direct payments and local budgets which were put in place to give individuals increased independence and choice under personalisation. However, people are often told they can only use direct payments and individual budgets with a provider on the local authority’s list i.e. a block contract provider and at the rates agreed within the block contracts. This list is also used to signpost individuals who do not qualify for funded care.

8.5 We have a situation where companies, vetted by the CQC, are excluded from the local authority preferred supplier list because they will not enter into block contracts, thereby restricting the diversity and quality of services available to people.

8.6 If the allocation of care by block contracts is fundamentally flawed (and I believe it is) then we need to review this method and abolish the preferred supplier list as it currently stands. I would suggest a system whereby information about all care providers registered with the CQC who are, after all, the care sector’s regulatory body, is shared with those in need of care services.

8.7 With the ever increasing numbers of elderly people clearly there is a requirement for shorter duration task based care but this cannot be accepted as the norm as it does not allow carers to focus on the needs and dignity of the individual.

Q. 5 What should be done now and what practical actions are needed?

9.0 One of the central pillars of quality care is ‘continuity of care’ whereby the same caregiver looks after a particular client. In order to assist with the delivery of continuity of care we are advocating flexibility in thresholds regarding benefits for care workers.

9.1 At present a Home Instead caregiver can work for 16 hours per week with no impact on their benefits. Imagine a situation, not uncommon, when a caregiver’s client requires additional support, perhaps just an extra two to three hours for a couple of week; after a fall, for example or after a spell in hospital. The current 16 hour rule means that a caregiver cannot sometimes continue to deliver care in the way that they, or their client, would like, a new carer needs to be introduced and trained in that’s clients needs. This is expensive, time consuming and not in the best interests of the client.

9.2 This may also not be in the best interests of the economy either if relatives are forced to take time off work to care for a family member.
10.0 With an ageing society we should also look at introducing flexible working patterns and career breaks for those with immediate family in need of care and support.

11.0 Abolish local authority preferred supplier lists (see 7 above.)

12.0 Education of workers in the healthcare sector – It is interesting to note that non-medical home care is relatively new and so many health professionals are unaware of its role or new levels of sophistication. A programme of education amongst health professionals is, therefore, also necessary to educate them about the range of services now available.

13.0 Education and communication - Providing a quality care service comes with it the need to recruit sufficient numbers of care workers. If a traditional task-based domiciliary agency care worker can provide ‘care’ for 4 clients in one hour, a quality provider will only visit one client so the pressure is on to attract more people to the sector.

13.1 We need to find ways to communicate that working in care doesn’t mean 15 minute calls and the threat of being filmed secretly whilst you try to do your job. We need to communicate that care work can be a hugely rewarding and now offers training with career progression opportunities as care companies become more sophisticated.

14.0 Many/all Job Centres now have an over 50s officer and they could be pivotal in signposting people to a career in care. In order for this to be successful they need to be informed about the wider opportunities.

Q. 6 How can we stimulate national debate about these issues?

15.0 Public awareness campaign to highlight the positives of a career in caring.

16.0 The media has, understandably, shone a not-too-positive light on the work carried out in the sector. This coverage will have deterred many from considering a career in the sector and the balance needs to be redressed. Home Instead Senior Care is currently in discussions with a documentary programme maker who is interested in showing positive relationships in care between carers and their clients. Those in the sector should be encouraged to pursue any such opportunities.

9 October 2012
Housing21—Written evidence

Introduction

001. The following is a submission of evidence from Housing 21. Housing 21 is a leading not-for-profit provider of housing, care and health services for older people. We manage over 18,000 homes for older people and provide accommodation and / or services to over 31,000 older people across England. Our vision is ‘a life of choice for older people’.

I. Does our culture about age and its onset need to change, and if so, how?

101. Old age and ageing are too often regarded in negative terms. Most media coverage of older people focuses on crisis situations; for example where older people are depicted as vulnerable due to maltreatment in care homes or hospitals. The dominant view of ageing is that it is not part of normal life but somehow ‘other’, separate, different, alarming. The media, advertising and popular culture are saturated with images of youth when the reality is that young people are increasingly a smaller proportion of our population. There are now more people over 65 than there are under 16 and this trend will continue. As Demos point out in their ‘Coming of Age’ report (2011)189

Ageing in itself is not a policy problem to be solved, but is in fact a unique experience for each individual, which varies according to personal characteristics, experience and outlook.

We need to accept that population ageing affects all of us. We are all getting older. It’s normal. As Demos point out (ibid)

Each individual’s experience of ageing, including their health, well-being and financial security, will be determined by their life-course in its entirety, rather than by the events of their later life in isolation. Therefore, policy activities to support positive experiences of ageing must aim to build people’s resilience throughout their lives, to prevent problems such as poor health or social isolation from arising.

102. At the same time, we need to acknowledge that population ageing doesn’t just add pressure on health care, housing and pension systems, but some commentators190 believe it will lead to a diminished appetite for transformational social and economic change that will be crucial to adapting to the new challenges of the 21st century. To counter this we need now to find innovative ways to mobilise and engage the knowledge and skills of people in later life.

103. One of the problems in developing public policy to address ‘old age’ is there is no clear consensus on when old age begins. A recent large scale US study of perceptions of old age191 involving nearly 3,000 participants aged from 18 to over 65 found significant differences in terms of the age at which old age begins, but the differences are less stark.

189 Bazalgette, L et al, Coming of Age, Demos, London (2011)
between older age groups. For example, people aged under 30 defined ‘old’ as being 60 whereas the average age at which old age begins for the next cohort (30 – 49) is 69. For the over 65s, the perceived age at which people become old averaged at 74. There were other differences according to ethnicity and gender. In terms of biological age, there is a widespread view that when a person has reached 85 they are definitely old, and certainly health data suggests that people over this age have more serious long term conditions that affect what they can do in everyday life.

104. Demographic change is about everybody, not just older people so what is required here is not a better ageing policy but a change in how the life-course is interpreted. Children and young people have some particular needs, as do older people, but most policy solutions need to impact on everyone in society. For example, Housing 21 is a leading provider of extra care housing – specially designed, accessible housing schemes typically comprising 50 apartments with access to a care and support service 24/7. Older people who may otherwise have been in residential care or finding it difficult to cope in family homes can remain independent in extra care housing. This in turn helps to keep younger people independent, by offering jobs in services to keep them economically active, apprenticeships and training schemes to enhance their skills and employability. This in turn can also reduce caring responsibilities for relatives.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

201. We are likely to live longer, have extended working lives and an extended period of retirement when we may need to buy in care and support services. Pensions seem a long way off for school children but financial planning for retirement should be referenced in the curriculum at secondary schools and Further Education establishments. People do not always plan for retirement because they don’t feel comfortable with the idea of getting old and they have no idea (or are in denial) of what the costs of living longer will be. If ageing is seen as a normal part of the life course rather than something exceptional and separate then it should be possible to incorporate this type of learning earlier in life.

202. There are provisions for child care in employment law but caring responsibilities vary throughout the life course. Multi-generational care is an increasing feature as the population ages. Many people in their forties may have dual responsibilities caring for children and older parents. It would be useful therefore to think about how people can be supported to continue care-giving and maintain employment throughout their working lives.

203. It would be helpful if the government would produce or publicise information on financial services for later life to all generations. There are of course insurance plans for over 50s but this type of planning should come into play earlier in life. Similarly, Chris Skidmore MP has recently put forward the idea of having a care ISA designed to function in a similar way with tax incentives to other ISA investments but would be specifically ring-fenced to pay for care and support in later life.

204. There is currently an under-supply of attractive and viable equity release products on the market. We know that a high percentage of the current generation of older people in England own their homes outright. Some may wish to downsize as they get older, some may want to release equity to pay for care.
Many people already work well into their 70s and 80s. Older people also make up the largest proportion of the voluntary workforce in the UK. Many studies demonstrate clearly that work is a key determinant of people’s identity and being made redundant or compulsory retirement can have a negative impact on self esteem so the abolishment of the state retirement age is clearly a positive step. Work should be a matter of choice rather than compulsion.

3. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

Public services are under severe pressure given funding cuts. As a result, many local authorities have seen no option but to cut services and raise eligibility thresholds for care. Linked to this, changes outlined in the Welfare Reform Act will severely limit the financial wellbeing of present and future generations of older people.

Barnet Council has provided an oft used illustration of the impact of demographic change on public services. In 20 years the council estimate that it will only be able to provide adult social care, no other public services at all.

We can’t look at public service reform without looking at welfare reform more broadly. Many changes are outlined in the Welfare Reform Act (2012) but arguably, for future sustainability, more radical reform is needed. The principle of universalism is politically charged, and there may well be some universal benefits which should be protected and preserved, but it is difficult to argue in times of austerity that free travel on public transport and the Winter Fuel Payment should be paid to everyone over 60. The government should seek to look at targeting this type of benefit to people in most need, and if some element of universalism is still deemed to be important then it could pay these benefits by default to people aged over 75 which research shows is the age many people start experiencing age related infirmity. Of course, there will be people below this age who should be eligible but a layer of means testing could be added or say, Winter Fuel Allowance could be paid to people in receipt of other income benefits only. It is interesting that several recent research studies highlight that many older people themselves consider that the Winter Fuel Payment is surplus to requirement. We have examples from Housing 21’s customer base where people have tried to pay this back or to give it to neighbours they thought were in greater need.

4. Do we need to redesign and transform public services for these challenges? If so, how?

We need to look at better co-ordination and integration of services across different sectors. At times of austerity innovation is critically important. Housing 21 invests significantly into research around new technologies and service innovations. It is not just large scale Research and Development activities, but ‘innovation with a small (i)’ that is necessary; finding ways of delivering existing services better and more cost effectively.

Our expertise in developing integrated services is delivering better outcomes for service users and commissioners alike, is demonstrated by our Bristol-based ‘portable care

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192 Guardian, 15/5/12 “The Graph of Doom”
project’. The project involves the transfer of care from extra care housing to the hospital when a service user is admitted, with Housing 21’s key worker care staff working alongside hospital staff in providing care. Case studies show that by sharing vital information with ward staff, key workers are able to communicate better with patients, thus improving their health outcomes and reducing hospital stays.

5. What should be done now and what practical actions are needed?

501. We need long term strategies to support people across the life course in maximising their resilience: financial, mental and physical, so they can maximise the chances of experiencing a healthy and independent later life. Strategies that start with the over 50s, over 60s or any other age band have proved less effective as they still effectively hive off ‘later life’ into a separate phase, wherever it is thought to begin.

502. Investment into housing is crucial as this is a long term social asset which can prevent more costly interventions. However, few local authorities are giving serious consideration to the impact of population ageing on the built environment. Research carried out in 2010 by the National Housing Federation (NHF)\(^{193}\) looking at local authorities housing strategies and how they were going to ‘future proof’ housing for demographic change found that even where strategies existed, they often aimed to meet only one type of housing need, such as extra care housing rather than giving broader consideration to the fact that everyone is ageing and only a small proportion of people are ever likely to live in specialist housing. Many authorities failed to look at future demand for support services, or the issues faced by older people in private housing. This failure to address older people’s housing needs proactively in the early years of the 21\(^{st}\) century is likely to lead to reactive and unplanned responses to problems when they arise, putting more strain for the acute care system. This doesn’t just undermine older people’s well-being may also result in higher costs to social services and the NHS in the longer term.

503. The NHS and the social care system are already heavily under strain and urgent reform is clearly needed. The emphasis on preventative services in various government policy statements is to be welcomed, but we urgently need hard evidence of the cost effectiveness of housing and social care in terms of delivering preventative health benefits.

504. The government’s social care White Paper (2012) goes some way to addressing the urgent demand for system reform. It recognises the value of preventative services, aims to give people more choice and control over their lives and sets out plans to ensure fairness, quality and alongside proposals on how to promote integration. However, the most urgent priority is to address the funding of social care and we recommend that the government now implements the reforms outlined in Andrew Dilnot’s Royal Commission report\(^ {194}\) which proposes a cap of what individuals would pay towards their care (£35K).

6. How can we stimulate national debate about these issues?

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\(^{194}\) Dilnot, A et al “*Fairer Care Funding for All*” July 2011, HM Government, London
601. There needs to be a sustained and growing public awareness campaign with buy in from public and private sector organisations and media groups around getting older. The debate should not be sensationalised, but matter of fact and grounded in the reality that all of us are living longer. People need to be presented with the facts and as such, Andrew Dilnot’s Royal Commission report on care was a step in the right direction as it sought to clarify what individuals and what the state should pay for long term care. The BBC’s recent ‘Growing Older’ series was a useful step in this direction, showing as it did the diversity of lived experience in older age, but such initiatives should not be one-offs.

1 September 2012
1. Technology can do more to support people living independently in their own homes for longer - something which research suggests is the best solution, both for personal happiness and cost effectiveness. Although concern is expressed about the fact that a proportion of older people are not familiar with computers and the Internet, that is a fairly short-term challenge: anecdotally, we have many site visitors on Independent Living in their 80s and 90s, and crossover devices such as smart phones, e-readers and tablet computers have encouraged increasing numbers of older people who perhaps weren’t interested in computers per se, to become engaged with this connective technology.

2. There have been successful trials of telecare products, such as the three-year West Midlands study, which showed how complex medication regimes can be managed successfully, even by very elderly individuals and those with cognitive impairments, saving local authorities and the NHS significant amounts of money. During the trial, even people who had been hospitalised previously because of problems with taking their medication, successfully took control of this vital area of their lives.

3. There is a stigma about wearing an alarm call pendant, and of course there is also a risk with anything that has to be put on by the user, that it will be forgotten or deliberately ignored. Alternative solutions that are more likely to be taken up are products that have a proven value to the user (most people automatically make sure they have their mobile phone with them, for example). Or systems that don’t depend on the user to work, i.e. sensor systems with software to trigger an alarm if, for example, the person doesn’t go into the kitchen within a certain period; if the temperature in the home falls too low; if smoke or gas is detected; etc. I know of such systems that could with benefit be more widely used.

4. If every old person’s home had Internet access (funded by the state and/or telephony suppliers, in those cases where they could not afford it themselves), then it should be possible to add on telecare services as they became necessary.

5. Ensuring proper funding for local Care & Repair organisations, which support people to continue living at home, and perhaps some investment in promoting the range of services they provide. If you need a handy person to put up a grab rail that will help you step out of the shower safely, where do you go? We are often asked this sort of question, and will refer enquirers to their local Care & Repair, but it seems that most people who need their services are completely unaware of their existence. The Social Care White Paper published earlier this year, recognised the importance of appropriate housing in the provision of social care, yet didn’t make proposals for ensuring that the 90% of older people who live in “ordinary” housing, rather than specialist adapted homes, can access the practical resources necessary to make their home safe for them to live in.

6. Perhaps we can also develop the community spirit that was displayed throughout the Olympic/Paralympic summer, where volunteers, with a modest amount of training and a lot of positive motivation, made a major contribution to the success of the events. Encouraging people to look out for each other in their neighbourhoods probably sounds a bit facile, but we have shown how successful volunteering can be, for all concerned, but if we can develop the habit further, we can probably save some resources that would otherwise be needed to
intervene when people need just a bit of support, to maintain their independence.

7. Another issue that sometimes prevents the best solutions being implemented is the artificial distinction between various budgets. For example, a person who is unable to get upstairs to use their bathroom may well be turned down for a stairlift or stair climber, and told instead to apply for a Disabled Facilities Grant to build an extension with ground floor facilities. This is going to cost significantly more money, but out of a different pot, so the social services department feels that they have saved money. If the system was properly joined up, so that the various departments communicated, and savings made were recognised, no matter where they came from, it would lead to more intelligent decision-making.

8. Lack of continuity of services is another issue that causes regular problems to our site visitors. If you need social care, it is likely that the local authority will be using a care agency to deliver the care. There is very little continuity: we were recently contacted by a woman whose husband had been attended to by 29 different people in the course of two weeks. Combining constant turnover with poor levels of training and lack of experience on the part of the carers, the fact that they are rushed because the time allocated is very tight, means relationships are strained, and this may result in unnecessary stays in hospital or care home, at great expense than if better quality domiciliary care had been available in the first place. Equally, the fact that local authorities can only afford to fund the most critical social care needs, means that more individuals risk falling into illness with consequent hospital or nursing home admission. Again, savings are being made from one budget at the expense - considerably greater - of another.

9. I don’t have any particular expertise in how the increased costs of providing necessary social care for an ageing population should be met. I can say that the expectation of a longer working life should accompany our increased life expectancy, and that putting a ceiling on the amount of care an individual should expect to pay for themselves provides a welcome level of certainty when it comes to financial planning. Most people would probably accept the principle of an insurance scheme to which they contributed, in order to cover extra costs that might fall on them.

13 September 2012
The International Longevity Centre-UK (ILC-UK) is the leading think tank on longevity and demographic change. We are an independent, non-partisan think-tank dedicated to addressing issues of longevity, ageing and population change. ILC-UK takes a lifecourse approach to demographic change. We consider the impact of an ageing society on all ages.

ILC-UK has a strong international remit and is one of fourteen international members of the International Longevity Centre Global Alliance. Our work draws upon the expertise and experience of these organisations. ILC-UK is a futures organisation. We are interested in how the world will change as a result of demographic ageing. We develop ideas, undertake research and create a forum for debate. We look for innovations which will help tackle the societal challenges emerging as a result of demographic change.

The following paper is based on evidence through the direct work of the ILC-UK from recent years and is necessarily brief. We hope to expand on broader themes relating to public services from our experience of researching demographic change if called to present oral evidence.

1. Does our culture about age and its onset need to change, and if so, how?

1.1 Our society should seek to become “age neutral”. Age is a poor proxy for, for example, ability, experience, skills, knowledge, and wealth, and yet policies in the private, public and voluntary sector are far too often based on age.

1.2 Our 2010 research on older consumers highlighted, for example, how the consumer marketplace fails the older consumer due to lazy assumptions about age (The Golden Economy – The Consumer Marketplace in an Ageing Society, 2010). This report also promoted the need for older people themselves need to be more demanding consumers.

1.3 Our experience of working on issues relating to older drivers also highlighted significantly negative perceptions of older drivers, perceptions which are not borne out by evidence. Almost one in four adults say that people should have to stop driving at 75, 70 or younger than 70, despite their being no evidence that age related bans would improve road safety.

1.4 We should take care not to overestimate the problem. Just one in six people agree that retired people play no part in the economic prosperity of the country (17%). (Population Ageing: Pomp or Circumstance, 2012). An ILC-UK think piece by Professor John Macnicol argued that whilst ageism has contributed to labour market problems facing older people, other factors have been more significant (Ageism and Age Discrimination: Some Analytical Issues, 2010).

1.5 Recent data from one of our reports suggested that two-fifths of the population think we are overestimating the effects of an ageing society (Population Ageing: Pomp or Circumstance, 2012). This suggests that a substantial portion of the population may not be supportive of measures to help adapt to demographic change. This viewpoint was not
concentrated among any one social group (based on age, social class, region, marital status, gender) but was one that was fairly evenly distributed among the population.

1.6 Almost half of adults (45%) believe that the NHS will not be able to provide a service that is free at the point of use because of population ageing (Population Ageing: Pomp or Circumstance, 2012). This demonstrates the widespread concern among the public about the impact of demographic change on public services.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

2.1 Expectations of Retirement: The meaning of retirement was originally bound up with the receipt of a pension, but has changed over time (The Future of Retirement, 2010). Between 1881 and 2008 the economic activity rates of UK men aged 65+ fell from 74 per cent to 10 per cent. Now, there is an expectation of retirement, and the majority of people can expect to live for at least twenty years in retirement.

2.1.1 Increasing longevity is beginning to challenge the economic reality of retirement for both the state and the individual. Faltering growth and the end of generous pension provision will for some, create a compulsion to work for longer. The increasing fiscal burden of an ageing society is emerging alongside the possibility of intergenerational conflict as today’s taxpayers are asked to fund the retirement of today’s retirees.

2.1.2 The concept of retirement which many have come to expect is unlikely to be delivered for future retirees who are making inadequate pension savings. Barely a third of people are contributing members of a private pension scheme (38 per cent of men and 34 per cent of women) (How will the Retail Distribution Review impact on people with small pension pots?, 2012).

2.1.3 There is an increasing need for individuals to plan early for getting older, particularly as limits on public service provision increase. However, getting people to plan ahead earlier is not feasible for many. There is a lack of recognition that many of the policies set in place affecting young people are likely to have long-term consequences as they age.

2.2 Working longer: An ILC-UK survey (Gradual retirement and pensions policy, 2012) on the prospects for extended working lives demonstrated a strong willingness across all age groups to work for longer in various circumstances. For example: 46 per cent of men and women would consider delaying retirement if their employer offered support for reducing their hours, or working more flexibly; 41 per cent of men and 39 per cent of women would consider delaying their retirement if they could defer their state pension entitlement in return for higher payments later; and only 2 per cent of men and 3 per cent of women said that nothing would make them consider delaying retirement. To a large extent, these circumstances already exist– but awareness of state pension deferral and the right to request flexible working, for instance, is very low, even among people approaching retirement.

2.2.1 Younger and older people are most likely to exhibit positive attitudes towards people remaining in the workplace for longer; those who are middle aged are least supportive of workplace flexibility (Population Ageing: Pomp or Circumstance, 2012). However, supportive attitudes among all ages are in the minority – less than half of people asked in March 2012...
agreed that ‘because people are living longer and healthier it is right that people work longer before they can claim a state pension’. Those who were in the lowest social classes were least likely to agree – this may reflect concerns about health and occupation type. Policies aimed at increasing the duration that people remain in the workplace and/or raising state pension age will have to recognise these differences in attitudes among different groups and their ability to work longer.

2.3 Citizenship and later life: In a recent report (Retirement in flux: Changing perceptions of retirement and later life, 2012), ILC-UK argued for a citizenship approach to later life. Citizenship implies that, in return for recognising our responsibilities and duties such as obeying the law and paying taxes, we have certain entitlements and rights. We believe that society needs to abandon the notion that people make contributions in their working life in return for support in retirement. Such an approach implies that retirement marks the point where older people’s contributions are no longer necessary or valuable.

2.3.1 In Retirement in Flux, ILC-UK argued that older citizens have a responsibility to remain in the labour market, where possible, to enable skills retention and minimise the fiscal burdens on taxpayers. But alongside this, older people should have a right to support from employers, and society more generally, to enable longer working lives (including access to flexible work and gradual retirement). We felt that older people should have a right to remain in their own home, but that it is fair that older people draw upon property wealth to help fund care costs. Whilst the idea of an obligation to volunteer is contradictory, we all have a responsibility to remain active in our communities. Opportunities to volunteer must therefore be appropriate: flexible, enjoyable, and oriented towards utilising the skills older people have developed during their working life.

3. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

3.1 An ageing society will change both the nature of demand for public services and the way they need to be delivered. The public is concerned about the impact of ageing on demand for services and there is a large degree of concern about future sustainability.

3.2 Health services: An ageing society will require us to rethink the prioritisation of health services. We are likely to need to invest more in preventative health across the life-course. This will pose difficult political decisions of prioritisation. In a recent report with Imperial College (Creating Sustainable Health and Care Systems in Ageing Societies, Global Health Policy Forum, 2012), ILC-UK has promoted a focus on preventative healthcare. Individuals’ ability to adopt healthier behaviours across the lifecourse is something that is sometimes overlooked – there is often an assumption that older people should be excluded from prevention programmes; with older people living longer this is no longer the case.

3.2.1 Alongside the impact of the growth in the numbers of people living very long lives, the cost of dementia is likely to play an increasingly important role in influencing public spending. The current cost of dementia represents 1% of Global GDP and this cost is set to rise substantially: dementia funding is not relative to the burden of the disease. Of the top four diseases (dementia, cancer, stroke, heart disease), dementia contributes 52% of the costs, but receives only 6% of funding (The Future Economic, Health and Social Care Costs of Dementia, 2011). Public research funding provision must take into account the financial and societal cost of this disease.
3.2.2 As another example of how services may need to change over time, over the last 12 months, ILC-UK has been working on the case for life course immunisation as part of the prevention agenda. As a society, the UK is very good at delivering childhood immunisation; yet with the exception of policies on influenza, there is no real strategy for delivering immunisation to adults (Life Course Immunisation: Improving adult immunisation to support healthy ageing, 2012).

3.3 Care, housing and communities: With regards to planning social care services, ILC-UK has endorsed keeping older people independent for longer and keeping care closer to home– this involves adopting cost effective and innovative models of delivery (Creating Sustainable Health and Care Systems in Ageing Societies, Global Health Policy Forum, 2012).

3.3.1 ILC-UK is a supporter of the recommendations arising from the Dilnot Commission. We believe this is critical area; the underfunding of social care is an enormous issue which must be solved immediately and will be an even greater problem if action is not taken as a matter of urgency.

3.3.2 Extra Care housing highlights but one of many examples of how services may need to change. Our research, using longitudinal data from three Extra Care providers, highlighted that it could play a major part in delivering better health outcomes and reducing the long term care costs facing older people (Establishing the extra in Extra Care, Perspectives from three Extra Care Housing Providers, 2011). In this research ILC-UK found that compared to those living in the community in receipt of domiciliary care, those in extra care housing are about half as likely to enter institutional accommodation. We also found that compared to a matched sample living in the community, Extra Care is associated with a lower likelihood of admittance to a hospital overnight and a lower than expected number of falls. These findings suggest that Extra Care housing could contribute significant financial savings to the public purse, particularly when taking a long-term perspective. Local authorities and public bodies could take a more proactive role in promoting Extra Care.

3.3.3 With an ageing society, we will need to ensure, more broadly, that our communities are increasingly built to ‘lifetime home’ and ‘lifetime neighbourhood’ standards. There is a strong ‘invest to save’ argument in designing our communities to be well designed for all age groups. Poorly designed neighbourhoods and housing has huge social and healthcare costs.

3.4 Inequalities within old age: It is vital that society does not assume that the needs of all older people are the same or even similar. People’s needs and wants arguably become more heterogeneous, not less, as we age and gain different experiences. Many of the issues we encounter in some fields, for example housing, are in part a reflection of a lack of choice available to older people – the choices available do not reflect the diversity in health and social care needs, socioeconomic backgrounds, and other characteristics of older people. If we are to address demographic change we need to recognise increasing not decreasing diversity in characteristics and inequalities with age.

3.4.1 People in lower social classes are around 40 per cent less likely than those in the highest social class to agree that they are more in charge of their own health more than other parties including the government, their hospital or GP, after controlling for other factors (Population Ageing: Pomp or Circumstance, 2012). It is not however, just class which creates a different experience of ageing. For example, an ILC-UK report from 2011 posits
that in the coming years, women will not only disproportionately bear the burden of dementia in terms of numbers, but also the impact of caring (Women and Dementia - Not forgotten, 2011).

3.4.2 There are also significant variations in the income and wealth of older people. Average household wealth peaks among those aged 55 to 64 declining gradually among older cohorts. The average weekly income of the oldest households (75 or older) in 2007 was around £300, or just under £16,000 a year, meaning that many older people live on very low incomes indeed. Additionally, even those on a high income can suffer from expenditure poverty and as a result will also spend relatively little in the consumer market. (The Golden Economy – The Consumer Marketplace in an Ageing Society, 2010).

3.4.3 Notwithstanding the inequalities of wealth issues highlighted above, it is vital that we increasingly consider how older people can and should contribute to the additional costs of an ageing society. We need a financial settlement for social care which would create a market and ensure older people knew what they needed to save to cover their own retirement costs.

3.5 Underestimating the challenges: There is a significant risk that society is continuing to underestimate the challenges of an ageing society.

3.5.1 Centenarians currently number 12,640, a figure which is set to rise substantially and expected to reach half a million by 2066. Our report on Centenarians, published in 2011, found that that there was some evidence that current cohorts of centenarians enjoyed better physical health during centenarian years compared to other groups of older people, effectively avoiding many of the conditions associated with old age. However, the report highlighted that future health and social care services may witness a higher demand from the centenarian population of the future, as increasing numbers may survive to 100 living with a non-communicable disease - gains being made in the survival rate may not match gains in disease-free survival. Quality of life among the oldest old is found to decrease with age and that the oldest old (aged 85 and over) are, as a group, at greater risk of poverty than younger older people (aged 65-85) (Living Beyond 100: A report on centenarians, 2011).

3.5.2 These trends are not exclusive to the UK. An ageing world is likely to impact not just on the priorities of public spending in the UK, but also of our international aid and development budgets. Deaths among over-60s caused by Non-Communicable Diseases in the developing world are over twice the number of those below 60 (Non-Communicable Diseases in an Ageing World, 2011).

3.6 Ensuring a fair share of the pie – future public service delivery and intergenerational solidarity: The transfer of wealth from young to old, and its consequent inequality, represents a challenge to the contract between generations embodied in various functions and policies of the UK state that rest on the principle of intergenerational solidarity.

3.6.1 The UK health system is a classic example of intergenerational solidarity (see Asset Accumulation across the Life Course, 2007). The NHS is funded in large part by taxes on the
working age population. However, usage of healthcare is significantly associated with proximity to death, which for most people is in retirement. A second example is the state pension. When working-age individuals make state pension contributions through labour taxes, their contributions do not in fact go into specific allocated pension accounts, but instead contribute to the cost of paying a state pension to older generations. Such intergenerational contracts rely on a continued sense of intergenerational solidarity among the population, and this sense of solidarity relies in turn on a perceived equity between the generations.

3.6.2 Two important findings from the Asset Accumulation across the Life Course research are the dramatic increases in the net non-pension assets of older generations in the decade after 1995, and the significant increase in the average household mortgage debt of younger generations.

3.6.3 However, this change should not be overstated. First, some - but by no means all - younger households have received transfers from older cohorts to help with property purchases. Second, older people have not ‘grabbed’ the bulk of wealth in society nor, in fact, do they now have a radically larger share of the wealth in society. The Asset Accumulation across the Life Course research found that the relative proportion of total wealth held by different generations has not changed dramatically in recent years.

3.6.4 An ILC-UK survey ahead of the last spending review found that seven in ten aged over 65 felt they would be most affected by the spending review, as did the same proportion of 25-34 year olds. Moreover, four in five over-65s felt that spending on their age group should be protected – as did over seven in ten 16-24 year olds.

3.6.5 We should take care not to assume intergenerational tensions in public spending. Somewhat counter-intuitively, younger people were more likely (one third of 16-24 year olds) to target education for spending cuts than older people (one in five aged over 65) (Intergenerational Fairness and the Spending Review, 2010). In another survey, a large majority of people – 67 per cent – do not support the idea that people above state pension age, yet still in employment, should continue to pay National Insurance Contributions. Strongest came from category of those aged 25-34, where 74 per cent of people disagree that people in employment aged above state pension age should pay NICs. Slightly more people aged 65+ than in any other age group – 33 per cent – believe that such individuals should pay NICs) (Gradual retirement and pensions policy, 2011).

4. Do we need to redesign and transform public services for these challenges? If so, how?
Demographic change demands that public services cannot continue as they have in the past. Our needs are changing and fiscal pressures require new innovative approaches.

4.1 We should recognise that public services have actually changed over the last 30 or 40 years as a result of societal recognition of ageing. In our ‘futures’ report, Care Home Sweet Home (2012), ILC-UK highlighted how for example, the quality of care home provision has changed significantly over the last 50 years and how care homes will need to adapt to a changing world. In the report, we argued that the care home now needs to become a ‘community hub’, integrating services and resources into the mainstream of local communities. However, we should not be complacent about progress. A recent ILC-UK report (Undetected sight loss in care homes, 2012) highlighted just one example of the
challenges ahead. It revealed that visual impairment and poor eye health is frequently ignored in care homes impacting on quality of life and independence for older people.

4.2 The greater involvement of older people in the design of services must play a part in change. In *Nudge or Compel*, (to be published 2012), we argue that there is a strong case for greater focus on co-design. We made similar arguments in a think piece we developed with NESTA (unpublished) where we argued that co-design was important for the future design of the workplace.

4.3 Health services must be transformed. We must place more of a focus on GP-led primary care. In doing so we must ask difficult questions about the relative investment in prevention, and we must accept that investment in care and in prevention may necessarily reduce the investment in other forms of health.

4.4 Innovation Case Study: Patient hotels, the concept of which was first developed in Scandinavia, are designed to offer accommodation for low dependency patients who do not need the full services of a hospital ward, but need to be close by just in case. Research reveals that the cost of accommodating a person in a patient hotel is considerably lower than placing them in hospital.

5. What should be done now and what practical actions are needed?
The scope of the inquiry is large and there are a huge number of interventions needed by the public, private and voluntary sector to help us cope with demographic change. We set below a small number of priorities for action.

5.1 Government must not shy away from difficult public policy decisions emerging as a result of our ageing society. Putting off such decisions could create more unfairness. For example, increases to state pension age or changes in eligibility to age related benefits would hit harder if people are not given adequate notice. Government must explore the fairness of public spending across the generations and consider for example, where the means testing of certain age related benefits would be fairer than universal benefits.

5.2 Government must lead. Government must bring together all relevant departments and agencies to deliver a new Government strategy on ageing and demographic change, one akin to the work on “Every Child Matters”. It is vital that this strategy goes much further than previous strategies and sets rights and responsibilities we can expect later in life. Previous strategies for older people have failed to get buy-in of major Government departments and a future one must be championed and led by a senior cabinet minister.

5.3 As individuals, we must accept that we will need to work longer to help fund the continuation of public services. The policy solution is not however about simply raising state pension age. Doing so does not inevitably lead to increased average retirement ages. Government and employers must ensure that gradual retirement and flexible working policies to facilitate working longer.

5.4 We must invest in lifetime home and lifetime neighbourhood standards. Planning policy must better accept the reality of an ageing society. The quality of our environment is a health determinant (for example: damp housing can aggravate respiratory illness). Housing tenure impacts mortality, with tenants having higher death rates than owner-occupiers. Older people's health and well-being can be negatively impacted by their housing because it
is too difficult or expensive to heat properly in winter, is difficult to navigate due to lots of stairs or inconvenient layout or is badly situated for public amenities. As people age, housing modifications may be needed to compensate for declining functional capacity. Our work on Extra Care Housing has exemplified how the right housing options can save money for the public purse whilst improving quality of life. The stock of retirement housing is not adequate to meet need.

5.5 We must focus increasing public spending on preventative healthcare. Like pensions, healthcare reform in the majority of countries is driven by a desire to control costs, which have been constantly increasing above the rate of inflation due to a number of factors including advances in medical science (drugs, technology and procedures), population demands and demographic change. But few countries have managed to successfully implement preventative health policies, which have the potential to reduce pressure on public health budgets.

5.6 We must invest more in innovation and co-design. All stakeholders must learn more from the experiences of innovation across the world. We must also better involve older people in the design of public services.

5.7 We must learn from the 'nudge' agenda. Over the past two years, ILC-UK has undertaken a wide range of work looking at the potential of behavioral economics to influence older people (for example: Resuscitating Retirement Saving, 2011; Can Older Drivers Be Nudged?, 2011; Nudge or Compel (To be published, 2012). Government must look towards the nudge agenda to influence older people and support ageing well.

5.8 We must accept that the responsibility for change lies on the individual, the private sector and the voluntary sector, as well as Government. The private sector has an increasingly important impact on our lives and is increasingly delivering public services (for example, as a result of the personalisation agenda). The consumer market is important to older people, providing (and influencing) the food we eat and the medications we take. At the same time older people are important to the market and the economy. Older people’s (aged 65 plus) spending reached an estimated £97 billion in 2008, around 15 per cent of the overall household expenditure. Yet despite the size of the market, ILC-UK has found that for many, the private sector does not meet their needs.

5.9 A debate of the age. In 2000 there was a Millennium Debate of the Age, organised by Age Concern. Over the past 10-15 years we have seen significant changes in policy, practice and demography. There is a strong case for repeating the exercise.

31 August 2012
Baroness Sally Greengross on behalf of the International Longevity Centre – UK—Supplementary Written Evidence

A vision for our ageing society

1) An Age Neutral Society

Age takes a prominent role in society, culture and politics. Yet with growing heterogeneity amongst the older population, chronological age is a poor way of assessing or needs or desires. In parts of the country we have 100 year old marathon runners, but in other parts we have low life expectancy where many are failing to reach state pension age due to ill health.

Our society must increasingly become age neutral. Outdated perceptions of the abilities of people at different ages come from a time before the demographic revolution gifted us with a huge number of skilled, able and willing older individuals to whom we are denying the opportunity to contribute. The end to the default retirement age and the Equality Act are first steps to true equality, but there is far more to be done to remove the stigma and discrimination in society’s attitudes to age.

2) Our services similarly are constructed round the reality of who needs to the services, e.g. the majority of older people in most cases

While we must not discriminate against people on the basis of chronological age, we must be realistic that a considerable portion of our population will soon need better support from their services. Areas as diverse as design of public spaces, to support in managing health budgets, must be designed with older people in mind. This in turn will make society more inclusive for a wider stretch of often-marginalised groups. Despite the need for age-awareness in design and delivery of services, age itself does not dictate individuals’ interest and preferences and services must also incorporate and reflect the heterogeneity of older people in society.

3) Full integration of health, social care and housing services.

For us to deliver improved services and cost savings, we can no longer see health, social care and housing as distinct services. For the recipient, they are inter-related. The failure of Government (at a national and local level) to adequately recognise this causes untold cost and inconvenience and results in poorer services for older people. For example, the failure to adequately support decent housing at lifetime homes standard adds significant costs to health and care services.

4) Dementia and cognitive decline must be better taken into account in planning services.

Dementia is a growing concern. It will add significant increasing costs to many public services over the next 20 years. If policy makers and service designers do not recognise this challenge the financial crisis ensuring from the rising rates of dementia will have catastrophic effects.

5) The design of the built environment and all public building should be as accessible as all for all ages.

Ensuring that our cities and public spaces are accessible is a vital part of delivering a society for all ages. Yet far too many parts of our communities remain inaccessible due to physical
barrier, poor transport or simply a lack of thought in service design. Through work over the past 10 years on Age Friendly Cities, progress has been made. But Government at a local and national level must push forward steps to ensure that our neighbourhoods are accessible for us.

6) **End of life care needs to be focused on meeting the needs of those who want to remain in their own homes or environments that are similar to hospices etc.**

Over recent years, the Department of Health and many providers have acted to improve end of life care. But for many older people, end of life care still does not meet their needs. We need to be less afraid of discussing end of life issues as a society. The real ethical challenges are not solved by hoping they will go away.

7) **We must better train/retrain service providers to meet the needs of the older population.**

With an ageing society, services providers are increasingly going to need to better understand how to reach and support the older population. This will require investment in training in the public and private sector.

8) **Invest in Prevention**

Governments must invest seriously in health promotion and prevention. We must move to longer term budgeting and planning cycles in order that public health decisions where the return on investment may take a long time, attracts funding. If we are to prevent or reduce potentially catastrophic future health and care costs, further investment in prevention is vital.

**“Scaring people to get change?”**

My view, in this respect, is that ‘scaring’ is probably not the right context – but instead warning of dangers of not acting appropriately and the dangers of not taking action is not suitable.

November 2012
Introduction

1. IPPR is pleased to submit its views to the House of Lords Committee on Public Service and Demographic Change. We welcome the Committee’s enquiry as it reflects the need to debate the long-term future of the public finances, often missing in current economic and political discussions. In responding to this call, we will draw on IPPR’s current programme of work on fiscal policy over the short, medium and long-term. Addressing short to medium-term fiscal concerns, later this year IPPR will publish a report setting out the options for tax and spend in the next spending review, highlighting the tough choices facing all political parties. With respect to the long-term, IPPR has a programme of work exploring the options for the public finances over a fifty year horizon. This work is analysing the long-term implications of policy decisions and wider social and economic changes on the UK’s fiscal outlook, and the political choices they imply.

2. Discussions about the UK’s public finances need to extend beyond the usual three to four year time horizons associated with spending reviews. An ageing population, technological progress in healthcare and growing national prosperity will, over the long-run, raise demand for some public services, benefits and state pensions. This raises the possibility of other areas of spending being squeezed, which may have profound impacts on the UK’s future economic performance and social outcomes. However at present, fiscal policy is often dictated by the short-term nature of politics and as a result policy often misses the long-term challenges.

3. It is also important to address process. Fiscal policy decisions should be determined by a clear set of national strategic objectives, acknowledged as likely to evolve over time. Decisions should be made through democratic debate involving citizens, since managing the public finances over the long run will require tough choices that will inevitably shape the lives of citizens. Public understanding of and support for whatever difficult decisions are made will be important.

4. This note begins by setting out shifts in public spending and revenues over the last 50 years, in order to show how population ageing and a range of other factors have driven spending priorities to date. We then examine the impact of population ageing on these trends, and the importance of ageing relative to other drivers. We finish by setting out the political choices available to citizens and policymakers in responding to these challenges. IPPR’s assessment is that these choices lie in four key areas: raising the growth rate and the level of employment; raising additional tax revenues; prioritising public spending; and reforming public services.

Historical trends in public spending and future prospects

5. Many of the trends in the UK’s public finances over the last 50 years will continue to influence future spending and revenues over the next half century and so understanding how previous governments have responded to these trends holds important lessons for future policymakers. It also reinforces the fact that none of these trends are new or unexpected; instead, they each reflect long-running and slowly evolving shifts in demography, technology and behaviour.
6. Over the last 50 years, public spending on healthcare, education and state benefits and pensions has risen substantially. Total public spending on healthcare, education and social security doubled as a share of GDP between the early 1950s and early 1980s, rising from 10 to 20 per cent of national income. After falling slightly during the 1980s, combined spending in these three key areas grew again from 1999, rising to 25 per cent of GDP in 2008. At this point, healthcare, education and social security accounted for nearly 60 per cent of all public spending.

7. In some periods over the last 50 years, rising social spending has been partially offset by falls in spending in other areas. Gross public sector capital expenditure fell from almost 9 per cent of GDP in the mid-1970s to less than 2 per cent in the late 1990s. This was partly the result of the privatisation of public corporations, but also stems from the transfer of publically-owned housing to the private sector and the dramatic fall in council house building which began in the mid-1970s. Central government capital spending was also squeezed more recently, in the 1990s, before growing slightly from 1999. This partly reflected concerns about the economic impacts of historic underinvestment in housing and infrastructure.

8. Defence spending has also fallen considerably over the last half century, freeing up additional resources for social spending. In 1955, the UK government spent more on defence than on education and healthcare combined. Over the next two decades, defence spending as a share of national income was cut by almost one half, and continued to decline over the 1980s and 1990s. Falling defence spending reflects shifting priorities for the UK on the global stage as well as the changing geo-political context.

9. These shifts in the structure of public spending show that prioritisation has been vital for all governments, but has often been driven by short-term interests rather than a consideration of trade-offs and consequences over the short, medium and long term. In addition, faced with rising demand for services and cash transfers, governments have rarely sought to raise overall tax revenues as a share of GDP to pay for additional spending. Instead, they have typically sought to switch spending from other, less priority, areas and, at certain times (as after 2002), allowed public sector debt to rise to pay for additional spending.

10. From the mid-1980s, governments were also able to rely on falling debt interest payments to offset rising social spending without pushing up overall public spending. Between the mid-1980s and 2001, debt interest payments as a share of GDP more than halved from around 4 to 2 per cent (with a brief spike in the early 1990s). Low and stable interest payments during the 2000s offset almost all the increase social spending between 1999 and 2008.195

11. Looking at the current spending review it appears that many of the trends experienced over the past half-decade will continue out to 2014/15. The NHS budget is protected in real terms, increasing the pressure on other departmental budgets. Capital spending is once again being squeezed, falling by more than a quarter in real terms over the four year period.

12. Over the long-run, it is not clear that governments will be able to rely on similar tools to maintain social spending without pushing up overall public spending. The long-term economic consequences of squeezing capital spending are becoming increasingly apparent and further substantial cuts to defence spending would require a radical

rethinking of UK foreign policy. Debt interest payments have risen in the last few years and are likely to be higher in the medium-term than in the 1990s and 2000s given the increase in public sector net debt.

13. One alternative being pursued by the current government is to freeze or cut working-age benefits in order to reduce the benefits bill while allowing the value of pensioner benefits to rise. This looks likely to be an important feature of future spending review negotiations but comes with some important trade-offs, such as the impact on working-age poverty and work incentives.

The impact of ageing on the public finances and future prospects

14. Rising public spending on social security, health and education has been a feature of all advanced economies over the last half century. Population ageing has been an important driver of these trends, particularly in pushing up demand for state pensions and pensioner benefits, which account for just over half of welfare spending (including housing benefit and council tax benefit paid to pensioner households). Ageing has also increasingly driven up demand for long-term care, although this accounts for a relatively small amount of total government spending so the overall impact on the public finances is not large.

15. The impact of ageing on healthcare spending is less straightforward because older people require only slightly higher levels of healthcare than younger generations, except in the last year of life. Ageing has some impact on demand for healthcare but its impact should not be overstated.

16. In future, demographic shifts such as population ageing will continue to have an impact on the public finances. However, population ageing is not a new phenomenon in the UK and future ageing will take place slowly and steadily. In fact, the UK, alongside the US and the Nordic countries, is already in a mature phase of the ageing process, and demographic pressures are more substantial in Japan and the Mediterranean countries.

17. Additionally, a lot of uncertainty exists around the future implications of population ageing on public services. The extent of future increases in longevity are not certain and higher than expected average longevity will put particular pressure on demand for state pensions and pensioner benefits, over and above those projected by the OBR. The IMF estimate that a three year ‘longevity shock’ would increase pension costs by between 1.5 and 2.0 per cent of GDP on average in advanced economies.196

18. One particular source of uncertainty is the cost of future healthcare spending. This is because of the changing health of older people, and since the NHS accounts for around one-fifth of public spending, any improvement or worsening of health in old age could have a substantial impact on projected health spending. There is a lack of certainty about how health in old age will develop as the population continues to age.

19. The way in which policymakers respond to population ageing will be just as important as ageing itself and it is not inevitable that ageing will lead to higher public spending or a worsening outlook for the public finances. A number of policy reforms have already reduced the costs associated with rising longevity, including staggered increases in the state pension age; and changes to public sector pensions that are projected to lower expenditure as a share of GDP over the long-term despite the rising number of

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pensioners in receipt of a public sector pension. The fiscal impacts of ageing would look very different to those projected by the OBR if additional reforms helped to raise the effective retirement age and older people stayed in work longer.

**Other drivers of increasing demand for public spending**

20. It is important to recognise that ageing is just one driver of increasing demand for public services and cash transfers. 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.

21. One of the most important drivers of increasing demand for services, pensions and benefits over the last 50 years has been raising prosperity. Increasing national wealth tends to push up demand for ‘luxury goods’ like healthcare and education faster than GDP growth, so that spending rises as a share of GDP. In the UK, most of this additional demand has been met through public spending, although private spending has also risen. Private welfare spending tends to rise when public spending is squeezed, suggesting that policy reforms designed to reduce public social spending do not reduce overall demand for services. Despite current economic challenges, long-run economic growth in the UK is likely to be on a par with that achieved over the last 50 years, implying continuing rising demand for healthcare, education and pensions that outstrips GDP growth.

22. The public finances are also shaped by other demographic trends beyond increased longevity, namely fertility rates and net migration. The OBR’s modelling shows that a young age structure, caused by higher than expected fertility rates, or high net migration would boost GDP relative to spending, so that the public finances would be on a relatively sustainable footing over the long-term without the need for changes to tax and spend policy. Alternatively, a zero net migration scenario implies very high levels of future debt without changes to current policy, although high net migration also comes with important trade-offs and political risks. Public policy can have a role in increasing the fertility rate, for example through leave policies and the generosity of benefits paid to families with young children.

23. Policy decisions about how benefits and tax thresholds are uprated, and about increases in public sector pay, will also have a significant impact on public spending, regardless of the pace of population ageing. Curbing public sector pay rises would allow rising demand to be met to some extent without cutting back on service provision, although it is likely to lead to recruitment problems over the long-term. The OBR’s modelling assumes that all benefits and tax thresholds are uprated in line with average earnings over the long-run, despite official government policy being to increase most benefits and thresholds with CPI inflation. Future governments could choose to use ‘fiscal drag’ and to allow the value working-age benefits to further decline relative to average earnings to pay for rising demand for pensions and healthcare without reducing coverage or generosity. This would create many more higher rate taxpayers and is likely to increase rates of poverty among working-age adults.

**Policy implications**

24. The OBR’s projections of long-term fiscal sustainability show how population ageing will drive demand for more public spending, without substantially increasing revenues. Other long-run trends will continue to drive rising demand for many public services,
pensions and benefits. However, governments and citizens have choices about how we respond to these trends, and have a range of options available to them. We have identified options in four key areas. A key point is that each option will require a consideration of the benefits and trade-offs over the short, medium and long-term, with no easy answers for providing high-quality services and decent benefits while maintaining fiscal credibility:

25. **Raise the long-term rate of growth and the employment rate**: governments have typically found it hard to sustain real terms fall in public spending and strong growth has been vital for achieving fiscal consolidation in the past. OBR’s modelling shows that strong economic growth could help to offset the impact of real-terms increases in public spending on the public finances. Over the long-term, their analysis shows that higher than projected growth rates would significantly reduce the size of the ‘fiscal gap’ and would see public debt falling as a share of GDP without requiring any changes to current tax and spend policies. Similar effects could be achieved with high net migration or if the employment rate among the existing population, including older people but also other groups like mothers and those with long-term health conditions, could be substantially improved.

26. **Increase tax revenues**: OBR analysis suggests that revenues from sources like vehicle excise duty and North Sea oil and gas will fall over the next 20 years, implying that higher taxes from other sources might need to make up the shortfall in future. Politicians and citizens also need to decide if total revenues should be higher in the long-term to pay for some of the extra demand for services and benefits. Additional revenues could come from increasing tax rates for the big earners like VAT and labour taxes, reducing expenditure on tax reliefs life pension tax relief, identifying new sources of revenue, or allowing fiscal drag to bring in additional resources.

27. **Prioritise public spending**: population ageing and other long-run trends are pushing spending priorities in particular directions – towards healthcare and pensioner benefits in particular - but there is often little debate about whether these are the right priorities over the long term. This should involve some tough questions about national strategic priorities and the trade-offs inherent in different choices. If we squeeze capital spending to protect the NHS budget will we have the right infrastructure to support jobs and growth? If we protect pensioner benefits but cut back on transfers to working-age adults do we risk damaging work incentives and pushing up poverty among working-age families to intolerable levels?

28. **Reform public spending**: continuing cost pressures in public services also imply the need for further radical reform to limit rising demand or reduce the cost of public provision. This could include increasing investment in preventative public services and further reforms to the state pension. Market reforms that limit the cost to the state of market failures like high private sector rents should be considered. In some areas, there may be a case for extending private provision, although the likely impacts on equity and efficiency will also need to be taken into account. Significant improvements in productivity in public services would help to meet increased demand without raising spending, but have proved hard to deliver in the past.

31 August 2012
TUESDAY 23 OCTOBER 2012

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope
Baroness Tyler of Enfield

Examination of Witnesses

Tom Josephs, Head of Staff, Office for Budget Responsibility, Kayte Lawton, Senior Research Fellow, Institute for Public Policy Research, Dr Martin Weale, External Member of the Bank of England Monetary Policy Committee and part-time professor at Queen Mary University of London, and Professor James Sefton, Professor of Economics, Imperial College London.

Q104 The Chairman: Good morning and a warm welcome to you and thank you very much for coming to help us with our inquiry. I am not going to go around our table. You see who we are and you might even have heard of one or two of us as well. We are sighted on who you are. So I will not, unless you particularly want to, ask you to introduce yourselves; but do so, if you feel that is useful, when you first speak.

As you know, it is being recorded. There will be a Hansard of it and so it is all on the record; not that that would change what you were going say, I am sure. We have quite a lot to cover and we had thought it might take about a couple of hours or so. If your diaries can allow that, that is what we provisionally thought and planned as our process. Clearly, if it needs longer, that would be good.

Welcome. Let me start off with the first question. In terms of how you respond, and clearly you will not necessarily want to run along the row because that would be a bit clunky, I am probably going to throw the question out and then leave you to see who grabs it first of all and then others can see if they wish to respond to that. It will probably be slightly different
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for Tom Josephs, because in a sense, Tom Josephs, we will be questioning OBR methodology and process. So you are almost going to be the respondent to some of the issues, I suspect, whereas others are going to be setting up. You may want to come in as a commentary at certain points, putting the record straight as you would see it or giving a gloss to what has been said. Does that work all right for you as a process that effectively I ask it to you and one of you respond and then another will come in if they disagree or feel they want to make the same important point? You do not all have to say an answer to every question unless you feel moved to. Does that sound over-engineered or can you cope with that? I am sure you can cope with that. Good.

Let me start off, then, with the first one, which is essentially about the OBR’s forecast of fiscal sustainability. Does it accurately show the impact of an ageing population over the next 10 or 20 years and are there any significant problems with the assumptions that the OBR is statutorily obliged to work with its methodology? Who would like to have a go?

Professor Sefton: My name is James Sefton. With Martin, we updated the generational accounts for the UK as of 2008 for the ONS. What I did yesterday was I compared the forecast that we did during that exercise with the OBR forecast published in July of this year to see where the differences were and to see whether I could eke out something from that. That is what I did.

The agreement is very, very high between our forecast and theirs, so there are no major differences. However, there were one or two that I want to highlight. Our revenue projections are very, very similar. Our projections of individual in-kind government expenditure—that is education, health, welfare transfers and such like. We also have very similar numbers to the OBR on those.

The major difference was in terms of collective expenditure. It was very hard to drill down into the numbers at that point, but what I noticed when we were doing the forecast is that government gross fixed capital formation expenditure—investment expenditure—is projected to fall quite dramatically down to 2015 and 2016. They are cutting it back very much in the spending reviews. The OBR has assumed that that low-level expenditure will carry on from there onwards, so as a fixed proportion of GDP that will remain exceptionally low going forward. That caused a major discrepancy.

In terms of what we are talking about, the intergenerational transfers—that is what we are focusing on today—within the OBR there is an assumption that investment has been cut quite dramatically, it will remain low and, therefore, we are effectively under-investing in UK plc in the future. Again, it will be the younger generations that will probably pay the price for that. That was in terms of the actual numbers. That is where I saw the big discrepancy.

In terms of the assumptions, when we worked on it over many years, labour participation was a key variable, particularly labour participation of the 50 to 65 year-olds. Again, the demographic is changing. Obviously, there is a lot of uncertainty around those numbers. I saw that they had estimated, using a cohort model, effectively over 1997 to 2008. Over that period, unemployment fell by about 2%, from 7.5% to just over 5%. You are estimating over a period where unemployment is falling. If you use those estimates, therefore, to project forward, you are going to get a slightly rosy picture of labour participation going forward. Obviously, that helps the revenues. It also helps in terms of expenditure because it reduces expenditure and that again makes the numbers look good relative to a more pessimistic assumption.

Productivity growth rates: that is another key number that comes into these forecasts. It is put at 2.2%. Again, I would like to think it would be 2.2%, but that is optimistic given the
Institute for Public Policy Research (IPPR), Office for Budget Responsibility OBR, Professor James Sefton, Imperial College London and Dr Martin Weale—Oral evidence (QQ 104-158)

recent history. There is an inflation wedge as well built into those forecasts. GDP inflation is forecast to rise at 2.5% and the CPI is forecast to rise at about 2% going forward. Tom will correct me if I am wrong, I am sure. That implies that you are expecting revenues to rise at 2.5%, the inflation rate due to the price rises, but expenditure is only going up 2%, so you have a 0.5% gain there. I think that is right. I am not sure. Productivity, labour and the inflation wedge were three assumptions that I would like to highlight.

Q105 The Chairman: Thank you. If you are right on your view, the reality could be slightly more difficult as a consequence as most of those, if your perspective is correct, have the effect of underestimating the forthcoming fiscal gap. Am I right on that?

Professor Sefton: I would think the risk is on the pessimistic side on those numbers. Yes.

Q106 The Chairman: Yes. Thank you. Dr Weale?

Dr Weale: Could I add to what James said in some sense with a prequel point. The general methodology that the OBR used is what I regard as standard. Obviously, as James identified, the differences emerge because people make different assumptions. You asked whether the forecast accurately shows the impact of an ageing society. I suppose, given recent experience of the difference between budget outturns and budget projections, anyone would be doubtful about using the word “accurate”, but, as I say, in broader terms the methodology is standard. While we can differ over the assumptions, I would not differ over the methodology.

Tom will be able to clarify this. There was one point that might work in their favour, but looking ahead, of course, the retirement age or at least the state pension age is rising and you might think that that would lead to more people working and, therefore, to larger income tax revenues. We should ask Tom to clarify whether that was built in or not because, if not, that would be something pulling in the other direction.

Q107 The Chairman: Shall we do that now? On CAPEX, Robert Chote told us in June, in fact, they had forecasts onwards from current expenditure. That is an extremely low level of capital expenditure, is it not?

Tom Josephs: Yes. It may be helpful if I explain a little bit about the general approach we take. The way we do the projections is that we need to make an assumption in the future on constant government policy over the 50-year projections. Our remit requires us to look at the impact of current government policies and not to look at alternative policies. The way we do that on items of public expenditure is effectively to assume that spending on those items essentially rises in line with overall GDP growth in the economy. That does mean that we take the shares of expenditure at the end of our medium-term forecast and then project those forward.

The way we do that is by looking at areas of spending rather than particularly at capital or current expenditure. We have breakdowns of expenditure by function—health, education and so forth. At the end of our medium-term forecast, we look at the share that those items of public expenditure have and then project forward on that basis. Then, on top of that, we overlay our demographic trends, which means that the actual expenditure in our projections will vary according to the demographic pressures underlying that.
Q108 The Chairman: On the two specifics: what James Sefton said about CAPEX and what Martin Weale said about participation rates—

Dr Weale: James raised the question. My question was about tax revenues.

The Chairman: Are they correct in that?

Tom Josephs: It is the case, because the Government are planning to reduce expenditure over the medium term and then we take that as the starting point for our projections. As James Sefton says, that is essentially locked into the projections going forward.

Q109 The Chairman: As we said, this is not a session to beat up the OBR. It is to try to get an understanding of the variability. Your remit by Parliament and statute is to take current policies and you can see why; otherwise you are into the rather difficult field of second-guessing politicians. The only thing we know for certain is that current policies will not stay the same and we are interested in the variability issues of those. In a sense, that leads on to the second of these two questions: the impact of an increasing number of older people on the demand for public services and the cost of services and the funding of public services. That obviously brings in the issue about the expectations we will have about quality and the cost implications of that. I do not think that is a question for you, Tom, but I would like James Sefton and maybe Kayte and Martin to have a go at that. All history shows that we expect to spend more on better quality public services as we get wealthier. Why will it not be different in the next 10 years?

Dr Weale: Assuming we do go on getting wealthier, I expect there will be continuing pressure from the users of public services for increasing quality. Of course, the fact that the users are not necessarily the people who are paying for them contemporaneously does mean that the normal mechanisms to make people think about how they would want to spend their money do not work in quite the same way.

Professor Sefton: In terms of pressure on public services, you can look at education first. There, with falling fertility rates, the pressures are probably mild. On pensions, again if you look back over recent history, the Government have had some success in controlling pensions. They certainly feel able to rewrite pension statutes quite regularly and there do not seem to be barriers to doing that. In terms of controlling pension expenditure, that seems possible as well going forward.

The big one is health, obviously, and health seems to be the one that is just uncontrollable. It is the one that can blow a hole in the finances. Again, if you look at the OBR projections, in annex B it did look at various alternatives. Certainly, when you look at history, at how much health expenditure has risen in real terms, it is roughly around about 3% over the last 20-25 years. That looked like the high end. If health expenditure carries on growing at the rate it has been doing, which includes rising expectations, the rising costs of drugs and everything, then that particular scenario looks probably more of a central estimate than a high estimate.

Kayte Lawton: I think that is true. One of the points the IPPR is quite keen to make here is exactly what you said; that as we get wealthier we want these things and it is not necessarily a direct impact of ageing, particular with regard to health spending. The actual ageing impact is perhaps overplayed, which can lead to a sense of, “Old people are a burden. There is a
looming crisis here”. We are quite keen to say that, as we get richer, we make a conscious decision that we want to spend more on these things. I think it is exactly right that that will keep on happening and there is no reason to suggest that it will not.

I just wanted to go back to one point about the assumptions in the OBR’s work. We, as a think tank, have not done lots of technical work on this, so I do not have the sort of input that James and Martin will have. We were just interested in the policy assumptions they made about up-ratings of benefit rates and tax thresholds, because they make an explicit diversion from current policy to up-rate those in line with earnings. There are good reasons to do that over the long term, but it is important to understand the impact that has on public finances.

The OBR, in its first long-term expenditure report, did modelling to show the difference that those assumptions make. It is something that we noticed and perhaps raised an eyebrow about why it had departed from government policy on that. It is important that the impact that uprating decisions have on public finances over the long term is taken into account.

Q110 The Chairman: Thank you. I will call Baroness Morgan in a second. Let me just close with one question that we picked up from talking to the demographers last week. We were obviously trying to get a picture, not simply of the numbers in certain age cohorts going forward in 10 or 20 years, but an understanding of the risk of morbidity in those cohorts. We asked the question: do OBR or the Department of Health make forecasts of the likely prevalence or increase of the chronic conditions that are some of the big cost drivers on the health system? At least, if you make the current assumption about current morbidity rates and look at the increased numbers in those cohorts, you could have a stab at looking at how many more people with dementia or other chronic illnesses there will be in the future. They thought that this was not done. Is that correct?

Tom Josephs: That it was not—

The Chairman: Did you do that or did you just deal in the aggregate with health expenditure, rather than looking at some of the big cost drivers of the system?

Tom Josephs: We have not looked in detail at individual costs of treating different diseases and tried to model that in the future, which is obviously a very difficult thing to do. We do have some analysis where we look at the issue of whether healthy life expectancy will rise in line with general life expectancy. In our core model, as life expectancy increases, life spent in ill health increases at the same rate, which is really a function of how the model works. Clearly, it may well be that as life expectancy increases also time spent in ill health decreases. We looked at producing sensitivity analysis of that to show the impact that it has on our projections.

It is fair to say that the impact that has on our projections is nowhere near as big as some of the issues that James was talking about around the level of productivity that you might see in the health sector. We agree with James that that is a very key issue for the future path of health spending. In our central projection, we assume that productivity in the health sector increases at the same rate as in the general economy and that implicitly means that the real provision of healthcare rises in line with incomes in the economy.
Q111 The Chairman: Why do you not assume that health productivity will continue at the same rate that it has continued in the past? That would be a more reasonable assumption, would it not?

Tom Josephs: We have looked in this report at that issue in quite some detail and it is certainly the case that the analysis that has been done by the ONS and some academic studies of productivity in the health sector suggests that productivity growth has been much lower than whole economy productivity. The ONS numbers, I think, suggest roughly flat productivity. Some studies suggest a bit higher than that.

I would say that measuring productivity in the public sector and in health is an extremely difficult thing to do. You have the issue of: effectively, what is output in the health sector? Some of the studies try to measure direct outputs—number of operations and number of consultant visits—and then attempt to adjust that for quality improvements, but it is a very difficult thing to do. There is lots of uncertainty around those estimates, which is why we have chosen to stick with a standard assumption of whole economy productivity growth but then show very clearly the consequences of something different happening.

Q112 The Chairman: You might, at another time, want to get a bit more under the skin of that because the cost increases of health expenditure, whether driven by volume or price, are reasonably apparent. Even if there were productivity increases, they are not necessarily going to be cost-saving productivity gains, are they? You have the potential for quite a significant divide, have you not?

Tom Josephs: Yes. You have certainly seen over the whole of the post-war period that nominal spending on healthcare has increased much more rapidly than most measures of real output from the sector suggest. It has clearly been a pressure in the past and is a key risk we identified for the future.

Q113 Baroness Morgan of Huyton: I shall be just a little more general, if I may. If I can go back really to the assumptions. Sorry, it is Tom again. Sorry, OBR. Obviously you have built in assumptions about the change in pension age. What assumptions, if any, have you built in about the number of older people working going forward?

Tom Josephs: On policy on the 50-year projections—this relates to the point Kayte was making on our assumptions on earnings and on tax thresholds as well—clearly, over the medium-term forecasts that we produce, for the next five years government policy is very clear and stated very clearly. Over the 50-year projections, in many cases government policy is not stated. Therefore, we have to make an assumption on what we see as a reasonable, constant policy assumption.

On pension age, that is an area where policy is stated quite clearly. We have factored in all the announced increases in state pension age. We do then make an adjustment in the way that the demographics work in the model, which means that more people will therefore be working around the state pension age, both in the run-up to the new state pension age and immediately after.

Professor Sefton: You said in the long run that you thought the unemployment rate would fall to about 5.2%. That was what you were targeting with your modelling. Given that we have gone through a crisis and you are now seeing a lot of long-term unemployed, there
always tends to be a lot of structural hysteresis in the labour market. A lot of old people—not old, but my age—will have dropped out of the labour market and, looking back at previous recessions, some of them are unlikely to get back into the labour market. Again, what you assume about that and whether they are going to get back can make a large difference in terms of the projections and revenues and stuff. It is a difficult job. I think it is an almost impossible job forecasting it, but it is an area of uncertainty.

Q114 The Chairman: If we wanted later on to get just a sense of how wide the span could be, if you just made adjustments to one or two of these highly uncertain variables, is that relatively easy work to be done? The modelling facility is there, is it, to be able to make different assumptions about health service productivity or participant rates in the economy?

Tom Josephs: Yes. Every year in our report, we—

The Chairman: If we took a view that we did not think the health service productivity was going to be as sunny as that, you would be able to tell us what the consequences of that would be.

Tom Josephs: We have done that in the report. We have a whole range of estimates of different productivities and the impact on spending in the sector.

Q115 The Chairman: We should do our homework and, if we cannot find it, come back to you then.

Tom Josephs: Yes.

Q116 Baroness Blackstone: I just want to pursue fiscal adjustment and fiscal planning. Assuming fiscal policies remain the same, and the way you work is assuming that government policies are current ones rather than alternative ones, how large a fiscal adjustment is going to be necessary to secure sustainability so that the ratio of debt to GDP does not get worse? I do not know whether you can produce such a figure. It will be interesting if you can.

Tom Josephs: We do produce those sorts of figures. The way we do that is we estimate something called the fiscal gap. What that does is tell you what the permanent adjustment you would need to make now in either tax or spending would be in order to hit a particular level of debt at a particular date in the future. In the report we show a whole range of these fiscal gap estimates for all the different projections that we do. To take an example, in our central projection, in order to reach a debt level of 40% in 2050, we estimate that you would need to make a permanent adjustment of 0.8% of GDP now. That would mean that you are alleviating the pressures on the public finances that are building up over that period from the demographic pressures that we set out in the report and, rather than debt rising, you would have debt reaching 40% of GDP.

Of course, in practice, you may not think it is sensible to make an immediate one-off adjustment in order to hit these targets, which are quite far in future, particularly given that these pressures are basically building up over quite a long time period. We also show that you can reach the same point, the 40% debt target, by making a gradual adjustment of 0.4% of GDP per decade over the next 30 or 40 years.
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Given the uncertainty in these projections, these estimates vary quite considerably depending on your particular choice of assumptions and your particular choice of demographic paths in the future. For example, the one we were just talking about, where we assume lower productivity growth in the health sector, the equivalent one-off adjustment would 3.2% of GDP; so much larger. It is important to emphasise that these projections are, as we have been talking about, very uncertain and so these estimates are also very uncertain, but they give an illustration of the kind of scale of adjustment that might be needed.

Q117 Baroness Blackstone: This is very long-term, if we are going to 2050, so it is not surprising the projections are pretty uncertain. If you were to do them over a 10-year period, how far does that increase the certainty, or are you still in the situation where you are very uncertain?

Tom Josephs: Recent experience shows very clearly that even very short-term forecasts are highly uncertain. One point to make is that any long-term projection is inherently very uncertain, but there are parts of the projections that we could have more confidence over. An example is we know that the demographic pressures from the baby-boomer generation will build up over the future and we can be reasonably certain that that will occur because that reflects events that have already taken place. Much more uncertain are all the other assumptions around longevity and migration and all the economic assumptions that we make.

Q118 Baroness Blackstone: All this work is not completely new. There must be some lessons to be learned from what has been done in the past. Can you tell us a bit about that?

Tom Josephs: Various vintages of population projections that the ONS has produced over time have moved about a lot. I think I am right in saying that the general trend is that the projections have generally increased over time. New vintages have projected higher levels of population in the future, but whether that will continue is very unclear.

Q119 Baroness Blackstone: Do the rest of you want to comment on this area?

Dr Weale: Another feature of the population forecasts, of course, has been that estimates of mortality rates have been revised down over decades now. The ONS has in some sense been trying to get ahead of the game. When I think of the problems of economic forecasting, I am quite glad that I have been involved in economic rather than demographic forecasting because the margins of uncertainty just seem to me so much greater. But it obviously does remain a major source of uncertainty.

The other point I would add is that the projections are assuming that the economy in some sense returns to normal after the crisis and, of course, that is something we have to bear in mind.

Q120 The Chairman: That is, is it not, the major immediate issue, because we are waiting with bated breath for the OBR’s next sustainability report. In December, is it—5 December or something like that?
Tom Josephs: Our next medium-term forecast is in December.

Q121 The Chairman: Yes. Without putting words in your mouth, it will be surprising if that shows quite as optimistic a picture as last year’s one. To a lay person—

Professor Sefton: I do add one thing. I do not know whether this is right. A quick equation, just to try to illustrate the uncertainty involved. It is a broad-brush relationship, but if you take the size of the primary surplus—that is the amount of revenues over and above the expenditures—how big does that have to be to support a certain debt to GDP ratio? There is a very simple relationship that the nominal interest rate on the debt minus the growth rate of the economy, in brackets, times the debt level to GDP roughly has to roughly equal the primary surplus.

The reason for bringing that up is to illustrate how important the interest rate and the long-term growth rates are in determining how much fiscal adjustment you are going to need, because if you pick figures that are in the OBR, that the interest rate is 5% and nominal growth is 4.75%, then R minus G is only 0.25%. Times the debt, you get a very small number, so it looks quite good. However, if you are less and, say, interest rates went slightly higher, 6%, growth never rose above 3%, and then you have the difference, less 3% times 80, which is 2.4%—I will correct that if I have that wrong—you get a much, much larger adjustment. The key point is it very much depends on your estimates of interest rates and growth rates. Those are the key numbers.

Q122 Baroness Blackstone: Can I just pursue that, too? Given the uncertainties that you have all emphasised, does it make any sense to try to have some sort of long-term plan to close the fiscal gap or should we just make incremental adjustments every year?

Dr Weale: It does make sense to have some long-term plan or long-term view about what needs to be done because in some sense the issue we face with an ageing population is how we are going to provide goods and services to people after they have retired and largely are not generating the incomes that they need to pay for them for themselves. People think of their own affairs. If you think, “I want to save up for my retirement so that I have something to live on after I am no longer working”, and you can apply the same principle to the public finances.

Could I make one other point, which was elided together: a stable or falling debt to GDP level over the sort of horizon we are talking about. I should have thought one of the major sources of uncertainty is whether there is another crisis like that that we have recently experienced. Even if you look back to the milder episode of around 1990, that had a significant effect on the government net financial position. As far as I remember, it was in some sense financed by asset sales rather than running up national debt, but you could imagine that if policy was simply to keep the debt to GDP ratio constant when there were not crises and then to let it rise during crises, you would end up with a problem. We need to have a long-term view of where we would like to be and we need to think not only of the sorts of marginal uncertainties that we have discussed but also of the possibility—I would not say more than that—that there would be another period of substantial economic disruption.
Baroness Blackstone: That is pretty convincing. Do you all expect further economic dislocation made worse by the huge pressures on public expenditure, partly from an ageing society? I am not sure that I agree that we can be as—I do not quite want to use the word “complacent”—pragmatic as you were about education expenditure. Fertility rates may have continued to come down a bit, but even that is not sure. We know from the very large increases in fertility in the immigrant population that there are now a lot of pressures on primary education in a city like London. Moreover, there may be a huge increase in demand for post-school education. At the moment, only 44% go to university and there is a demand for more apprenticeships and so on. I just want to get a feel for how optimistic or pessimistic you are on the general issue of dislocation.

Kayte Lawton: If we look back over the last 50 years, we have had a lot of population ageing already and we know that countries like the UK, the US and the Nordic countries are in quite a late stage of population ageing. We have not seen that rise leading to a continuously upward trajectory of public spending. We have not seen a fiscal crisis or the crisis of welfare states that were predicted. There is therefore no reason to think that the demographic trends and rise in national prosperity that we hope to have over the long term necessarily need to lead to a crisis any more so than they have so far.

If you look back over the last 50 years, what has happened is that policymakers and politicians have made choices about how money is spent and a lot of that has been dictated by things like ageing and demand for public services. That will be the same in the future and the question is how we as policymakers, politicians, citizens, make choices about that spending. There is possibly a slight danger of getting carried away with the OBR projections and thinking that they show you what will happen. The one thing the OBR projections show you is what will not happen, because policy will not be the same and people will make choices and change policy. I think those are the important questions, rather than saying, “We have this huge crisis building up and we need to worry about it”.

Lord Bichard: I just want to underline that, because that is where I was going. You are not making, any of you, a case for saying that our response to an ageing population should be driven by the projections. What you are saying is that we should, as with most public services, be trying to increase the productivity of healthcare and social care. We should be moving some of the costs on to the individual, whether that is through raising the pension age or whether that is, as we will come on to, through things like releasing equity and those kinds of activities. We should be concerned about improving the quality of life for all people, but not least people who are getting older. That is what you are saying. You are not saying we should all suddenly stop and realise there is a huge fiscal crisis coming at us that should drive our response to an ageing population because of the uncertainties.

Dr Weale: Sorry. You have described me as saying many things, and I suppose I thought of some more than the others. I should stress I am not commenting about the immediate fiscal position, but looking ahead it seems to me quite a strong case to say that a prudent public sector would run its affairs to allow for the risk of increased pressures coming later on. It would be likely, at least to some extent, to save up in advance and you might well say—in fact, it is quite a good argument—that because of the uncertainty involved, far from saying, “We should not worry about it and it is all just too uncertain”, because of the uncertainty involved, that strengthens the case for ensuring that we have something in hand should it be needed.
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If I could say more generally, over the last 20-25 years Britain has been one of the lowest-saving—this is looking at the nation’s saving, not just households—of the advanced economies and essentially it is because we have been a very low-saving economy that we now have worries about pensions and we have worries about all sorts of things. Again, as I say, this is not any comment at all about the current economic situation, but in the medium term the economy does have to be saving more. A part of that, I should have thought, would be likely to be the public sector thinking about what cost pressures and expenditure pressures might come in the future, even though and almost because they cannot be forecast with certainty.

Q125 The Chairman: Would anyone else like to comment on Lord Bichard’s suggestion? That was what you were saying, James Sefton?

Professor Sefton: You are absolutely right that we are getting hung up on the numbers; also replying to Baroness Blackstone’s comment. The point was you can show where the pressures are going to come and this is one thing that you can forecast. You can say that, even if education expenditure did rise, we are talking numbers of plus and minus 1% of GDP, whereas pensions is plus or minus 2-3% of GDP, whereas health is plus or minus 6% of GDP. You can see where the big changes or the real pressures are going to rise.

To follow on what Martin said, on our projections, because of the demographic change or the baby-boomers retiring in between 2020 and 2030, you can see, if we are going to have stable debt to GDP ratios, that you should be starting off that period with a very low level of debt. You should not be taking this 80-90% GDP through to 2020, because then you will possibly face substantial pressures.

Q126 The Chairman: That is, in a sense, one of the key issues—that the fiscal consequences of an ageing population by themselves are not that dramatic. It is much more about what the overall demand on the health service will be. The issue is that we look as if we will end the 2020s with a high level of aggregate debt and if we have a fiscal balance or a primary balance by then we will all be extremely pleased. We have, in a sense, used up the sort of caution that you have in the system by having a low level of debt to be able to absorb shocks in the system. It is a bit crude and layman, but is that broadly true?

Dr Weale: I would certainly say, having just had a big shock, the capacity for absorbing another big shock is much less than one would have liked. That is not because it is forecast. Shocks, by their nature, are things you cannot forecast.

The Chairman: Exactly.

Tom Josephs: Just quickly on the sort of general question: what is the point of these projections? I would say that we are very clear that there is a huge amount of uncertainty around the projections and that is why we try to be very transparent about all the assumptions we have made and show a huge range of different scenarios to show the implications of taking different judgments. People can then pick and choose the ones that they prefer. It is also clear that under most of those scenarios you essentially see the pressure from these demographic trends building up.

It is not as if that only comes through under some very specific assumptions. It is pretty much there throughout all of the scenarios we do and that kind of general trend and general
risk to the public finances comes through quite clearly. I do not think it would be very sensible to say, “Well, there is a huge amount of uncertainty. Therefore, we can just ignore these projections”. There is quite a clear message.

Q127 Baroness Blackstone: I am assuming, from what you are saying, even though, as Kayte Lawton said, it is a matter for policy choice as to what we do, that you would assume there will be very direct pressures as a result of demographic change in the current fiscal position on healthcare, social care, residential care and pensions as far as the elderly are concerned. I would just slightly qualify what Lord Filkin was implying, which was that there are pressures on health services generally, but so much of this comes from the elderly population. If you look at the proportion of expenditure on health on the elderly, it is a very, very large chunk of it. You would all agree that all of these services are going to be under considerable pressure.

Tom Josephs: Those pressures build up over quite a long time period, but yes.

Q128 Baroness Finlay of Llandaff: Can we just move a little bit to something that is perhaps the elephant in the room, which is the Dilnot Commission on Funding of Care and Support and where that is going and the size of the risk that the proposals may represent at the moment? Linked to that, I want to ask you whether you feel that the present levels of social care provision, in particular, can be maintained and, if they are, what the implications will be in relation to the quality of those. All the pressures are about driving up the quality and highlighting examples of poor quality, but the cost of that social care is a huge part of the expenditure from the health and social care budget.

Dr Weale: A general comment to break the silence. The services provided are different, but I do not see that as terribly different or distinct from the issues associated with the provision of healthcare. Of course, what the Dilnot commission did identify was some form of insurance for people who want to protect themselves or their descendants from the uncertainty surrounding how much social care will be needed. That has to be seen in the context where a lot of the dialogue at the moment is people using social care, particularly residential care, wanting other people’s children to pay for it so that they can leave legacies to their own children, which is an understandable biological equilibrium, I suppose. But, as I say, in broad terms, I do not see the pressure issues as being terribly different from those associated with healthcare, where there are the same points about quality: an increasing very elderly population and so on.

Q129 Baroness Finlay of Llandaff: I would completely agree with you, because where you put that line between what is so-called health and so-called social care is arbitrary and they are completely interlinked. It may be that the whole provision may need to renegotiate where that line sits. I wonder if you have any thoughts on that.

Kayte Lawton: Just small points on the issue of social care. I think what has been said is true. It is worth noting that social care is now a very small part of public spending and you can argue about whether that is right or wrong. It is much clearer that ageing pushes up demand for social care in a way that perhaps the relationship is less clear for health, but we are starting from a low base in social care. I do think it is important to look at the quality
issues. They are potentially different in healthcare and particularly the low wages and low quality that we have in social care. I would imagine that as we continue to age there will be more and more calls for quality to improve, which has to be partly about improving wages. There is a pressure there, but, taken as a whole, social care does not have the huge impact that something like healthcare or pensions have, just because we do not spend very much on it at the moment.

Q130 Baroness Finlay of Llandaff: Or is it that we are spending it but it is being put in the health budget, so it comes under things such as continuing care, inpatient care or care at home and it is being delivered, then, by people who are not regulated and who would really sit more in the social care sector? I am thinking about the care assistant; the care delivery.

Kaye Lawton: Yes. I am sure all of those things are true but I do not have enough expertise on the detail of social care to say much more.

The Chairman: Are there any other comments from the panel? No.

Q131 Lord Bichard: There is an argument that people should be expected to pay out of the value of their homes for some of the care that they need. Local authorities can already do that, but they do not do it because of the problems you might describe as bridging problems. You incur the costs now, but you do not get the value released until later. Do any of you have any thoughts on how that issue could be addressed? Should we be looking for someone to do the bridging? Who should take the risk and how should this show up in public accounts?

Dr Weale: In general terms, of course, mortgages do exist, although typically not in that context. In other words, there is not any obvious procedural difficulty in securing debts on property.

Lord Bichard: It could be an equity release arrangement.

Dr Weale: It would amount to equity release. No, I have not studied this. From what you were saying, I was wondering whether the issue was as much political as anything else; that is not politically popular.

Q132 Lord Bichard: What is not politically popular?

Dr Weale: Relying on a large scale on it. You said that local authorities tend not to do it. I found myself wondering whether it was not just that it did not create money upfront, a financing problem that you would have thought could be resolved.

Q133 Lord Bichard: How might it be resolved? Local authorities are having their budgets reduced by 28-29% over three or four years. They are not in a strong position to be releasing resources themselves. If they pay for additional costs in the hope that they are going to get some of that back in 15 years’ time, it is not an attractive option at the moment. Could the Government have some role in facilitating that?
Professor Sefton: On the equity release of reverse mortgages, from what I understand, the market is not particularly big at the moment. It is just not very big and, because of the risk effectively that you do not get the payment until the house is vacated, whatever the reason, there is considerable price risk there in these reverse mortgages and they tend to price in that risk at quite a high level. Therefore, there is a certain reluctance, as I understand from people in the industry, for people to take on these reverse mortgages. Again, this is a bit outside my areas of expertise, but maybe there is a role for Government in trying to reduce that risk. Certainly, if it can be reduced, then it would possibly push up the rates that people get on their reverse mortgages and that would expand the market. The market is, at the present moment, relatively small.

Q134 Baroness Finlay of Llandaff: Can we come back, then, with a different approach, just hearing Lord Bichard’s question, and that is whether you feel that, rather than there being a central policy about how the services, particularly care services, are funded, there is a subtext policy of, “Let it happen by stealth”, whereby, as local authorities get more and more squeezed, as NHS provision goes through the turmoil it is going through at the moment and people want to access more convenient appointments in a service that is becoming increasingly squeezed, they will on an individual basis opt out into private care provision. Allowing that to happen by stealth allows any Government not to have to take the political risk of declaring any kind of policy on the issue, but in the long term this drift out from public service provision into privately-funded, privately-provided provision to plug the gaps that people need is something that is going to happen. In the public sector, the regulatory framework will remain more than the actual provision on the ground.

Professor Sefton: It would be unfortunate if it was done by stealth because I think there is a lot the Government can do to get a better outcome. There is a danger, if it is done by stealth, that you do not get the best outcome. You get the one that nature sort of floats towards and there are some other questions on this list that I thought we were going to address about intergenerational transfers. That for me is a big question. When you do it by stealth, what is the intergenerational outcome that you will end up with and who will be the winners and losers in terms of the generations? Obviously, if you have an explicit policy, you can try to come to a better outcome than you would if you did it by stealth.

Q135 Baroness Finlay of Llandaff: That was one of the questions that I was going to pick up. Shall I pick it up now? How much should public policy take account of intergenerational transfers implied by current policy and should we focus more on these than on what the fiscal position is at any one point?

Dr Weale: I think we need to focus on both. There are many features of the political economy of public finances, which means that people may receive benefits in some sense at a higher level than their historic contributions to the public finances would have paid for and, of course, that is not magic. It has to be paid for by someone else. It is an intertemporal shift. The other substantial intertemporal shift in the economy that has taken place has been the increase in house prices and the way that transfers resources from young people to old people. I certainly think that in reviewing whether policies are desirable or not we should not simply be thinking about what we can afford today but also about whether we regard any intergenerational implications they have as being desirable.
Professor Sefton: I ask my students regularly in class, “Are you angry at the generational deal you are getting?” I am always surprised by the response. I get very few. Maybe they are just reticent. They do not hold up their hands. They do not seem that angry. They should be angry. I think the deal they are getting is poor. Martin mentioned that there are a lot of transfers going on within the system that are from the young towards the old and the awareness of it is very poor. We can break it down to that, but eventually it will come out. Land prices, house prices: that is one huge transfer. Then there is the rising Government debt, partly because we bailed out the banks and saved the claims. The claims belonged to the pensioners. They were in the pension fund. This was a large debt. You were again transferring the debt to the future generations to pay off. Unemployment is very high now. In the crisis, again, youth unemployment is the highest; so they are bearing the costs there.

There are a lot of big changes on education as well. The costs of education have been borne much more by the private than the public. That is another large transfer on to the younger generation. A lot of the transfers of the burden of this crisis are on the young and there are a lot of shifts in policy that put the burden on the young. Added up, it makes for a big, big shift and big, big transfers.

One attempt that we have had to look at it is a thing going on called the National Transfer Accounts. It is run by Ron Lee and Andrew Mason in Berkeley in the US. They try to look at these transfers and compare them across countries and see whether they differ. We recently calculated one for the UK. The transfers look at the difference at each age between your income and your consumption and somehow that difference between the consumption and income has to be financed. It can either be financed through public transfers, private transfers or savings. What you observe in the UK is that the percentage of that deficit when you are young is mostly financed through private transfers in the UK, a much higher percentage of private transfers than in any other European country; whereas the transfers in old age are mostly through public transfers in the UK. Again, we are on the high end of the range of countries there. You can see it in those numbers that the UK is not transferring, through public transfers, to the young. It is transferring to the old.

There are obviously offsetting mechanisms at work in the economy to say that it goes through the private transfers and it is going through the family and whatever. Again, that is the offsetting mechanism in the UK, but it is markedly different from some of our European partners.

Q136 Baroness Finlay of Llandaff: You say, though, that this will play out and at the moment the younger generation are not angry about it, but you are anticipating that they will become more aware and more angry. What do you see as the social consequences then of that anger?

Professor Sefton: I have not seen it yet. Maybe they will just put their heads down and work harder and make sure they are okay. Maybe it becomes an individual burden. I would not dare forecast that there is going to be a generational uprising.

Q137 The Chairman: Let us stay with the argument, because it is an extremely important one for us. Clearly, the argument that is put against is that the pensioners are suffering because quantitative easing has destroyed the value of their savings and their annuities; they did not go to university and the current generation does go to university.
Baroness Blackstone: Can I just ask a supplementary on that? We have often said that we ought to look at the distributional consequences of policy development, but we always look at it in terms of horizontal rather than vertical distribution; in other words, within a particular generation rather than inter-generationally. Is there something that prevents us thinking much more about intergenerational impact of policy change? I was strongly opposed to the shifts made in charging young graduates the cost of their tuition and higher education because it is highly regressive in generational terms. That has never ever been discussed properly and that is just one example of this. It is shifting the expenditure from rich, middle-age, middle-class parents, not so much the elderly, on to young graduates.

Dr Weale: No. In general terms, one hears the distributional comments after a budget day, “This has been bad for a family with two children, but good for an old aged pensioner couple”. Of course, the family with two children are going to turn into a pensioner couple. The more informed question is, “How does it affect different people over their likely remaining lifetime?” They are going to be very imprecise, like everything else, but those are the sort of questions that people have the techniques to answer. If politicians were to press for answers to those sorts of questions they could be delivered and they could be delivered without knocking a large hole in anyone’s budget.

Kayte Lawton: Yes. I do think in policy terms we do have a big problem in this country about how we do long-termism and how we get long-term priorities into our decisions about public spending. You can see that with the most recent spending review that we had where the NHS was protected, and pensions, and then capital spending is slashed. It is easy to cut back on those sorts of long-term investments where there is not that constant political demand that politicians feel they have to respond to. But we all know the long-term impacts of not doing that investment and that is problematic. I fear that those discussions are not properly held in the public debate, so people are not told about the impact of not building power stations and roads and investing in home building over the long term. Those things do not feature in the discussions we have.

I always think it is interesting to look at some of the Nordic countries and the way that they structure their spending. Obviously we know they spend more of the share of GDP than we do, but they also structure their spending in quite a different way. They invest much more in things like education, in training, in labour market programmes and in childcare. It feels to me that that spending is much more focused on long-term strategic priorities. 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”. The opposite of that is the US model where spending is really concentrated on pensions and healthcare and there are huge problems in infrastructure investment.

We need to do more work on understanding where that has come from in the Nordic countries, but you can see a real sense of long-term strategic priorities in the way that politicians structure spending and there seems to be some sort of consensus, politically, that that is the right thing to do. They spend less on healthcare and more on some of the pro-jobs-type policies. Perhaps, ahead of the next spending review, if there could be a much more open and public debate about our long term priorities, that would help.

We are talking internally about ideas on how to get the parties and governments to set out their long-term objectives and perhaps tell us in their spending reviews or in big policy announcements how what they are saying fits into long-term objectives as well as how it delivers short-term benefits. Some of those things are important, but it is difficult to do well.

The Chairman: It is fascinating and I would welcome spending another hour on it, but we should come at it from a different way through Baroness Tyler. Do you want to open up some of those issues on your questions?

Q138 Baroness Tyler of Enfield: Yes. The area I wanted to get into generally was the politics of all of this, by which I do mean the big and difficult choices that politicians of whatever hue have to take; how they take them and the political and public debate that surrounds them. I wonder if I could just start, Kayte, with the point you were just making. We were very interested in that bit of your evidence that talked about needing this clear set of national strategic priorities to help inform some of these longer-term decisions. I think I am right in saying you felt that should be very much informed by big democratic debate.

Two issues there: first of all, what stops that from happening at the moment? Secondly, would that not almost slow things down because of the time it would take to get any sort of consensus going?

Kayte Lawton: Yes. The first thing to say is that we do not have a perfect answer on this. We need to do more work on the democratic processes that you need in place. As I was just alluding to there, there are things that you can do around the big set-piece announcements, whether that is the budget, the spending review or the autumn statement where politicians set out their long-term priorities and explain how the decisions they are making today support that. There is a certain extent to which you are then reliant on those Ministers to do that and to be honest about the priorities and trade-offs. There is a danger that you will be told, “These are all our long-term priorities in every policy area and everything we are doing supports all of them”.

You have to make a case to politicians that they need to say, for example, if asked about a Nordic-style approach to affordable childcare, “We are going to invest in that for the long run and these are our arguments for why we think it is a good idea and that means, unfortunately, we are going to make some difficult choices about health or about pensions provision”. I do not know how you make politicians do that because there are obvious voting problems around some of that for them, but in time what we want to do is to make these arguments to politicians that they need to be doing that. Also, just having those debates in public will mean that voters will start to ask some of those questions, but none of it is easy at all.
Baroness Tyler of Enfield: Just to continue on this point. You did make the point about people voting and Professor Sefton may have thoughts on this. I just wondered how you felt about the extent to which the demographic changes are likely to worsen the overall fiscal position. We have talked about the degree to which that is going to be the case. Older people tend to vote more than younger people. What is the extent to which you think that makes it more difficult to take the measures that might need to be taken to try to address these fiscal issues? Do you think there is a mismatch in expectations between what the state will pay for and what individuals need to pay for and what people are willing to pay for in tax levels generally?

Professor Sefton: The trouble with the intergenerational question—we had it when we did the generational council and tried to communicate the results to people—is that it is a very, very difficult concept to communicate. In fact with the Treasury, when we tried to communicate it, we gave up. We simply did not get anywhere with it. What are the right measures that quantify the net transfers of a generation with the Government? Have they done well out of policy or badly compared to another generation? Coming up with a figure to quantify that is very difficult and, until you have those figures, it is very difficult to have a debate because people are not quite sure of the size of it.

The only work that I know of is John Hills' work in 1992 where he tried to identify the welfare generation. Which generation had benefited the most out of their net transfers with the Government? It was the generation born in the 1930s, I think, that he identified as the welfare generation. Then he comes up with a number in pounds and then you have something to quantify—you have a concept—and it will come out very clear from the numbers that the current generation and what they expect to transfer with the Government are very heavy contributors to the public purse whereas previous generations had benefited from the public purse.

Dr Weale: You mean current young people?

Professor Sefton: Current young people, yes. Current young people will be contributors whereas older generations have not been. Until you have those numbers to start on it is very hard to even get the debate going.

Q140 The Chairman: That did not stop you earlier, James, giving a very clear view that there was intergenerational unfairness going on at present, did it?

Professor Sefton: Yes, that is a very fair comment.

The Chairman: No, I am not being cheap because if we wait for the numbers we will never have a debate and it is important to have a debate.

Baroness Tyler of Enfield: Just to summarise what I wanted to ask: in terms of trying to reframe this national debate, do you think it is going to be more productive to focus on the focus that you have put on intergenerational inequities or possibly on the focus that Dr Weale put of taking a life course perspective and understanding what is going to happen to you through the course of your life and indeed your overall family situation, which has intergeneration aspects to it?
**Dr Weale:** I do not see a clear distinction between them. What is going to happen to current young people over their life course reflects the history of these generational transfers. They are, more or less, two different ways of looking at the—

**Baroness Tyler of Enfield:** It is two different ways of coming at the same thing.

**Dr Weale:** Explaining both of them to people would be helpful and saying, “There has been this transfer and this means that, even though you earn X, you are only going to have Y to spend because a part of it is going to be transferred to the generation who are doing well out of the welfare system”.

**Q142 Baroness Tyler of Enfield:** None of this is easy territory, as you have all acknowledged, for any of us to get our heads around. Is there a way of doing it other than trying the approach, “You should be getting very angry”? Is there another way into this debate?

**Lord Bichard:** May I add a supplementary to that? I was really struck by Baroness Blackstone’s comment about tuition fees. I had not thought of it in quite the same way. What is there that we can learn from that? That was an example of expecting a group to make a much greater contribution to a public service. It was sold, in so far as it was sold, or it was imposed on the basis that universities needed it and you, the individual, were going to benefit a great deal in your later life by the economic benefits of it. It was not absolutely popular but it has happened and the world has not come to an end. Are there things that we should be learning about that shift towards the individual for the payment of a public service that we could apply to older generation?

**The Chairman:** Yes, it is a good question. Can we take it as a separate question; otherwise we will lose the first one?

**Lord Bichard:** It is a comment really, I suppose.

**The Chairman:** Can we come back to that after we have dealt with the previous one, otherwise we get wreckage. You cannot answer two questions at once. Mike. Will you come back to that when we have had that one? Claire, I have forgotten your question now.

**Baroness Tyler of Enfield:** I think it was about—

**Lord Bichard:** It was meant to reinforce the question.

**Baroness Tyler of Enfield:** Given that this is tricky stuff for any of us to get our head around, is there a way into it that makes it real for people other than saying, “You should be getting very angry about this”, which is obviously one way of doing it?

**Professor Sefton:** Martin touched on the key issue when he said that we should look at the houses of old people and the transfers. That is the number one issue. Housing is the number one store of wealth. There is a strong feeling that that should be protected and that it is their right to pass that on as an inheritance to their children by private transfer. So it is keeping it in the family rather than making it a public transfer—forcing people in some way to use that wealth towards their health and therefore saving the taxpayer money. Therefore, redistribution again to the younger generation is done through public transfers and hopefully the distributive consequences of that will be a better outcome. That is the key issue: the housing and what the housing does, because that is the major store of wealth.
Q143 The Chairman: If you are thinking about intergenerational policy, just because there are intergenerational policy effects, it is pretty obvious, is it not, that younger people will work longer than was the case ten years ago and that the state pension age will rise even further than current projections? You do not need a big guessing machine to get there. You could therefore argue that it is fairer that the current older generation have some of that consequence accelerated to them, politics apart, so that they are also contributing towards their own care. Would not another mechanism for addressing the issue be that you raise the state pension age earlier and that you push policies to increase labour participation for older workers more vigorously?

Professor Sefton: We are all in it together.

The Chairman: Yes.

Dr Weale: It is certainly true that if expenditure exceeds income there are two things you can do: one is to do with your expenditure and the other is to do with your income. Raising participation rates of old workers is a way of raising both the Government’s tax revenue and the nation’s income.

The Chairman: Okay. Lord Bichard, you cannot have forgotten your question?

Lord Bichard: Is it the supplementary one?

The Chairman: Whether it was supplementary or not you were clear what you wanted to ask, so do have a go.

Q144 Lord Bichard: Are there lessons that we can learn from tuition fees? You are making the point, which is absolutely right, that a lot of older people are sitting on quite a lot of wealth. We are making the point that the cost of health services, and social care in particular, is increasing. We are making the point that, in generational terms, although it is a difficult debate to have, the younger generation have probably suffered more than the older generation. Could not the same case that was made on tuition fees be made through a public debate for older people to carry more of the burden of their care? How can we do that better?

Dr Weale: No. Hearing you saying that, I was thinking of the issue of when people are expected to use their homes to pay for residential care and the sense that that was what led to the Dilnot commission. That is a politically sensitive issue. One can extend that politically sensitive issue to a wide range of other public services but, of course, that will make it more and more politically sensitive. If there were to be greater means testing or means testing of provision of a range of services you would have many more unhappy elderly votes.

Q145 Lord Bichard: No one says it is going to be easy, but we cannot leave it there. We know the politics of this are quite difficult, but the politics of tuition fees was pretty difficult, too. People always talk about means testing. They do not talk often enough about taxing because that is another way of getting to the issue that may be more acceptable. What we are trying to explore is: are we going about this in the right way? Are we framing the debate in the right way? Are we missing a trick here? It is all very well us talking to you about the fiscal consequences of an ageing population. One of the major fiscal consequences of the issue that we have is that there is a lot of old people sitting on quite a lot of money. Not all of them, but some of them are. Surely one of the issues is how we can engage with that group about how that money could be released for the benefit of everyone. Are we going
Institute for Public Policy Research (IPPR), Office for Budget Responsibility OBR, Professor James Sefton, Imperial College London and Dr Martin Weale—Oral evidence (QQ 104-158)

about the debate in the right way? I know it is a difficult debate, but it is not enough surely to just say, “It is a difficult debate”.

**Dr Weale:** That is really an issue for politicians to do the engaging, not—

**Lord Bichard:** We are all in this together, though.

**The Chairman:** Just to keep score, Baroness Morgan was signalling and then Baroness Shepard. You wanted to come in with your question did you?

**Baroness Shephard of Northwold:** I wonder if I could come in with my question, because I do have to go at 11.30am.

**The Chairman:** Please do.

**Q146  Baroness Shephard of Northwold:** I predicted before you came that you would certainly say, when it got very difficult, “This is a job for politicians”, because actually it is. Of course it is. In what sense do you think there is not at the moment a public debate? It does seem to me that on every channel at every hour and in every newspaper and every day there is something about this issue: about how are we going to deal with an ageing population, increasing health needs and so on. I believe there is a public debate, rather as there was, shall we say, on badgers. There has been the public debate and there was a decision and today I see on the monitor there is going to be another decision. What do you do? What would you call a public debate? There is one, I think. You might be able to give advice, if not to politicians, on how to make the choices or at least how to step up the debate and make it relevant to people. I feel there is one. I feel that people will, of course, take sides according to their own interest, which voters always do, understandably. But, as Lord Bichard said on the fees issue, in the end the Government said, “Right, that is it. We have listened to the debate”. But there was a debate. How do we do it? It was in Kayte’s submission from the IPPR that there should be a debate. How should it be done?

**Kayte Lawton:** Those debates tend to be about:- particular policy choices around tuition fees or how we deal with NHS. They are not sufficiently tied to a sense of what—it sounds a bit grand—our national strategic objectives are; by which I mean: what do we want to be doing as a country? We have a very difficult economy at the moment. Everyone is very aware of high levels of unemployment and those sorts of problems. Do we want to, as a country, prioritise jobs and growth? Not just as an emergency response, but over the long term? Do we want to look like Sweden or Denmark, which have the highest employment rates in the world and, because of that, very dynamic economies and better living standards? I would say those are the sorts of things we should be prioritising and that means you have to make some choices about other areas of services that are incredibly popular in the short term.

It is the role of politicians, but it is also the role of people like us to make this case to politicians that they should be doing this and to set out what their priorities are and then we can have an election based on those priorities. If there are parties with different priorities we can choose the ones we want. When we talk about things like tuition fees I do not have the sense from politicians about where they see the higher education fitting into our priorities or where they see health spending and NHS fitting into our priorities in a long-term sense. It is all quite short term, appealing to different groups of voters. I know they have to do that and that is completely understandable, but some sense of long-term priorities—employment, jobs, living standards, things around childcare, and supporting
families to deal with difficult choices—are all the kinds of things that I would be looking for those politicians to be prioritising.

Q147 Baroness Shephard of Northwold: It is interesting that you say all these things because, to my ear, that is what all politicians of all parties are saying all the time. They are talking about jobs and growth. They are talking about childcare. They are talking about long-term prosperity. They think they are doing it. I am one, but that is what they think. How can it be done better so that it is clarified for voters, because it is such a valid point? The way we take public opinion is through elections, of course. How can it be done better?

Kayte Lawton: They do talk about it, but if you look at the structures of public spending it is not set up in a way that does that. I would think, as a think-tank, that I want to be out there saying that to people and that being in the press and on the news. Then eventually, if lots of people do that, voters will be saying to politicians, “Well, you are not backing this up”. We are still having a situation where the NHS is taking up a huge amount of our budget, where benefits that perhaps are not completely focused on work and jobs are taking up a lot of our spending. We are using the benefit system to plug holes in things like rents, childcare costs and low wages rather than having a proper strategic review of what is driving up costs in those areas and proper reforms to bring those costs down. All of those things are not happening. You are right, there is a gap between the rhetoric and the action, but it is probably incumbent on people like us to make those arguments to drive forward politicians in these areas.

Professor Sefton: Also, the debate has to be changed. If you look at the education versus the healthcare thing, to paraphrase slightly, people say, “I have worked the whole of my life. I should be looked after when I am old”. For young people they say, “Well, you are going to get the benefits of your education because you are going to earn more. Therefore, you should pay towards it”. Alternatively, you could say —

Baroness Shephard of Northwold: I could add, “and what is more, I did not have the chance you have”. They could add that to young people.

Professor Sefton: Or you could change the debate and say, “Look, if you are a responsible adult you should make provision for your old age, so you should be able to look after yourself. The young people are going to be the future of the country and therefore we should invest in them.” But that is not the terms of the debate. It is the former, not the latter.

The Chairman: Other comments on Baroness Shepard’s question and on Kayte’s gloss on it?

Dr Weale: I suppose the debate, as James said, is conducted in very general terms and not in the sense of what the intergenerational transfers that we mentioned a moment ago are. In an environment of generally rising prosperity, you can produce an argument that there ought to be some sort of transfers from young people to older people, but I suspect it would be harder to defend those on the scale that we have seen them. People talk about their priorities, but not very much about the implications of those priorities and who gains and, more importantly, who loses from particular choices.

Q148 Baroness Blackstone: What underlies some of this is the need for very, very substantial cultural shifts in attitudes. We are all in it together, as you said. Of course,
politicians have to play a very big part in that and they have to be braver, more courageous, in some respects, but that is quite a hard question to ask them to pursue. It is also important that those who shape policy through doing the analysis and looking at the consequences of different kinds of approaches and so on try to work on these issues as well, along with journalists and the broadcast media. Asking the question, “Should there be more employment among older people”, has to be turned from, “They are going to make me go on working and I had expected to retire when I was 60”. Also, working is a very positive way of spending time in your 60s and indeed your 70s: first, you will earn some money; secondly, you will have a lot of contact with the rest of the world; thirdly, you will have something interesting to do; and you are more likely to be healthy as a result of all of these, both mentally and physically and so on. I am just giving you one example of this.

These are the sort of issues that need to be challenged. Civil servants should be thinking about them, as well as Select Committees like this, and people should be writing about them. It is challenging pre-conceptions about what will make for a happier and more satisfactory life, because not working at all from the day you are 59 and a half is not going to necessarily make for a happy old age. That is one example.

**Dr Weale:** Perhaps I may add a bit of substance to that. An interesting study in the United States showed that a change in state pension arrangements meant that a slightly younger cohort was somewhat disadvantaged. It was found—or at least the study suggested—that their mortality rate declined relative to that of the people just older than them. The author suggested that the effects you described were in place.

**The Chairman:** Can you send us the link for that?

**Dr Weale:** Yes, I can.

**The Chairman:** Thank you. Other comments on Baroness Blackstone’s question?

**Q149 Baroness Finlay of Llandaff:** I should like to follow up on that. I am just reflecting on the history of the university fees debate. Initially it was kicked off, if I recall rightly, by some vice-chancellors who saw their Higher Education Funding Council for England income not necessarily keeping pace with their costs and, therefore, by charging fees, that would become a way forward. In a way, the group who had a vested interest in maintaining the institution of the universities began to kick off that debate. If that is the case, as seems to often happen with these debates in politics, who would be the people who would have the vested interest in kicking off this debate along the lines that Baroness Blackstone has outlined about working longer and shifting responsibility for old age? Would it in fact be your organisations?

**Dr Weale:** I was thinking you would ask the question: which generation, which cohort, would have the interest? Of course, as far as I can see, the cohort is the cohort that has a low voting rate and tends not to be very politically engaged. That, to some extent, explains the current terms of the debate.

**Baroness Finlay of Llandaff:** Exactly, but they are so disparate that it takes a critical mass of people coming together to begin to articulate the arguments around it.

**The Chairman:** I wonder if we should leave that hanging for a second and come back to Graham Tope’s question. Then we have a few minutes to come back to other issues that either you want to make us think about or that we want to test you on.
Q150 Lord Tope: I just have a contribution to the last bit. It is about managing expectations. Most of our generation have grown up acquiring wealth, much of which is invested in our home, and we expect that we are going to leave that to our children or else it is going to be available for us to travel the world or whatever we want to do. We do not believe that we worked hard all our lives and acquired our homes in order to transfer that money to a care home or to our care and our children naturally are expecting that as well. To some extent it is about changing that expectation. If we have moved to assuming and accepting, fairly or otherwise, that people are going to have to pay for their university education then perhaps we need to be doing a bit more about getting people to understand about paying for their care when they are too old to look after themselves. If you look back not very many generations that was a family responsibility anyway. It is only fairly recently that that has changed.\(^{197}\)

Sorry, Chair, I will get back to my question now, which is headed, “The Scale of the Challenge”. We have probably been on that all morning. Do the UK’s past experiences of fiscal adaptations to ageing give clues about how manageable the current demographic challenge might be?

Dr Weale: One example I would give relates to the late 1970s and early 1980s. People started to worry about demographic influences on ageing and the old age pension was indexed to prices instead of wages, which obviously led to substantial savings. At the time the Government thought that people would adjust to that. They would gradually build up private savings to make up for the fact that they were getting less out of the state pension than they might have inferred.

But, in fact, at least the way I read it, the policy proved to be unsustainable so in 1997, when we had a change of Government, the new Government introduced the very popular policy of pension credit. One can see it in different ways, but in some sense that was filling the gap that had arisen because the state pension had not grown as rapidly and people had not behaved in the way that had been hoped. If you rely on people to do things for themselves and you do not help it happen then you may well get to a situation where, as then, the policy becomes politically unsustainable. Any policy does need to be very carefully handled. Not only do you need to get people to think about it well in advance but you need to have mechanisms in place to make it easy for them to do more than just worry about the implications.

Kayte Lawton: Just to follow on from that, there is an interesting point about understanding that demand for some of these big public services and cash transfers will be there regardless of how much the government of the day decides to allocate to those things. Just because public spending is cut back or we find ways to make reforms that perhaps reduce spending on things like health and pensions does not mean the demand is not there and then that gets filled in by private spending. You can see a very close relationship between private and public spending, particularly on things like healthcare. You just have to be very aware of the kind of implications of that, both in terms of equity and also efficiency, and whether private spending is ever going to be as efficient.

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\(^{197}\) Subsequent comment by Professor James Sefton: “There are two more demographic trends: a) Younger generation staying at home for longer b) But more worrying, though not as marked – skilled young labour migrating for better opportunities. Evidence of a shift in the generational contract.”
Institute for Public Policy Research (IPPR), Office for Budget Responsibility OBR, Professor James Sefton, Imperial College London and Dr Martin Weale—Oral evidence (QQ 104-158)

There is a reason that we do some of these things publicly. It is not just because it achieves better outcomes for people in terms of equitable outcomes but also because it tends to be a more efficient way of providing these things. John Hills of LSE has done lots of work on this looking at various pension reforms. At times when Government have tried to pass on more cost to individuals and employers, that has not had the success that they thought it would do because the market is not there. The market is not willing to take some of those risks. I just think that is an important point when we are thinking about all these issues: the relationship between private and public and spending.

Tom Josephs: In terms of this scale of challenge, post-war social security spending has basically been on a pretty steady upward path, as has health spending in the UK, mainly driven not by the demographic pressures that we are thinking about for the future but other factors. Essentially social security has risen because of increases in the generosity of the system and healthcare has risen mainly because of increase in demand for better care. The pressures that we are thinking about for the future are different from the ones that we have seen over the past.

In purely fiscal terms rather than the distributional questions that you have been talking about, 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—in the medium term in the Government’s fiscal consolidation plans—is much greater than the one that we are talking about for the future.

Q151 Lord Tope: In their written evidence to us the Fabian Society argued almost that: that given the scale of change since the Second World War, the scale of change to be needed is quite achievable without too much difficulty. Are you agreeing with that?

Tom Josephs: As I say, these pressures build up gradually over quite a long time period, which does mean that there is plenty of time to make these adjustments. Certainly the scale of those adjustments does not look that large compared to adjustments that have been made in the past or are being made now.

Q152 The Chairman: Is there a problem or is there not in terms of the fiscal gap because of ageing?

Kayte Lawton: I would go back to some of the points that I was trying to make about priorities. I do not think there is necessarily a huge problem about the sort of overall amount of spending that we could expect to see. The real challenge is how those demographic pressures and rising prosperity drive the particular structure of our spending. If we look back over the last 50 years we have seen a very rapid rise in social security and overall increases in healthcare spending and at the same time defence and capital spending has been cut back, partly to pay for that. Obviously that has long-term implications that I do not think, as I said before, have been properly taken into account. The real question is how those drivers shape choices about public spending rather than a sense that there is any big fiscal gap created by ageing.

Q153 Baroness Morgan of Huyton: I am on to question 9. We have gone all over the place and we have touched on some of this already. It is about the tax and benefits system. I
am just wondering whether you can talk a bit more about any possible change you see that would be useful in the tax and benefit system. I am slightly wary that we say quite glibly, “Well, it is good to increase the pension age. That will get more people working. So that is going to be good for the fiscal situation. It is good for everybody’s health”, and we do not recognise that there will be at least a body of people who cannot get jobs. We are seeing older women at the moment finding it very hard to get work and they probably will not get back into the labour market. Even if more people are able and fit for a lot longer, there is nevertheless a group who are not. Therefore, if we just automatically keep shifting the pension age up, are we then increasing the benefits bill for another group or are we just going to give up on that group?

We had a brief conversation last week about flexible retirement. Everyone says, “Yes, that is a really good idea”, but has anybody done any serious work about that and is that remotely a runner? How can we make the tax and benefit system assist people to work longer and encourage people to work longer while recognising that not everybody can do so?

**Dr Weale:** On flexible retirement, I cannot quote any particular study on this but I have heard people say that in countries that try and have flexible retirement nearly everyone retires at the earliest opportunity. Of course, that in part depends on the terms. I do not know of evidence to suggest that the terms on which people can defer the state pension have a significant impact on people’s decisions to go on working beyond the state pension age. More probably that is just seen as a form of financial planning. People bet on their own life expectancy or look at their parents and ask whether it will give them a good deal.

I am not sure what can be gained from flexible retirement but in some sense the issue you raised is slightly different from that. It is: how much and how generously do we support people whose health is poor and who find it very difficult to work for one reason or another; and how do we manage to do that without encouraging people who are perfectly capable of work to take advantage of that? Of course, that is the classic problem in designing a social security system. The move to the universal credit is intended to reduce some of the distortions but there is the general problem. If you withdraw benefits only gradually then you can easily find that you need to put more money into the system. That is not unique to the issue of retirement. I would say that that is a more general problem and we do have a major policy change coming whose effects we will then be able to study.

**Professor Sefton:** I cannot give you the exact paper but work has been done by the IFS on the sensitivity of people to changing tax incentives at retirement or from the ages of 50 to 65. The econometric evidence is that they are quite sensitive to those changes in incentives. There is an opportunity there for various tax changes. The obvious ones are to make the contributions into the state pension more valuable when you are older. Also the tax-free limits on contributions into private pensions are already age related but you can exaggerate that relationship. You can make it more pronounced, so again increasing incentives. Again it is not going to be a massive difference, but there are at the margin things that you can do. Yes.
employers who see this as, “No, we would like to get shot of them all at 65”. I am being crude, but there is not a great willingness to think that this is an important agenda. There are exceptions—some of the supermarkets—but by and large this is seen as a problem rather than an opportunity by employers. I am putting it rather crudely. That is one of the issues that has to be shifted: the attitude of employers to flexible work and longer working. That is pivotal to addressing these issues. Do you agree or not?

Kaye Lawton: Yes, I definitely agree. I have done less work on keeping older people in the labour market but there are some interesting arguments. Professor Paul Gregg makes the point a lot that there are potentially regulatory changes that you can make to improve labour supply essentially among people where that is weak at the moment—mothers, disabled people, and older people. He talks a lot about some of the maternity leave reforms where you are using regulation to encourage women to stay in the labour market—giving them the maternity rights and so on with which to do that. It is difficult to shift employers’ attitudes in an abstract sense but you can use smart regulations to open up opportunities for part-time work, for flexible working, for parental leave policies and so on. Over the long term they could have an impact. At the moment the politics are difficult there because of the economy and some of the political debates that we have about labour market regulation, but I do not think we should let that stop us. There are some interesting avenues there.

The Chairman: Thank you.

Q155 Lord Bichard: Sorry, Chairman, and this may be completely off the wall. I just worry sometimes that we are not as imaginative as we might be. Are there ways in which we could use incentives to encourage older people, if not to be in full-time work, to be making a contribution back to society? It is, for example, quite possible to envisage a world where civil society is making a greater contribution to the care of the very old and older people who are not very old could be making a very useful contribution to civil society in that respect if they were given some incentive or some recognition for doing so. I am not sure what it might involve but we are now prepared to say to people who are not looking for work, “If you do not look for work you do not get a benefit”. If you are old and you are not contributing in some way or another, maybe some penalty should be attached to that. These debates never seem to me to take place and I wonder why. Are we using all of the incentives at our disposal to encourage older people not just to be a negative burden on the state but be a positive part of society?

Baroness Blackstone: Should we also be thinking about ways in which we can incentivise employers more? You talked about regulatory ways of doing so, but your examples were about younger women and therefore not terribly relevant to this. Are there regulatory approaches in relation to employers’ behaviour with respect to older employees or are there other ways of incentivising them as well as the sort of things that Michael Bichard was talking about in relation to the elderly themselves?

Kaye Lawton: This is more for people with long-term health problems, which is often older people, but one thing off the top of my head is whether they can have some right to retention or 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. When people hit these crisis moments in their 50s they often drop out of the labour market and they do not come back. That is just one example. You could look at the kind of reforms that have worked in improving mothers’ labour supply and
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look at whether there are ways in which they could then be applied to people with health problems and people who are older as well.

**The Chairman:** Other comments on either Lord Bichard’s or Baroness Blackstone’s question.

**Dr Weale:** I have two comments. First, of course, Lord Bichard was suggesting a range of incentives outside the normal range that is discussed. That was an interesting point.

On the issue of changing employers’ attitudes, of course, we do have to wait to see the effect of the abolition of a fixed retirement age. One might think that that would be something that would be likely to change employers’ attitudes and, of course, participation rates by old people have been rising recently after a long period, down to the late 1990s when they were declining. That process has been reversed. A part of it is people thinking about how they are going to pay for retirement but I should have thought that it must also point to a slightly more sympathetic working environment as well.

**The Chairman:** You will be almost relieved.

**Q156 Baroness Finlay of Llandaff:** I thought you were just winding up on that. I was struck when you were talking, Kayte, about the expectations in society versus the age shift in society. I wonder whether you have any way of weighting the difference in the economic pressures that will be brought by the much higher expectations of the generation that is coming through now from the way that they live and the services that they should obtain versus the overall apparently lower expectations of the cohort that are currently much older.

**Kayte Lawton:** No, I have not done a huge amount of work on those questions about expectations. I am mainly drawing on the kind of OECD studies that look at the way in which, at the national level, income affects demand for things like healthcare relative to the impact of ageing but we have not looked much at shifting expectations. It has not been part of our work, I am afraid.

**Q157 Baroness Finlay of Llandaff:** My other thought was in relation to your comment that in those areas where people have been given the option of flexible retirement, they all go flexibly early. That is an all around expectation. How does one shift that expectation so that they would want to stay there for longer? There are some parts of society—the university sector in some areas is a classic—where those who have retired continue to contribute on a notional, sessional basis and probably contribute far more, particularly in the teaching arena and mentoring. It may be one session a week but they may be running several tutorial groups and doing quite a lot and remaining active in sharing their expertise. They become very cheap in the system.

**Dr Weale:** Yes, I suppose I would caution against thinking that it is easy to generalise from the people who work in universities. They typically love what they are doing and want to go on doing it.

**Baroness Finlay of Llandaff:** There are people in healthcare who love what they are doing, even at what you would term a low level. There are some domestics who are devastated at having to retire because they love going into the hospital and working.
Dr Weale: Yes, but equally you would probably find that the proportion of people who want to carry on until they drop is higher among academics than in most other occupations.

Q158 Lord Bichard: Then you need to look for incentives to encourage them to do so if you are going to get the kind of intergenerational transfer that you have been talking about. We have a behavioural insight unit in the Cabinet Office that is supposed to be looking at how we encourage people to change their behaviour and maybe, since this is one of the biggest policy challenges that we face in this country, they ought to start turning their attention to this issue rather than some of the other things they were looking at.

Dr Weale: I should expect that the increase in the state pension age will have a very perceptible impact. With the increase in women’s state pension age there were some hints that maybe participation above age 60 was rising even before the pension age went up. I do not know how far that view has survived the decision but not getting a state pension is quite an incentive to go on working.

The Chairman: Thank you very much indeed. We have had two hours of you. I think it is one of those many transcripts when we will want to look and think about what you have been saying to us and may require us to do some more serious follow-up work on it. Thank you for your good humour in coping with us as politicians at times asking you as economists to answer questions for politicians, but that is the nature of outsourcing and how it works. It has been extremely helpful for us, even if at times probably slightly frustrating for you. Thank you very much indeed.
Ipsos Mori, Social Research Institute—Written evidence

1. Does our culture about age and its onset need to change, and if so, how?

1.1 Anecdotally, Ipsos MORI’s research suggests that there are many misconceptions about what it means to be older in this country. For many, being ‘old’ is a state of mind related to your health and ability to remain independent, rather than a ‘digit’. The public does not necessarily associate being ‘old’ with retirement age or being in your 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. A recent survey for Love to Learn198 of adults aged 50+ reveals that when asked when middle age starts, the median answer was 55 years old. It also shows that Britons did not see themselves as elderly until they are nudging 70, which suggests that the concept of ageing is changing.

1.2 At the same time there is a common view amongst the public that the state will provide for them when they are older, and as such people, particularly younger age groups, give little thought to planning for their old age. 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.

1.3 Deliberative research carried out for the Department for Work and Pension (DWP)199 in 2007 suggested that some members of the public are not fully aware of the challenges posed by demographic change. For example, the ramifications of increasing life expectancy were seen to be related more to the burden this would place on the NHS (e.g. the increased need for specialised care and treatment) as opposed to welfare provision. But, on being forced to deliberate and discuss the issues and challenges, participants in this research did raise concerns about what this all means. They were concerned that there will be fewer funds available to fund the state pension due to diminishing revenues from taxation, and that the state may be unable to continue to pay the state pension in the way it does currently.

2. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

2.1 Given the ageing population, there is a need for a more fundamental review of how we plan for getting older in this country. The age of retirement has already been increased, and the government intends to implement automatic enrolment into workplace or government pension schemes as a way of encouraging people to plan financially for their retirement. At the same time we have seen the reporting of Andrew Dilnot’s commission into the future funding of the social care system.

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198 Middle age begins at 55 years, survey suggests, 18 September 2012, Love to Learn featured in http://www.bbc.co.uk/news/education-19622330

199 Ipsos MORI (December 2007): The challenges facing DWP in the future: Deliberative research with the public. Research study for the Department for Work and Pensions
Ipsos Mori, Social Research Institute—Written evidence

2.2 Ipsos MORI research demonstrates that the extent to which people feel positive about retirement seems to be largely determined by age. A qualitative study for DWP on the future of pension provision200 showed that younger participants in their twenties and early thirties felt more confident that they will have a comfortable and enjoyable retirement than older participants who were more likely to report feeling worried about retirement.

2.3 None of the participants in their twenties had started to save for retirement, either because they felt it was too far away to think about, or because they said they could not afford to. Younger participants tended to have other priorities for their money such as repaying student debt, socialising, saving for travelling or buying a first home. There was also a feeling that saving for retirement was something which they would do when they earned enough.

2.4 Conversely, for older participants, the affordability of saving for retirement was less of a worry – these participants tended to be more concerned about whether it was worthwhile to save for retirement at all, and if so, what was the best way to save.

2.5 As well as age, it is those in higher social grades who are more likely to be positive about saving for retirement, and property appears to be considered the most attractive way to do this.

2.6 Our research has also demonstrated a lack of understanding amongst the public, both about the State Pension and pensions in general. Our research suggests that whilst many members of the public fully support the principles underpinning the State Pension and are concerned about anything which might affect their entitlement, few know the current levels of State Pension provisions and what their State Pension Age actually will be. There are also negative views and misunderstanding about workplace pensions – particular instances of fraud or mismanagement of pension funds by private companies has arguably led to mistrust and reluctance by some to invest in private pension schemes.

2.7 Another qualitative study201 showed that employees’ attitudes towards retirement tended to fall between two extremes: retirement would be an enjoyable time in which they could pursue personal interests, travel and spend time with grandchildren; or it would be boring, with their quality of life reduced by ill-health and inactivity. Regardless of how they envisaged their retirement, these employees - who did not have access to a workplace pension scheme at the time - tended to assume that they would have sufficient savings to live on, without the need to rely entirely on the State Pension. Some employees, particularly those on low incomes, thought that they would probably carry on working for as long as possible (because they actively wanted to and/ or through necessity) and felt that their lack of personal savings (and their low expectations of the State Pension income they would receive) would, therefore, not be an issue. Only a small number of older employees (those aged 45 and over), who recognised that they may not be able to work forever, either

200 Ipsos MORI (August 2011): The future of pension provision. Qualitative research on behalf of the Workplace Retirement Income Commission

201 Ipsos MORI (2009): Understanding why some employees don’t participate in employer pension schemes. Research carried out on behalf of the Department for Work and Pensions
due to ill-health or a lack of employment opportunities, expressed any real concern about their retirement income and felt that they had not saved enough to continue their current standard of living. Lack of interest in retirement issues in general meant that employees' knowledge of the different options available for saving for retirement was fairly limited.

2.8 Despite their lack of savings, none of the employees interviewed expected to rely on State support when they retired and all stressed that they were personally responsible for saving for their retirement. Most employees assumed that the State Pension would either be non-existent or extremely small by the time they reached retirement age but, nevertheless, there was an expectation that the State would always support those who were most in need. The research demonstrated that in order to combat current under-saving it will be important for government and employers to promote not only the necessity of saving for the future but also the benefits of doing so.

2.9 Another area of significant focus for Ipsos MORI research has been social care and care for the elderly. Our research shows that, as with pensions, care in old age is something the public gives little consideration to. Generally, there is low awareness of, and common misconceptions about, who is responsible for looking after older people in need. The public often struggles to distinguish between social care services and health services provided by the NHS. This can lead to confusion about which services are currently free at the point of need and which are not. Awareness of how care and support services are funded – and how much they cost – is very low, and many people continue to (wrongly) assume that the state will automatically pay for their care in old age, as the following chart shows. This means that people often have no plans to save for future care needs.
Low levels of awareness and planning could, at least in part, be symptoms of the lack of information people have about social care in general. There is a clear information gap – people do not feel well informed about social care funding and discussion about this topic appears to be outside most people’s terms of reference, making it a very steep learning curve when they do have to navigate the system, often in difficult personal circumstances.

When informed about current arrangements for funding social care, people often conclude that they are unfair. However, public views about ‘fairness’ in the delivery of public services are complex, with different people attaching different meanings to this concept. In this case there appears to be a conflict between two long-term, underlying social values: the need for equality and collective responsibility and the importance of individual rewards and responsibilities.

The majority of the British public agrees that the country’s care and support system needs to change (74% versus nine per cent who disagree) and this is primarily driven by concerns about fairness and everyone’s ability to pay as the following chart demonstrates. But, there is no clear view on how funding should work.

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2.10 Ipsos MORI /DH Care and Support Green Paper Tracking. All respondents, around 900 English adults aged 16+ per wave.
3. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

3.1 Our work looking at pension and social care reform, as well as public service reform more widely, demonstrates how challenging it can be navigating public perceptions about these issues. Through our research we find that the public believes there will always be sections of society (the ‘deserving poor’) in need of support and the state should provide help in these circumstances. There is also a belief that it is morally right to provide a system of help and support; the public sees this as being the hallmark of a modern and caring society that is responsive to the needs of its citizens.

3.2 Ultimately, when it comes to caring for older people, the public feels strongly about the role and value of the government “safety net”. There is a great deal of emotional attachment to the welfare state as it currently stands too, particularly amongst older people who have grown up during the post-war years and have witnessed the implementation of the welfare reforms, as proposed by Beveridge under Atlee’s Labour government. These people expect the state to provide to those in need and do not see any reason as to why this should change.
3.3 But, who should pay? Our work on welfare reform\textsuperscript{203} suggests that many believe that the ability to claim money from the state in retirement is their “right” and something that they have “earned” after contributing to society for so long. Some see their state pension as a pact they had made with government; they have little sense that the money that they contribute via National Insurance Contributions (NICs) and through general taxation is being used to fund public services now. Rather, they assume that their contributions are being saved for their own use in the future.

3.4 Our public opinion research for the Commission on the Funding of Care and Support\textsuperscript{204} found that in terms of the balance of responsibility for funding of social care between individuals, their families and the state, there is a perception gap between expectations and reality. Public demands on government are high, with a majority of people agreeing that responsibility for funding social care should rest with the state, rather than families and individuals.

3.5 Our work for Age UK looking at proposed future options for funding social care suggests there is a general view that older people should not be expected to pay for their social care given they have paid taxes all of their lives - contributions made through taxation mean that people expect to be able to access social care when they need it in the future\textsuperscript{205}. People feel strongly that housing assets and savings should not be used to pay for an individual's social care - retaining housing assets in later life and to pass on to children is seen as an important right.

3.6 In thinking about how the state should pay for social care, most participants in this research supported principles of progressive taxation – ensuring the burden falls to those most able to pay. At the same time, they want assurances that those who have worked hard all their lives to accumulate assets and wealth are not unduly penalised. This is a difficult line to tread. For the participants in this research, the burden of taxation needs to fall on the top end earners (or “super wealthy”) and business and corporations. Importantly no-one in the research (even higher income earners) saw themselves in this category.

3.7 The question of entitlement, and specifically about means testing of services in order to reduce the cost to the state, is a divisive issue. As the chart below shows, the majority of people want to see everyone receiving support in older age from the state, regardless of their income. However, at the same time most people are also comfortable with means testing of ‘extra support’ for those in most need. While these views appear contradictory it is possible that they can be explained if the state is viewed as a ‘safety net’ - everyone should be able to rely on the state in times of need but that doesn’t mean everyone needs the same financial support. Also, few people would think of themselves as ‘high income’ and therefore would assume that the ‘high income’ people in the second question would be ‘someone else’ rather than them.

\textsuperscript{203} Ipsos MORI (December 2007): The challenges facing DWP in the future: Deliberative research with the public. Research study for the Department for Work and Pensions

\textsuperscript{204} Ipsos MORI (February 2011): Public opinion research on social care funding. A literature review on behalf of the Commission on the Funding of Care and Support.

\textsuperscript{205} Ipsos MORI (July 2011): The future funding of social care: Qualitative research for Age UK
Figure 3: Should everyone get the same support?

<table>
<thead>
<tr>
<th>Q</th>
<th>To what extent do you agree or disagree with the following statements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Strongly agree</td>
<td>% Tend to agree</td>
</tr>
<tr>
<td>No matter whether they have a high or low income, everyone who has worked hard and paid taxes all their life deserves the same support from the government in old age</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>55</td>
</tr>
<tr>
<td>65+</td>
<td>63</td>
</tr>
<tr>
<td>Retired people with high incomes who don’t need financial help should not receive extra support from the government such as winter fuel payments</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>55</td>
</tr>
<tr>
<td>65+</td>
<td>57</td>
</tr>
</tbody>
</table>

Source: Ipsos MORI/Age UK
Base: 1,253 British adults 18+ including 235 aged 65+, 27th August – 5th September 2010

4. **Do we need to redesign and transform public services for these challenges? If so, how?**

4.1 The challenging economic backdrop and the changing demography of our population are providing a driver to do things differently. Although there is a growing realisation amongst the public that there is a need to cut spending on public services in order to pay off the deficit (as the following chart shows), many still seem to think that greater efficiency in public services (rather than cuts to services) should be enough. This presents huge challenges for policy makers in communicating the very real challenges ahead.
Figure 4: A growing realisation amongst the public that spending cuts are necessary, although views converging again

<table>
<thead>
<tr>
<th>% Agree</th>
<th>% Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>44</td>
<td>56</td>
</tr>
<tr>
<td>45</td>
<td>57</td>
</tr>
<tr>
<td>35</td>
<td>62</td>
</tr>
<tr>
<td>37</td>
<td>63</td>
</tr>
<tr>
<td>41</td>
<td>59</td>
</tr>
<tr>
<td>48</td>
<td>52</td>
</tr>
<tr>
<td>44</td>
<td>56</td>
</tr>
<tr>
<td>43</td>
<td>57</td>
</tr>
</tbody>
</table>

Base: c. 1,000 British adults each month

Source: Reuters/Ipsos MORI, Political Monitor, 2011

4.2 We also see that there is no clear consensus on the role of the state and the balance between “big society” and “big government” – we are split down the middle on the broad principles. We are also self-contradictory on whether the government should be setting laws to protect us or we should fend for ourselves. Of course we want flexibility, responsiveness and other desirable features. But, we are unwilling to countenance risks to the “safety net”.
**Figure 5: We don’t know whether we want to be American or Scandinavian...**

<table>
<thead>
<tr>
<th>We don’t know whether we want to be American or Scandinavian...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q People have different views about the ideal society. For each of these statements, please tell me which one comes closest to your ideal.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>2006</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>A society which emphasises the social and collective provision of welfare</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>A society where individuals are encouraged to look after themselves</td>
<td>46</td>
<td>49</td>
</tr>
<tr>
<td>A society which emphasises similar incomes and rewards for everyone</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>A society which allows people to make and keep as much money as they can</td>
<td>46</td>
<td>44</td>
</tr>
</tbody>
</table>

Base: c.1,000 British adults (18+) each month  
Source: Ipsos MORI Political Monitor

4.3 Playing to the British public’s sense of fairness, most prioritise the protection of services for those who need them most. When asked about the best way to reduce the deficit, most (75%) will support the statement “The government’s priority should be to protect services for people who most need help, even if that means that other people are harder hit by tax rises and cuts to the services they use”. Conversely only one in five (20%) support the statement “The only way for the government to reduce the deficit is to cut spending on all services, even if that includes services that are mainly used by people who most need help”.

4.4 Accordingly, it is services for the elderly and the vulnerable which people want to see protected. When asked specifically about services for older people it is the universal services including the NHS and state pension that the public and older people themselves hold most dear. Our research suggests those aged 65+ not only value these services but also appear to value free bus travel more than the wider public as an important service for older people.
Figure 6: Specific priorities for older people’s services

<table>
<thead>
<tr>
<th>Q</th>
<th>People aged over 65 benefit from a wide range of government spending. In your view, which two or three of the following are most important to protect from spending cuts?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% All</td>
</tr>
<tr>
<td>NHS treatment</td>
<td>53</td>
</tr>
<tr>
<td>The state pension</td>
<td>49</td>
</tr>
<tr>
<td>Winter fuel payment</td>
<td>40</td>
</tr>
<tr>
<td>Care for frail and disabled people</td>
<td>29</td>
</tr>
<tr>
<td>Free bus travel</td>
<td>40</td>
</tr>
<tr>
<td>Means-tested benefits to cover rent and council tax</td>
<td>19</td>
</tr>
<tr>
<td>Cash benefits for frail and disabled people</td>
<td>17</td>
</tr>
<tr>
<td>Home repairs, adaptations and sheltered housing</td>
<td>14</td>
</tr>
<tr>
<td>Post offices</td>
<td>12</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
</tr>
</tbody>
</table>

4.5 Looking at the broader altitudinal landscape, our research with partners DEMOS\[206\], drawing on British Social Attitudes Survey data, suggests some generational shift in where the public stands on the role of the welfare state and the notion of the public service “safety net”. As the following chart shows, we may be witnessing a generational shift in attitudes with younger generations less supportive of redistribution than their parents. The percentage of the population agreeing with the statement, "the government should spend more money on welfare benefits for the poor, even if it leads to higher taxes" peaked in 1989 and has been on a broad, downward trajectory ever since.

4.6 Not only are younger generations less supportive of redistribution than older ones, but attitudes appear to remain steady within cohorts over time. There is little sign of a "lifecycle effect", in which our attitudes become more like those of our parents as we grow older. The implication is that the declining public support for redistributive policies may not be cyclical, but rather a glimpse of the future.

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Figure 7: “The government should spend more money on welfare benefits for the poor, even if it leads to higher taxes”

“The government should spend more money on welfare benefits for the poor, even if it leads to higher taxes”

Base: c.2,000-4,000 GB Adults for each wave of British Social Attitudes Survey

4.7 As local public services look to drive out inefficiencies, new service delivery models are emerging, and matched with a drive towards localism, we are likely to see more diversification in how local public services are delivered on the ground. Our research into public service reform shows that people are generally in favour of greater local control in principle – but, they have concerns and reservations too, particularly in relation to fairness and the creation of a so-called “postcode lottery” (see next chart).
4.8 We have also looked at where the public sit on many of these new and increasingly likely forms of service delivery. For example, when it comes to outsourcing, there is general support for greater involvement from the voluntary and private sectors amongst the public – especially in non-core services – but, some people still need to be convinced. The private sector is seen as efficient by some, but others are concerned about the profit motive. We know there is strong opposition to user charging, especially for core services like GPs, and resistance to user charging on top of the existing tax burden. But, there are those who can see advantages. In particular, higher earners and infrequent users of public services. What this demonstrates is that the public can be amenable to new forms of public service delivery, although typically their initial response is likely to be a demand to retain the status quo. It will be important to understand where there is most potential for the public to accept changes that drive efficiencies, and to provide suitable reassurances about fairness.

5. What should be done now and what practical actions are needed? / 6. How can we stimulate national debate about these issues?

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207 Ipsos MORI/2020 Public Services Trust (March 2010): What do people want, need and expect from public services?
Due to the status quo bias often seen in public opinion (where people are reluctant to give up something they currently have) it will be vital to encourage people to start thinking about changes and the reasons they could be necessary as early as possible.

Recent work we have conducted on the perceived acceptability of different types of behaviour change interventions suggests (perhaps unsurprisingly) that people are most supportive of being provided with information. The research looked at four different challenges: planning for retirement, stopping smoking, healthy eating and sustainability. In all instances, over nine in ten people supported information giving.

Support for providing incentives dropped to 90% for planning for retirement (vs. 87% average across the four areas), 79% for auto-enrolment (vs 69% average across the four areas for more interventionist approaches), and 69% for making enrolment in a pension mandatory (vs an average of 62% supporting banning the four behaviours). In all these instances support for Government intervention was higher for planning for retirement, than it was in the other areas the study explored, suggesting the public might be more receptive to change in this area.

Figure 9: People want financial incentives to save for their pension, and 7 in 10 support being forced to save

<table>
<thead>
<tr>
<th>Option</th>
<th>% Strongly support/tend to support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide information</td>
<td>92%</td>
</tr>
<tr>
<td>Provide incentives</td>
<td>90%</td>
</tr>
<tr>
<td>Make pension scheme enrolment automatic</td>
<td>79%</td>
</tr>
<tr>
<td>Make pension scheme enrolment mandatory</td>
<td>69%</td>
</tr>
<tr>
<td>Make employers contribute to pension schemes</td>
<td>87%</td>
</tr>
</tbody>
</table>

Base: c.500 – 1,000 residents aged 16-64 (18-64 in the US and Canada) in each country, November 2010

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Ipsos Mori, Social Research Institute—Written evidence

Ipsos MORI (September 2012): Presentation to the Commission on the Funding of Care and Support
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Ipsos MORI/ Age UK polling: 1,253 British adults 18+ including 235 aged 65+, 27th August – 5th September 2010
Ipsos MORI/ Reuters (various), Political Monitor
Ipsos MORI/Economist (2010), Political Monitor

24 September 2012
The figures in Table 1 below are projected numbers with disability and various diseases from a macro-simulation model SIMPOP based on the MRC Cognitive Function and Ageing Study (MRC CFAS). An earlier version of SIMPOP has been published (Jagger et al., 2009) as has brief details of the current version (Jagger et al., 2011). The following should be noted:

1. The current version of SIMPOP uses the 2006-based population projections for England and Wales. The estimates shown in Table 1 differ from those in Jagger (2011) as they have been adjusted to the 2010-based population projections (by applying the prevalence rates in 5 year age groups from SIMPOP to the 2010-based population estimates). The difference between the estimates adjusted for 2010 population estimates and the ones obtained from the current SIMPOP are generally small, being 1% or less for numbers aged 65+ with arthritis, stroke, CHD and diabetes for all years, and numbers aged 65+ with dementia and with disability for 2010 and 2030; and 1.3-1.4% for numbers aged 65+ with dementia and with disability in 2020.

2. The estimates are under the assumption of ageing of the population only, i.e. no change in age-specific prevalence of disease, or in the incidence or recovery rates to disability. This scenario is identical to the Central Health Scenario in Jagger (2011).

3. In SIMPOP disability is defined as participants’ inability to put on shoes and socks, have a bath or all-over wash, or inability to transfer to and from bed. This level of disability requires at least daily assistance by another person and therefore may be viewed as moderate or severe need for social care.
Table 1: Simulated total and disabled populations and numbers with key diseases (thousands) aged 65+ under the assumption of ageing of the population alone

<table>
<thead>
<tr>
<th>Ageing of the population¹</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>9164</td>
<td>11265</td>
<td>13772</td>
</tr>
<tr>
<td>Disabled population (%)</td>
<td>1015 (11.1)</td>
<td>1383 (12.3)</td>
<td>1931 (14)</td>
</tr>
<tr>
<td>With arthritis (%)</td>
<td>4888 (53.3)</td>
<td>6029 (53.5)</td>
<td>7415 (53.8)</td>
</tr>
<tr>
<td>With CHD² (%)</td>
<td>2033 (22.2)</td>
<td>2510 (22.3)</td>
<td>3069 (22.3)</td>
</tr>
<tr>
<td>With stroke (%)</td>
<td>718 (7.8)</td>
<td>905 (8)</td>
<td>1139 (8.3)</td>
</tr>
<tr>
<td>With diabetes (%)</td>
<td>1037 (11.3)</td>
<td>1258 (11.2)</td>
<td>1510 (11)</td>
</tr>
<tr>
<td>With dementia³ (%)</td>
<td>1088 (11.9)</td>
<td>1431 (12.7)</td>
<td>1964 (14.3)</td>
</tr>
</tbody>
</table>

¹ no change in age-specific prevalence of disease, incidence or recovery rates to disability
² coronary heart disease (heart attack or angina)
³ defined as moderate or severe cognitive impairment (MMSE score 0-21)

References

Acknowledgement
This work was undertaken as part of the Modelling Needs and Resources of Older People to 2030 (MAP2030) ESRC-funded Grant No. RES-339-25-0002

January 2013
The Chairman: Good morning and welcome. Thank you very much for coming. You are no doubt aware what this Committee is about; it is essentially asking a simple question: is our society ready for ageing in terms of its policies, its public services, as individuals and as government structures? That is essentially what we are doing, taking a diagnostic and hopefully making a clear and strong critique of that and what the implications are. We are looking forward to the session with you because we want your thinking on what some of the key choices are as a consequence of an ageing society; I deliberately phrase that broadly but you can see from the questions you have been sent there are a number of areas where we particularly welcome your evidence.

I will not introduce the Committee because you can see who we are. I think we know who you are but would you mind just running along the row and saying a few words about yourselves?
Michael Johnson, Centre for Policy Studies, Paul Johnson, Institute for Fiscal Studies and Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010-11—Oral evidence (QQ 583-606)

**Michael Johnson:** Good morning, everybody, my name is Michael Johnson. I am an unsalaried research fellow at the Centre for Policy Studies, and had a former career within the City and subsequently in policy formation working with Oliver Letwin in the 2006-2007 period. I do not believe I have any vested interests to defend. That is all. Thank you.

**Lord Warner:** I am Norman Warner. I am former Labour Health Minister in the Blair Government and had some responsibility for NHS reform. Subsequently, I was a member of the Dilnot Commission on the funding of care and support that the Coalition set up after 2010.

**Paul Johnson:** I am Paul Johnson. I am Director at the Institute for Fiscal Studies where we have done quite a lot of work in the areas of pensions and public finances, income and equality and taxation. I have previously worked in the Treasury in the public spending area and Department for Education and other bits of Government.

**Q584 The Chairman:** Thank you. Let me start by asking each of you an impossibly broad question as to whether our existing public services and policies are prepared for the greater demand for them and the greater expectations of an ageing population. You might also then—I am sure you will—come on to what public policy reassessments or shifts you think might need to be made. That is the question. We will probably spend about 10 or 15 minutes on that, at least initially. Michael, you are signalling you would like to go first and say some landscape points first.

**Michael Johnson:** Yes, thank you, my Lord Chairman. I thought it might be helpful if I laid out what I consider to be a few guiding principles for this broad context, starting with equality, both sectoral and intergenerational, which should be an absolutely enshrined principle to guide the sorts of remedies that we might produce to address what we perceive to be a population challenge.

Secondly, I think it would be extremely useful if we maintain a healthy scepticism about the value of modelling. My attention was drawn to this recently when I was looking at GAD eNews of April 2009 which suggested the national insurance fund next year (2013) will be somewhere over £100 billion, and a much more recent piece of paper from GAD points to a number in the region of £26 billion. That change materialised from modelling within the space of four years and the difference of £70-billion odd is pretty staggering.

The third point I would like to make is that general remedies—for example, sending the state pension age into retreat—can be extremely counterproductive and I would encourage thoughts and concentration on targeted remedies particularly when, for example, we have a relatively high degree of spare capacity in the labour force and it might be worthwhile spending time looking at skills training.

Fourthly, let us keep it simple. Please do not co-mingle objectives in policy initiatives; the classic one that one regularly sees is wealth re-distribution objectives combined with some other driving force behind the initiative and that just makes it very complicated. Finally, I think we need to reconsider the meaning of the word “retirement”. It would be helpful if we distinguished between fit retirement and frail dependency, and at the moment that is not a distinction that is in common parlance.

**The Chairman:** Good, thank you. Is that it for now?

**Michael Johnson:** Did I pick up earlier the question, “Are there reasons to be optimistic about the prospect?”, or is that something you might come back to a little later?
Michael Johnson, Centre for Policy Studies, Paul Johnson, Institute for Fiscal Studies and
Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot
Commission) 2010-11—Oral evidence (QQ 583-606)

The Chairman: I did not ask it specifically. It was essentially a question about whether we
were prepared, in your view, in terms of policies and services for what we are pretty certain
will be happening—a significant increase in many older people and many older old people.

Michael Johnson: The short answer is that I do not know but I make the observation that a
lot of the metrics that we use to determine benefits—for example, the indices within
those—are completely mismatched with the actual costs that are being incurred. This goes
to the root of looking at what are the underlying drivers of cost and what are the underlying
drivers of income and seeing how fundamentally mismatched they are. That, I think, is
something that we should address. For example, when it comes to the State Pension, clearly
a driver is the size of pension and population, and the form of indexation that we may
choose, be it something like the triple lock. But the other side, the ability to pay for State
Pension is rather disconnected from those drivers because that is essentially driven by the
performance of the economy, longevity expectations and so on. To answer that particular
question, I think we are not very prepared.

Q585 The Chairman: Thank you. Paul, would you like to have a go?

Paul Johnson: I will try. I suppose the place to start is to ask the question, “What is special
about an ageing population and why is it that we are concerned here?” It seems no doubt
there are several reasons but there are two big ones. One is to do with health and the
period, to be blunt, running up to death where there is a lot of cost associated with health
and social care. The other is associated with not being in work and the fact that those over
a particular age are much less likely to be in economic activity than those who are not. One
of those feels like it may be much more susceptible to change than the other. Death is
something that we cannot change and I rather suspect that dependency in late old age for
large numbers of people is also something that we are not going to be able to change. So for
that there are issues around what the appropriate policy framework is.

For the not being in work bit of it, particularly for those who are reasonably healthy, then
that does seem to be susceptible to change and is not a fixed element of the “problem” that
people perceive to be ageing. The core question about policies for an ageing population, or
one of the core questions, must be about what policies are going to help and encourage
people to stay in work as long as they can. As you all know better than I, things like the
state pension age and indeed working participation have not only not kept up with increased
longevity in terms of the labour force, but moved in the other direction, at
least up until 10 years ago or so and we still have much lower participation than we had 30
or 40 years ago.

One fundamental issue about having public policy that deals with an ageing population, it
seems to me, is one that focuses very clearly on that issue of the incentives—not just the
incentives but the provision of services that allow continued participation in the labour force
and that do not provide very obvious focal points at which you leave. Your occupational
pension allows you to leave at 60 or 65 and the state pension age is 65, and the benefit
system becomes more generous at a particular moment associated with your age rather
than any other characteristics that you may have.

If it were the case that the population were ageing but people continued to work up until
the three or five years before death, which was the average 40 years ago, in that economic
sense we would be much less concerned about it. How far you want to drive that, I do not
know, but that seems to be one part of the issue and one area where I think we still have a
long way to go to have a set of public policies that have adapted to changing longevity, some
of which is just associated with policies that take a long time to change or to unwind. If you have pension promises then it is for very obvious reasons difficult to step back from those pension promises. That takes me to my second theme here, which is the one about who bears risk. I think that is associated with what Michael was saying about who bears risk when it comes to quality of services or level of pensions.

In one sense what we are seeing at the moment is that large parts of the pensioner population have been wholly protected from what has been happening to the rest of the economy over the last five or six years. Clearly there are groups who have done very badly as a result of quantitative easing and lower interest rates and so on, but equally there are groups with occupational pensions which were already in the bag and, on state pensions, who have not shared the risk that the rest of the population has shared. As I say, it is not easy to create that risk sharing in that sense because once you get past a certain age you cannot do much to undo things that make you worse off but it is noticeable that that kind of risk sharing has not occurred.

There is also another kind of risk, which looking forward we need to think about, and that is: how do you think about the risk associated with any individuals saving for retirement? We have moved from a world where the state, which is pretty good at bearing these kinds of risks and 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. Again, I do not know the answer to this but it does seem to me to beg a fairly clear question which is: how can you socialise some of the risk that individuals currently bear in terms of the individual pension pots that they are building up?

That then relates very closely to the Commission that Lord Warner was involved in, the Dilnot Commission, because where did they end up? When you are looking at long-term care at the moment, again, the individual bears all of the risk here until such point as their assets fall to an extremely low level, and what the Commission was essentially saying was we should socialise part of that risk and the individual has a certain amount of level of responsibility but beyond a certain level we should be socialising that risk. I think that is a useful framework, at least, for thinking about some of the other issues that are relevant when we are thinking about ageing populations, whether that would be to do with pensions or to do with health more generally.

Q586 The Chairman: Can you just make the last point more explicitly, taking the model of socialising the risk around social care costs? You say that model might be applicable elsewhere as conceptual thinking. What did you mean? After Paul has spoken, Michael, come in as well if you want to.

Michael Johnson: Yes, I would like to.

Paul Johnson: As I say, I would not claim to have thought this through to the point of answering and providing a clear policy prescription but, for example, when the market is providing an annuity, particularly if it is an index-linked one, there is a significant cost associated with the risk that the individual might live beyond 90 or 95 or 100, and one example would be: is there scope for socialising some of that risk? Is there scope moving in the other direction for individuals to take on some responsibility at least for the costs of health?

When you think of long-term care and contrast it with health, you have the situation where at the moment with long-term care you sell everything until you have nothing in order to
pay for it, and in health you do nothing—you get it all provided without anything up front. Again, can the two meet at least one step further in each direction? It seems to me these are just helpful ways of thinking about it. The point about the long-term care structure is that it is so different from anything else we do in public services, and what the Dilnot Commission was proposing really was to take it one step towards a world in which the state is providing some of the insurance that it traditionally does but still stop a long way short of the state doing everything. I think it opens up the question of: are there other areas where the state can move in that direction but other areas where it can move back a bit?

The Chairman: Very helpful.

Michael Johnson: On the same theme, in the way that the insurance industry categorises risk, it would say that in the context of the Dilnot structure—which I like—the low frequency, large claims, the tail-end distribution, is moved away from the individual and placed with the state, whereas the individual assumes the high frequency, low claims end of the distribution. There are very few other instances—there is only one I can think of straight away—where we compel people to take that risk and that is in car insurance, third party car insurance.

The reason we do that as a society is because if one hits a third party and does serious damage and is faced with a claim for £1 million, most people cannot afford to meet that claim, hence compulsory insurance. The observation I think that Andrew Dilnot himself made was, “What is actually the problem we are trying to solve?” I think he concluded it was that individuals do not know whether they are going to need long-term care or not, and secondly there is not a deep insurance market available if they decided they wanted to hedge that risk.

The most common long-tail risk for which there is no effective market in depth is longevity. Clearly, at the moment the state assumes longevity risk through, for example, the state pension. The markets have distinguished very clearly, and in the context of Dilnot the attachment point, in the language of the industry, is (currently proposed) at £35,000. One of the variables in terms of remedies outside of the context, for example, of long-term health care is: what is the ballet between the attachment point in the example of Dilnot of £35K and the proposed structures for means tested benefits? That is the other component that is at play here in terms of risk distribution.

Following on from what Paul was saying, maybe somewhere in all of this Beveridge is making a reappearance, because his model of the world—and he did not like means tested benefits because of the poverty trap—was very much incorporating and adopting the word “insurance”. I am going to make a massive leap here, and I can provide the evidence subsequently if necessary: this raises the question in my mind whether we need pensions at all.

The Chairman: Okay.

Michael Johnson: I am sticking my head and shoulders above the parapet here. If one steps back and looks at the incentives framework that we have for pensions, particularly private pensions, tax relief and its rebates for employer contributions and so on, this totals roughly £50 billion a year. In my mind much of that is extremely ineffectively spent. It is skewed towards the wealthy and so on. So that begs a question as to whether the state should be moving in a funded solution way. This is one of the key questions about whether to go unfunded or funded when hedging risks and providing for benefits. Should the state step
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back and look at the Dilnot structure and ask itself the question of “Would it be more effective if we provided a Dilnot structure, which is a hybrid, to meet what we all currently call state pension needs?”

Q587 The Chairman: Just illustrate what that would mean in practice, would you?

Michael Johnson: The Conservative Party gave us a subtle hint at the end of 2005 when the ethos of personal responsibility started to be bounced about, and in my mind that could be translated as, “Folks, you are on your own”. We have seen the State in retreat; the state Pension Age is in retreat, we are having NHS rationing, although we may not call it that, and we are seeing welfare benefits being cut. There is a general trend of retreat in terms of the state assuming risk, which is something that Paul touched on earlier.

Where does the State Pension fit into this? If we took a Dilnot type structure with an underlay of means tested benefits, would we provide perhaps an even lower State Pension and a lot more incentives for people to get back into the labour force? My guiding principle right at the beginning was about the distinction between fit retirement and frail dependency.

My hunch about the challenge of an ageing population is that it is a proxy conversation for a mismatch in the demand and supply of skills. There is a demographic dividend to be seized here, in the sense that one of the consequences of an ageing population is that unemployment will probably go down, and yet we have potentially a huge number of fit retirees who would be available for training and providing care, but there could be a fundamental rethink about the question of the State Pension in its entirety, given that population of current retirees who are very fit. Therefore, I think that prompts a revisiting of how we fund the State Pension. I am going back to your question now, and a Dilnot type structure, I think, would fit better with that observation about this large population of fit retirees.

The Chairman: Thank you. Fascinating. Is that set out in the paper that you sent, which I have not had a chance to read yet?

Michael Johnson: No, that is rather a different paper but what I would like to do, my Lord Chairman, is perhaps to write up my notes in a coherent fashion subsequently.

The Chairman: Yes, that would be helpful so that we make sure we have understood you and then we can decide whether we engage with it and agree with it.

Michael Johnson: But the broad message is I really like the Dilnot structure. I think that Andrew has done some fantastic work there and it lends itself to other applications, as Paul has said.

The Chairman: By implication, you are agreeing with Paul because the Dilnot structure is essentially a different striking of the balance about what risks are socialised and what are not. You agree with taking Paul’s question that we should be looking across areas of public policy and thinking which risks are socialised and which are not. Is that right?

Michael Johnson: Excuse me; Lord Warner has not yet had an opportunity to speak. Crucially when we do that let us be clear about the sort of data that we are looking at. We hear a lot about age dependency, particularly old age dependency ratio. I would suggest that is completely misleading because the solution, the remedy, that we have adopted at the moment is to send the State Pension Age into retreat. That is the wrong solution when we have unemployment and very high under-employment. When we are looking at other
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applications for Dilnot, let us be very clear about some of the more fundamental points that have got us concerned about the ageing problem, because a lot of what we are looking at at the moment, such as old age dependency ratio, is inappropriate.

Q588 The Chairman: Norman, we have kept you waiting.

Lord Warner: No, I am listening. I did not realise we had constructed so much of an edifice for a wider social policy when we were doing our report. We have not even built the edifice that we have proposed yet, before we get too carried away.

I would just like to say a little bit. My expertise is mainly in health care and social care, and one of the biggest challenges coming out of an ageing population does relate to the NHS and social care. One of the fundamental problems, I think, is that to some extent they have a serious symbiotic relationship particularly with an ageing population because, in the way it used to be described, what is the difference between a social care bath and a health bath? Not a lot for the elderly person who is having the bath. You have this overlapping set of services, one of which is means tested and one of which is free at the point of use, in that it is essentially a cash-limited, tax-funded service.

What we have seen historically, and I think history is quite important, when Beveridge set up the NHS, the NHS was—give or take—about 3% of GDP. It is now over 9% of GDP. Although Beveridge has now achieved sainthood, he had this touching belief that if you had a national health service you would cure disease and it would pay for itself in a way. I am simplifying it, but that was the drift of his thinking. What has happened is that science has not let that happen and public expectations have not let that happen. The big drivers of NHS expenditure under successive Governments have been three things: medical advances and science, rising publication expectations on what they get from that service, and a mixture of demography and disease profiles.

They are the big drivers and historically what they have done is drive the NHS, in particular, along a path where, give or take, it has become used to—and I use that term advisedly—a 3% per year real terms increase in its funding. There have been some good years and bad years, but over the 60 years or so that has been the driver. One of the problems with that is this public service, which Nigel Lawson described as the nearest the British have to a religion, has got into a pattern of expenditure and it has strong advocates for that way of doing business. In a way that is different from some of the other services because of this history and this folklore around it.

The questions that other people are starting to raise and the Committee might want to think about are: is this folklore valid and is it causing major problems for any Government and other public services? You have a situation now where the NHS costs more per year than education and defence combined and a bit more. This is such a big chunk of public expenditure that the combination of this and welfare benefits dominates the stage. They really dominate the stage and the NHS, in particular, is very susceptible to an ageing population. The impact on it is very considerable with an ageing population.

You could just let the NHS go on its happy way, the way it has been going on, through a lengthy period of low economic growth and very considerable fiscal constraints as a tax-funded service. The Nuffield Trust has just produced this very interesting report on the NHS, A decade of austerity? I would question whether the question mark is altogether valid but, nevertheless, as a research-based organisation I think they thought the question mark gave a veneer of respectability to their findings. But, if indeed we are having a decade of austerity, the NHS and an ageing population—historically very vulnerable to the public
wanting more of the scientific benefits that are being invented and having rising expectations about a service industry—is a pretty difficult conundrum to grapple with, not least because you are then deep in how you change public expectations, how you change public culture, how you change their behaviour, and what is the impact on other public services.

I think that is where we are; we are at a pivotal moment about what we do about this much revered public service, and it is not easy to see what you do that is politically easily acceptable. That is the great conundrum, in a way, that is different from pensions where—Lord Hutton will know more about this than I—there seemed to be a public and political acceptance that we had a problem where, to some extent, we could outsource the solution of it to an independent commission, and on the whole its findings attracted a fair amount of support.

We do not seem to have at the moment an Adair Turner solution for the conundrums that the NHS and social care face, and they are now in a very clear symbiotic relationship. It is very clear already—and you have just listened to some of the stuff that is coming out of the King’s Fund—that what is happening is, if you tighten the screws on the funding of social care, you put an extra load and burden on the NHS. It is a pendulum that swings around depending on what you do to one side of the scales, to mix my metaphor, or the other. That is one of the major issues that the Committee would need to wrestle with.

The logic of Dilnot, if you try to apply it to health, is that you shift the balance of responsibility to the citizen to pick up more of the tab. That is the logic of it. I am not saying you should do it, but I am saying it was easier for us on the Dilnot Commission to do this because social care has always been means tested. There has always been a system in which you only received publicly-funded social care in terms of both your assets and your income and there was a means test that was applied and income was applied to your capital assets to turn capital assets into income for means testing. That has been long established.

What we found when we surveyed the public was large chunks of the public did not differentiate in their mind between social care and the health service. They did not realise that it was means tested. They only found out it was means tested when there was a crisis in the family that prompted them to discover that very quickly. It is easier to do transfer of risk in a means tested system than it is in a much loved, 60-year-old tax funded health care system that the public is extraordinarily attached to. Where we are now is that it has become worse because we have backed a particular business model for that health care system. The business model we backed is hospital-based care and we have a funding system that sucks money into the most expensive part of the system, which is the acute hospital sector, when the disease profile has shifted for the ageing population to 15 million, and rising—people with chronic long-term conditions with occasional episodes of acute hospital need—but the business model is dominated by the acute hospital provider.

The Chairman: Thank you. All that you have said, we will want to come back to on subsequent questions in more detail. I would like to pick up part of the conversation we have had, which is essentially about risks and needs.

Q589 Baroness Blackstone: You have each, in what you have said so far, touched on this or alluded to it indirectly but I wonder if I could encourage you to be even more explicit about what risks and needs the individual should manage and what should be managed by the Government.
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**Lord Warner:** It is interesting just to unpick the costs around social care, who pays for what. If you have home-based care, the citizen is paying for their own accommodation for the most part, unless they are on welfare benefits of one kind or another. They are picking up the tab for accommodating themselves. They are, by and large, picking up the tab for feeding themselves as well. The argument that has been around is they should pick up the tab for continuing to look after themselves unless they do not have the financial means to meet that cost. What you have is a sharing of the risk of the people who need a large amount of care provided in basically a community home-based setting. If they are so ill that they need to go into hospital, that risk immediately gets transferred to the state. That is what happens.

You have a set of circumstances there that are not replicated in the NHS because the NHS does provide for your accommodation. It does feed you and it provides care. We find it very difficult to provide the same risk model in the health care system as we do in a social care system. I am not suggesting that we should do any of that. I am just trying to analyse in a helpful way who is bearing the risk. What we have now is a situation in which it is becoming more and more difficult for the citizen to benefit from some of the risk-bearing behaviour in social care that the state has traditionally picked up. You are tightening up the eligibility of the state’s responsibility for picking up the care risk in social care.

Indeed, you are opening up the citizen’s access to services in the NHS because every year a new drug is invented or a new set of service provisions are invented and they become available, sometimes fast and sometimes less fast, to the citizens. All the risk on scientific advance in health care is borne by the state, pretty much, and that is one of the major drivers.

**Michael Johnson:** My biggest concern about allocation of risk is our absolute love of punting it into the future and passing it down to the next generation, and I think this is one of the fundamental flaws with the pay-as-you-go or unfunded approach that we have to, for example, the State Pension. That is a strong argument in favour of, for example, funding public sector pensions, but the Government is not sending a clear and consistent message on this risk allocation question in terms of generations. For example, we have a funded Local Government Pension Scheme, whereas the Royal Mail scheme that was funded has just been requisitioned, if that is the right word, and £28 billion of assets have been taken into the Government and £37.5 billion of liabilities have essentially been punted into the future and passed down to the next generation to worry about. That seems to me to be fundamentally inconsistent in terms of the vision of the Government to say, “What do we really want to achieve?”

There are several other choices in terms of the risk, and the first one is the question of whether we are in favour of universal targeted benefits, because it seems to me that as the disparity in life expectancy between the wealthy and the less fortunate widens—and it is widening pretty rapidly—that will pretty quickly put an end to universal benefits. For example, in the United States since 1977, the richest half of the population’s life expectancy has improved by about six years. The figure for the poorest half is about 1.3 years.

The observation I would make—and this is bearing in mind the current minty White Paper that may or may not appear on a universal state pension—is were we to go down that road and were life expectancy to continue to diverge, we would get to a point fairly quickly where it is patently daft for the wealthiest quartile, let us say, to be in receipt of a state pension at all. That is a risk flag that I am waving fairly energetically. I am linking risk distribution with life expectancy with the question of whether we have funded or unfunded
benefit structures, because unfunded is an absolute invitation—and, boy, do we take it—to punt the risk into the future.

That is why my first guiding principle is that we should enshrine in whatever we do a principle of inter-generational equality and, part B, sectoral inequality. I am thinking here of the work that Lord Hutton has done on public sector pensions and, much as I admire the work that was done, I disagree with the outcome. I think we are going to very rapidly have to revisit the question of public sector pensions for one reason and that is that while there are substantial benefits on the horizon, expressed as a percentage of GDP in 50 years’ time—and that in itself is a major risk because we have no idea what GDP is going to do in the future—what is going to change public opinion is the cash flow gap between pensions and payments and contributions.

Four years ago that was an irrelevant £200 million. This year it is forecast to be £11.6 billion. In four to five years’ time it is forecast—this is OBR numbers, not Michael Johnson numbers—at £15.4 billion, and rapidly rising. That is the gap that is being plugged by the Treasury. If we add to that £17.24 billion employer contributions funded by taxpayers to get over £32 billion, then we are looking at about 80% of public sector pensions being funded by the taxpayer. I think that is going to be very difficult to live with for many in the private sector and that is happening very quickly. The reason that that has popped up is something that was not in Lord Hutton’s report but was thrown in at the end, which is the grandfathering of all those within 10 years of retirement because essentially that has ruled out the prospect of any meaningful cash flow savings within the next decade and by then it will be far too late to assuage public opinion.

I have talked about public sector pensions to illustrate the consequence of the imbalance between private sector and public sector in this example, but also to restate the point about inter-generational issues and equality.

Q590 Baroness Blackstone: In contrast to what you were saying at the beginning in advising the Committee not to get involved in what I think you called wealth redistribution questions, you are saying, in answering this question, it is important to look at distributional issues.

Michael Johnson: No. To be clear, I was suggesting that we do not co-mingle those two different objectives in one policy initiative. For the purposes of wealth distribution, that should be the role of the income tax framework. Let us keep it simple. We do not want to spend much time talking about national insurance here, but if we dive into the detail of national insurance and the way that the whole framework operates, we have an enormous co-mingling of objectives, which include elements of wealth redistribution depending on where your income is, in terms of the volume of NICs that you pay and so on. I am just making the point that all that staggering complexity, which is a result of co-mingling objectives, is not beneficial to anybody. To be clear, I do believe in wealth redistribution.

Paul Johnson: Just a couple of thoughts very briefly. One is the general issue around thinking about risk distribution between Government and individuals. Wherever you end up, you just have to recognise the trade-off that you are ending up on. When you think about the existence of means-tested benefits, for example, that is essentially a way in which Government is taking on some of the risk that individuals will not have enough income for whatever reason, whether it be unemployment or disability or what have you, and similarly with disability benefits. The Government is taking on risk there and it is entirely
understandable why the Government takes on that risk, because it is unacceptable to us to see people on incomes below a certain level.

As soon as the Government takes on a risk like that you are on a trade-off because if individuals see the Government take on a risk like that then their behaviour may be impacted. It may be impacted in the sense they are less likely to look for work or less likely to save for retirement, and you might even think the health service has a similar effect. If the Government is taking up all the risk then maybe individuals take less care of themselves. These are trade-offs and there is no way of getting away from those trade-offs because either the Government takes on the risk, in which case it is affecting behaviour, or it does not, in which case you assume it will just leave people to starve, which it will not. In all of these discussions you just need to be very clear about which trade-off you are thinking about and what the costs of the particular place you end up on the trade-off are. I think in all of the things that we have discussed those trade-offs exist.

I just wanted to refer back to one very specific issue about risk that I mentioned earlier, which is the one about the risk that individuals who privately save bear. To repeat myself slightly, again for reasons that I find entirely understandable, we have moved from a world in which the Government and indeed future generations, which are quite handy for sharing risk—we have moved from that as the main bearer of risk in terms of people’s incomes in retirement through to one where employers have borne a lot of risk and had more and more risk piled on top of them to the point where they say, “We are just not going to do this at all any more”. For people in the private sector, essentially they are the bearers of all of the risk above the basic state pension for their income in retirement.

That does not feel like that is likely to be the right place for the large majority of individuals and some role for the Government in bearing some of that risk may be possible going forward. That is slightly different from what Michael is saying. If you can make that contract work, then sharing risk between generations is one of the ways that you can think about sharing risk.

Q591 Lord Mawhinney: Lord Warner, my question stems essentially from what you had been saying to us. All of the risk in the NHS lies with the Government. Some of it lies with the individual in social care. From the time that you were a distinguished Health Minister, probably before it and certainly to today, Governments have been saying, “There is too much emphasis on the hospital, we want to get people out of hospitals and into the community”. We have all heard the mantra and we have not seen a huge amount of delivery on that mantra. If a policy was adopted whereby the NHS budget remained the same but was top-sliced so that 20% or 10% of it, or pick a number, had to be spent in social care, with all of the benefits that that would produce in the health of the nation, first of all, does that idea seem to you worth thinking about?

Secondly, what would it do to the risk profile that you have talked to us about? If patients had to be treated in the community because they had to follow the money, presumably the hospital risk would remain the same with the Government. What do you think would happen to the risk profile for the individual in those sorts of circumstances?

The Chairman: Can you answer relatively succinctly? We are coming back to health as a specific topic in a minute, but pick up the risk point if you could.

Lord Warner: I think essentially you could save the capital overheads of the hospital, in essence. If you pursued the kind of policy that the new chairman of the Academy of Medical
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Royal Colleges is saying, essentially he is saying that we have too many 24/7 acute centres and we should consolidate those services on smaller sites. The logic of that is that you create the space to start thinking about doing what you are suggesting, which is taking a chunk of money out of acute hospitals to create some sort of fund for developing community-based services.

What lies behind your question also, I think, is an implication possibly that, if you were providing more of the services in people’s own homes through community-based services, the line between health and social care would start to get very blurred indeed. You would start to open up the possibility that some of what is now regarded as a health risk borne by the Government could be seen as a social care-type risk that could be borne by the individual. But all the while they are getting those services in hospitals, it becomes more difficult to do that kind of transfer of risk.

The Chairman: I think we should move on to Graham, because we have such limited time now.

Q592 Lord Tope: It does follow on from the debate we have been having and indeed we want to encourage and stimulate public debate, which also needs public understanding. Do you think the public need greater clarity and stability about what the state will and will not fund in the likely economic climate?

Michael Johnson: First of all, I would like to make the distinction between clarity and certainty because I think many in the public will confuse the two. For example, one could be extremely clear and say the State Pension in future is going to be indexed to GDP, but one has introduced conditional indexation and therefore the certainty element has gone away. I think this is a great scope for confusion.

Concerning stability, of course stability helps the individual to plan, but this is not what the Government is interested in because it removes flexibility; so one automatically has a tension here. My main comment on the whole question of clarity is at the moment we have all sorts of perverse incentives. At the top of the tree we have what I call Push-mi-pull-yu government. We have the Treasury that is extremely keen for us to go and spend lots of money and therefore it can collect lots of VAT, but on the other hand we have the DWP who is very keen to encourage people to save: that translates into all sorts of mixed messages.

In the context of an ageing population, and I think it is a truism, people are going to have to work a lot longer. I think we all know that, but why then do we have full eligibility for NICs at 30 years? That seems daft to me. I wrote to the DWP not long ago to ask them, out of curiosity, what my eligibility was and I discovered that I was fully eligible when I was aged 46, because after the age of 16 I went and did A-levels and accumulated NICs. So at 46 onwards—and I am a bit more than 46 now—from a NICs perspective in terms of earning rights to state pension, there is nothing in it for me. That is crazy. There are many other completely misaligned incentives and I have written a whole list of them, which I will not bore you with now, but the message that comes out of this is—and this goes back to my distinction; to be fair, it is Baroness Hollis’s idea—between fit retirement and frail dependency. We focus on fit retirement: what are the initiatives, what are the clear messages that we can be giving to people to encourage them back into work? One, for example, could be to say to them—there is a whole suite of clear messages to incentivise part-time working and improve the ballet between receipt of state pension and receipt of benefits—“You can have a much larger state pension if you are prepared to delay receiving...
it until you are 75”. Really, you want to get people back into the labour force. Perhaps this is a bit more contentious, and it does beggar the question of: why do we give people benefits simply because they are deemed to be old? So I would like us to revisit the meaning of the word “old” attached to the meaning of the word “retirement”. Why do we give people benefits simply because they are old? I was in a little race a while ago where a gentleman trotted past me. It was a marathon. He was 81 years old. He trotted past me. So my message about clarity is, at the moment we really do not help ourselves in terms of all of the misaligned incentives. We should remove incentives that encourage people to retire early—maybe we should consciously think about removing certainty from pensions. Final salary schemes, now in the private sector of course, are disappearing through economic pressure but the degree of certainty that one will continue to enjoy in the public sector in terms of pension incomes is of course rather different. Similarly, we should not just incentivise for people to stay working but remove the disincentives to carry on working. There is an imputed tax if one works beyond state retirement age because one is by definition not necessarily then collecting a pension that one has already contributed to. In summary, on the whole question of clarity of messages, we do not help ourselves at the moment because of all the misalignment of incentives and disincentives.

Paul Johnson: I think that distinction between clarity and certainty is rather an important one and I think we have the two mixed up very much. I think there is a lack of clarity about where the uncertainty is or should be, so I think we end up with a world in which some groups are not given a considerable degree of certainty with clarity and a certainty that is very expensive—so the certainty that you will get your two-thirds of final salary if you are on an occupational scheme. That is one of the certainties which has resulted in the end of occupational schemes in the private sector so it was a forced certainty, and it is a certainty which goes with some of the public sector schemes, which make them expensive relatively speaking, and it is a certainty which makes it very difficult to change arrangements for state pensions even in difficult economic times. There is a different thing, which is the clarity, which is to say we will make changes under this set of circumstances, which creates uncertainty but may create more clarity. I do find that distinction rather helpful. I think there are areas where there is uncertainty and unclarity around the various aspects of Government policy towards, for example, the tax structure and pensions. You can end up in different places here but it would be good to know where the Government wants to end up and what it is that will result in it changing its view, which would potentially change so that people can plan with at least clarity about where the uncertainty lies and why it may lie where it does. So I think a clarity about the long run structure of policies is important, and honesty about where there is uncertainty and honesty about where we may or may not want people to bear risks in older age and honesty in being clear that at the moment we are taking a segment of the population and we are saying, “We will protect you essentially from anything that the world may throw at us”. But are we going to ask ourselves the question, “Are there points at which we may want to withdraw that protection?” As I said at the beginning, I think that is a difficult thing to do because once you get beyond a certain point in your life, you cannot respond to changes which means that your income goes down relative to what you were expecting, but I think some clarity of thought about where that level of certainty may be or may not be too expensive is probably needed.

Lord Warner: Viewed from my experience on the view on the Dilnot Commission, there is a major task of public education about what their entitlements are in terms of state funded services. In the health care field, there is monumental ignorance about what the costs of these services are that are taken for granted. So it is, I think, very difficult to have any kind
of sensible political dialogue with the public without a better knowledge base about some of the, what you might call, realities of life about some of these services, which to a great extent are taken for granted. They are part of the social fabric so you would be asking elected politicians to engage in a rather difficult set of conversations with the public. What you have, I think, is a set of services which do not themselves want to engage in those conversations with the public. You do not see a squad of doctors, with the possible exception of Baroness Finlay, willing to stand up on public platforms and say, “You would be better off travelling another 10 or 15 miles for a better stroke service than you are getting in your rather not very effective 1960s District General Hospital around the corner”. You have a set of public discussions that need to take place between the elected political class and the public which do not start from a good information base in the minds of the public.

**Q593 Lord Tope:** We have the possible advantage of being unelected politicians and we hope that our report will stimulate some debate on that which you say is not much spoken of now. What sort of strategic choices do you think we should be posing, or would you be posing, to try to both educate and stimulate that public debate?

**Lord Warner:** The starter for 10 would be to start with social care because that is now on a lot of people’s minds. It is an issue that is on a lot of people’s minds and it is to a fair degree—I do not use the term “crisis” very often—rapidly approaching quite a substantial funding crisis which will affect a lot of families. So, on trying to explain and set up, which is what we proposed in the Dilnot Commission report, we are looking for local services to be able to give better information about what is and is not likely to be available as publicly funded services, but also, instead of as is traditionally done by local government to inform people about their services, to tell them about all the other services which they may be able to purchase for themselves. There is an issue about what the role of public bodies is in trying to educate the public, and that is an issue that needs to be tackled sooner rather than later. That is not a big cost item, to begin that kind of process.

**Q594 Lord Hutton of Furness:** We have taken evidence from a number of people about the funding of social care and, Norman, you have just been talking about that. Essentially, people have identified three challenges around funding of social care with us. The first is obviously to raise standards for the minimum wage work force and there is a challenge there. There is also the very real risk that a lot of people out there need social care support and currently are not getting it. There is a huge dollop of unmet need and of course there is the issue that Dilnot was set up to look at, which is the unfair hand of fate that touches the shoulder of those with some assets, who could face catastrophic costs if things go wrong in their personal family lives. Those are three very different competing pressures. It is a cash-limited pot even though there is co-payment in the mix. Those are the three competing priorities and they do seem to compete with each other. What do you think, if you were giving advice to the Committee, you would say to us should be our number one priority as we try to wrestle with the challenge of demographic change, which is overall pushing up demand?

**Lord Warner:** There is a historical deficit in their pot of money. That is what it comes down to. I think you have to do something about that deficit because what is happening is that—and this is increasingly a poor person’s problem—their eligibility for services is getting squeezed and squeezed in two ways. Firstly, their eligibility, then the amount of service they get even if they are eligible and then the third dimension that you mentioned: the pay of this work force is being squeezed to really quite potentially dangerous levels, so you have a triple whammy going on there in terms of those services. Dilnot does not put right that
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historical deficit of funding, and one really fundamentally has to ask the question: why should the NHS not have a transfer of resources across to social care? The NHS has done very well and it has not delivered the bacon in terms of productivity. Just look at the ONS data on productivity between 1997 and 2007: 60% increase in real terms in inputs, minus 4% in terms of output. You can have a debate about whether the form of measurement is right but the big message is clear. I think we do have to look to the NHS rather than other public services or taxpayers to start funding the historic deficit. Moving forward, there is the fairness issue about those, as you put it, that the hand of fate strikes randomly and unfairly and I do think that we need a pooled risks system. We can have a debate about whether the cap that Dilnot proposed was right. Personally, I would go for a higher cap of somewhere between £50,000 to £60,000, that sort of order, but the thing you have to start really facing up to is that people's savings for old age are often locked up in their housing assets. That is what you have to start releasing. That is the pool of wealth that you start releasing and that is why we recommended a standardised equity release scheme so that, in effect, the local authorities could incur debt that they would collect after death from the estate and the housing assets, and it would be a national scheme and they would be able to charge interest set by whoever is the Government of the day, which would cover the costs of the public sector borrowing for that money before it was collected. So that is the kind of model. I think there is a movement within the elected political class. I have to say as a former appointed Minister, I still did not get a much better hearing than my elected colleagues did on some of these issues. There is a kind of movement I think, and a recognition, that we have to do something about equity release and getting some of these housing assets into play in terms of increasing the social care funding pot.

The Chairman: Develop that point if you could. What do you mean specifically?

Lord Warner: What specifically I think you have to do is you have to accept—and it would require legislation—that people just cannot suddenly find the money because often these crises come quite quickly, so you accept the principle that you can defer the costs of your residential and nursing home care effectively and you could do the same for very high levels of domiciliary care in my view. So you build up a debt on that individual and for that family and that debt is only paid back when that person dies, unless they choose to rearrange. It is voluntary in the sense that whatever happens, when the Grim Reaper comes, you have to pay the debt out of the assets but otherwise, you also can release your assets and pay as you go.

Q595 Lord Hutton of Furness: So your answer to the problem is that we need a transfer of resource from the NHS into social care, assuming that there is not going to be any great opportunity for increasing the total amount of additional spending. Do you think we could make that sort of paradigm shift in an orderly fashion and keep the NHS standing up at the same time because the solution seems to be that it needs quite an urgent and radical refinancing of social care, and the transference from one part of the public service to the other is a difficult thing to do if one is trying to keep services afloat?

Lord Warner: It is a difficult thing to do and it is not an overnight thing. My preference would be to aim to take something like £10 billion to £15 billion out of the acute hospital sector by concentrating services in a staged way over five, six or seven years. It would need a bit of start-up funding—probably a couple of billion—to start the process but I would ring-fence that as a fund, as Lord Mawhinney suggested, and I would not let the acute sector get its hands on some of that money. However, it does mean going down the route that the Academy of Medical Royal Colleges's chairman has suggested and just to give you a figure, in
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maternity services what the suggestion was on the modelling that they had done was you went from 220 24/7 acute maternity units to 170. That is a big reduction. If you look at what has happened on the stroke service in London, you have reduced very dramatically the number of places providing a very effective stroke service. I think the medical specialists are up for this; what they need to be given is political permission to drive that agenda and what is lacking is the political permission to drive that agenda.

Michael Johnson: A few quick points, if I may: I would like to reiterate Lord Warner’s point about productivity growth. Productivity growth has been our get-out-of-jail card to date and I think when we examine the policies around incentives, one area to really concentrate on is incentives that will improve productivity for both the private sector and the public sector. The second point is to do with the question which I am sure a lot of people have asked you in particular which is how are we going to pay for Dilnot. I think, and it resonates with something Lord Warner said an hour or so ago, on the observation about parallels between the NHS and the pensions world, we should put an end to higher-rate tax relief and take that saving of roughly, post the Autumn Statement, £6 billion a year which goes to the wealthy almost exclusively, and divide that £6 billion into the £2 to £3 billion that Dilnot would require and the remainder for paying for care at home, again as part of the social care package. I am really passionate about this. We need to put an end to higher-rate tax relief because it is so ineffective and I would suggest that Dilnot is a very good place to divert it to. One observation, if I may, about equity release: equity release has been with us for 10 to 15 years. It was much touted and great hopes of it existed in those days and it has not really happened. One must question why and I think there are several answers, one of which has to do with essentially very poor documentation in the early days but, on the behavioural side of leaving the home, the emotional link to the home really cannot be overestimated. While, yes, it is clearly attractive given the hundreds of billions we have tied up in home equity, there are still some market mechanisms that do not appear to be working very well. I think we should look at why that is the case.

Lord Bichard: Can we follow that up?

The Chairman: Can we just check how we are for time, because we have to come on to the NHS, otherwise we will miss a large chunk, although we have started that. Are you all right for a few more minutes after 12.30? Is the Committee all right for a few more minutes after 12:30? Okay. Mike.

Q596 Lord Bichard: Previously it was not clear whether the market was going to work and why it has not worked. I think we feel now probably it is more difficult to make the market work because no one trusts the market anymore, so your suggestion about some kind of back-up for equity release or the local authority idea may be an attractive one but I am just not quite sure—and you are probably going to tell me to go back and read the Dilnot report—how you deal with the transitional costs of the scheme that you have just suggested.

Lord Warner: There are several transitional costs. The first transitional cost is start-up money for Dilnot anyway, for the cap. So you have some start-up money required there and the argument for that is it should essentially free up some market mechanisms in terms of insurance in some form or another. If you look at the commercial equity release schemes, the rate of interest is rather high. It is not a particularly good deal for many people but the political climate has been—essentially across the parties—the Englishman’s home is his castle, so there is not a kind of social acceptance that you might actually have to release some of those assets to pay for your long-term care, and we are back to the public
education issue there as well because it has been deemed to be, for a long time, politically unacceptable to force the release of that.

**Lord Bichard:** Although equity release could be a way of keeping you in your home?

**Lord Warner:** It could be and that is why it is almost certain that local authorities via the Treasury, and Paul knows more about this than I do, could borrow at a more advantageous rate than insurance companies running equity release schemes. You still have to get back to this issue of how you pay the bills initially. We are then particularly back to the problem that you have to start some kind of seeping of money across what Frank Dobson called the Berlin Wall. You have to do that. How much? I do not think we can sit here and decide the precise sum but some of that money would go into helping local authorities bear the costs.

**Lord Bichard:** So a pre-condition of the type of scheme you have suggested is getting money out of health and social care.

**Lord Warner:** An absolute pre-condition is that you have to put the finances of social care in better shape than they are now because they simply could not cope with a deferred payment, which equity release requires.

**Q597 The Chairman:** Just a bit of sign-posting: I think most of the remaining time we should have on anything else on the NHS but we were discussing earlier—I think one of our advisors articulated for us—that if you did not get higher activity rates of older people, that would have a depressing effect on GDP growth. That is essentially what we were advised and we were discussing whether that was true or not. Could you give us, as at least two of you are economists, your views on that?

**Paul Johnson:** If you have a population, a larger part of which is not in work and is reliant on the work of the rest of the population, then you would expect that to have, as you describe, an impact on GDP growth relative to a world in which those people were staying longer in work. So a world in which the majority of people are in work between 65 and 70 would be for the country a world in which GDP per capita would be higher than one in which that was not the case, so I think that must be true.

**The Chairman:** Thank you. Therefore, that is a double argument, is it not, that clearly in economic terms, it is beneficial in public expenditure terms and socially it is beneficial?

**Paul Johnson:** Almost certainly socially beneficial as well.

**The Chairman:** For all of those reasons as to why you would want to do this?

**Paul Johnson:** Yes.

**The Chairman:** Very clear. Anybody else want to add to that? If you agree, just nod. If you do not, fine, so there is unanimity on that.

**Michael Johnson:** May I make one point? General immigration is not necessarily the answer. If one buys into the idea of fit retirement and frail dependency—

**The Chairman:** I am not sure we are going to recommend it is.

**Michael Johnson:** Let us leave it there then.

**Q598 Baroness Finlay of Llandaff:** We have already discussed to a certain extent the need to shift into social care but we also have within health care the cohort who are
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currently using the acute services for what are really long-term conditions, often acute exacerbations, because long-term conditions have not been managed well in the community so a crisis arises. Sometimes, it is not dealt with effectively and there certainly is no 24/7 cover out in the community to keep people there. We are really wondering whether, firstly, you agree with this as a problem in the community services and then how the current reforms are going to deliver the shift from the acute hospital-based approach when more and more people seem to be arriving at the hospital door, and how we will get the shift to the services being there out in the community to prevent that flow in happening. One area that concerns me in that is really where the responsibility for managing these long-term conditions clinically is going to rest, because we know that the number of GP referrals has not gone up but the patients arriving unscheduled at the hospital door has certainly gone up.

Lord Warner: My starting point would be the kind of numbers that were in the recent Dr Foster report on acute hospitals, which have been known for a long time, which is that, give or take, 25% to 30% of the people in acute hospitals should not be there. That is a good starting point. I do not think there is any dispute. Research evidence over a long period of time has shown that to be the case. So you then have to start asking questions why that has happened, and why it has happened in my view is that the 24/7 primary care service is highly deficient. I have had personal experience of that with relatives. A classic would be urinary tract infection of someone living in a nursing home. The home panics and says, “Ring the doctor”. Some out-of-hours service doctor arrives, calls an ambulance and they go into hospital. The hospital does not quite know what to do with them. They see some young man on Saturday night in an A&E Department. He admits, or she admits, and they are there for three or four weeks—traumatised, difficult to return—whereas if someone had actually administered an antibiotic in the nursing home and a bit of tender loving care, three or four weeks in a hospital at £3,000 a week would have been avoided. We have to start with primary care and that means you cannot suddenly grow a lot of GPs overnight but it does mean a much more robust approach to the GP contract in terms of what they are expected to do. We need to get back to the old system where GPs, if they signed up for the NHS, had a 24/7 personal responsibility for their patients and that was lost in the new GP contract.

Baroness Finlay of Llandaff: Should they be employed by the NHS rather than independent contractors coming in?

Lord Warner: I am not sure. I am not averse to having independent contractors per se provided it is clear what their responsibilities and obligations are. We are asking too little of them.

Baroness Finlay of Llandaff: But they will claim that they cannot cope because of the new demands of the clinical commissioning groups and so on. Do you think that the clinical commissioning groups are going to deliver the changes that are needed for this large group of generally frail and not requiring highly specialised services patients who are, as you described, particularly at weekends, ending up in hospital?

Lord Warner: I think part of the problem with general practice is its own structure. Still having large numbers of single and double-handed doctors is not a model for very efficient primary care in today’s age, so there is a set of issues about whether you just allow contractors to carry on with that kind of model. To make the transfer of money from the NHS to social care work, there have to be cashable savings in the acute sector. You have to take money out of the acute sector and move it across, so no fantasy savings but real
savings in what you pay for the services. To ensure you get cashable savings you have to reconfigure acute hospitals. There is no other way. I would say you have to be one of life’s great optimists to think that 200-plus local clinical commissioning groups are going to deliver that scale of reconfiguration, change and cashable savings. I know there are Ministers who take the view that that is possible; as a former Minister I do not happen to share that view.

**Q599 The Chairman:** Can you just explain why not, because there is obviously resistance, but you need some coherent plan, some coherent pressure, some coherent leadership? Is that it?

**Lord Warner:** Their scale of operations, in some cases, is too small. Unless they are going to operate across in some kind of federation of biggish numbers, they are too small. They simply do not have the budget muscle to deliver the reconfiguration of services on their own and we do know that the history of commissioning—since Ken Clarke started it 20 years ago—is very patchy. Some people have mastered doing good public sector commissioning in health, some people have not. Going back to 200 commissioning units when frankly where we were needing to go was to 40 or 50 commissioning units is a retrograde step in my book because they simply do not have the budget and the power to do it. A lot of hope is being expressed about health and well-being boards to deliver some of this change but I am old fashioned enough to believe that he who has the money delivers change, whereas planning units on their own do not deliver a lot of change on the ground.

**Paul Johnson:** To be honest, I do not have anything to say about the structure of the NHS. I will just leave it there.

**The Chairman:** You were nodding, though, at a number of points.

**Paul Johnson:** It sounded plausible to me.

**Q600 Lord Mawhinney:** Lord Warner, I am not sure whether I am damaging your reputation or my reputation or maybe both but you are absolutely right. The essence of the health service has been money. We talk about patients and patient care and quality of care but if you have been a Health Minister it is all about money. You stand at the dispatch box and all your colleagues ask you about is numbers of beds and money, so I agree with you. The idea that intrinsically out of the reforms big changes are going to happen is not real. Government must handle the big picture and then the others can handle the smaller. That leads me to the question I wanted to ask you out of your answer to my earlier question. I was wondering about blurring the edges between social care and health care in the primary sector—you deduced correctly. My question is: given that most people think the NHS is about hospitals, would you be worried about the status of the NHS if that fudging did take place in primary care so that the NHS in actuality, rather than just in perception, became more about hospitals and we called what happens in the community something else?

**Lord Warner:** Personally, I would not worry. I still think there is a lot to be said for also maintaining, as part of the NHS, the generalist primary care physician as a gatekeeper because they do demand-manage. If you compare us with other countries, that demand-management function is quite important because otherwise you would end up with a huge amount of self-referral to expensive specialist consultations. With all their foibles and weaknesses, primary care has an important gatekeeping function so I would keep that.

If you look at some of these other services—dentistry, opticians, pharmacists—they have established over time a co-payment system. Certain things have been ruled out of the NHS.
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Dentistry is a good example where a lot of it is cosmetic so it does not get paid for by the NHS. We have to probably become, once we have achieved this happy state of cashable savings from the acute sector, more robust about what we are prepared to include in the NHS envelope in my view, particularly as you have a lot of support for the idea of integrating health and social care. You have a ready-made, means tested system in social care already and I would try to gravitate some of those services into that area. Any such reputation as I might have within my political party has now probably been ruined by that remark.

Q601 Baroness Finlay of Llandaff: Can I come back to you on the gatekeeper in particular, because I completely agree with you over the role of the GP as an effective gatekeeper when you have a good GP. But we have other so-called gatekeepers now with different telephone advisory services that you may go through, I had this last weekend with a relative—three hours, three different calls. At the end of the day it was about getting a very simple prescription. It was a waste of the layers of people that we had to repeat the story to time and time again. I do not know how much it cost but it would have been much quicker if a GP had been a gatekeeper.

I wonder how, when you talk about changing this, you are going to change professionals’ behaviours to become less risk averse and begin to take risks that used to be taken but now are not. An example is the business of having to have a hospital bed in the house before some patients are discharged to home when they could be managed perfectly well in a single bed but the district nurses will not accept them at home. These are used as rationing tools and excuses to keep the workload down as it shifts from one sector to another. Yet we will not get people out of hospital fast unless we free up a lot of those behaviours. I wonder where you see the levers to change those behaviours happening in the system.

Lord Warner: I always like to come back at some point to what happened in the mental illness hospitals, the great Victorian asylums. There was a period of political leadership by Enoch Powell in which the decision was taken that we needed to get out of that model, although it took quite a long time for it to be achieved. One of the most important features of it is that once you remove hospital beds, when they are not there by some magical process people start to find other ways of coping. All the while you keep a very large number of beds which you do not need, I can predict that they will be filled and they will particularly be filled if you have a reimbursement system for hospital which pays for them to be filled. That is what we have, so if we want to cut some of this out, you have to shrink that acute hospital bed sector. It is a very uncomfortable thing to do, it is not obviously publically plausible but we have to begin the process of trying to get the professionals to start explaining to the public, with political permission, what is the safest and most sustainable way of delivering this health service that everybody loves because now the present system is not the most sustainable way.

Baroness Finlay of Llandaff: Do we need to be looking at going over to a co-payment system across the NHS just as we have in social care?

Lord Warner: I have been not only a Minister, I have been a civil servant. I cannot tell you how many times we would have been over the grounds of co-payments in previous Governments and the trouble with the co-payments in the present system is that they do not raise that much money—hotel charges and so forth, attendance fees at general practice, for example, which other countries have tried—and the administrative costs are quite high and the political resentment by the GPs of being, in effect, a tax collector for the
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Government is so high that you lose goodwill that you want in other areas. I am not sure that anyone has come up with a plausible co-payment system.

Baroness Finlay of Llandaff: How else can you start that political dialogue that there needs to be a change?

Lord Warner: The drivers for change have to be the medical specialists because we have to get this concentration of speciality services to free up the cashable resources. We missed the boat when all the extra money was going into the NHS. I would be saying different things, but there is not much spare cash around, so we have to take some of the money that is locked up in the system in capital plant and move it into the community based services.

The Chairman: Make it as a quality case rather than as a saving case.

Lord Warner: Absolutely. That is not a phoney argument.

The Chairman: Anything from Paul or Michael on the simple topic of the NHS and how to change it before we move on to public sector pensions?

Michael Johnson: It is not my area of expertise.

Paul Johnson: I will just make one quick statement about the issue of protecting NHS spending and some numbers that we put together last week. Just to illustrate the importance of the NHS and protecting the spending, if you look at the Government’s plans through to 2017 now, the public service spending looks like it will fall by about 17% in real terms from 2010 to 2017, so about 17% across the board. Because the NHS is being protected within that, or assuming it continues to be protected within that, plus schools and overseas aid which are very small—schools is very small compared with the NHS—then the cuts for all other departments, so this is transport and defence and local Government and so on, comes to one third. Because we are protecting the NHS, instead of 16% across the piece it is one third for those departments not protected. That is to have a sense of scale of spending on the NHS and its impact on other things.

Q602 Lord Bichard: I am tempted to ask Lord Warner whether with the benefit of hindsight we might have negotiated a different contract with GPs when that sort of money is rolling round and whether or not we could renegotiate, but that is not my question.

Lord Warner: You should talk to your fellow Committee member.

Lord Bichard: I can ask you – now that Lord Hutton has left of course; you can be entirely frank – Michael has already touched upon this, but on the issue of public service pension reform do the other two members at least feel that what we have is sustainable, adequate or appropriate?

Paul Johnson: I am glad you did not say affordable because that is difficult. In a sense it is affordable if we want to afford it.

Where do we end up with public service pensions going forward and what should we be benchmarking them against? Public service pensions are part of the remuneration package in the public service and so the appropriate thing to do is think about: what does the remuneration of public servants look like relative to the remuneration that they would alternatively be getting in the private sector and what role does pensions play in that? It is clear that pensions play a much bigger role now in the public service than they do in the...
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private sector as part of remuneration and that is true across different public services and across people at different points at the different levels of skill and pay.

Where does the rest of the remuneration package stack up? It looks like, on average, in the public service once you take account of different levels of education and so on, it is not too dissimilar between public and private sector for men. Women in the public sector do rather better than women in the private sector. That may reflect problems in the private sector more than anything else if you just look at pay.

Broadly speaking, the pensions look like a bit on top. Is that appropriate? I do not have a view as to whether the overall remuneration of the public sector should or should not be more than the overall remuneration of the private sector but that is broadly where it looks. Why do we have a situation in which pensions are so much more important in the public sector than the private sector? In essence, you could argue it is because the Government is able to provide pensions in a way in which employers are not able to provide pensions, so there the Government is able to provide this stuff. It provides it though in a way which puts the cost into the future and so one always worries about a situation in which the cost is pushed so much into the future.

It does not look like pensions are a recompense for low pay in the public sector. There are elements of low pay and there are regions where pay in the public sector are relatively low, but on the whole pensions are not looking like they are recompense for relatively low pay. What you end up with is, and this is not true just for pensions but in other areas, a public sector remuneration package and deal which looks increasing different from that in the private sector, so if you peel back 20 or 30 years the private sector also had quite a lot of significant defined benefit pension schemes. It was also significantly unionised. It is also significantly based on people moving up pay scales and so on. None of that exists in the private sector anymore but it still exists in the public sector. The differential treatment of pensions is part of what has been a long-term divergence between the way that public and private sector labour markets remuneration packages work.

Lord Warner: I only know about the NHS pension scheme, but there is a wider problem with the NHS. We did cap the employer’s contributions in the NHS scheme, or we started that process of capping employers, but by the time we got round to that the mismatch between the employee’s and the employer’s contribution was very large indeed. The driver had always been that if you wanted to keep that pension scheme in step it was the employer’s job rather than the employee’s job to bear the cost of the increases. That shift has started to help.

It is not just the pension scheme in the NHS. The NHS, as evidence from review bodies has shown over many years, has had higher wage drift than many other parts of the public sector and private sector. It has higher absentee rates and sickness rates than many others, certainly much more than the private sector, and in some cases more than other parts of the public sector. You have a situation where overall costs of remuneration are extremely high in a service where two thirds of the spend are labour costs. You can focus on pensions but there are wider sets of issues about the way the labour cost budget is constructed and managed.

Q603 Earl of Dundee: Mr Johnson, in your very interesting remarks earlier on about the case for reform of pensions when you began to explain it you reminded me of the words of Sir Alfred Mond, who happened to be the first Chairman of ICI in the 1920s and 1930s, and spoke passionately against pensions and on political platform said, “Why should a working
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man contribute to an old age which he won’t reach for the benefit of a widow which he hasn’t got?”, and his case was of course that at that time we did not live very long. Your background is the precise opposite. We live to be very old and you give us the explanation to why we might be at a crossroads where it is time to rethink the whole thing. If we were to rethink the whole thing, how much solidarity might we get within the global village from other countries who may already be in this new direction or would we be entirely ploughing our own new furrow?

Michael Johnson: Some countries in the developed world, and I am thinking immediately of Holland, have taken much more strident steps than we have in addressing the sustainability point and I divide sustainability into two components, affordability and fairness. With one minor exception, I think I am right in saying that in this country we have never reduced pensions in payment. In 1973 to 1974 we froze indexation for a year. What we are seeing in Holland is they have roughly 450 large occupational schemes. In April next year (2013) they expect to reduce pensions in payment in 81 of those. They have come to that point because within the structure of the schemes they have control levers and when a funding ratio falls below X a lever gets pulled and then there is a series of discussions about what they are going to do about this, which means: what are we going to cut? That includes looking at accrual rates but it also includes cutting pensions as well. That is a significantly further step than we have ever taken.

The Chairman: Could you send us a note on that?

Michael Johnson: Yes, indeed. I have written a book on this.

The Chairman: A note is even better.

Michael Johnson: I can tear the page out for you. This was backed by Baroness Hollis and Lord Blackwell in competition to Lord Hutton’s report. Maybe that is for discussion a little later.

There are two questions here; there are Lord Bichard’s points about public sector pensions and then there is the broader point about pensions in general. In the context of public sector pensions and what we should do: we should be preparing that community, with an observation which is that post-Lord Hutton’s reforms public servants will continue to enjoy certainty of income in retirement until the day they die—not final salary but career average base, certainty of income until the day they die. That is paid for by the 80% of private sector workers who no longer enjoy such certainty because by and large the private sector has become a DB desert.

That is the fairness component of the sustainability question. What to do about it? In the context of public sector unfunded schemes—and we have to distinguish between funded and unfunded—I am very keen on unfunded cash balance as a structure and funded cash balance is something the DWP was looking at in the context of funded schemes. Cash balance, just to summarise, is a structure whereby an account is credited for individual employees and a growth rate is assured on that account—that pot, a virtual pot in the context of unfunded schemes to the point of retirement. At the point of retirement there is X in the virtual pot virtually. That credit is then handed over to the retiree who is then encouraged to buy an annuity. The retiree assumes the longevity risk and I really like that because that represents a major transfer of risk from the state, and taxpayers in general, to the individual within the public sector, and—let us be clear—almost everyone in the private sector today bears that risk.
Michael Johnson, Centre for Policy Studies, Paul Johnson, Institute for Fiscal Studies and Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010-11—Oral evidence (QQ 583-606)

**The Chairman:** Hutton mentioned that but it was a very small paragraph, was it not?

**Michael Johnson:** Yes. The DWP is doing a lot of work on CDC, collective DC, which is also an area for investigation here, and also Defined Ambition, but maybe now is not the time for that. To go back to your point, sir, at the beginning: are we in the vanguard of considering change? No we are not.

Q604 **The Chairman:** Thank you, Mike, that was well-handled. Thank you all for staying longer. Paul, would you like to have the closing word, because I am aware that we have not given you quite as much floor space as we probably could have gained benefit from doing so? Having heard where we are at, having listened to the conversation, are there two or three points that you would like us to go away with and reflect on?

**Paul Johnson:** The point about the scale of spending in these areas is an important one. One way of looking at this is, if you look back to the late 1970s, we spent about a third of everything the Government spends on health and social security. It is now about half and if you look 40 or 50 years hence half is just on health and pension. Half of everything the Government will do will just be on health and pensions, so that is one way of thinking about the scale of change and the extent to which the state has just become a source of providing health and pensions. If you add on social security then it will come to about 60% or more looking forwards. That is just one sense of scale.

I do think terribly importantly in the other things that we have been talking about are firstly this issue, where we kicked off, about risk sharing in all of this. We have had a good discussion today, but something that has not been well-aired publicly is this question about who bears risk and how. That relates both to the build-up of pension provision for a particular generation, how you share risk between generations and the role of state and employers in bearing that risk, and we have got things horribly wrong in the past. One of the things that went wrong with defined benefit pensions in the private sector was all risk was lamped on to employers and that went horribly wrong. We have now lamped all risk on to individuals and that is highly unlikely to be optimal. We need to think about that both in a direct and in an intergenerational context.

Then there is also this issue that we talked about in terms of the difference between certainty and clarity. I am sure you have had lots of people complain about the fact that pensions policy is always changing and people do not have the stability in which to plan. Inevitably things are going to change. Things change over time. Beveridge is no longer applicable now, and it was 60 years ago. Whatever we do now is not going to be applicable in 60 years’ time, but more clarity about the way which change occurs and the broad structure and framework in which policy is being made will be incredibly valuable, because I do not think we have anything approaching that.

**The Chairman:** I do not understand what you mean by that last sentence.

**Paul Johnson:** Take as an example tax relief. Michael has views on tax relief; I have views on tax relief. I have no idea what the Government’s view on tax relief is. I have literally got no idea what the Government thinks about the appropriateness of tax relief on pensions. It has changed its view at least twice in the last two years. We just ought to know.

**The Chairman:** Nice clear example.

**Paul Johnson:** We have had changes in the way in which the state pension is being indexed. The Government has said it is going to keep it up for this Parliament but where is that going to go and what would push it in another direction? What are the things that would cause
change and what are things that would not cause change? Where does the Government believe it is as opposed to feeling it has to be at the moment because of political pressure? There is a lack of a framework that I see in big areas in which these decisions are made.

Q605 The Chairman: Thank you, Michael.

Michael Johnson: My Lord Chairman, may I make two final optimistic points? First of all, the baby boom bulge will pass. It will move through the population and there will be life and enjoyment beyond the passing of the baby boomers. The other point is that while life expectancy is improving and increasing, the relevant question is how many of our additional years will be spent in unhealthy state? The data seems to be suggesting that, proportionately, the amount of time that we will spend in an unhealthy state is diminishing as a percentage of our total life expectancy. I take that as grounds for optimism, rather than living with five or 10 years of disability. It may be that the period of frail dependency is going to stay or even reduce from typically two and a half to three years, in care homes, down to maybe one or two.

Q606 The Chairman: Lord Warner, do you want a final word or not?

Lord Warner: I just want to emphasise this issue that we looked at, which is the whole issue of intergenerational fairness. It is something that does not get much of an airing publicly and politically and when we were doing the Dilnot Commission we were very conscious that it was very easy to go down a road in which you concentrated on the needs of the ageing population but you were stacking up a lot of trouble for the next generation down.

The Chairman: Yes, indeed. Thank you. Can I thank you all very much? It has been a fascinating and very helpful session. If there are further thoughts that you have when we signal, do please send a note and that will be much appreciated. Thank you all very much indeed.
Paul Johnson, Institute for Fiscal Studies, Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010-11 and Michael Johnson, Centre for Policy Studies—Oral evidence (QQ 583–606)

Transcript to be found under Michael Johnson, Centre for Policy Studies
The Joseph Rowntree Foundation (JRF) is one of the largest social policy research and development charities in the UK. For over a century we have been engaged with searching out the causes of social problems, investigating solutions and seeking to influence those who can make changes. JRF’s purpose is to understand the root causes of social problems, to identify ways of overcoming them, and to show how social needs can be met in practice. The Joseph Rowntree Housing Trust (JRHT) shares the aims of the Foundation and engages in practical housing and care work.

Summary
JRF welcomes the establishment of the House of Lord’s Committee on Public Services and Demographic Change and the Call for Evidence. This response provides an outline of issues drawing on some of our existing evidence. The Committee may also be interested to know of work in progress (where research evidence will publish over the coming months). We would be delighted to offer further briefing on these areas should this be of interest:
- A Better Life for older people who have high support needs
- Risk, trust and relationships in an ageing society
- Risk and relationships in care homes
- Neighbourhood approaches to loneliness (multi-generational approach)
- Creating dementia-friendly communities and neighbourhoods for all ages

We would urge the Committee, in discussing the challenges of an ageing population, not to lose sight of the bigger picture: increased life expectancy is to be celebrated and our society and economy is all the richer for the participation of older people. Discussion regarding demographic change is often focused on pensions and social care funding debates – both are important issues, but so too are housing, community life, and the way we all (as individuals and families) prepare for and understand the realities of longer lives. Old age is about all of us – a message highlighted through our website: Old Age, New Thoughts (http://betterlife.jrf.org.uk)

1. Introduction

1.1 JRF believes that all of us have yet to fully grasp the ways in which our society and economy will change due to our ageing population. Many of us are unprepared for the costs associated with a longer life – under-saving for pensions and remaining unaware of the costs of social care. Our labour market has not yet changed to enable people to work longer, and crucially, more flexibly – to take into account the fact that an ageing population also means a population living with health conditions and impairments, and caring responsibilities. Our public services – from transport, to health, education, housing and social care – could better reflect the needs and priorities of an older population which is more diverse and (in some respects) more demanding than previous generations. The government is not leading by example. Whilst pension reform is welcome, we still see (for example) the poor treatment of older people by health services and insufficient prioritisation of social care reform and appropriate housing (despite recent announcements). We need a revolution in the way we think about ageing and old age to drive the change required at the individual and household level, all the way up to national government. We must recognise that old age isn’t about ‘them’ –
it is about all of us. Below we outline issues which need to be tackled to make this concept a reality.

2. **Ageing and the individual**

2.1 The political debate regarding ageing often turns into a narrow discussion regarding pensions and social care costs. However, the challenge of an ageing society is not simply a financial one – but a social and cultural one. It is also a challenge which demands an approach that looks across age, lifestage and different generations, without assuming the presence or absence of intergenerational conflict.

2.2 Taking on board that we, and our families, friends and neighbours will all live much longer than previous generations means changing our expectations on several fronts – about working and retiring, about becoming carers and needing care ourselves (often at the same time). More of us will experience ‘sandwich’ caring (e.g. looking after parents, grandparents and children while also working; Mooney et al 2002). Household composition will continue to evolve and diversify.

2.3 Of great concern: we know that many people remain unaware of the potential costs of care in later life, remain inadequately informed and prepared. This compounds distress, hardship and poor quality of life for those currently experiencing the care system (Beresford 2010, Stone and Wood, 2010). While care funding remains under review, there are fears that it will be several years before a fully functional, fair and sustainable funding system is in place. Moreover, in the current climate, caring and needing care are seldom compatible with working longer (Mooney et al 2002), and indeed both are often associated with financial, physical and emotional hardship (Young et al. 2007, Himmelweit and Land, 2008).

3. **Community life**

3.1 At community level, hopes are for a more visible and active older population, playing a role in economic and community life. Older people value trust, social bonds, and meaningful relationships with friends and family (Bowers et al 2009; Katz et al 2011). As they grow in number, communities will increasingly become shaped by these demands – not simply by older people being ‘recipients’ of community support but as active participants – giving as much as they receive. (Brindle, 2008; Branfield and Beresford 2010; Cattan and Giuntoli 2010). Already older people comprise a large number of community activists and volunteers.

3.2 Community and voluntary life need not take the shape of working-age volunteers ‘looking after’ older populations. Older people can and do look after each other (Bowers et al 2011), often providing valued and cost-effective self-help or peer support in ways that are cost-effective, improve outcomes, and merit financial and other support (Centre for Policy on Ageing 2011). There could be greater recognition of the role of older people as givers and receivers of community support through the government’s localism and community agendas (Brindle 2008; Wistow et al, 2011).

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4. Intergenerational compact

4.1 The current economic downturn and growing housing crisis mark a clear difference between current and future generations of older people, and give rise to important and difficult discussions around intergenerational fairness and distribution of resources. The current baby boomer cohort, the majority of whom are home owners, are likely to be far more financially secure relative to both their predecessors and successors. Dwindling numbers of working age adults are set to support larger numbers of pensioners, whilst at the same time struggling to provide for their own old age and unable to get on the housing ladder (Clapham et al 2012). Sharing the burden more fairly is essential for widespread buy in and support for any future care funding settlement (Hirsch and Spiers 2010, Stone and Wood, 2010; Keen 2008). Two-tier solutions, for example tapping in to current older people’s accumulated assets and at the same time asking younger people to accumulate slowly, could be a most promising way forward (Hirsch and Spiers, 2010), as it recognises that an asset based solution to care funding will be less suitable for future generations of older people. Public caution and government equivocation regarding equity release needs to be tackled, recognising such products have become better protected and more flexible over the last decade (Terry and Gibson 2011).

4.2 Less researched but of increasing significance is the ethnic composition of different generations – which is already marked in some neighbourhoods, towns and cities where populations comprise of a growing population of mainly white older people and a growing population of mainly black and minority ethnic younger people. This will bring both opportunities and challenges, and we should also expect the specific dynamics to play out differently in different places across the UK (even at the micro-level - in different streets, estates, neighbourhoods).

5. The economy

5.1 More people are being (and will be) required to work while managing health conditions or caring responsibilities, as well as being able to work longer. We cannot assume that only healthy and fit people with the ability to work full time can carry the economy and generate adequate income from taxation to support ever increasing numbers of people locked out of the labour market and prematurely made dependent on benefits and public services. Yet, many older people leave the labour market in line with increasing age, ill health and caring responsibilities, often without the option of bridging jobs, which would allow some continued income whilst taking into account these other factors. For those who do leave, their risk of poverty increases and they are at greater risk of social isolation (Hirsch, 2003).

5.2 Improving opportunities for older people to work longer requires action on several fronts as others (including recent work by think tanks like Policy Exchange and the Resolution Foundation, as well as work by campaigners like Age UK) have identified, including tackling ageism in the workplace, increasing the number of flexible and part time positions and ‘bridge’ jobs, improving guidance for older workers to forge new career paths and improving life-long learning.
6. **Priorities for public service reform**

6.1 The shape and nature of all public services must change to recognise that a growing proportion of service users are older people, with a diverse range of needs (Falkingham et al 2010; Blood and Bamford 2010), who also want to be able to shape services to meet those needs (Beresford and Andrews, 2012). This is true of adult education as it is of healthcare, but nonetheless, the JRF recognises that the government’s priorities for reform must lie in health, care and housing if it is to have an adequate response to an ageing population.

6.2 First and foremost, the balance between health and care must change. Investment and political emphasis has always been on health, but this is the mark of a time when life expectancy was much shorter and people often died of treatable illnesses. In such a context, acute care and ‘treat and cure’ services understandably took precedent. But that time has passed. Now, more people die from lifestyle related and long term conditions and people live much longer with life limiting illnesses. This requires greater integration between health and care so that we can shift our focus from curing to managing conditions, and from acute care to providing on-going treatment and support (Beresford and Andrews, 2012).

6.3 Second, social care must become more empowering. Our ageing population is not simply a question of growing numbers, but also of the changing characteristics of the older population. Older people are a more diverse group, with greater expectations that their diverse needs will be met. They demand more of the services they receive, and who delivers them. JRF has a growing body of research providing insight into how expectations are changing across all care user groups (see Beresford, et al., 2012; Mauger, et al., 2010; Bowers, et al., 2009; Glynn, et al., 2008; Hart, et al., 2007; Branfield and Beresford, 2006 and 2010; Innes, et al., 2006; Godfrey, 2004). These include increasing expectations:

- of person-centred support, where users participate and engage in planning and managing their own care rather than receiving support in a passive way);
- that care and support will facilitate greater independence, independent living and social engagement, including in residential settings and among both working-age and older care users;
- that care and support will actually deliver a far wider range of outcomes than those narrowly falling within either health or social care – including supporting housing, leisure, social and family outcomes within local communities, and being able to achieve a ‘normal life’ or live on as equal terms as possible to non-disabled peers;
- that there will be possibilities for people who use care and support to be more involved in the wider design, commissioning, delivery, monitoring and evaluation of support and services generally.

6.4 Whilst the government has moved forward on many of these fronts, the shortage of adequate funding will naturally limit the impact of such reforms (JRF Response to the Dilnot Commission, 2011; Beresford and Andrews, 2012). Moreover, these expectations inevitably require a rethink of the approach to risk, and the regulation of risk, in social care - and this is not something the government has yet tackled in any
meaningful way. A wholly risk-free environment, which social care practice has moved towards due to fears of blame and compensation culture, is not only artificial – it can also stand in the way of greater independence and empowerment, and undermine the quality of the caring relationship valued by older people (Berry 2011; Glasby 2011).

6.5 Third, we must invest in preventive and early support services. Costs associated with physical and mental decline with age are not inevitable. This enquiry is rightly concerned with tackling the fiscal implications of an ageing society - investing in preventative support must be a central feature (Raynes, et al., 2006). There is evidence that many low-cost interventions can prevent or delay the additional health, care and other needs associated with physical and mental deterioration in later life. Many can achieve so-called compressed morbidity (i.e. delaying the onset of chronic and disabling diseases and conditions until the last years, and perhaps months, of life) (Centre for Policy on Ageing, 2011). Promoting independence and quality of life with low-level preventative support is highly valued by older people and in great demand. Many older people say they want what is best described as ‘that bit of help’, to help them remain independent and enjoy a better quality of later life (Clarke, et al, 1998; Raynes et al 2006).

6.6 Another public service strongly connected with an ageing society is housing. Our current housing stock, and planning, investment and building regime is not fit for purpose in the light of increased numbers of older people living independently at home. For example, the specialist housing currently on offer does not provide older people with the choices they want – there is a limited supply of properties for purchase (rather than rent) and two few with two bedrooms. Housing providers tend to focus on retirement villages and housing with care when thinking about housing that is ‘suitable’ for older people, and there is slow progress in developing different housing options for older people and in integrating these within mainstream new housing developments (Pannell et al 2012). Yet the quality and suitability of an older person’s home has a significant impact on their mental and physical health and well-being. A suitably adapted, conveniently located home can make all the difference to an older person’s sense of social inclusion and independence, and can certainly delay, if not remove altogether, the need to move into residential care settings. The findings of the HAPPI report 210 published in January 2010, gives a clear picture of what can be, and has been, achieved in the UK and in other countries in terms of innovative and cost-effective ways of building sustainable and inclusive homes and communities for an ageing population. It includes a case study of Hartrigg Oaks, a continuing care retirement community built and run by JRHT in York.

6.7 JRF therefore welcomed the importance placed on the integration of housing with care and health in the recent government White Paper on social care, as well as the funding announced for the Disabled Facilities Grant and Handy Persons, and capital funding for new accommodation. However, it is too early to say whether such measures will fully address the issues, or whether, for example, the balance between building new accommodation and investing in existing accommodation (to enable people to ‘stay put’) is appropriate (Hill and Sutton, 2010; Pannell et al 2012).

210 www.homesandcommunities.co.uk/housing-ageing-population-panel-innovation.htm
7. **Overview**

7.1 No one, and not a single business, organisation, institution or community, will be untouched by our ageing population. With a challenge of such scale, change must be driven, and leadership by example is vital.

7.2 The government must lead by example showing courage to think longer term at a time when short term economic crisis management is top priority. If we are to cope with an ageing population we must rebalance ‘treat and cure’ and condition management in the NHS. We must rethink our housing and planning strategy in ways that reflect the needs of all ages and generations, including improving the housing ‘offer’ and support for older people to move house should they wish to. We must invest, at a time of scarce resources, in “that bit of help” for older people. We must look afresh at how to create non-discriminatory and inclusive workplaces for those who need to work part time and flexibly to meet the challenges of older age and/or of combining work with caring responsibilities. We must create a transparent, fair and sustainable funding system for social care, which enables people to plan for later life, armed with the knowledge of what the state will and will not fund when it comes to care and support costs.

7.3 The focus of this call for evidence has been on the impact of an ageing population on public services. Key to this issue is the achievement of greater financial sustainability. It is of concern that health and care costs may absorb an ever growing proportion of GDP and that our economy is configured to function effectively only if fit, able and younger workers considerably outnumber those who are disabled or older, or who have caring duties. Maintaining sustainable public services in the face of an aging population is not only dependent on structural reform. A **cultural shift** at an individual and community level as well as in the workplace and in public services is equally important if reforms are to enjoy widespread public support and have any real impact on the quality of life of older people and their families.

7.4 Therefore, alongside the areas for reform highlighted above, it will also be important for government to support or drive more nebulous cultural changes:

**Within families and communities:**
- A shift in expectations – of being active in one’s community and economy for longer, and of providing care and of needing care
- A greater understanding of the need to prepare financially for later life and to maintain healthy ageing, making use of ‘that bit of help’

**Within public services:**
- A change in the top down provider/recipient model to one of mutual support and reciprocity
- An expectation that older people will have a much stronger voice in shaping the services they receive, and possibility a role in delivering them
- A more positive and enabling approach to risk, to achieve greater independence and personalisation for older people around outcomes that they value
- Sensitivity to intergenerational fairness, recognising that an ageing population also has an impact on younger generations.
7.1 As we noted at the outset of our response, ageing – old age – is not about ‘them’. It is about all of us. We hope that this point will remain front of mind as the House of Lords Committee on Public Service and Demographic Change considers the responses it receives to its Call for Evidence.

**Biography**


31 August 2012
Joseph Rowntree Foundation, McCarthy and Stone, National Housing Federation and Care and Repair Cymru—Oral Evidence (QQ 159–214)

*Transcript to be found under Care and Repair Cymru*
Joseph Rowntree Housing Trust, Professor Pat Thane, King’s College London and Fellow of the British Academy, Age UK and International Longevity Centre—Oral evidence (QQ 72–93)

Transcript to be found under Age UK
Further Questions
Whether the Government has a goal of sustaining independence, and whether it should have such a goal.

John Kennedy’s response:
People want to remain independent and engaged as long as possible. It is a personal goal and would be a worthwhile goal of Govt too. By helping people, through advice, information, services etc not only benefits the wellbeing of the population but will also reduces the impact on communities, care and health systems.

Sustaining independence will be different for different for people.

Of course it is about good accessible housing, access to health care and health advice, access to advice on finances and access to “that little bit of help”.

There are though other powerful factors which need to be recognised. Loneliness can have a devastating impact on an individuals health and wellbeing. Stigma and exclusion (ageism, dementia unfriendly).

Government can:

Be clear as to what its responsibility is vis a vis the citizen. Particularly in terms of finance but also in terms of overall responsibility.

Be active in encouraging people to think about their futures. Their finances, housing, community.

Be an enabler of providers and people to access a ‘toolbox’ of solutions and not just rationed, traditional services. It is really important to encourage the growth of low level services which offer a ‘little bit of help’, a stitch in time! Too much of the current system is focussed on the crisis end when it is too late.

Give people more ‘permission’ to be good neighbours. ‘stranger danger’ may have become too entrenched in the psyche and inhibits community responses and neighbourhood solutions.

Engage professional services e.g. Solicitors, financial advisors, Doctors, Estate Agents etc to include in their ‘scope’ the subject of the future.

Genuinely enable personalisation to become a reality, with real choices and options. Encourage development of housing for older people.

People can:

Be proactive in thinking about their future. Consider the future when making financial decisions. Take responsibility where you can.
Consider when making important decisions in life ie moving, starting a family, etc. How might this affect me when I am older, what do I need to think about.

Think about making and keeping good relationships were they can.

Think about making life moves ie moving to the coast\Costas etc precisely at the time they will need their networks and support.

Be part of the future you want. Volunteer. Keeps you active and could build a sustainable network when you need it.

John Kennedy, Director of Care Services

8 November 2012
The King's Fund, NHS Commissioning Board, Professor David Oliver, Carers UK, Care Quality Commission and Age UK—Oral evidence (QQ 215–288)

Transcript to be found under Age UK
TUESDAY 27 NOVEMBER 2012

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Finlay of Llandaff
Lord Mawhinney
Baroness Shephard of Northwold
Baroness Tyler of Enfield

Examination of Witnesses

Dr Ros Altmann, Director-General, The Saga Group, Richard Humphries, Senior Fellow, Social Care and Local Government, The King’s Fund, Joanne Segars OBE, Chief Executive, National Association of Pension Funds, and Professor Noel Whiteside, Professor of Comparative Public Policy, University of Warwick.

Q463 The Chairman: Thank you very much indeed for coming. I will not introduce all of us; you can see our name badges. Please go along the row and introduce yourselves to us with a couple of words.

Professor Whiteside: I am Professor Noel Whiteside. I work on comparative public policy. I think I am here because I have recently finished a European comparative study of pensions.

Joanne Segars: I am Joanne Segars, and I am the Chief Executive of the National Association of Pension Funds, which is the trade association for the UK occupational pension sector.

Dr Altmann: I am Ros Altmann, currently Director General of Saga, which specialises in over-50s. I am also an independent pensions expert, and for many years have done academic and public policy work on pensions, savings and investment.

Richard Humphries: I am Richard Humphries. I am Senior Fellow at The King’s Fund, which is a health policy think tank, and I think my boss, Professor Chris Ham, has given evidence to you recently.

Q464 The Chairman: Absolutely. Thank you very much. You know the essential thrust of our inquiry, which I think is asking a pretty simple question: are we as a society, as individuals and in terms of our public policies and services, ready for the ageing that is
happening to our society? If not, what does that then imply? Clearly this session, which is essentially looking at the funding of social care and pensions, is a critical one because people are going to live longer than perhaps is expected; how will that be funded and what are the consequences for care costs and so on? That is the broad thrust. We have spent a lot of time up to now on other aspects of health and social care, but this is essentially focusing on funding.

We will start straight off, and I open it with a question I think you have seen already: will our population due to retire in 10 or 20 years’ time be able to look forward to a comfortable retirement with adequate pension? It is a fairly broad opening to give you plenty of scope. So in a sense come in on questions as you wish, maybe by signalling. Do not feel you have to answer every one if it is not your expertise, but I suspect all of you will want to say something on this. Who would like to start?

Joanne Segars: As the Pensions Commission itself set out, there is no immediate pension crisis for today’s pensioners, and perhaps somewhat counter-intuitively, today’s cohort of pensioners of almost every age group are better off than pensioners 10 years ago. I think the problem is for those who will be the immediate next cohort of pensioners, who will not, for example, benefit from the auto-enrolment reforms the Government has just introduced. The Institute for Fiscal Studies has just produced some very good research on who, in that age group between 50 and state pension age, is likely to miss out on pensions. They find that 12 per cent of people between 50 and state pension age will have income at state pension age from state and private pension provision below the pension credit guarantee level, so there is a particular problem for this cohort of pensioners who are about to retire. That golden generation has retired, but the next generation will be considerably worse off.

The Chairman: And that is those who will retire in five to 10 years’ time?

Joanne Segars: Yes, those between 50 and state pension age currently.

The Chairman: Very helpful, thank you. And that is the IFS study that came out?

Joanne Segars: That is in the IFS study.

The Chairman: We will have a look at that, thank you.

Professor Whiteside: I am worried because of two features. I broadly agree with the statement that has just been made. I am not terribly sure it will be that much better in 20 years’ time, but that is also to be left to one side. There are two main problem areas, and these are portability and persistence. We get an awful lot of evidence that has snapshot studies of how much coverage there is at a given point in time. We know very little about the persistence of people contributing to their private pensions over the long term, particularly if they move into part-time work or they change jobs—the portability issue. I know Steve Webb has been working on this. I do not know how far he has got, but this is going to be a major problem because it is going to leave pensioners in the future with lots of little pension pots. They lose touch, companies merge and change hands, they do not keep records for 40 years, and this will create a great deal of difficulty for people actually trying to claim what is due to them.
There was a piece in the Financial Times recently—I am afraid I have not brought it with me—that stated that at the moment there is £3 billion-worth of pensions unclaimed, and that will rise to over £300 billion\textsuperscript{211} by 2050.

**The Chairman:** Can I just check I have understood the points you are making? It is partly the issue about a person who is retiring being able to access their separate pension pots because they aren’t consolidated.

**Professor Whiteside:** Yes, absolutely.

**The Chairman:** Is it also that we in policy terms are not sighted on what is happening to individuals’ accumulation of pensions?

**Professor Whiteside:** Exactly, yes.

**The Chairman:** For the latter, surely there must be surveys that do that?

**Joanne Segars:** I think that is one of the advantages of the IFS study. Their ELSA study—English Longitudinal Study of Ageing—does take that longer term view. It does track people through their pension-saving history, and we have published some research with the IFS on this subject, particularly relating to annuities, which we would be very happy to share with the Committee.

**The Chairman:** Thank you, we would welcome that.

**Dr Altmann:** From a public policy perspective, I would be coming at this from a very different angle from my colleagues.

**The Chairman:** Good, we like a bit of a debate.

**Dr Altmann:** We do have a pensions crisis, and it is something I have been writing about for the last 15 years or so, certainly for the last 10 years. The issue here is that we are not thinking clearly about what the demographics that we face mean for all of our futures. We have to radically rethink both pensions and retirement. Pensions alone will not solve the crisis we face or the problems faced by people who are trying to retire in the conventional, traditional manner, and thinking they have a hope of having a decent lifestyle on the amount that they manage to save during their working life.

We have a disconnect between financial reality and expectations for those of working age, who are being encouraged to put money aside in what is called a pension, which is basically just one financial product, and somehow thinking that that is going to magically transform into a decent income from a particular age or a roughly particular age, to sustain them for the length of their extra life expectancy. It just does not work.

We have to rethink retirement. We have a pensions crisis because not enough people are saving for their future. That is one issue. The pensions crisis, which the Pensions Commission said was not a crisis, will lead to a pensioners crisis, and is already doing so now, as Joanne just described.

**The Chairman:** I would not have thought you would necessarily disagree with that, would you?

**Professor Whiteside:** No.

**Joanne Segars:** No.

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\textsuperscript{211} “Professor Noel Whiteside subsequently indicated that, being unsure of the figure, she would prefer the transcript to read “substantially.””
The Chairman: It is an additional point rather than a contradictory point, is it not?

Joanne Segars: Yes, and we have said very clearly at the NAPF that pensions are not the only way of saving for retirement. For most people on lower incomes, they will be the main way of saving for retirement. We do need to make sure that people have a clear picture of what they are likely to get from their pension, so we do not have this problem of people assuming that they are going to have a very comfortable income when they do not. We do have to educate individuals, employers and the financial services industry about how we rethink that pensions part of the retirement jigsaw, but I do not think any of us would suggest, and certainly not the NAPF, that pensions are the only way of saving for retirement, and that we do not need to rethink what retirement means, and in particular that work into retirement.

The Chairman: We will come back to that.

Q465 Lord Mawhinney: I would like to ask Dr Altmann a question, if I might. I am slightly in awe of someone who bangs on for 15 years about this, comes here and tells us it is a crisis, and if by reputation you are whom I think you are, you will continue to bang on about this. So this having been exposed, everybody having been told and knowing that it is all pretty awful, what is it in practical terms—I am not interested in theory—you would want us to say that might enhance your optimism about the next 15 years, given that the last 15 years have been a prelude to crisis, which is your word this morning?

Dr Altmann: I certainly think from a policy perspective there is still some denial about what can be achieved. We have this policy of auto-enrolment, which will be encouraging every worker to put a small amount of money into pension schemes. They will have no idea what they are going to get out of it, but somehow policy is saying, “If you want to save for retirement, if we want to solve this problem, we have got to get people putting money into pensions”. That is not the answer. We need to rethink retirement.

The Chairman: I think I know what you mean, but you are not saying it. Spit it out, if you would.

Dr Altmann: This all stems from the demographics, which is great news. Lots of people are living longer; work is easier. We have had health and safety, which may be ridiculed in parts of the press but has done tremendous things to make it easier for people to keep working. If you are fit, healthy and have human capital into your 60s and beyond, there is a whole new phase of life waiting there to be grasped. It is a phase of life after full-time work where you are cutting down but not stopping altogether. You are still contributing to the economy. If we do not do it, we will have this whole demographic baby boom cohort stopping work, not contributing anything to the economy, not having a lot of money to live on, and wasting their talents.

Policy needs to work with that. We have missed a lot of years when we could have been encouraging it. The sooner we start, the better. This Government has started to some degree, in terms of accelerating the state pension age increases and getting rid of the default retirement age, but we still have a significant issue in our pension system because the state pension penalises both private working income and private pension income. As long as you have got nearly half of pensioners entitled to means testing, whether or not they claim it, you cannot get the right incentives working for the masses—the ordinary people. The very well off are okay, I suspect, but the lower to moderate earners will not understand the reality or the opportunity that they have for themselves. Because society writes them off, they write themselves off.
Q466 The Chairman: Is it an incentive issue or an understanding issue?

Dr Altmann: Both. We have not even got to first base in many ways. Most people think that somehow just putting money into a pension will allow them to stop work completely at roughly the traditional age.

Joanne Segars: We have to be realistic about this, do we not? I take a rather more positive attitude on auto-enrolment than perhaps you have just outlined. Auto-enrolment will give 6 million to 9 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. That will give very many people some income in retirement that otherwise they would not have had. We need to augment that, and one of the things this Committee might usefully say, to go back to your question about some of the practical things we can do, is that we have been waiting for a very long time now for the Government to make its announcements on state pension reform. We are all hoping that we will see some announcement on that next week after the Autumn Statement.

We need a decent foundation for that private saving, which at the NAPF we call a foundation pension—something that gives people a very clear and easily understandable amount of pension from the state. If they get that amount from the state, which we think will be about £140 a week, what they save on top of that cannot be means tested away. That will be the good incentive for people to save, and it will give people a very clear indication of what their income prospects will be in retirement, and whether or not they do need to, for example, extend their working life.

Perhaps where public policy has missed out is thinking about how we extend employment opportunities for older workers. We have seen an enormous number of people post-state-retirement age now in the labour force, but, as a nation and as public policymakers, we have not thought quite clearly enough about what the opportunities are to re-skill and help people. It is very easy to say the answer is people have to stay in work for longer. Clearly some people will not have that opportunity, but there are issues about how we re-skill people and give them those opportunities, and I think that part has not been properly addressed.

The Chairman: Very helpful. We will come back to some of this in more detail.

Professor Whiteside: I just want to make a couple of short points. Apropos auto-enrolment, the research on KiwiSaver in New Zealand, on which our auto-enrolment scheme was based, shows quite clearly that after an initial burst of auto-enrolment, the drop-out rate is huge for one reason or another, so I am not particularly impressed by the long-term prospects of auto-enrolment.

The Chairman: We will come back to that in a minute because it is crucial.

Professor Whiteside: The second point I wanted to make was to address the issue of social justice. At the moment we allow people to enter the labour market at 16 - if they find work, admittedly that is a big ‘if’ at the moment. They work for 50 years and at the end they get the same state pension as someone who has entered the labour market at 26, 27 or 28. While I support the idea of 30 years as a minimum gender-neutral remit for gaining a state pension, one must realise that in social justice terms this is extremely unfair.

The Chairman: So what is the fix?
Professor Whiteside: The fix has to be to reward people who work longer through the state pension.

The Chairman: In pension terms?

Professor Whiteside: In state pension terms.

Lord Mawhinney: Can I just do a follow-up, given it was my question that kicked this bit off?

The Chairman: All right, if you can keep Lord Bichard quiet.

Q467 Lord Mawhinney: I am slightly confused. Public policy terms by and large in this area are how you look after people who do not have a private income coming in. Yet all of the answers we have heard have been that people should work longer and so on. That is fine; I am all in favour of people working longer if they can and want to, because that enhances their economic well-being. But what about all of the people who do not? I think what I am hearing from Dr Segars and Professor Whiteside—I did not hear it from Dr Altmann—is you are simply saying Government have got to spend more money by raising the pensions for those who are not able to work beyond a certain age. It would be helpful to know whether that is what you are saying. If you are not saying that, what are you saying? I am getting confused.

Dr Altmann: I am saying that there should be a different way of thinking about later life income support than the current national insurance system delivers. That would mean a basic minimum state pension. One can argue about the age or terms on which it is paid, but it is a basic minimum—that is all. Everybody while they are working would know that there will be some minimum level of state support they will receive, but they do not know exactly what age it will be received at, which is very important, because then they do not plan for a magic age beyond which they should think they cannot do anything and they are on some kind of, if you like, labour scrapheap, which is what most people currently think. If you have a basic state pension, which is not means tested, everybody will be able to understand and plan on that basis.

In later life, if all I want is £140 a week and I am happy with that, I will not bother saving; I will not worry about any extra money—that is it. Society then would in most cases leave them to make their own decisions and would not have the extra responsibility to them because they are giving them the minimum level, but everybody’s self-interest would then allow them to understand that they do have to do something for themselves.

Q468 The Chairman: What you have described, put crudely, is essentially what Turner recommended, is it not?

Dr Altmann: No, Turner was not really talking about this kind of minimum pension. I wish he had. He was talking about continuing with the current complex system into 2050, and then eventually having a flat-rate state pension, but nobody would know exactly what that would pay by the time it became flat rate. Nobody could plan against it, so you would not get rid of means testing for decades, not until all the baby boom generation has gone through.

We have an opportunity now to say there is a flat-rate minimum state pension payable at an age that will be decided depending on life expectancy, but it does not mean that you should not expect any other income. If you want more income, you need to think about where it
will come from. Whether it is a pension, savings, selling your house or doing some part-time work, you can plan that; you will have to make some provision for that. We have not even talked about long-term care, but just talking about the pre-care-need retirement phase or later life phase, we have an opportunity for people to think reaching age 65, 66 or 68 does not mean “no work”.

The Chairman: Can I just go along the row? Joanne Segars and Noel Whiteside, do you disagree with that or not?

Joanne Segars: I think that arrangement that we are moving rather too slowly towards, of having a single-tier, flat-rate state pension paid, we think, at £140 a week, uprated hopefully in line with the triple lock, gives 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 to some. We think that is the right formulation and a good sharing of responsibility between the state, the private individual and their employer.

Professor Whiteside: I am very worried. There have been a couple of articles in this week’s Financial Times, yesterday and today, about work and the labour market, showing that jobs are coming in at the upper echelons, the well paid, and the very, very low echelons. I have got a lovely historical quote here that I am dying to read out just to lighten the tone a bit.

The Chairman: Is it savings? We are going to come to that in the next question.

Lord Bichard: The conversation has moved on slightly, Chairman, since I was going to ask my question, but I will rephrase it slightly. There are two questions; one to Dr Altmann and one to Professor Whiteside. You confessed to have been looking at this for 15 years. Is your big idea a basic minimum state pension? The question I was going to ask you some time ago was: if you have been looking at it for 15 years, tell us the three practical things that you think should happen that are not happening. I am tempted to say you are
veering towards the suggestion that people should just work longer, which I thought you disagreed with. What are your three ideas?

Professor Whiteside, I do not want to lose the point you made earlier, which we glossed over, about people not knowing how to get hold of the pension that they have accumulated. You mentioned a quite horrifying figure by 2050.

Professor Whiteside: This was one cited in the Financial Times, I do not know whose research it is.

Lord Bichard: No, but do you have some thoughts about what might be done about that, because in the context of this discussion, that is pretty important stuff. We should not lose sight of it. But Dr Altmann, first, what are your three ideas? You have got a clean canvas. We will do whatever you want. Tell us.

Dr Altmann: I have many more than three ideas. If you want to talk about the major opportunities for us, I think number one is to embrace this new phase of life, which is a period of part-time work. I am not talking about people working full time necessarily; I am talking about enabling and helping people to grasp the opportunity of cutting down in their later years. So they would work for two or three days a week maybe, and have four or five days a week free and more money to spend.

Lord Bichard: But people have been saying this for years. What are you suggesting should be done to encourage it?

Dr Altmann: Getting rid of the default retirement age is the first thing. Allowing people to understand that there is this opportunity, which has to be led by Government and has not been so far, would be the next important issue.

Q470 Lord Bichard: Do you want a communications campaign?

Dr Altmann: Part of that would be very useful if you were helping people understand that their life has another phase. This has been building up for the last 30 years. You are not going to solve this in three months, but the sooner we get people understanding that opportunity, the more realistic our futures and our children’s futures will all be. At the moment you have got three phases of life: you have education, full-time work and then you stop work completely. We need new thinking about life, and not just in the UK—this is general.

The Chairman: We have had plenty of evidence that would support that, but it is a bit tough expecting Government to take it on the chin, is it not, and give everybody the really bad news.

Dr Altmann: It is not bad news; it is good news. That is the thing. That is what politicians have not understood.

The Chairman: Let me rephrase my point. Clearly it can be presented positively, but the media will be at risk of taking it negatively.

Dr Altmann: I think you can carry the media with you.

Q471 Lord Bichard: I am looking for you to give us some thoughts on how you can incentivise that. People do not make this huge shift in the way they think about life and the future just like that. As somebody who has looked at this for so long, what are the incentives that you might throw in to help people?
The King’s Fund, National Association of Pension Funds, The Saga Group and Professor Noel Whiteside, University of Warwick—Oral evidence (QQ 463–495)

**Dr Altmann:** First of all, it has already happened for women, and I see the parallels here exactly. Some 30 or 40 years ago, if you had gone to a woman who had just had a baby and said, “When are you starting work?” she would have looked at you like you were mad. It happened. It was facilitated by the labour market. Women said there would not be part-time jobs or jobs they could fit around the children. But it has happened.

I am quite confident in 20 years’ time it will happen for older people too. It is already happening. It is just that policy is working against it. For example, pension credit has a £5 a week earnings disregard. For the very poorest pensioners who have stopped work, if they claim means testing and go to work, they lose money. Where is the sense in that? It is not just about putting in incentives; it is also about removing disincentives. We are starting from a position where we do need to work from a very low level to get to where we need to be. Removal of the default retirement age is an excellent first step.

The next idea, if you wanted the three, would be to recognise that pension saving is not the only way of supporting yourself in retirement. At the moment we have got an auto-enrolment policy that says: if you want to save for retirement, it is pensions or nothing. Because pensions are so inflexible and not suitable for many people, that means they will get nothing. It would be much more sensible to think about pensions as retirement saving or later life saving, not just this one product. We need to improve the flexibility of pensions.

**Lord Bichard:** That is easy unless you are old, poor and disabled.

**Dr Altmann:** What do you mean?

**Lord Bichard:** What is your policy response to that?

**Dr Altmann:** I do not understand your point, sorry.

**Lord Bichard:** You can think about different ways in which you can top up your foundation pension or do other things. If you are old, disabled and poor, for some of the reasons we have already touched upon, that is not as easy, is it?

**Dr Altmann:** I am not saying this is easy. Saving is certainly not easy. That is absolutely correct. But if you have a system that leads people to believe that they can put small amounts of money away and have large amounts in later life, we are not being honest with them. Even if they lock it in, it will not necessarily deliver.

**Q472 The Chairman:** Joanne Segars, you look as if you differ. If there is a difference, can you bring it out?

**Joanne Segars:** I think we really do have to give auto-enrolment a chance here. You are quite right that if you are old, disabled and poor, then your opportunities in retirement will clearly be much, much more limited. One of the powers of auto-enrolment is that it will start to put people into a pension scheme at the age of 22, if they earn over £8,500 a year currently, with an employer contribution. That will extend pension provision enormously. We have now the lowest levels of workplace pension coverage that we have had in decades. So extending pension provision up to 9 million working people is enormously powerful. It will mean that, yes, the levels start low, but we all expect the contribution, which will be 8 per cent initially, will go up over time so that we get to more realistic levels of saving.

Auto-enrolment, combined with that foundation pension, will be a major step forward. If we can get people starting to save earlier, then it is the maths, is it not? The very nature of compound interest will mean that hopefully by the time people do get to retirement age, whenever that may be, and it is clearly going to be higher than it currently is, they will not
be quite as poor as they might otherwise have been and they will have more choices. One of the things that concerns me about the discussion around people just having to work for longer is that it becomes a bit of a counsel of despair—people are working longer not because they have, as we will have, the choice to work longer, but because they are forced to work longer because they simply do not have the floor of income.

Professor Whiteside: I just want to reiterate my point about keeping people in there, and also go back to Lord Bichard’s question about the portability issue. The trouble is that people move and change their names. Having NEST there is fine, but people will leave a NEST employer and go to a private-sector employer who has his own pension scheme, then will leave and go into the public service, and then will become self-employed, and may or may not contribute to their NEST. They probably will not contribute, because I think self-employment, which is going up, disguises a great deal of under-employment and unemployment.

Having said that, what can we do to respond to this problem? I again look overseas. In 1985 Australia introduced a mandatory so-called Super scheme, which is shorthand for superannuation, and it is a bit like our auto-enrolment project. Contributions are made by employers, and in the 25 years that followed, a workforce of around 8 million managed to create 10 million lost accounts. So the Australians have decided to use the tax number unique to each employee to keep track. The Government will keep track of their contributions to each plan, so there is a central record. They have just introduced it. Whether it works or not is anyone’s guess. It is coming on line this year. That is one option.

Sweden goes further. They have got another mandatory scheme, their personal pension plan, which is again privately managed. There the contributions are collected centrally by the Swedish Tax Authority and apportioned by the Swedish Premium Pension Authority (PPM) to the various funds as chosen by the contributor, or to a default fund. In fact in Sweden many contributors are lapsing into default funds. However, there you have two possibilities. Admittedly those are both mandatory schemes, but I certainly think the Australian example might be worth looking at, especially to see if it works, because at least it will allow—

The Chairman: Better tracking.

Joanne Segars: Yes, to collect your records together. The Government are looking at this currently, and have consulted on how people can consolidate their pots. The Pensions Minister, Steve Webb, has been quite clear about this, and calls this his Operation Big Fat Pension Pot, so that people do consolidate their pensions. He has two potential options at the moment. One is that the individual’s pension pot follows them from job to job. We at the NAPF, the TUC and Age UK have raised concerns about that because somebody could move from one pension scheme to another, and that pension scheme could have much higher charges attached to it, so that could cause consumer detriment. None the less, that is one option that the Minister has looked at.

The other is to have a smaller number of consolidators, so that when somebody leaves a job, they can put their pension into one of these consolidators, and that would sit there for people to collect their pension. Our argument at the NAPF is that we could have fewer pension schemes to begin with. At the moment we have something like 46,000 separate defined contribution schemes, most of which are utterly tiny, uneconomic, poor value and poorly governed. If we had fewer, larger pension schemes, we would be more certain that people could get good value for money because larger schemes have lower charges.
Secondly, there would be fewer people flitting around between schemes in the first place, so you would deal with that consolidation problem, but it is an issue that is a very live part of the debate at the moment.

**The Chairman:** Thank you. We are going to come back to lots of these issues in subsequent questions. We cannot pretend to deal with all the questions just on the first question. Richard, you have been waiting patiently, and we will come to the issues on social care. But let us open up that terrain by moving on to the next question.

**Lord Mawhinney:** Chairman, would you forgive me?

**The Chairman:** We will come to all of these questions later on, in order.

**Q473 Lord Mawhinney:** In which case, why not pursue the momentum of the moment? I would like to ask a question that relates to Baroness Shephard and me, and not to the rest of the Committee, primarily. Between the two of us, we have fought about a dozen General Elections. If I understand this correctly, we are being told that we should go to the electorate and say, “You guys may not have thought about it in these terms, but there are four phases to life: education, full-time work, part-time work, and when you cannot work anymore”, at which point the opposition candidate will say, “You do not want to vote for those people; they are going to make you work till you die”. Forgive me; do not shake your head please, because I have had people say that to me on the doorstep.

**The Chairman:** Do you want to give them a chance to answer your assertion, Brian, or not?

**Lord Mawhinney:** Yes, absolutely. I would like to know what it is we should be saying to them in pursuit of what you are telling us now.

**Professor Whiteside:** People who enter the labour market at 16, and many people who do manual and heavy lifting work, particularly if they have contributed to NICs for 50 years, deserve something better than just the same pension as someone who has gone into the labour market at 28 or whenever, having finished a postgraduate degree and having the same trajectory. In some ways I am sympathetic to what Ros is saying, because there are ways in which you can see a white-collar worker can go on part time at least, or one day a week at least, for longer.

**Dr Altmann:** Absolutely.

**Professor Whiteside:** But for the van driver and the lifter and all the rest, they deserve to be told—I think that is the way round it—there is not just one retirement. You must think about a working life of 40 years plus, and a fade out rather than an abrupt stop. But if you start at 16, you start fading out at 56.

**Dr Altmann:** The message on the doorstep is, “Look what we have done for you”. We have invested in the health service. We have invested in health and safety at work. Now you will be living healthier for longer. You are not going to be old at 60. You are probably not old at 70, so why write yourselves off? We have created these amazing opportunities for you to live differently and better.

You smile, and I suspect 30 or 40 years ago somebody sitting here saying this about women who had just had babies would have had perhaps a similar reaction from the audience, but it has happened. It has to happen. The alternative is economic decline, given the demographics that we are starting from, if you allow people to write themselves off and not embrace the opportunities of the healthier lifestyles we have and being able to work part
time. Work is not just 40 hours a week anymore. You can work from home; you can do
different types of work.

Joanne Segars: Some people can.

Dr Altmann: Yes, not everybody, but the majority can. At the moment there are people in
their 50s who are disabled who cannot work. People age differently of course, but that is
also where our system lets society down, because it assumes that everybody will reach the
age at which they cannot work at one age, and that does not happen.

Q474 The Chairman: You made a point earlier about how we had, in public policy terms
and through shifting the argument, shifted the labour markets and attitudes to women and
work in child-bearing ages. We do not have time now, but I would be interested in a note
from you on the sort of public policy adaptations and argumentations that ought to be
thought about in making a similar shift for these later years, because we have had that
thought. There is a direct analogy. We have done it there; what could we do here? So can
I leave that thought and question with you? Any of the others, if you wish, should come
back on that as well.

Let us now turn to what Noel Whiteside opened up, the question of savings. Clearly all of
this is saying that we are not saving as a society, in all its diversity, as much as would be
ideal, given that we are going to live longer, let alone to save for the risks of our social care
later on. You made the point that saving is unpleasant because you have to forgo
consumption, but we cannot leave it there, can we? What should be done to shift attitudes
to savings?

Professor Whiteside: I have never been one reluctant to open her mouth when there is a
bit of silence. Working at a university, I am very aware that people in their 20s will in future
be going out into the world with even bigger debts than they have already. With £9,000 a
year, and that is just fees, never mind living costs, they are constantly being told, "You
should write down your student debt". Although your savings opportunities are going to
arrive at a lower income than your debt repayment obligations, I think it is fairly reasonable
to say that no one likes living with this huge debt. That is the first point I would make.

I have been trying to sound positive, but this does sound a bit negative. The second point is
that the returns on savings have been lousy for the last decade. Looking forward to the
next decade, I for one am not optimistic, and I would have to swallow very hard to try to
tell someone to put money into savings when the alternative might be to put it into a
mortgage on a house, which may depreciate less rapidly.

The Chairman: Crudely, that is the attitude of many young people: "I cannot afford to
save in my pension; I am going to save for a house".

Professor Whiteside: It is, yes, exactly, which addresses Ros’s point about alternative forms
of saving. So I think we are really looking at the 40 and 50 year-olds rather than the young.
If you are going to encourage saving, when one looks at many earnings profiles one
discovers, in white-collar workers anyway, that earnings tend to go up in the 40s and 50s,
and maybe go down slightly in the 60s. That is the point when usually the kids have gone.
Not at the moment, but one hopes. Usually it is not quite time for the parents to
degenerate to such an extent that someone has to give up work to look after them. Again,
that is also a bit dodgy. However, that is the point at which savings can be made, and those
are really the target years, 38 to 60.
Q475 The Chairman: Accepting your point, in public policy terms, what should be done to encourage that? Apart from us all saying we ought to be saving like the Chinese, and we are not, how can we incentivise that?

Professor Whiteside: I think a little bit of a safeguard on savings would not hurt. The German Riester pension actually guarantees that the contributor will get back at least the cash that he or she has put in.

Q476 The Chairman: Who underwrites that? The state?

Professor Whiteside: Yes.212

The Chairman: Joanne, anything on that terrain of savings?

Joanne Segars: Yes, I think with pensions and savings generally, inertia is incredibly powerful. That is why I believe auto-enrolment is going to be a very powerful tool. If you start to get people in early, it will be a case of “what you have never seen, you never miss”. When pensions were compulsory prior to the mid-1980s—that was abolished in 1988—a lot of people saved in pensions, and they retire now and they say to us, “Thank goodness I was put into my pension scheme, because I have now got a decent amount of money to live on”.

The Chairman: Are you saying compulsion?

Joanne Segars: It used to be compulsory, yes. You could be put into a pension scheme, your employer’s pension scheme, and it was a compulsory condition of employment. That was abolished in the 1980s. That is why auto-enrolment will have a very, very powerful influence. People are being auto-enrolled; they do have the right to opt out, but after three years their employer will come back and try to re-auto-enrol them. If we can start today, then we will get pension saving as part of the culture.

One of the remarkable things about Australia is that whilst pension saving is compulsory, pension saving in a Super is part of the national fabric in the way that the NHS is here. If we can start to get that as part of the national fabric of the UK, then we will have made a huge breakthrough. The power of inertia should not be underestimated when it comes to saving for retirement.

Q477 Baroness Finlay of Llandaff: I just wanted to come in on Professor Whiteside’s mention of the group who are 30 to 40. They are the young adults who have got young children, and they are at a time of maximum expenditure. Some of them are also finding that job security is not there, and many of them in the future may well have come from a situation that a lot of young graduates are in now, which is they come out, they have a large debt, they do endless so-called internships, which is actually unpaid employment effectively, and then they never quite get the definitive job because there are so many of them chasing very few positions. So you have young people with good degrees from good universities who just cannot quite even get on the income uptake. The clock is ticking. They then do have their family, but they never get out of that cycle of even getting started. I do not see this 30-to-40 group as a group that are kind of making it and doing well by and large as a large cohort, because they are not realising the earning potential that they thought they had before they went to university.

212 “Subsequent comment by Professor Noel Whiteside: “The Riester guarantee is covered by reinsurance paid for by all registered pension providers, managed under collective provision (not unlike the Pension Protection Fund in the UK)”.”
**Professor Whiteside:** I agree with you absolutely on that. I think I slipped a bit; I said 38 to 60. I am pushing a bit higher, so I am really looking at people in their 40s and 50s. Of course, the argument against that is that you lose all the accumulated interest that you would have had you started in your 20s, but since the accumulated interest is not keeping up with inflation, there is not really much point. This is why I am looking at the people who must start thinking about retirement a bit more fully. If it means continuing on in part-time work, where your part-time salary is also pensionable, while you are drawing part of your pension. This offers a degree of flexibility and, some schemes are beginning to introduce this, which is an improvement.

**Baroness Finlay of Llandaff:** When we look at demographic change, the age at which people are having their children is going up. Many people are actually having children in their late 30s and early 40s. So if you start off at the end of your 30s or early 40s, you are not looking even at the point where the children are necessarily at school.

**Professor Whiteside:** There is a question coming up later on about women. Do you want me to do deal with this now?

**The Chairman:** I am glad for your help in trying to keep some sort of order to the process.

**Professor Whiteside:** It is an interesting point, and needs addressing.

**Q478 The Chairman:** If people are not thinking about pensions, the idea of saving for social care has not crossed many people’s minds ever, has it?

**Richard Humphries:** Indeed it has not. I think most people would be completely unaware that in retirement a quarter of us will need care costing £50,000 or more. 10 per cent will need care costing £100,000 or more.

**The Chairman:** Not now, but could we have that data?

**Richard Humphries:** Yes, of course, absolutely. Even if people were aware of that, I think many would think, “That is okay; the NHS will meet the care costs, and we do not have to worry”. Many people do think that until it is too late. Even if they realise that the bill is more likely to fall on them, especially if they have assets or savings of more than £23,250, you actually look at the marketplace and what is available to encourage people to save, and it is not there. The necessary incentives and inducements to make it possible are not there. So the system fails at all three levels. If you think it is bad for pensions, it is even worse for social care.

**The Chairman:** We will come back to that when we get on to dealing with it in our other questions. It is a critical question. Ros Altmann, did you want to come in on the savings point?

**Dr Altmann:** Yes, please. I still think what we have, and I would urge the Committee to consider, is that we are still working with this almost obsession about the word “pension”. It is as if, when you are coming to save, it has to be pensions. That is just one product. Of course there are vested interests in the pensions industry that want us to think that all our problems can be solved by pensions. It does not work. We need to be honest with people. You mentioned talking to people on the doorstep. We cannot go along to tell them auto-enrolment is going to solve these problems. It is not. We need to be thinking about a new word, not “pensions” necessarily. Pensions may be the thing that the Government gives you, a basic minimum, but the rest is private savings, lifetime savings. As long as we are
thinking that we just need to encourage people to put more money into pensions the way the UK does pensions, we are not thinking broadly enough.

In Australia, you do not work towards buying an annuity. They have a different means-testing system. In other countries you do not work towards buying an annuity. This is the third of the most important points: think about savings as a capital sum, not an income. If you want to restore some confidence in pensions, one of the first things you can do is talk about people saving a few tens of thousands of pounds rather than ending up with a few pounds a week of income. The average pension fund for the defined contribution fund is about £30,000. If you told people they were going to get £30,000, most people—not those in this room, but most people in the country—would probably think that is quite a nice sum of money. But if you tell them, “Actually, you are going to get a few pounds a week for life from your pension”, they will think that has not done them much good. If you talk about lifetime savings, you are automatically enrolling people into a savings vehicle that is theirs. Like in America, if they want to buy a house, that is a valid form of saving. They can use some of that money. If you want to, you could consider auto-enrolment in a different way so that the employer contribution and the tax relief stay locked in, but your own money you can access either under certain circumstances or if you wish to, and you would get a lot more people putting money in, in the first place.

Young people do not want to engage with pensions. They feel that the way we do pensions in the UK means their money is being confiscated from them. However much they need it, they cannot have it back until they are in their 50s. To someone in their 20s, that does not sound very attractive.

The Chairman: An interesting point. Joanne, you are shaking your head.

Joanne Segars: Yes, I do not think there is any evidence to say that if pensions were more flexible, young people would save more for them. There have been many research projects on that, and there is no evidence to support that. We have been talking about how pensions are not giving people an adequate enough income in retirement. I find it rather bizarre that we should be saying to people, “Actually you can dip into your pension pot to pay for a deposit on your mortgage”, or whatever. When I speak to pension policymakers in Australia, particularly those who set up the compulsory Super system in Australia, they say that they really regret not making annuitisation compulsory, because they now have people who are retiring with decent sums of money, which, because of the means-tested state pension system in Australia, gets spent, and there is a big reliance back on the state. So we do need to be very careful what we wish for here. If what we are talking about is people not having enough money to live on in retirement, which we have been talking about, then giving people that flexibility to dip into their pension pot is something that I think could be quite risky. The Government consulted on this two years ago, and the weight of evidence was this is not the direction in which we should be going.

The Chairman: You sound quite close to saying the answer is obvious: that it has almost got to be compulsory saving.

Joanne Segars: I think if auto-enrolment is not proved to work, then that question is one that remains open. It is very difficult to do at the moment because of our means-tested state pension system. I agree that pensions are not the right way of saving for everybody. There are some people, particularly low-paid people, at the moment who should not be saving, which is why we decided to go down the auto-enrolment route to the soft-compulsion route and not the hard-compulsion route, but one of the questions that will be
open to us is whether we follow the full compulsion route—do we go down the Australian route?

Dr Altmann: But then they lose the employer contribution.

Joanne Segars: No, not necessarily.

Dr Altmann: If they are not willing to save in a pension, they lose the employer contribution. If they want to repay student debt, they cannot get an employer contribution for their pension. If they want to save to buy a house, they do not get an employer contribution towards their pension. If you leave the employer contribution and tax relief locked, at least they will have some money accruing, and then they can use their own money for other things along the way. That would mean they put the money in, in the first place. At that moment that will not happen.

Q479 The Chairman: I will study this transcript with great interest. A closing word, Noel Whiteside?

Professor Whiteside: I have just a brief point. At its root, the Australian system was an attempt by the Premier in Australia to try to stop pressure on wages in the mid-1980s by promising blue-collar workers the same lump sum that white-collar workers got when they retired, which was nice. The trouble is that lump sum has got bigger and bigger and bigger because people have accrued for longer and longer and longer, and now the state is beginning to think about taxing it, because actually the public finances in Australia are not as solid as they might be, and this is very much under discussion.

The reason I recounted that the way I did was to make two points. First, there is a widespread mistrust of markets. I know the insurance companies have been fairly clean, but, and one hates to say so, and begging Joanne Segars’ pardon, the banks have not. All the slurs that have arrived on the popular press about banking scandals translates into public distrust that infects the entire financial sector. On the other hand, you have got the political risk. One hates to say so, but the last Government took a quick bite out of the pension funds when they were looking extraordinarily healthy after a period of enormous growth. It is not past the realm of possibility that a future Government might not take a bite out of your savings when you actually draw it down. That is really at the nub of it, which is why I would push very hard for what the Pensions Commission advocate: a permanent Pensions Commission, a bit like the Office for Budget Responsibility, to publicise and say, “Look, this is under discussion, folks; what do you think?” In other words, government should widen the debate a bit rather than having decisions being made ad hoc across the board.

Joanne Segars: Certainly a permanent Pensions Commission is something that we have called for as well.

The Chairman: All of this discussion is about what the individual should do and what the state should do and how we get that right, is it not?

Baroness Shephard of Northwold: That is my question.

The Chairman: It is your question indeed.

Q480 Baroness Shephard of Northwold: It seems to me that we have been discussing it for the last 40 minutes. I cannot imagine that the panel have very much more to say on the issue. Is there anything anybody wants to say about what the balance should be? I believe we have had these answers, because it depends on the circumstances of individuals,
The King’s Fund, National Association of Pension Funds, The Saga Group and Professor Noel Whiteside, University of Warwick—Oral evidence (QQ 463–495)

what age they are, the state of the economy, and more particularly perhaps the state of trust in the functioning of the economy. All of this is against a moving background, which is why anywhere on this side of the table we all looked at each other when we heard the words “permanent Pensions Commission”, which would indeed mean that, provided there were principles laid down by a courageous political party that then got elected, the changing circumstances could be examined as they developed. Would anybody like to say more about that suggestion, because in a way it could lead to an answer—it certainly would lead to an answer on the balance of responsibility, which would be something that the Commission would be taking into account according to changes.

Dr Altmann: We are still working on the word “pension”.

Baroness Shephard of Northwold: Yes, but leave that for a moment—a body.

Joanne Segars: We would be very happy to send you the terms of reference we have already for such a body.

Baroness Shephard of Northwold: Is Professor Whiteside in agreement with your objectives?

Professor Whiteside: I have not seen the NAPF’s proposals, I am afraid. My comments were based largely on the Finnish Centre for Pensions, which is a body of professionals who study demography, insurance, finance, they analyse the lot. They are used by the insurance industry. There are 10 main insurers involved in Finnish pensions. The Government and the Cabinet consults them, and a committee like this would call them in and quiz them about current and future trends. They provide advice to the public, and also monitor the financial advisers and act as auditors as well.

Q481 The Chairman: Do they also look at the Dilnot social insurance market, or the hoped-for insurance market of social care?

Professor Whiteside: Yes.

Richard Humphries: They do.

Joanne Segars: One of the potential benefits of such a body, not to necessarily use the P word, is that it can start to join up different aspects of Government policy. So it can pick up some of the issues we have talked about in terms of employment opportunities and how we change the employment market for older workers, and the issues about the interface between pensions and long-term care. It would also have a very important job in an independent assessment of whether or not we are on track, whether or not auto-enrolment is a success and whether we therefore need to go beyond it. That is certainly one of the primary purposes we see of this.

You talked about the model in Finland. Perhaps a model closer to home is that in Ireland, where the Irish Pensions Board has the dual role of being the regulator but also having a wider public policy function. Again, that is potentially a very useful model, so I would be very happy to send you our work on this.

Q482 Baroness Shephard of Northwold: There is an analogy, in a sense, in the Boundaries Commission.

The Chairman: A dire thought.

Baroness Shephard of Northwold: Well no, not at all. The Boundaries Commission as opposed to the Boundaries Committee in fact has a similar role. It has to make decisions
based on demographic changes within a very narrow remit compared with this, but such institutions already exist. It is the only one I can think of off-hand that is directly concerned, as it were, with political considerations. I am very intrigued by all of this, and that will therefore conclude my question.

The Chairman: Hansard has not yet picked up nods, which is a failing of it. Richard, did you want to make a comment?

Richard Humphries: We would strongly urge that if such a commission were set up, part of its responsibility should be to keep under review the financial responsibilities of paying for care and how they are shared between the individual and the state. We have argued that you probably need different solutions to that at different stages as different generations come through with different profiles of income and wealth.

The Chairman: That is very helpful. Let me just push you a little bit, though, because Baroness Shephard is moving us on, and she is right to. We are all delighted at the thought we are going to live 10 years longer, hopefully in decent health. There is not much of a debate about who should pay for that. The assumption of many people is that somehow or other the state will pay for it. They will get a pension, and if there are social care costs, that is what the NHS is there for. It is tough to expect Government to lead with its chin all that sort of stuff, is it not? How do we get a more informed debate about some of these realities, or is it our job as a Committee? We can speak truth without too much fear of election.

Dr Altmann: The Committee needs to recognise first of all, importantly, that we must move beyond pensions to recognise the demographics. Currently the pension will not fund social care.

The Chairman: We are interested in how we get the debate to the public.

Dr Altmann: You do it by talking about saving for later life and then explaining what those needs are. That is part of the important role that politicians have. People do not currently know that our system is so unfair that we have got both a postcode lottery in terms of how much you need to pay and also a health lottery. Some aspects of getting ill in older age will be fully picked up by the NHS. If you get ill in a different way, you have to fund everything. We still have this obsession with means testing, so that those who have saved and do save are then penalised, whereas if you did not bother saving, you get everything picked up by the state.

As long as we have this system that says saving for later life is all about pensions and if you have no money the state will pay for you, we cannot make this work properly. As we are going to have more and more older people in later life needing social care and not realising they have to pay for it, maybe even having pensions that cannot be used to fund social care because they have been annuitised to provide a small amount of income, we are not going to be moving in the way the demographics need us to move.

The Chairman: Let us move on then, unless anybody has a transformational thought.

Professor Whiteside: It is just an idea, dealing with the PR of it all. The age of 65 was first decided on in 1925. That was when it was decided that a state pension could be first drawn. Beveridge stuck with it, and he transformed what was an addition to a declining income in old age into a full retirement pension, and that is really the problem. There is a public expectation that retirement means you stop working. I think part of it, which ties in a bit with what Ros has been saying, is that you should be moving towards seeing a pension
or your savings as a supplement to your declining earning power. Why not go back to the earlier 20th century? That is what will happen. We need to understand that for a period of 30 years after the Second World War we were extremely fortunate, there was good economic growth and we could afford to think about retirement.

The Chairman: Very helpful. This leads us on to a couple of questions from Lord Bichard.

Q483 Lord Bichard: Yes, Chairman. I want to preface this by saying Dr Altmann is keen that people should carry on working longer, given the way in which a similar question from me was misreported by the BBC and the Daily Express, which I think picks up your point that this is going to be sold on the doorstep. So Dr Altmann, you want people to work longer where they can. I do not feel that we have got behind that sufficiently yet to talk about the practical incentives. We all agree generally with what you have been saying—that it is not just about pensions. We probably all agree that where people have a contribution that they can continue to make, we should encourage them to make it. The only practical idea I have heard so far is that we should do something about the disregard, which seems to make sense. What else can we do to encourage people to continue to make a contribution if they feel able—and want to do so, in case the BBC is here again?

Dr Altmann: I have been trying to get this across, but it is not being picked up.

Lord Bichard: I am giving you another opportunity.

Dr Altmann: Thank you. We have to think differently about what we do and how we say what we are doing.

The Chairman: We have come on to public policy. It is essentially a question about what should change to pension and benefit systems to effectively incentivise people being more keen and willing to have a more flexible way along the line. That is what the question is about.

Dr Altmann: Okay, first of all public policy is led by politicians, who have to be honest with people. We need to help people understand the value and benefit of staying at work longer, rather than sitting at home for 30 years with very little money and not a lot to do.

The Chairman: I am sure we will say that, because plenty of the Committee think that is a message we have to get across. But the question is how should we change the incentives?

Dr Altmann: We get rid of the means testing first of all. It is not just changing incentives. First of all we have to get rid of disincentives, which are currently rife throughout the system. The pension system and the means-testing system have disincentives—disincentives both to work and to save. We have to get rid of those disincentives before we can start on the next path—incentives.

Actually there are some incentives in the current system in terms of national insurance for people working longer.

The Chairman: There are—big ones.

Dr Altmann: But you are giving with one hand and taking with another, and that means the system does not work well as a whole.

The Chairman: Thank you. Noel Whiteside, do you have any comments?
Professor Whiteside: I think I have said a lot of what I was meaning to say under this already, which is unfortunate, but the pension rights for men should reflect more fully the years spent in the labour market. I am making that a gendered question, please note.

Lord Mawhinney: Chairman, could we make a note to ask the Treasury when they come if they could give us an estimate of what would be the economic or financial cost of doing away with disincentives? One can understand the argument, but it would be useful to know what the argument was going to cost.

The Chairman: It is the balancing of it. Do you get sufficient economic growth as people are working longer to compensate for what you have lost in taxes? Absolutely.

Baroness Finlay of Llandaff: I was just listening to all this debate and wondering whether we could ask people if they have got some modeling with some hard numbers in for different groups, and what would happen if any of these changes came through. We are actually talking with lots of theory, but some hard models would be useful.

The Chairman: It is similar to Brian’s point, is it not? Are there economic models that demonstrate this?

Baroness Finlay of Llandaff: Yes.

Richard Humphries: There is an excellent paper by the Institute for Fiscal Studies, which looks at tax and benefit arrangements, and the extent to which they incentivise older people.

The Chairman: Can you send us the link?

Richard Humphries: Yes.

Q484 Lord Bichard: That would be really helpful, thank you. The basic question that I should ask is whether or not you think the current timetable for raising the state pension age is right.

Joanne Segars: At the NAPF we have said that it probably strikes the right balance. We have obviously accelerated the rate of change, but we also have to make sure that we give people sufficient notice so that they can plan. We clearly saw the political fallout last year when all of a sudden it was announced that a small cohort of women were going to face a very rapid rise with relatively short notice. So I think it is about achieving the right extension to state pension ages, and I suspect there is a natural limit beyond which that cannot really extend, but also giving people the right notice.

Q485 Lord Bichard: But this is not where you think we should be focusing our attention?

Joanne Segars: I think one of the issues we need to think about and, again, the Government have been remarkably silent on—having held out the prospect of something exciting earlier this year—is some independent body that might look at how fast state pension ages might need to rise in the future in relation to rising longevity. This perhaps again goes back to Baroness Shephard’s point about a commission.

Baroness Shephard of Northwold: I would love to claim credit for that, but actually it came from you.
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**Joanne Segars:** But I think it dovetails neatly with the point you were raising on the commission.

**The Chairman:** And it is exactly the issue that was a small footnote in Hutton, was it not? For our public sector pensions, the cost of future shifts in longevity, which we all hope for, currently all falls onto the taxpayer. That is questionable, is it not? Noel Whiteside, did you want to come in on SPA?

**Professor Whiteside:** I am roughly in the same boat as Joanne, except my only observation is that there should be more publicity. One knows why the Government does not give it more publicity, because it does not look popular. However, for women, in their 50s particularly, to have planned for this sudden steep escalation, when for men the escalation was not so steep, does not look fair. I think it produced a lot of rumbles, and certainly there are women who still think they can retire at 60. One talks about engaging the public. Well this is precisely the sort of question the public should be fully engaged in.

**The Chairman:** I take that point. It is surprising that none of you have argued for pushing it a bit further, because the decisions on those would have been taken by politicians making judgments about how much the public could stomach, without a sophisticated view of future longevity shifts, and clearly it is one of the biggest incentives to have a more open-minded view about your earning career, is it not?

**Dr Altmann:** It would be very helpful if the Government could encourage people to recognise that the state pension age does not mean a retirement age. At the moment, because the word “pension” is associated with so much means testing and a disincentive to earn, it is perceived in society that the state pension age is the age beyond which you do not work. And if you do work and you have not got much money, you get penalised for it. That is very unhelpful.

I would argue that the issue of the state pension age is much less relevant than the issue of the new phase of life. If you have a basic minimum amount of state pension, there is no reason why people should not be able to choose, if they wish to, to continue to work on top of that.

**The Chairman:** The public expenditure implications of a shift of one or two years on SPA are phenomenal. It is the biggest public cost driver in the room.

**Dr Altmann:** Assuming that people stop work.

**The Chairman:** No, I am talking about public expenditure, not in economic terms.

**Dr Altmann:** Well, it is not just economic terms, because you still have the tax revenue from people working, the extra economic growth created by the people who keep working part time and the lower drain on public expenditure that they will then cause.

**Q486 The Chairman:** Let us move on because there is plenty more to cover. Let me just ask one quick question, and then I will pass it to Baroness Finlay. I think you already said, Noel Whiteside, or was it Joanne, that auto-enrolment leading to 6 million to 9 million more people saving into private pensions is highly optimistic, put politely, and there is not much evidence for it. That is what I recollect hearing.

**Joanne Segars:** That is certainly not my view.

**The Chairman:** Was it you, Noel?
Professor Whiteside: Yes, it was me. I do not think it will work.

The Chairman: Could you just make the case?

Professor Whiteside: My evidence is drawn from KiwiSaver in New Zealand, which was the first system of auto-enrolment. Admittedly, the New Zealand Government gives a public subsidy to encourage young people to auto-enrol; in other words, “If you put in so much, we will put in so much”. So everyone enrolled in order to get the public subsidy, and then it stopped. Well, not everybody. That is an exaggeration.

The Chairman: Is it too early to pick up evidence now, is it not? We cannot know yet what is going to happen.

Professor Whiteside: Not in the very long term, no, but certainly in the first five years you see a steep decline. Mostly of course these are young people, and that is exactly the same group who tend not to be pension saving here, so maybe in the fullness of time they will return to their KiwiSaver.

The Chairman: If it is not 6 million to 9 million—it is 4 million rather than 6 million—what are the consequences?

Joanne Segars: Perhaps I can give you some evidence from work we have done on this, because we take a rather more positive view. I do not think KiwiSaver is a perfect analogy with auto-enrolment, not least of all because, as I understand it, the New Zealand Government reduced the subsidies, so not surprisingly people decided to stop auto-enrolling, and they are just about to increase the subsidy again in order to get people auto-enrolling again, so perhaps there is a warning for Government here not to tinker around with the system too much.

We have done quite a lot of surveying over the last two years to assess people’s attitudes to auto-enrolment, and that tells us that about two-thirds of people say they will stay opted into their pension scheme once they are auto-enrolled. We have done that over the last two years, so two cycles of the same survey. Those numbers are broadly consistent with what the DWP’s own analysis shows. So even if we do not get 9 million but we get 6 million people auto-enrolling, that means 6 million people who otherwise would not have access to a pension or an employer contribution or the tax relief that goes with that. If we can increase the number of people saving for retirement over the next five years by 6 million, we will be doing remarkably well. That would be a really fantastic achievement.

As I say, we are much more optimistic. My members at the NAPF are working very, very hard to make sure that they get auto-enrolment in place on time, and that they do get those very, very high take-up levels that we are all looking for. I am much more optimistic. As I say, I do not think KiwiSaver is a perfect analogy to auto-enrolment.

The Chairman: Thank you very much. Baroness Finlay, over to you on women and pensions.

Q487 Baroness Finlay of Llandaff: Yes, can I turn to the gender issue? We have touched on it already. Does the pension scheme need to be improved for women, and are there role models from abroad? Within our changing demographics, we have got lots of other streams changing, and one of them is an increasing number of older women who find themselves on their own because of home and marital breakdown. There is very good evidence that when people are severely ill and dying, one of the main factors that allow them to be looked after at home, and therefore decrease their care cost, is having a wife, for the men. For those women who do have a husband, that does seem to be a factor too,
but for men the main factor seems to be having a spouse there. So there are a lot of pressures on women as they get older now that are possibly increasing from where they were before.

Professor Whiteside: Yes. You are looking at me. Is that an invitation for me to answer first?

Baroness Finlay of Llandaff: It is really, because you raised the gender issue again. Then I would be very interested to know what Richard Humphries feels.

Professor Whiteside: It is not just wives; it is also daughters.

Baroness Finlay of Llandaff: I am talking about women generally.

Professor Whiteside: I think there is a complete disregard for the amount of elder care that is done. Although we have pension credits for childcare in the state pension, we do not for elder care, and that is a huge hole. This again raises the ugly spectre of more state expenditure, but there is no care credit outside the public sector—the auto-enrolled pension or the public-sector pension or whatever—for either childcare or elder care. A lot of European countries, particularly Germany, again, and those in Scandinavia, offer childcare credits for women who are off the labour market for that reason, but right across Europe credits for elder care are not addressed.

For those countries such as Sweden, Finland and Denmark, in particular, where part-time work is not an issue—and of course in England it is a major issue—you will get proficient support for childcare, which again raises public expenditure and allows women to either be in the labour market full time or not in the labour market; this protects their pension prospects. What is really damaging, and you can see this in Germany and the Netherlands as well as the UK, is that women tend to go part time once they have children, and they do not always return to full time work. So for the most key earning years through the middle, from 28-30-ish onwards, part-time saving is for a part-time pension.

That brings me to the annuities question, because as long as we do have annuitisation, 66 per cent of men who are annuitised go for the simple single-life option, because the annuities market is complex, it is not understood, and that means that when he dies, she is left in her late 70s or early 80s facing a substantial fall in income. This is very important, and reinforces what Ros is saying. We have to think of giving more money to people in their 80s, and at the moment the stats show quite clearly that it is women in their 80s who are the poorest of all and they need more money. It is this rebalancing that just is not happening.

The trouble is that an annuity, as any financial adviser will tell the lucky customer, will be much more expensive if it has survivor benefits attached, and even more expensive if it is index linked. So usually the man says, “Oh, I will take that and get more money immediately”.

Q488 Baroness Finlay of Llandaff: Have you looked at the Canadian model of a carer’s allowance in relation to how it affects pension?

Professor Whiteside: No, I have not actually. I am afraid Canada did not fall within my remit. I am sorry, I cannot answer that.

Joanne Segars: At the risk of being boring and talking about auto-enrolment again, we do have to recognise that, given your comments on annuitisation and men taking single-life level annuities, we want more women to have pension rights of their own. Clearly the main
beneficiaries of the changes to the state pension that we have talked about will be women. But for auto-enrolment as well, the main beneficiaries will be women, and up to an additional 3 million women are likely to benefit directly as a result of auto-enrolment. I would also point to public-sector pensions, which we touched on briefly. Women do very well from the pension system when they are working in the public sector, because of women’s participation in that sector. We need to be very careful there that the changes that are being introduced to public-sector pensions do not undermine that and, because of the increases in contributions, do not price anybody, women in particular, out of those pension schemes.

Professor Whiteside: Can I just make one supplementary remark? We are not going to see this immediately, because those retiring in the next 10 years were recruited in the 1970s when defined benefit schemes were more common, and by and large husbands—if I may use such a word—stayed with one employer. Their widows will get a survivor’s benefit, so it is not an immediate but a longer term crisis, because with the growing dominance of defined contribution schemes, this is where the question of annuities is going to become really significant.

My second point is that although women are working in the public sector, they are working part time and necessarily a part-time salary translates into a part-time pension.

Richard Humphries: You wanted me to comment. There is some evidence of the economic benefits of investing in better social care support for carers that enables them to hold down jobs or return into employment, and thereby access occupational pensions that they would not otherwise have. I can send you the link to that.

Q489 Baroness Finlay of Llandaff: There are some schemes where the social care costs, where people have got personal budgets, are now being used to pay their own families. Should all of those payments be included in a pension scheme?

Richard Humphries: There is an argument that says they should.

Baroness Finlay of Llandaff: One of the difficulties is you have public money going round in circles, have you not?

Richard Humphries: That is right, and obviously that would have an impact.

Baroness Finlay of Llandaff: And then you have the cost of processing it and so on.

Richard Humphries: Yes, and it would reduce the volume of money available for actual care itself.

Dr Altmann: Public policy has not yet picked up on the extent of the dramatic increase in the numbers of very much older people, which is why we are here today. The idea of credits for people who are caring for older people in the same way as we have credits for people caring for their children is one that we really do need to take more seriously. The idea, in terms of the pension system, of a fixed number of years for which you work full time, and then perhaps you become eligible for this basic minimum pension from the state, would help as long as you get credits for periods in which as a woman you are caring in the way that society wants you and needs you to care for others. The National Insurance system has not done that for women properly, which is why women lose out obviously in the private-pension market, because they do not earn as much as men through their lifetime, but unfortunately they are also losing out in the state pension, because our state National Insurance system did not credit them in in the way that it did for men.
So a system where the pension age depends on the number of years for which you have been working full time or caring full time, or part time with adjustments, would certainly be very helpful in moving us to where we need to be to cater for the demographics, plus this idea of credits for caring, which at the moment we have not taken seriously enough.

The Chairman: A crisp point if you could, Noel, because we have to move on quite quickly.

Professor Whiteside: It is the business of models; you raised models. One for consideration: in Riester in Germany, pension splitting between couples is allowed, although it is voluntary and not very widely taken up. However, it is there and worth having a look at.

The second point concerns the 401(k) schemes in America; if a husband has a 401(k) scheme he cannot do anything to alter it without his wife’s agreement. So if he chooses to change provider or split it in different ways or make an inheritance that involves it, she has to countersign. At the moment we regard these pension pots as private personal property far too much, and I would suggest we have to understand them as something else.

Q490 Lord Mawhinney: That is an excellent intro to the question I wanted to ask, Professor Whiteside. Some years ago we changed the tax system in this country, and we separated husbands and wives or partners, or whatever their arrangement was, into two streams. Has any work been done on a similar separation in terms of public expenditure to families—benefits and pensions?

Professor Whiteside: I will have a look.

Lord Mawhinney: Could you tell us what you find?

Professor Whiteside: It is a big ask because you are combining so much. Taxation and benefit systems have changed themselves over the years enormously, particularly with working families’ tax credit and so forth.

Lord Mawhinney: But think how disappointed you would be if this sort of Committee did not ask you the occasional big question.

Professor Whiteside: Yes, of course.

The Chairman: Thank you for catching the ball, even if it is difficult.

Q491 Baroness Tyler of Enfield: I have desisted from coming in on the pensions questions, but I have been listening with great care to everything you have said. Turning now to the funding of social care, you made some introductory comments about this, Richard. I am sure we are all familiar with what the Dilnot Report said, and the concept of capping and pooling of risk for catastrophically high care costs. I would be really interested in your thoughts. If this is accepted and political decisions are made that a cap is the right way forward, albeit there is still detail about the level of the cap and when it can be introduced, in your view does that start to address most of the concerns that have been raised around the funding of social care? Or does it still leave a lot of funding questions unanswered?

Richard Humphries: It is always worth posing the proposition: if Dilnot is the answer, what is the question? Actually I think there are three big questions about social care funding. The first is what is the total quantum of resource that you would need to fund a decent system of care and support that we would be happy to use ourselves and for our families to
use? The second question is how are those costs shared between the individual and the state, on the assumption, and I think most people agree now, that there has got to be a degree of cost sharing? You cannot let it all fall on the taxpayer, nor can you expect people to make their own way in a completely private system. The third question, and probably the biggest of all, is where does the money come from, both private and public?

Now Dilnot is the answer, or an answer, to the second question, and that is all it is. If you look at the Dilnot terms of reference, he was not asked to come up with the all-encompassing pot of gold at the end of the rainbow: what is the answer to the meaning of life in relation to social care funding? He was asked to come up with a brief for the second question. I think informed opinion broadly supports his proposition, which essentially is a compulsory social insurance scheme with an excess payment of £35,000 or £50,000, or whatever. So the deal is you pay so much and then the state picks up the tab. In our view that makes two important breakthroughs. The first is that it removes the anomaly that social care is about the only public service, I think, where people’s liabilities for care costs are potentially unlimited. The second thing it does is dispel the fog of misunderstanding and confusion about who pays, so it creates a very explicit framework and set of signals to private individuals, local authorities and to financial services: “This is the deal; in future you will be responsible, if you have got it, for the first X thousand pounds”. We think that is a big breakthrough.

Government are making heavy weather of the cost of that, bearing in mind the cost of Dilnot will not start to come through for at least four years. Our view is that it should agree to do Dilnot not just in principle but in practice, commit to implementation, and then turn to this much bigger question, which is how we pay for the whole system and where the money comes from. There are lots of choices and trade-offs, and that is the really tough bit: not how costs are shared, but where the money comes from.

Q492 Baroness Tyler of Enfield: Can I press you a bit on that? As you say, there are a range of options for where the money comes from, and we have heard quite a lot about how going down this sort of road should help to stimulate a private insurance market, which I guess is one way. What is your thinking about what the options are for where the money comes from?

Richard Humphries: There are four broad ways you could do it. The first is you could look at existing public spend on older people, where we have an absurd and incoherent picture. I think in 2010 the figures were £140 billion spend and just 6 per cent on social care support. It seems crazy to me that we are spraying money indiscriminately, up to £4 billion, through things like winter fuel allowances and TV licences at people who may not even need it, and yet we ration essential support with an almost Stalinesque brutality. There is no coherence in the way we deploy public spending on older people.

The second way is looking at reprioritising other areas of public expenditure. The obvious example that springs to mind is the NHS, where we have long argued that we should take a much more integrated approach to funding services from a single pot of money rather than separate pots of money. We have to be careful we do not get into robbing the NHS Peter to pay the social care Paul.

The third approach to finding the money is to change existing tax allowances and benefits. There are many examples. The IFS report I quoted earlier goes through them all and how much they would cost. One game changing option is if you restricted tax relief on higher rate tax-base contribution to pensions; that would release up to £7 billion a year. If you
limited winter fuel allowance and TV licences to people on pension credit—I may need to check this figure—you release up to about £1 billion a year, so there are things that you can do.

The fourth broad option for raising the money is through an entirely new kind of taxation or charge altogether. In the past people have talked about the option of a care duty or of a modified inheritance tax that would allow people to make a contribution towards care costs through a lump sum payment out of their pension or out of their property at different points in their lives. That could involve a charge on their estate after their death, and hence it got christened a while ago as the death tax. So that is the origin of that.

The Chairman: That is very clear. Do you have a paper that sets that out for us in more detail?

Richard Humphries: I can send you some details about that.

Q493 Baroness Tyler of Enfield: I find that extremely clear, so thank you very much. There are just two supplementaries. First of all, on category four, when you talked about new kinds of taxation, were you including within that new approaches to equity release from properties whilst people are still alive?

Richard Humphries: Yes. I would not describe that as taxation.

Baroness Tyler of Enfield: No, sorry, that was just your broad category.

Richard Humphries: Yes, absolutely. There is where the public money comes from and where the private money comes from, and how people access their own resources. Again, one of the absurdities of our current social care system is that the option for people to draw down the wealth that they have got is very difficult and very limited. There are all sorts of criticisms and problems with equity releases schemes. 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. Another aspect of that is the very poor quality in places of information and advice. Again, we have this anomalous situation where social care is probably the only area across the spectrum of private goods and services where private money might actually get you a worse outcome than public money because of limited access to advice. People do not often get the assessments and so on.

Baroness Tyler of Enfield: I am sure other witnesses have got thoughts in that area, and I am still particularly keen to hear whether you think we are going to see a growth in this private insurance market as a result of Dilnot and decisions taken on Dilnot.

Richard Humphries: I think not, in terms of prefunded care insurance policies. There is nowhere in the world, to my knowledge, that relies on these to any significant extent for all sorts of reasons, both on the demand and supply side. But one could see a potential growth in specific products, like equity release and disability-linked annuities, for example, and asset-protection schemes that would cover and protect people against their particular contribution up to the cap. So there might be some options there, but I have to say that I do not sense amongst the financial services, and particularly insurers, any great sort of rejoicing at the prospects that the Dilnot framework would offer, so I am not holding my breath on private insurance.

Dr Altmann: In answer to your specific question about whether there would be an insurance market developing, that does importantly depend on the level of the cap. With the kinds of levels that have been suggested, it is unlikely that you would get insurance
because most people would not be expected to actually spend up to the cap. If you were trying to insure someone against something that is unlikely to happen, the cost of providing that insurance relative to the benefits would not really be economic to provide. So in terms of insurance, it is unlikely in that respect.

Unfortunately, of course, when you think about care, it is an ideal and natural insurance type of situation. Unlike pensions, where the vast majority of the population would hope to reach the age at which they would at least get a pension for a little while, when it comes to care it is maybe one in four of us, and the rest of us will not need this kind of expensive long-term care. So forcing everybody to save for it is probably not an optimal answer. Insurance would make sense on a national level, but we have not got that. So you are looking at how we can perhaps group people together to insure themselves, and that is where I would suggest there is a role for the family.

One of the things that would be sensible to consider is incentivisation of family care saving plans, so maybe four people in a family, or whichever number you choose, join together in a family care saving plan, where they each put in some money to cover social care in later life for one of them. It does not have to be themselves.

Q494 Baroness Tyler of Enfield: Are there any examples of those at the moment, either in the UK or abroad?

Dr Altmann: No. It is something I would like to see introduced, and I do think there would be a role for that. You could then introduce insurance on top, and I have been talking to one or two insurers about this. If all four of you happened to need care, that money would not be enough. A family could have £30,000 or £50,000 saved up somewhere, whether it is a portion of their home or a few years’ worth of ISA allowance, in case somebody needs care.

The Chairman: They do that informally, do they not? Let us have a note on it. Are there any closing comments from others?

Professor Whiteside: I just wanted to draw attention to the long-term care insurance that is run in Germany. There is a public-sector scheme and a private-sector scheme. One of them is running at a huge deficit. The white-collar worker one is fine, but the other one is not. Germany has five separate funds for social insurance, and they are all self-sufficient. One could think of a similar huge private sector scheme, but one would have to keep it off the public accounts, and how you define public and private expenditure in this day and age is extremely complicated.

Baroness Finlay of Llandaff: Sorry, but the German one is public, is it?

Professor Whiteside: Yes, it is public.

Q495 The Chairman: We are out of time now. Richard Humphries, thank you very much for that. I am sorry we did not have more time. You raised three questions, the first of which was how much. We did not really get into that, but can you send us a note on the public and private spend, how we compare, and your best estimate of what we should be spending to get to good standards of care in say 10 years’ time?

Richard Humphries: Certainly.

The Chairman: Noel Whiteside, I think you mentioned, and my good colleagues reminded me, a report that you did to the EU on comparative national pension policies.
The King's Fund, National Association of Pension Funds, The Saga Group and Professor Noel Whiteside, University of Warwick—Oral evidence (QQ 463–495)

Professor Whiteside: Yes.

The Chairman: Can we have a copy, preferably in a version that we would understand, is that is possible?

Professor Whiteside: Of course, yes.

The Chairman: Totally transparent?

Professor Whiteside: Yes, absolutely. I mean, one has to write these reports in as transparent a way as possible.

The Chairman: For politicians. Excellent. Thank you very much indeed. It has been a fascinating session. It has been challenging both ways, and we are grateful for the time. We have asked for further bits. If you could bear to send them to us, we would really appreciate that. Thank you all very much indeed.
The King’s Fund—Supplementary written evidence

Introduction
This note sets out the key features of how the health and social care system might look in 2025. It draws on four King’s Fund publications, attached for the Committee’s reference.

- Transforming the delivery of health and social care: The case for fundamental change (2012)
- Where next for the NHS reforms? The case for integrated care (2011)

The vision set out is a preferred vision and not necessarily the most likely vision. Medical and technological advances offer new means to treat disease and enable a much more collaborative and integrated approach to care that truly empowers patients and service users. However, unprecedented financial pressures in the short to medium term, alongside growing demand for care, pose a number of threats: first, to the viability of many providers of health and social care; second, to the NHS’s capacity to provide a comprehensive range of services; and third, to the quality of health and social care services. The way in which health and social care are delivered needs to be fundamentally reformed if services are to rise to the financial pressures facing the system and provide care appropriate to the needs of the population in future.

The population being served in 2025
As the Committee will be well aware, in 2025 the population will have many more people aged over 65, with the numbers aged over 85 expected to grow rapidly. These people are the most intensive users of health and social care services and account for a high proportion of the costs of care. For example, the current health and social care costs of people aged over 75 are more than twice those of an adult aged 35–44. The population as whole will also be carrying a high burden of chronic disease with many people having multiple chronic conditions. By 2018 the number of people with three or more long-term conditions is predicted to grow from 1.9m to 2.9m. Many people will also lack immediate social support as the number of people aged over 65 living on their own is also expected to grow.

A new model of care
Demographic changes and the shifting burden of disease require a re-assessment of the hospital-centred model of care that currently prevails. A new model of care is needed, less oriented to treating people when they become ill and more focused on prevention. This must be accompanied by a progressive shift in resources away from acute hospitals to providing care in and closer to people’s homes. Meeting the needs of an ageing population, and especially people with multi-morbidity, requires services to be integrated to overcome the divisions between primary and secondary care, physical and mental health, and health and social care that inhibit the provision of high-quality co-ordinated care.
Key elements in the new model

Prevention of ill health: action at the population/community level and targeted at individuals to identify people at risk, address risk factors and fully engage the population in bringing about further improvement in life expectancy and quality of life, and reduce health inequalities.
What this means in practice: doctors, nurses, health and social care providers and commissioners making much greater use of population-based information and then working in partnership to improve the wellbeing of the local population. Targeted approaches, including brief interventions by GPs, could result in improvements in people’s health-related behaviours such as smoking and drinking. These interventions need to recognise the clustering of risk factors and unhealthy behaviours, and the wider determinants of morbidity and premature mortality that lie behind this clustering. Action across government is also needed to tackle risk factors such as obesity and overweight.

Supported self-care, shared decision-making and self-directed care: action to enable individuals, carers and families to make choices about their care and to continue to play a key role in looking after themselves.
What this means in practice: People will be actively involved in decisions about their care and fully informed about the risks and benefits of different treatment options. Individuals will be equipped to manage their own health and care. This could include the use of smart phone apps, assistive technologies in the home, home adaptations, access to personal budgets and training programmes. The miniaturisation and automation of drug delivery will also enable more drugs to be self-administered and more care to be delivered at home, for example, the provision of intravenous antibiotics. It is important to note that each individual will have a different degree of enthusiasm and capacity to take on responsibility for their care and services will need to adapt to this.

Enhanced primary care: action to reduce variations in the quality of primary care and to provide additional services that help to keep people out of hospital.
What this means in practice: This requires a network of primary care providers in each locality in order to promote and maintain continuity of care with local people and act as hubs not only for the provision of generalist care but also for access to diagnostics and chronic disease management. There will need to be active support to help practices improve practice and reduce unwarranted variation in standards of care. Primary care needs to be more accessible to patients out of hours to reduce inappropriate demand on overstretched hospitals.

Co-ordination and integration of care: action to link primary care teams more closely with specialists and with health and social care professionals to ensure patients and service users receive care that is effectively co-ordinated.
What this means in practice: This will be facilitated by IT systems that connect different parts of the care system, health and social, mental health and physical health. Access to a shared care record, active support for team-working, investment in new skills for many workers – particularly frontline care staff – and greater clarity about the respective roles of specialists and generalists within the team will enable effective multidisciplinary working. Networks of primary care providers must work closely with community nurses, social workers and other community staff to provide a rapid response to the needs of patients and to make a reality of care closer to home.
High-quality, safe specialist care: action to concentrate specialist services in centres of excellence able to deliver the best outcomes where this is supported by evidence, supported by networks that link together expertise in different settings.

What this means in practice: Hospital provision will become increasingly differentiated. People will no longer be able to look to their local hospital as a comprehensive provider of care. In many cases, patients currently cared for in hospitals will be looked after in their own homes with support from multidisciplinary teams. In other cases people will be treated in more distant hospitals able to deliver better outcomes for patients needing some forms of specialist care. Developments in care co-ordination should mean that any stay in hospital is not experienced as an isolated episode of care but part of a continuing relationship with care services. Hospitals will work together in networks to provide access to the right care in the right place.

Conclusion
The approach we advocate requires a shift in the way care is delivered, with much less reliance on clinicians practising autonomously in a ‘cottage industry’ model and greater emphasis on standardising care around best practice guidelines supported by routine monitoring of performance and transparent reporting. This includes understanding in real time the experiences of patients and service users and using the results to bring about improvements in performance. The focus in future needs to be on the whole system of health and social care and how this can be effectively co-ordinated around the needs of patients to deliver high-quality care in the most appropriate settings. More care will be provided in people’s homes and in the community and hospitals will focus mainly on the treatment of patients who need the specialist expertise that cannot better be provided elsewhere.

January 2013
The King's Fund, Nuffield Trust, Dr Chai Patel CB FRCP, HC-One and Care Quality Commission—Oral evidence (QQ 607–638)

Transcript to be found under Care Quality Commission
Laing & Buisson (Consultancy) Ltd, Wiltshire Council, WRVS and English Community Care Association—Oral evidence (QQ 373–462)

Transcript to be found under English Community Care Association
MONDAY 10 DECEMBER 2012

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Lord Mawhinney
Baroness Shephard of Northwold
Lord Tope
Baroness Tyler of Enfield

Examination of Witnesses

Julie Foster, Associate Director for Adult Social Care, Torbay and Southern Devon Health and Care Trust, Dr Shane Gordon, CEO, North East Essex Clinical Commissioning Group, Dennis Holmes, Deputy Director of Adult Services (Strategic Commissioning Portfolio), Leeds City Council, Professor Elisabeth Paice, Chair, North West London Integrated Care Management Board, and Tony Watts, Independent Chair, South West Forum on Ageing.

Q554 The Chairman: Good afternoon and welcome. Thank you very much for coming, some of you quite a long way and at relatively short notice. We are very appreciative. I am sorry that we have given you such a small bench; it is basically my fault, preferring smaller rather than larger Committee meeting rooms. I hope that you have got a clear view as to what the Committee is looking at. It is essentially asking a very simple question: is our society, in terms of attitudes as individuals, as public services and policies, ready for that ageing that will come over the next 10 to 20 years? Our focus is 10 to 20 years’ time, to try to get clarity by looking at that period about what is changing and therefore what might need more than incremental adjustment. That is what we are about essentially. As you have probably seen, we have had a lot of evidence already about health and social care. What we particularly wanted was some understanding of how things were on the ground, so that we were informed by real life rather than just by high strategy and people talking at a national level. So you are our real-life exhibits if you can cope with that this afternoon. I am not
Leeds City Council, North East Essex Clinical Commissioning Group, North West London
Integrated Care Management Board, South West Forum on Ageing and Torbay and
Southern Devon Health and Care Trust—Oral evidence (QQ 554–582)
going to introduce all of us, which I hope you will forgive, but I wonder whether you would
just run along the row and say who you are.

**Tony Watts:** Lord Chairman, my name is Tony Watts. I represent the South West Forum
on Ageing, which I chair. This is one of the nine bodies set up in the wake of the Elbourne
review to ensure that older people were involved when decisions were made on their
behalf in terms of strategy, policy, new practices et cetera. For the purposes of this meeting,
I have brought together my experiences in other forums in ageing around the country and
the South West Seniors Network, which represents 50,000 people in the south-west. So
hopefully today I am here representing older people in the round.

**Dr Shane Gordon:** I am Shane Gordon; I am a GP and a clinical chief officer of one of the
new clinical commissioning groups based in north-east Essex around Colchester and
Tendring.

**Dennis Holmes:** I am Dennis Holmes. I am the deputy director of adult social services for
Leeds City Council. In that role, I am also responsible for strategic commissioning for
services for all adults in the city.

**Professor Elisabeth Paice:** My name is Elisabeth Paice. I am a consultant rheumatologist,
then turned postgraduate dean for medical education and now chairing the two integrated
care pilots in north-west London.

**Julie Foster:** Hello. My name is Julie Foster. I am a general manager for health and social
care for Torbay and Southern Devon Health and Care Trust. I am also on secondment at
the moment to be the associate director of adult social services.

**Q555 The Chairman:** Thank you. Can I just before we dive in explain the structure at
slightly less than two hours? Initially, we would like to ask each of you to give a succinct
perspective on the challenges of making health and social care integrate effectively and
personally around older people to get the outcomes that they want and on what you have
learnt from what you are doing that you think is relevant to us. If you each do that, we will
probably keep it relatively closed and tight as a session for about 40 minutes. Then, just to
see if we get a bit more sense of real life, we shall ask you to have two discussions about a
couple of the case studies—I think that you have seen the case studies provided by Age UK
and Carers UK. That is an aid just to talk about the issues that those case studies illustrate.
A couple of my colleagues will lead the questioning for each of those two case studies. At
the end, we will come back to some more traditional questions that I think you will again
have seen, but we will throw one or two extra ones in, I am sure, because we always do.
That is the plan and we will see how much it goes to course. Let us start off with asking
each of you really to describe the key challenges of providing integrated, person-centred
health and social care services for older people and how you have addressed that in your
areas. Maybe I could start, if I could, with Professor Elisabeth Paice.

**Professor Elisabeth Paice:** Yes, indeed. So the challenges are that the funding streams are
not necessarily aligned and depend on the organisations. There are perverse incentives
sometimes to integration, just simply from the finance. That is probably the biggest challenge
to be overcome. The second challenge is that accountability is not shared but is allocated to
different departments, people and organisations. The second step, I think, is shared
governance, and the third is data. Even within a hospital, you have different systems between
A&E and the wards, never mind between GP and GP and between different organisations
and providers. Sharing of data would be the third obstacle, or potential enabler, if you get it
right. And the two others, for me, are the need to engage patients themselves in co-
designing the system that supports them and the need to engage the professionals in a way which is collaborative. We do not train healthcare professionals necessarily to be collaborative but to be independent, autonomous beings. Instead of the lonely hero, we need to develop a culture of collaboration. Finally, I think, we have learnt the need for constant innovation. Constant innovation does not necessarily require constant reorganisation, which is an obstacle rather than an enabler of progress. Would you like me to take the time to go through how we have addressed some of those things?

**The Chairman:** Yes, please.

**Professor Elisabeth Paice:** I shall start with the collaboration and shared governance and all the things that I talked about. What we have done in north-west London in two pilots, one of which started a year after the other, is bring together acute primary and care - GPs; mental health, most importantly; social care, very importantly indeed; patients themselves; and community trusts. That is a large group of agencies coming together in a voluntary way, without creating a merged organisation of any sort but coming together in a sort of club—the lawyers call it a club—and voluntarily agreeing to behave in a certain way, which is developed by the group themselves. So that is the shared governance—agreeing what we are going to do and holding ourselves to account for doing it.

**The Chairman:** And that is not a proto Health and Wellbeing Board, for example?

**Professor Elisabeth Paice:** Not really; it has been more a club, a provider collaboration—I think that that is what I would call it. The people who are very important to have at the table besides acute care and GPs are mental health and social care and the patients’ organisations. The second thing was organising some financial incentive, because what I am going to describe took funding. It took time and the time needed funding. So some work needed to be done to raise the money to pump-prime this changed behaviour. Interestingly, sharing data was an obstacle at first in that people thought that it would be too difficult, that confidentiality would be an issue, that patients would not like having their data shared and bandied around from organisation to organisation and that it would be technically difficult. What we found was that technically it really was quite difficult, but once we started going with a tool which could provide the same front page for A&E, ambulance, social care, pharmacy and mental health, the attraction of the concept became such that immediately the tool that we had was inadequate to meet the burgeoning expectations. That is going to need some work, but it is so clearly the way forward. The interesting thing is that of 24,000 patients asked to consent for this shared data, 300 did not wish to consent. So it was 300 out of 24,000.

**The Chairman:** Wow.

**Professor Elisabeth Paice:** Exactly. Mostly, what we got back was: “Sorry, are you not doing that already?” So those are big steps forward. The culture thing is easily brushed aside and considered easy; actually, it is very difficult. It is in the way we train professionals from day one. If you are talking about 10 or 25 years ahead, one of the important things to do is to start inculcating people with a different culture. How to do that is obviously something I am very interested in, with an educational background, but it has to be education starting right from the beginning but also starting right from the end, in that there is no point in training the young differently if the people who are already in post and even approaching retirement have a different culture and you have a conflict of cultures in the system. It needs a huge educational effort to turn this one round. I believe that it is well possible, but it needs
Leeds City Council, North East Essex Clinical Commissioning Group, North West London Integrated Care Management Board, South West Forum on Ageing and Torbay and Southern Devon Health and Care Trust—Oral evidence (QQ 554–582)

an effort and a strategy. Then, finally, the thing that is making the difference for patients is the development of multidisciplinary groups. There are 10 in inner north-west London and 17 in outer north-west London. These are groups which have GPs, consultants and all the people whom I mentioned come together talking about the care that they wish to deliver to their patients, discussing patients at case conferences, collecting information about patients, discussing with patients their own personal care plans and entering them on this shared data, so that you start to be able to re-stratify the patients, call the most complex ones for discussion at these multidisciplinary case conferences and then hold ourselves to account for what has happened; for example, how many have had a care plan, has it been carried out, how many admissions have there been et cetera. The aim of all this has very clearly been to improve patient care and experience, quality outcomes and experience, improve the professional experience, with less frustration and more job satisfaction, and to reduce costs by reducing hospital admissions in the long term.

The Chairman: We will come back to some of that, I am certain. I think that we might take Dennis next, because he was nodding vigorously at some of that, but before we do so, let us just take two short questions from Lady Shephard and Lord Bichard.

Q556 Baroness Shephard of Northwold: It is really not a question; it is a request. We have witnesses representing very different areas of the country and different population sizes. If they could just tell us the sort of population size that they are talking about—for example, north-west London is clearly different from Torbay—that would help us.

The Chairman: Good question. It would.

Professor Elisabeth Paice: I am talking about around a couple of million.

Baroness Shephard of Northwold: If each of our witnesses could give a rough figure.

Professor Elisabeth Paice: That is a rough figure, but it is in that order. It is 8 million in London.

The Chairman: Why that size?

Professor Elisabeth Paice: It is just the way in which London is divided up into sections.

The Chairman: It is SHA boundaries, is it?

Professor Elisabeth Paice: Yes, that is right.

Q557 Lord Bichard: I preface a very short question by saying that I think that you have just written most of our report in a brilliant contribution. You talked about this club being at the core of a lot of the things that you have mentioned. Is it just a question of setting up a club or would you still be looking for something from Whitehall and Westminster to enable this more effectively?

Professor Elisabeth Paice: It is interesting. The difficulty we had at first was of people feeling anxious about loss of autonomy, which is very precious to professionals anywhere. So being taken over by another organisation was being badly received. Even if it was a new organisation, it would still have been a threat to things that people held precious. What happened as people talked about the potential benefit to patients was that people started to align and come together and start to get excited. But it was crucial to doing what we did that no one was taking over anyone else’s turf and that it was voluntary participation—
Leeds City Council, North East Essex Clinical Commissioning Group, North West London
Integrated Care Management Board, South West Forum on Ageing and Torbay and
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people could leave and some did leave or join later. If you are in the club, there are the
rules, but it was not something done to; it was something agreed on. Whether that needs to
be the way that it is forever, I do not know. All I would say is that we built the platform
from which you could launch new innovations. At the moment, everyone concerned is
interested in the next step forward—a whole-systems approach. We took only two
conditions: diabetes and those aged over 75 and over in the first tranche. Now people are
looking at, “Let’s widen the scope”. Does it need a further external reorganisation thrust
upon people? No, I do not think so.

Lord Bichard: If you wanted us to say something to government—“This would help us to
do this even more effectively”—what would it be?

Professor Elisabeth Paice: Everybody struggles with dealing with the funding streams.

The Chairman: What do you mean by that?

Professor Elisabeth Paice: If you are an old person, for example, you do not see yourself
as needing social care and healthcare; you need care. It is simply a mystery and an irritation
to find, “Well, that pocket does not count, because that’s a different budget, so we cannot
do that”. All that sort of fragmentation is very difficult.

Q558 The Chairman: We have got a question on funding later on, so can we come back
to that in some detail, because clearly it is an important topic. Excellent. That was very
clear. Thank you. Dennis, you clearly were nodding. Does that mean that you agree with
quite a bit of that analysis?

Dennis Holmes: Yes, I thought that it was an excellent exposition of the situation. It has
ticked all the boxes that I had on my sheet. To answer Baroness Shephard’s question, Leeds
has a population of about 760,000, so it is a big place. With one local authority, three clinical
commissioning groups, a very large teaching hospital trust, a mental health foundation trust
and a community healthcare trust, it is a big NHS family. In reverse order, one of the big
issues that we face is data. Identifying the patient between organisations is a real issue and
one that we are striving to address as well across all those different NHS organisations
and—dare I say it?—across GP practices, many of which have their own IT systems as well.
So it is a real practical problem that we will need help in overcoming and moving forward.

I want to dwell on the fragmentation question for a moment. One of the things that we find
really tough in local government is the almost constant reorganisation of the NHS, which
has two real effects. The first effect is that, from working previously with one PCT and one
set of colleagues we now work with four different organisations—the three clinical
commissioning groups that were set up and the community healthcare trust, which is the
provider bit of the trust. That makes it very difficult to maintain relationships, because,
especially, successful integration is built on good relationships. If you have got good
relationships between local government and the NHS family of organisations, you are more
likely to succeed in integrating these services than if there are poor relationships between
those particular individuals. The second thing is that when the NHS restructures itself, it
sheds people and people leave, so an effort has to be made to build relationships with new
faces in local NHS organisations, sometimes just to get to the same position that had been
gotten to with previous NHS administrations. It is a real effort to continue to do that. One
of the issues that local government faces now and is increasingly going to face, particularly in
the light of the Autumn Statement, is the funding position. Local government faces very
significant reductions in its budget. Adult social care and children’s social care already
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consume a significant amount of any local authority’s budget, so when we are looking at pooling resources within the NHS, there is a risk from the NHS perspective that any pooling will help in some way to cross-subsidise council services. That was never the intention, but I think that that fear is there. Sometimes that leads to reluctance to embark fully down that route.

The NHS itself will face financial issues as it approaches standstill budgets. It always faces an issue in moving resources from acute care—that is, hospitals—into communities, which is largely where integration is taking place. Populations are innately conservative when it comes to closing hospitals or some hospital facilities and reproviding those facilities in community settings. That is a real political challenge for locally elected members and non-executive directors in local NHS organisations which we will need to confront. In terms of what we have done in Leeds, again, I kind of echo my colleague’s comments. We do not have a club; we have a nascent Health and Wellbeing Board which we are trying to make as inclusive as possible. Certainly, elected members have got a key role to play as representatives of their communities. Also, the voice of the patient is going to be absolutely critical in influencing the health and well-being strategies that every Health and Wellbeing Board will bring into play in the coming years all being well. As Health and Wellbeing Boards develop, they will spawn what you might call subgroups which hopefully will take care of the governance around integrated commissioning and be able to take on the views of providers within localities about how that commissioning can best be achieved. We have high hopes for our Health and Wellbeing Board in the way that it will conduct its business.

The second point is practical and again mirrors my colleague’s comments. By April next year in Leeds, we will have our adult social care social workers co-located with community NHS staff, coalesced around GP practices, because we think that that is the right unit of currency, and providing integrated care around a restratification model as my colleague described it. We recognise that we need to target particular groups of old people and divert them from consuming more expensive acute health and social care services. We see the collaboration and essentially the co-location—not organisational integration, because there are significant problems in trying to re-engineer different organisations. We have wasted a lot of time trying to do that in the past. I do not see the point of trying to do it in the future around standard outcomes for older and disabled people in those communities.

The final two things that I would say that we are trying to do, looking further forward, are to stimulate the creation of local responsive services to meet older people’s support needs. I talked about the critical care needs and diverting people from acute care, but older people need relatively simple supportive services to help them maintain their confidence in the communities that they live in. We know for a fact that loneliness is one of the biggest causes of older people losing confidence in their ability to cope in their communities. By fostering what we call social capital in our local communities in Leeds through the use of volunteers and voluntary groups that will provide friendly visits to older people in those communities, we see that as being a very powerful investment that will help in the future. So it is stimulating the voluntary groups, again. The final thing is being attentive to older people’s housing needs, which goes hand in hand with the need to develop some more technological solutions for some of the problems that we see older people experiencing. Really trying to invest in facilities such as extra-care housing and bumping up the numbers of that type of housing for older people, we see again that as being a powerful tool in our efforts to help the ageing population in Leeds. That requires a whole-council approach. It requires planning officers’ involvement. It involves housing providers in really looking at the city and how the space is designed in it to accommodate a city that is going to be fit for older people in the
future, particularly anticipating higher numbers of people experiencing dementia—over 85 is where the highest incidence of dementia is, but it starts to kick in from 21 onwards in my city.

Q559 The Chairman: Very clear. Thank you very much. Tony, let us hear what you hear from your interest groups of members.

Tony Watts: I am looking at this obviously from a different perspective. We do not have that expertise at the centre of organising commissioning et cetera. What I can tell you about is the sharp end of things, where people are suffering at the moment. I have a brief list here, basically, which I shall rattle through if I may, because you obviously know some of these issues anyway. We have got ideas behind all of them, basically, to try to sort some of them out. It has been pointed out several times already that older people should not necessarily be seen as a challenge and a problem; they should also be part of the solution. By actually engaging older people—not necessarily just inviting them in and saying, “This is what we are going to do, chaps”, but saying, “Please help us design these services. Please give us your experience and your expertise and, by the way, would you like to be part of a community organisation which is part of the support system?”. Everyone recognises that there is not enough money to go round and that we are going to have to help each other a lot more. So it is about engaging people. When these Health and Wellbeing Boards are being set up, they should not have just one or two token people occasionally being invited in; they should be integral, because these are the people who actually consume most of the services. These are intelligent, eloquent and experienced people whose passion, concern and interest should be harnessed. I will raise a couple of points if I may. The first is that a disproportionate number of older people lives in rural areas—this is often forgotten. It raises particular issues, not only about transport and getting to and from hospital but also about the additional cost of meeting those people's care needs in the home. If they are part of privately provided service, they do not get their 15 minutes even; they often get less than that, because of the time that it takes to get to them, and they get a raw deal. The system at present does not focus sufficiently on the compression of morbidity, which I am not sure whether you we have discussed before.

The Chairman: We have.

Tony Watts: Basically, this is what it should be all about; it should be about prevention. There are small issues like inefficient or inadequate chiropody services, which lead to people losing their mobility. I have seen this first hand. Even taking away swimming lessons from older people is a classic example of silo thinking. You think, “Okay, we are saving money over here”, but, over there, you are going to end up with less fit, less able part of the population. The whole issue of NHS continuing care is not understood by older people and I suggest that a large reason for that is that it has not been explained to them adequately. For an awful lot of people, it is inconsistently applied around the country and an awful lot of people feel browbeaten when they find out about it, try to apply it and the health trust involved fights them every inch of the way before it will pay anything. Even though the person may be dying or have major health conditions, it seems to be impossible in some parts of the country to get fair treatment. There are certainly postcode differences in the level of care that local authorities provide free of charge. Carers get forgotten, frankly. A bit of help towards supporting carers would go a huge way. Most carers themselves are elderly and end up needing care because they are trying to look after their partner, are not sleeping or eating properly and not getting any respite. A small amount of care for those people would actually go a huge distance. I am told that they cannot get access to counselling from
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GP surgeries. Many are left traumatised after the event, which is often forgotten. They come through this experience; they have not slept; they have not eaten; they feel guilty about the whole situation. They are left at the end, often, shells of people who need picking up and looking after. Bed-blocking—I am sure that you know all about that—is totally inefficient and bad for the patient. People are dying early because they are being kept in an environment where they should not be. The assessment process of those requiring care will give a true picture. Older people can be very proud. People come into their home and they will not necessarily give them all the facts. This often leads to people not being given the care or support package that they really need.

Q560 The Chairman: Very clear. Thank you very much. Let us hear, if we could, from Julie Foster from Torbay.

Julie Foster: You would like some details of the area that we cover. Torbay and Southern Devon care trust covers a population of 375,000. Within that, Torbay has a population of around 45,000, so it is a mixed urban and rural population. We work with two local authorities, Devon and Torbay, and one acute trust, South Devon Healthcare Trust. Within that, we have 11 community hospitals and 40 GP practices. I shall just tell you a bit about the age demographics, seeing as I have them here. 25 per cent of our population is over 65; 8 per cent of our population is over 75; and 4 per cent is over 85, so we have quite an elderly population. It is really wonderful to have the opportunity to come and talk to you today, because I feel very privileged that I was part of the beginning of Torbay Care Trust. I was one of the first general managers for health and social care to be appointed. I have been with Torbay Care Trust on its journey and it has been a really exciting one, because I feel that we have been able to get some things right for our local population. I agree with everything that people have said before about the need for joined up care, particularly around finance. In my view, there are three main ingredients for making integration work. The first ingredient is definitely leadership.

Baroness Shephard of Northwold: You mentioned the Torbay Care Trust. How was that set up and by whom?

Julie Foster: Our first chief executive was Peter Colclough, who has now left. It was an alliance between Torbay Council, which is an unitary authority, and Torbay PCT.

Baroness Shephard of Northwold: So the decision was taken by those who set this up. When was that roughly?

Julie Foster: About seven years ago. The reason that the two organisations came together was that it felt like the right thing to do for the customer. I think that there are three main ingredients to setting up integrated care that works. The first is leadership. Organisational cultures and values are really key to any success. I think that we have been really lucky in having some fantastic leadership. Our first Chief Executive introduced the concept of Mrs Smith, who some people might have heard of. Torbay’s Mrs Smith is famous. We talk about Mrs Smith all the time to our front-line teams and at management team meetings. Our aim in life is to make things work as well as possible for Mrs Smith and her family, whoever she may be. Having that real-life person at the centre has helped us to bring our message alive. When we started off thinking about the care trust, we first went out to the community, to Mrs Smith, to ask her what she wanted and how she wanted to see services improve. She told us lots of things, but two of the main things were that she wanted to tell her story only once and she wanted the professionals involved with her care to talk to each other. They
Moving on from leadership, the next most important ingredient for success is to put together operational systems which work across organisations. We co-located multidisciplinary teams. We call our areas “zones” in Torbay and Southern Devon. Each of our zones works with a cluster of GP practices. I shall tell you about the one that I know about most, because it is the one that I manage; that is, Brixham, which only has a population of about 25,000. We work with our three local GP practices. All my staff work solely with the patients from those three GP practices, so the team knows the GPs really well.

My co-located team is based in one large, open-plan office which consists of occupational therapists, physiotherapists, social workers and social care, the community nursing team and our community matron. I am the general manager, so I have a management team consisting of a lead professional from each of those four professions. We also meet the GPs as a management group on a regular monthly basis as well as contact established with them to focus on patient need. We have created a single point of contact; we have a single access point to our organisation—one telephone number for GPs and for the public. You ring that number, and then you will be routed through to the zone that deals with you as determined by your GP. On the end of that telephone is a post that we have created called the health and social care co-ordinator. These people are able to take referrals. They are able to make some decisions about whether services need to go in to make a situation immediately safe. So they could put in low-level services such as community meals or domiciliary care at the very first point to make the situation safe. Then there will be a discussion about who is the most appropriate professional to take on that case. It could be a district nurse or any of the professions making up the zone team.

Backing that up, we have a single health and social care record. That has been quite hard to achieve, but we have got there. It is not the most ideal system. It is quite cumbersome. All our staff are employed by one organisation; they are all NHS staff; and we all use the same computer system across health and social care. I think that we are one of the only organisations in the country that has been able to do that so far. We do not have a really good communication system, in that all GPs have separate systems which need to be entered into separately, but our nursing staff can access the GP systems that they work with. We try to get as close as we can to it. We also have “yellow folders”, which we use for people with long-term conditions and complex care. Those folders stay within the person’s own home and we will update the care plans in those yellow folders so that anyone visiting, including the emergency services, can see what is going on. There should always be a contingency plan in those yellow folders to avoid emergency admissions to hospital if possible. I am also going to tell you about intermediate care. We have a very well developed intermediate care service which again is multidisciplinary. That means that, as an alternative to hospital admission, and if the GP rings us and gives us the information about a patient who he is concerned about, we can be in there within three hours and offer an alternative to hospital admission. That can be a multidisciplinary team working with that person in their own home, or we have a spot or block-contracted beds in residential and nursing homes across the bay. All attempts are to avoid unplanned hospital admissions if we can. We also have community hospitals with which we work very closely. We have very good relationships with our local acute trust. We also have a hospital discharge co-ordinators. These staff are similar to Health and Social Care Co-ordinators but they are sited on eight of the acute wards and are able to start discharge planning with the patient almost as soon
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as they are admitted. It joins up the threads, by talking to us in the community teams about
we need to do to put Mrs Smith’s care in place when she is discharged.

The final one of my three ingredients is about finance; you cannot really help but get back to
that in the end, I think. We have local decision-making in Torbay and Southern Devon
Health and Care Trust. We are able to make decisions about continuing healthcare at our
local zone panel and we also make decisions in a separate panel around social care funding.
So, at the moment, at my level, I have access to both health and social care funding streams
and I can use them appropriately for the community in Brixham. I think that there are
beginning to be some challenges around that. As budgets tighten up, particularly from the
local authority, we have to be much more careful about how much money we are spending.
I really agree with what Dennis was saying earlier about making more use of the voluntary
sector, because, as budgets get tighter, more people will fall off the end. We need to do
much more now about prevention—that would be our next step—and low-level services
trying to help people to support themselves so that they do not need to come to the
statutory organisations.

The Chairman: Very clear and fascinating.

Q561 Lord Griffiths of Fforestfach: Chairman, I wonder whether I could ask,
practically, who allocates money for the care trust’s budget.

Julie Foster: The two local authorities set the budget for social care, and the health budget
is set through the healthcare commissioners.

Lord Griffiths of Fforestfach: Do they collaborate in the way that they set that budget?

Julie Foster: I do not think so.

The Chairman: This is true.

Lord Griffiths of Fforestfach: If you wanted more, how would that work? If you felt that
you were really up against it and there was a great need, could you then go back to them
and say, maybe throughout the year, “We now need more cash”?

Julie Foster: The budget-setting is done the year before for that next year. I think that there
is risk-sharing agreement if we cannot balance the budget, but I do not think that there is
the opportunity to ask for more money.

The Chairman: Ilora, and then Lord Mawhinney wants a quick one as well, which means
that we need to start talking quicker.

Baroness Finlay of Llandaff: When the PCT goes and you have the clinical
commissioning group, what is going to happen to your organisation?

Julie Foster: At the moment, we are a provider trust. Our board has decided that we need
to acquire a partner. We need to find a trust with foundation status to link ourselves with.

Lord Mawhinney: You get money from the local authority and from the health
department. Are you required to spend the health money on health things and the local
authority money on social care?

Julie Foster: Absolutely.
Lord Mawhinney: Or once it becomes yours, can you do whatever you like with it?

Julie Foster: No, we have to account for the money to each of our funding streams.

Lord Bichard: Is that helpful?

Q562 The Chairman: We do have a big question on funding later on. It is massively frustrating, I know, because you have an extremely complicated story. If you have got things that you think that we should have heard, or if you want to describe in a bit more detail the changes that you have made or the challenges, please send us a paper or two and we will read them. Last but not least, Shane, over to you.

Dr Shane Gordon: Thank you very much, Lord Chairman. Just to answer Baroness Shephard’s question, north-east Essex has a population of a third of a million people. It has a mixture of moderately urban and very rural areas. The Tendring district in north-east Essex has the average oldest population of any district in Europe. It also has the third most deprived ward in Europe within its boundaries, so we have some significant challenges both of age and deprivation.

Baroness Shephard of Northwold: Which is it?

Dr Shane Gordon: It is Golf Green ward in Tendring. It is the third most deprived ward in Europe apparently. It faces a great range of challenges, both through the age of the population and the varied circumstances in which they find themselves. There are four basic challenges in the time horizon that you have set of 25 years. The first is the public purse, which I am sure you have already heard much about, but I do not see in my professional lifetime the public purse recovering from where it is now. That means that the pressure that my colleagues in social care are under, which is leading to 30 per cent reductions in spending in some areas on keeping people well and the relatively static funding in health, is only going to get more challenging as we go on, because the need is rising inexorably. We are expecting in north-east Essex, in Colchester, which is one half, a 17 per cent growth in our population by 2020, and in Tendring, the elder part, 12 per cent growth in the same period. Almost all that growth in Tendring will be over 65s, because it is a coastal area—people retire there; it is a nice place to live—but it means that the burden of care that we have to give goes up and up.

As you get older, of course, you collect illnesses like football cards, so people over 65 have an average of three long-term conditions each. That means not just dementia but diabetes as well and heart disease or some other long-term condition, which places a burden both on their ability to care for themselves, their carers and their families but also on the statutory services that have to support them.

The second challenge is governance and the funding mechanisms that we work under. We have a clash of cultures between health and social care. The healthcare system is not built as a healthcare system; it is a 19th-century sickness service in its bricks and mortar. The big challenge for the governance of the health service is if we carry on funding and preserving a sickness service, we will very soon not be able to afford it, because the people that Dennis and his colleagues can no longer support because of their budget squeezes on the well-being side will of course become sick and add to the burden that we have already in health trying to deal with that burden of sickness. The challenge for us is that we want to join up commissioning between health and social care. We are part of a community budget pilot of which there are four around the country—there is one in Essex. We are all working hard to align what we want to deliver, but I fear that, because when we have to account, as you
have been hearing earlier from Julie, for the money that we spend, we are accounting to people with different priorities in different organisations—local government and the national commissioning board—and we will get pulled apart. So unless we resolve that difference of priorities in the people we account to, I do not see how we keep joined-up commissioning together. I have been in the health service for only 16 or 17 years in my professional life, but I have already seen several instances where great things like care trusts—there was one near to us locally—got pulled apart when the funding squeeze came on, because everybody retreats into their different corners with their different priorities. They want accounting for every single penny on health, and every single penny on social care, and, if you account like that, the sums do not add up. So that is a real challenge that you could help us with.

The third challenge is, I think, the most difficult, which is expectation—public expectation, the expectation of the nation. We believe that we are a first-world nation, and we have been, but the world is changing. I am not even an amateur economist, but I can see what is happening to the OECD ranking of the country: it is dropping, and it will drop and drop as far as I can see. Unless that recovers, we have to cut our cloth according to our means. We have at the moment a social contract which says, “We will provide all the care you need, whatever that care is”. But we are now moving to a situation where we have more economically inactive people than economically active people in the country. Where will the wealth come from to deliver all the care that we need through statutory services? It cannot. So there is a question about how we reinvigorate families, the desire to care for our family, heal the disconnect in families where the working-age, economically productive adults live in a different city from their elderly relatives and sometimes a different town from their young children. How do we get that back into the equation? How do we deliver even the expectation that Derek Wanless had of a fully engaged society, which was before the credit crunch was a reality? We have not even got near delivering that. That is a huge challenge and I do not know how we fix it unless we have an honest conversation in the public domain about what we can expect from our statutory services in the medium to long term, because an unrealistic discussion is happening at the moment.

Fourthly and finally, on information and information-sharing, we are hampered in our efforts, despite some really good work that has been done locally and elsewhere, to join up the provision of services between health, voluntary sector, social care et cetera, but we are prevented, for example, from assuming consent to share information between social care providers and healthcare providers, because the information governance Act and Caldicott’s rules say that they are separate domains of information. We may not assume that you can share. Every patient has to be asked for their consent to do that, which means that you cannot assume that you are going to get it and construct a system where you can easily share that information, even just to work out how much you spend.

Q563 Baroness Shephard of Northwold: That is so interesting, because you find this an insuperable obstacle, as it were, but there are models, in a sense, whose advice you might be able to take.

Dr Shane Gordon: And we do.

Baroness Shephard of Northwold: You are dealing with a vastly greater population.

Professor Elisabeth Paice: We do have to ask consent.

Baroness Shephard of Northwold: Yes, you do, but you still have two million people to ask.
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**Dr Shane Gordon:** And each one of them must be asked separately.

**Professor Elisabeth Paice:** But they all have a GP to have a conversation with. If you are talking about individuals at the centre, then maybe having those conversations is not an intolerable burden because those sorts of conversations should be taking place.

**Lord Bichard:** Is there a recommendation that you would like us to make on this?

**Dr Shane Gordon:** Dame Caldicott is reviewing her recommendations at the moment, so what an opportunity to say, “Actually, do you want a set of rules that forces the systems apart or one that brings them together?”

**The Chairman:** That is fine. Shane, very clear. Thank you. Just to conclude this, Shane said some things that were different; there was clearly an overlap. Do any of you differ? On which of the things that Shane said, do you the rest of you differ? I was particularly interested in his description of effectively a health service which was an illness service, which has overlapped with what Chris Ham of the King’s Fund has been saying about a service focused on acute services and acute health which is hospital based. Do you differ from anything that Shane said and the significance?

**Professor Elisabeth Paice:** I think I am very much in agreement with what has been said.

**The Chairman:** This is a seriously dull session; you are all agreeing massively, aren’t you? I am teasing you. That is very helpful. If on reflection you disagree, just send us a note.

**Professor Elisabeth Paice:** All right, what I will say is that I think that this sort of integrated care approach works very well for the people at the top end of the risk triangle. I do not think it is necessarily the answer for the 2 million. The people who are currently at a low risk of hospital admission because they do not have comorbidity still need a service which will respond to their acute needs when they get acutely ill. This is not the panacea. This is an approach to this risk group.

**The Chairman:** That is helpful. Baroness Finlay?

**Baroness Finlay of Llandaff:** Professor Paice has answered my question, thank you. I was concerned about where the acute services are going to be in the model that Dr Gordon was describing, but we will not take time now.

**The Chairman:** Can I do some agenda-checking with the Committee because we are already at least 10 minutes adrift? If the witnesses can bear it, we either overlap slightly and do two case studies or we just have one case study. How is the Committee for going on a bit longer? I think that we are pressed to go after 4 pm so that probably says we just do one case study rather than two. Watch what happens next. Baroness Shephard, over to you to lead the first case study.

**Q564 Baroness Shephard of Northwold:** You have heard information about the case study of Jenny and James—I think you are familiar with that. Jenny is essentially describing her problems of caring for James who was diagnosed with—I cannot pronounce this—Lewy body dementia. For example, every six weeks she has to put him into respite care and on his most recent trip, when she collected him he had no shoes on, his glasses were missing and he was wearing somebody else’s clothes. He was frightened, he had bruises on his body and had lost eight pounds in seven days. She says that should not be acceptable and that she has not felt she can put him there since. How different is that in your areas? Not everybody
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needs to reply but what would you say to the people who are responsible for his care, and which people would you address?

Dennis Holmes: Clearly, in Leeds, I am responsible for commissioning care worth around £60 million for older people in long-term residential and nursing care, including respite care, that is paid for by the local authority. The sense that I take from the case study it is that these people are funding their own care but materially there should be no difference. Poor standards of care like this are something that we are striving every day to try and iron out of the sector because it is completely unacceptable. Clearly there is a significant role there for a local authority. I contract with the overwhelming majority of care homes in the Leeds area and I have contract officers who go into those homes on a very regular basis to satisfy ourselves that the levels of quality are there. When we identify that levels of quality have fallen to the standard that is exemplified in this case study, we will stop doing business with that company or home until the standards of care have risen. We will advertise that through our website so that even people who are self-funders can see that we are not actually placing people in that establishment.

Baroness Shephard of Northwold: It is important in this case that they are self-funders. She therefore feels herself outside the system, but you would say in Leeds she could have access to a website which, even in her situation as a self-funder, she could use?

Dennis Holmes: Yes, it is absolutely essential. People who are funding their own care need to have access to the same kinds of facilities as people who are publicly funded. There should be no difference.

Baroness Shephard of Northwold: What about the support in the construction of the care package? One of the worst bits is that she has had to deal with everything. Where would you start, especially when it is the ill person in your household that will be taking up your attention and emotions?

Dennis Holmes: Our social workers would help anybody to construct a care plan. I think the difficulty for people who are funding their own care is understanding that that is where they would go in the first place to do that. I think there is scope for the local community organisations that I was previously describing to have a role to play in supporting independently funded people who want to organise their own care packages. There is also scope—I know that some of the larger independent sector care companies are looking at this—for setting up their own facilities to support people who have independent means, and in a sense do the care brokerage on behalf of that individual for a small fee. I think that there are number of different avenues that people could go down and will be more widely available in future than is exemplified here but I think the important thing is making that information known to people that they can actually do that. That is the challenge for us, to get that message across.

Q565 Baroness Shephard of Northwold: There would not be, I hope, a rejection of Jenny from any official organisation where people said, “Well, you are paying for it yourself, you can get on with it”?

Dennis Holmes: Certainly not in Leeds. Everybody has access to it. The challenge is people actually taking advantage of that.

Professor Elisabeth Paice: This is one of the things that we have been struggling with, talking of that, in trying to move to a whole system concept for the top of the risk pyramid.
One of the things that we have been discussing with a lot of interest is the concept of funding coming down in a way which is a capitation so that there is a sum of money, whether it is social or health care, that a high-risk person has some control over or can discuss with their GP how they will best use it to be kept well. The idea of perhaps having the GP as the person who is able to use those resources in discussion with patient care to access whatever kind of care they need is extremely appealing, but it does take funding change. This is still at the moment an ideal. Part of that ideal would be funding for a care co-ordinator for each of these high-risk people who would able to say, “You’ve got those resources yourself, and we’ve got these resources coming down for you. What about a package where you pay for that and we will pay for this?”, co-ordinating the care whether it is privately or publicly funding.

Baroness Shephard of Northwold: Can I ask Julie Foster about the organisation that she has outlined in Torbay in South Devon where you have groups of GP practices? You mentioned the name of a post that I cannot now remember.

Julie Foster: A health and social care co-ordinator.

Baroness Shephard of Northwold: Would that be the sort of person in your area that Jenny might be able to approach, even if they were funding their own care, and could she expect help from that co-ordinator? I suppose she could because James would have a GP. Would that be the first port of call?

Julie Foster: She could certainly expect an assessment of her needs, because that is a statutory right of everybody in that position. I think there is an increasing risk as our social care workforce is reduced through reducing funding, more and more we are having to say that if people are self-funding they need to take more responsibility for themselves in finding their care. We would support them but if they had it was a lower level of need we would be signposting them to the right source of help. Certainly they would be assessed and helped to care-plan. What we would like to look at is more of a brokerage role so that we can assist people to set up their own services.

Q566 Baroness Shephard of Northwold: Yes, because these kinds of slightly more complex funding arrangements may proliferate in the future. Can I ask Dr Gordon what he would feel as a GP if he were approached by Jenny saying, “You know what James’s condition is. We need to get a care plan and who do I go to?” What would you do? Would you have time and resources?

Dr Shane Gordon: They are two slightly different questions. If there were the time, then being a part of that planning process for every individual as they plan would be ideal. However, we already have a 4 per cent workforce shortage in general practice as it is. Like every part of the service, we have a rapidly increasing expectation of what we will do and the number of people coming through the door going up every year. I am not sure that is the best use of a general practitioner to do it. It might be if we were able to organise the service so that some of our other duties were discharged in a different way, so it may be just about the way we organise the service. There is something very attractive about personal budgeting which I think is absolutely crucial to this. You were hearing a minute ago about passing down that portion of the resource which is predictable that we are going to spend on them each year. It offers very small amounts of money, but that, combined with their own funding, can be quite liberating. I wonder what the role of the voluntary sector is
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in brokering these sort of care packages for self-funders. It seems to me to be a perfect voluntary, third-sector niche.

Baroness Shephard of Northwold: Citizens Advice possibly. I think there are solutions coming from the south-west.

Tony Watts: About the solution, I have a few points. It would be nice to think this is an exception rather than the rule, which I am sure does not happen in these areas, but in fact I hear these sort of stories all the time. This is commonplace, so we have to accept this is a breakdown in the system as it stands at the moment. There are several elements which are particularly relevant. There is no mention of the carer’s support in here at all. This person has not been provided with something, and why not? There is a person who is obviously going to be on the ragged edge fairly shortly, not only physically and emotionally but also financially. That comes in at the very last minute that this person is going to run out of money at some point. You get the feeling that, if you have a bit of money, you are okay. If you have got no money at all, basically the state looks after you and you have got a support system. It may not be very high quality but there is some sort of consistent support there. If you have got a lot of money, it does not really matter, but it is the people in the middle who really are—as the expression goes—the squeezed middle. These people have enough money to start the process, and keep a sort of care package going, but they really cannot sustain it and they do not qualify for any assistance at all at the moment. It is those people in particular which are going to be singularly affected by these sort of circumstances.

Baroness Shephard of Northwold: Do other Members of the Committee want to come in on that? That is all I want to ask.

The Chairman: Do not encourage them. It was brilliant chairmanship, Baroness Shephard.

Q567 Lord Bichard: One or two people have suggested to us and have actually written to me saying that, where care homes are concerned, why cannot we have a more informal system of monitoring which involves older people themselves? So, for example, schools have got governors—I do not want to say prisons have got visitors because someone will misquote me on it—but you know what I mean: someone who is going in on a regular basis and making the home feel part of the community but also keeping an eye on what is going on in the home. Do you think that is a good idea?

Tony Watts: It is not only a good idea, it is a brilliant idea and it works in certain parts of the country. Often you have got communities that are rural rather than urban.

Lord Bichard: Do you think that it should be the norm?

Tony Watts: I think that it should be the norm and I think there is a will there but often you get older people’s groups coming together and they act as a community support network within themselves that has that momentum. One of the issues that came up in my region last year was that an awful lot of these groups are closing down because they used to have a bit of support from the council or a bit of support from the health trust. All those streams of money are now disappearing so a group of people who could do a huge amount for their community just need a bit of seed-corn money to make it happen. They will go out of their way to perform these roles. It is a better community transport system that gets people backwards and forwards to hospital for visiting that goes in some areas. Loneliness was mentioned and is hugely important because this is a greater health risk apparently than obesity or smoking. This is something that has to be addressed and that can be done by the
Q568 Baroness Finlay of Llandaff: The case that I want to discuss is Joanna and links in to the comments on how you assess from people themselves what is going on, and how you get that dynamic feedback on what is going on in an organisation. The thing that really struck me is that it says, “She was assessed for continuing care, but didn’t qualify. She was doubly incontinent, had regular falls, didn’t know who people were and couldn’t be left alone”. How do you determine the level of continuing care? How do you review it and what is to be done at a national level about the wide variation in eligibility because it seems to be somewhat illogical. The lady went on in the story not only to be badly cared for but then to die soon afterwards.

Professor Elisabeth Paice: If we go back to this concept that if people do not want to have to tell their story more than once, they surely do not want to be assessed more than once and they do not want assessments to come out with widely different answers just because of where they live. So the concept of the portable assessment is one which would have made a difference to this particular lady.

Baroness Finlay of Llandaff: Why would a portable one have made a difference to her?

Professor Elisabeth Paice: She was assessed as having substantial needs and moved somewhere else where her needs were not assessed as being so substantial. They were only assessed as moderate. That was the case we were talking about. Oh, have I got the wrong case?

Baroness Finlay of Llandaff: No, I am talking about Joanna who had vascular dementia who got progressively worse and I would have thought she was pretty barn door for continuing care wherever she was.

Q569 The Chairman: I think some of us struggle with what is the difference between continuing care and the definition of social services, so could you unpack that for us?

Dennis Holmes: Obviously you are going to get this from a local government perspective. Continuing healthcare is the NHS’s responsibility, and it is their responsibility to assess people’s qualification for fully funded NHS care in a whole range of different settings so the NHS has got quite rigorous processes in place to assess and review people. I am sure that NHS colleagues would share the view with me that, since the framework changed two years ago, more people are becoming eligible for fully funded NHS care in the community, and that places significant stress on NHS community budgets. I think that there is some nervousness in the system about largely increasing numbers of people leading to unsustainable financial prospects for clinical commissioning groups. It may well seem that a restriction is being placed on the system that may make the bar higher depending on the financial circumstances of the NHS organisation who is administering the fund.

Q570 Baroness Finlay of Llandaff: Is this an administrative convenience for the people administering the fund because somebody like this has both health and social care needs and yet the NHS is then taking over all the social care needs? Would the model be to put more funding into the social care end so the social care needs carry on being met under social
Dennis Holmes: Certainly in the pooled budgets for people with learning disabilities that I host—the increasing numbers of people that are entitled to fully funded continuing health care—the funding contribution increases from the NHS to pay for that and the social care is still met from the contribution by the local authority. We have managed to manage that effectively within that pooled budget arrangement.

Julie Foster: My understanding is that if someone is entitled to continuing healthcare—they are assessed against a series of domains to see whether they meet that—that by law has to cover all of their needs so I did not think that it was possible for social care to be paying for part of it, but I then stand corrected on that.

Tony Watts: One of the things that I mentioned at the beginning is that people who on the surface of it should be receiving NHS continuing care in certain parts of the country were not receiving it because those authorities and organisations were fighting tooth and nail and they actually dragged the appeal process out. Why cannot this be assessed independently? Why should the health trust be policing itself?

Baroness Finlay of Llandaff: You mean have a national assessment criteria against which people can appeal which is benchmarked nationally?

Tony Watts: Absolutely, or someone coming in so it is not necessarily the health trust itself deciding whether this person should have this money. It is somebody independent who has the ability to say, “Looking at the criteria nationally, we think this person should qualify.”

Dr Shane Gordon: We should be aware about the potential financial risk that opens up. We would look at this case and all feel extremely sympathetic towards it. However the reality with continuing healthcare is that it is extremely expensive and therefore even a small percentage increase in the number of people receiving the funding effectively places an intolerable financial risk for the commissioning end.

The Chairman: Why is it more expensive than social services having to pick up the tab for caring for the person?

Dr Shane Gordon: My understanding is it is usually more extensive services.

Julie Foster: People are also required to make a contribution towards their social care so if they have some funding of their own, they might have to pay towards it.

Q571 Baroness Finlay of Llandaff: Going back to feedback, in this case scenario it is clear that residents and their partners do not complain because they are terrified of repercussions in what is clearly a bad place of care. When another nurse goes in to visit she says to the daughter that as next-of-kin she has to demand that a doctor comes to see this woman who has now got pneumonia—and, by the sound of it, is dying—because, as one nurse to another, she is not having that request accepted. What are you doing to get dynamic feedback from people who are vulnerable and in places of care who may be terrified to speak up? That seems to be a recurring problem. What are the barriers to doing something really simple such as the “I want great care” feedback which there is now around doctors, which is just a few pointers in the grading scale? It could be done in a completely anonymous way.
Julie Foster: In our organisation we strongly encourage all the members of our multi-disciplinary teams to raise incidents when they discover anything untoward with the care settings that any of our patients are in. That would be reported centrally and we would look at any trends or patterns emerging from there. We would also use our safeguarding adults service. Both of the scenarios that we have got here would constitute valid alerts into safeguarding adults. That would lead to some investigation of the situation, possibly a whole homes investigation.

Q572 Baroness Finlay of Llandaff: But we know that healthcare professionals are really loath to raise the alert on other professionals. That happens time and time again, yet patients and relatives will describe bad care. We have had the papers full of it recently, yet the clinicians would say they are not terribly happy with that bit of the service but have not actually whistleblown on it. Why not use the direct recipients of this bad care to give you feedback?

Dennis Holmes: That is an excellent idea. Picking up on Tony’s point, it is one of the things that we do in Leeds in aged persons homes as part of the contract review that I was talking about earlier. We have a small team of older people—the dignity champions we call them—who go into the homes with our contracts officers to speak to older people, because often older people will trust another older person who is an expert by experience. That itself is an investment that we decided to make, but it is the kind of thing that might get cut because it might be seen as something that is a luxury, perversely.

Baroness Finlay of Llandaff: Are they substituting for your inspection process?

Dennis Holmes: No, they are augmenting our contract monitoring process.

Lord Bichard: But they are not going in as someone on a regular basis who is almost a visiting team? You are using this as a contract review, which is different from what we discussed?

Dennis Holmes: It is still quite frequent and these people are still volunteers and they still have independence. There are two other things that I draw the Committee’s attention to: the Healthwatch organisation, which will have that kind of intervening role not just in care homes but in hospitals, where some of these episodes have sadly been recorded.

Baroness Finlay of Llandaff: Where will it have its teeth?

Dennis Holmes: It will have its teeth nationally and locally as part of the local Health and Wellbeing Board. There is, it seems to me, the need for a very close relationship between the independent Healthwatch organisation localities and the Care Quality Commission, because ultimately the Care Quality Commission is the regulator of all these kinds of services. Ensuring that the relationship is tight and close between local Healthwatch and regional CQC is going to be absolutely essential.

Tony Watts: The CQC should be performing this role. Obviously they do not because we keep seeing the failures. I think there is scope for a consumer version where all the people can fit into a TripAdvisor-type arrangement.

Q573 Baroness Tyler of Enfield: Like everyone, I am sure, I was appalled by this case study yet we all know that it is not just a one-off. There are too many examples of this sort of thing. Baroness Finlay has already asked my main question, which is who in the system should have stepped in and done something about this who did not? If there was a different
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sort of system, who might be able to do that? I am particularly interested in your thoughts about this idea about corporate accountability for neglect and abuse being placed on the owners of care homes. I think, if you read this, we are talking neglect and abuse. Has anyone got any thoughts about doing something to make the current system much, much sharper?

Dr Shane Gordon: We have had similar incidences locally where we have worked with our county council colleagues to close down particular homes and move residents out. When those sort of stories come to light our safety teams have gone and inspected the homes and done assessments with their colleagues in local government. I hope that they would be responsive to any story like this that came out. The question is whether there is that culture of institutional silence that prevents the story from coming to the ears of the commissioners, and finding a mechanism that has been suggested that brings it to our attention and triggers that response is really critical.

Tony Watts: One big drive for this is money, obviously. Local authorities do not give sufficient money to the care homes to each resident. The level of local authority funding is actually below what it generally costs. Therefore, within a home, you often have private patients subsidising local authority-paid people, so within the total system not enough money is actually in there to pay people properly. 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 rather than being something that pays properly and where people feel they have respect.

Dennis Holmes: I would not like to feel that was a position that was across all local authorities. I certainly do not feel it is a position that applies in my local authority where we have done a lot of work on the fees that we pay. We can never legislate for badly run businesses and you can never legislate for the situations that I have observed where a well run home changes the manager and within a matter of weeks the standards of care in a home can go down through the floor. Just to answer a specific question about responsibility for intervention, I think that is the safeguarding board. I think the safeguarding board needs to have the apparatus at its disposal to intervene. The police are always members of safeguarding adults boards and I think that they have got an important role to play when standards of care are this poor. In terms of actual enforcement, then clearly that is a role for the Care Quality Commission.

Baroness Tyler of Enfield: Who tends to chair the safeguarding board locally?

Dennis Holmes: Most adult safeguarding boards these days have got independent chairs, people who are hired just to fulfil that purpose.

Q574 The Chairman: Thank you very much. Baroness Finlay and Baroness Shephard, they were very helpful micro-sessions. We are about to get a Division, but we will keep going until we do and then that will just pause us for about six or seven minutes. I turn now to the third part, which in a sense is standing back a bit and starting to ask some of the public policy and system-change questions which you have been alluding to. There are three questions to give you the flavour. The first is to what extent people are looking forward and starting to plan for the demographic change that is coming—you have seen that question. Then there is a question about funding structures. Then there is a question about what changes you recommend for the system to work better within the financial realism that you have all been commendably talking about. Let us have a go at those, with the first one being from Baroness Blackstone.
Baroness Blackstone: What planning are you doing and what thought have you given to projections of the population of elderly people increasing in your areas? Does this require any kind of reorganisation of the services that you are currently providing? What particular pressures do you see this leading to and how will you respond to them when you come? I assume that there is some forward thinking going on and that you are not simply waiting for this to happen without considering how you approach it.

Dr Shane Gordon: Yes, we do plan for it and our joint strategic needs assessment process, and now the joint health and well-being process, addresses the forward look of demographic change in the population. The conclusions are very similar to those which we have drawn during the past five years, which are about shift of services from hospital settings, empowerment of carers and integration of services. Those themes, I am sure, are familiar to all of us. The barriers are very much the ones which we highlighted earlier: split governance trying to achieve often very divergent things which stop us integrating; funding systems for healthcare which at the moment support hospital services, fund them preferentially to other services and make it very difficult to get effective shift of care; and then just the challenges of universal increase of expectations despite constraint of resource.

Professor Elisabeth Paice: We have been thinking about it hard. Around 5 per cent of our population is 75 and over. It is growing proportionately more than the rest of the population, so that is the expanding group. As I have said before, there is a high level of comorbidity and complex conditions within that group. The plan is to move care upstream to be more preventive and more proactive and to move it away from hospital by providing it in the patient’s home wherever possible—the rapid response teams, the hospital at home, that whole shift. In order to make that happen, there are a couple of problems. One is that we have not got the workforce to do that right now. We need a different kind of healthcare worker. We need people who are able to take on more varied tasks, if you like, and to cope with and manage a higher level of risk in dealing with things at home. Some of that, you can see coming from the acute hospitals into the community, but a certain amount of it will have to be by training people differently for a different kind of working. Having recruited new people, we need to try to keep them in the system and help them to develop careers that are different from what they signed up to when they joined the health service—this is not the plan that they had for their careers. That is a big cultural barrier to overcome. What we need to do to achieve that is to recruit some more people. We reckon that we probably need between 250 and 500 new people coming into the health and social care system to bring about the sort of shift that we have been talking about. It ends up being a bit of double-running, because you cannot denude the acute hospitals while you build up the service that will take people from it. That is a problem, because people are looking for short-term savings. Achieving the long-term management of this demographic change will require investment in the people who deliver the service and getting them trained in the setting that will work, as opposed to the setting that people are currently working in. That is another educational challenge.

Q575 The Chairman: Would you mind if I just sharpen the question slightly? Does each of you—I think that Tony is excused in this case—know, because the ONS knows, how many 75 and 85 year-olds will be in your respective areas in 2020 and 2030? Have you got those sums? Secondly, have you done some rough-and-ready modelling? You know the number of people you have got with the main chronic conditions now in your areas. Have you looked at that age profile and applied current incidence rates, which is a crude approach, to that increased number of 85-pluses et cetera to give you a picture of what the likely number of people is with dementia, with cardiac problems, with diabetes et cetera, in
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order to show for the long-term conditions, which is really what we are talking about as the big cost-driver, what is going to hit your systems in 2020 and 2030? That is what you would expect a planner to do. They would at least have some hypothesis of what demand is going to hit the system and then ask the question: is it remotely possible that current ways of working can cope with that? Have you done that or is it much too simplistic?

Dr Shane Gordon: We do it and we refresh it regularly. It is notoriously difficult to predict what the burden of disease is going to be; for example, we built a very sophisticated local dialysis service for the expected significant rise in the number of patients needing kidney dialysis only to find that they have not materialised because preventive care in the mean time has got better so there are fewer people whose kidneys are failing and the number has stayed roughly the same, which is very helpful. So we did model and we got it wrong, and that was on a five-year time horizon. So, yes, we do; but it is inaccurate, but we still do it. No, we cannot stay the same.

Dennis Holmes: I completely concur. Yes, we do; we know what the projections are; we can predict the incidence and prevalence rates. I take a slightly different view. I know that we are looking at the top of the pyramid of need, if you like. Looking that far into the future, we have an opportunity to look at the next tier down and to ask ourselves about the kind of supportive services that we will need to invest in to address issues which are not at that most acute level. They are issues like loneliness and carers needing support in communities. We need to ask what we can do as a local authority to make our communities more resilient to be able to look after those people who would otherwise make their way through that pyramid of acuteness. I reiterate what I said previously about looking at housing and technological solutions that will help people maintain and sustain themselves in their homes and communities.

The Chairman: The thrust behind the question was essentially not that you necessarily make a plan that you want more dialysis units but that you take the best view that you can of the likely aggregate pattern of demand on the system in a 10-year period. If that says that the demand on the system is going to be, for example, 30 per cent plus, which is the forecast for social care, you know straightaway that, given what you accurately said about the economy and the fiscal realities, some big choices have to be made about what the state does, how we use limited health and social care budgets and what we each of us pay for and do not pay for. The point of doing this 10 to 20-year horizon stuff is not to find solutions but to ask, “Will incrementalism work?” I am just interested in how many really do this and say, “My God, that is what is really going to hit us, on the only assumptions that we have got”. Elisabeth, do you want to have another go at that?

Professor Elisabeth Paice: This sort of discussion is going on. I agree with the business about “Yeah, well, it is not so easy to forecast medical advances or changes in disease patterns”, but this sort of conversation is taking place right now.

The Chairman: What does it show in terms of demand?

Professor Elisabeth Paice: Well, that demand will go up and become unaffordable very rapidly unless we radically transform the way in which we deliver healthcare.

The Chairman: Can you send us the data on that so that we can see what your assessments are?

Professor Elisabeth Paice: Yes.
Q576 Lord Tope: I am very used to the planning, the conversations, the discussions, the mapping and the uncertainty of any future projection, obviously. What actually happens, though? You have all the discussions and the planning. Does anything actually change as a result or is it too difficult—it is in the future when you have enough problems trying to cope with the present—so it simply gets parked? So what actually changes as a result of the planning and the mapping?

Professor Elisabeth Paice: The two integrated care pilots that I am involved with were set up to deal with exactly this issue. It feels like something being done; it feels like a lot of people working quite hard to do things differently. One of the things that have come out of it is that, because of registering the patients in these two groups and sitting down, having 45-minute to one-hour care planning and pulling together all the issues that these patients have, you are starting to get quite a good database of who has got what. In the process, the diagnosis of dementia, for example, has shot up because people are sitting with people individually and talking about their individual issues. Discussing the difficult ones with colleagues from the various other professions is sharpening our understanding of the population that we have got right now, which will help with the process of looking forward.

Q577 Baroness Blackstone: I just wanted to come back to the question as to whether an ageing population necessarily means an increase in ill-health. It is sometimes argued that it does not. It is simply that the period in which you have these health problems moves forward to an older age group, but it does not mean that there are far more people making enormous demands as far as the healthcare system is concerned. They may be making bigger demands because, as people get older, dementia becomes more common. I am quite surprised that you would imagine that you would necessarily have more people with renal problems, leading them to need more machines to keep their kidneys working. Do you see the point that I making?

Professor Elisabeth Paice: I totally see your point. That is exactly the idea behind trying to move care upstream, so that, wherever possible, people are being helped to stay healthy until they suddenly die of something at an old age having been relatively healthy up until that point. That is the ideal. Certainly, none of the elderly patients that I have talked to as a result of this pilot has any desire to spend any time in hospital if they can help it. Harnessing the patient’s own decisions to help this happen is a really crucial part of it, because we understand that obesity and smoking are self-imposed, if you like, but so can loneliness if people are not helped to take those steps to overcome loneliness and to accept the opportunities which might be there. These things can help prevent the sort of illnesses that nobody wants to spend years having.

The Chairman: I thought that the reason we were getting higher demand was, first, that people were now living with things that previously would have killed them and therefore were requiring ongoing care—cancer being a classic example of that, or some heart conditions—and, secondly, that, because we have a lot of much older people, we are getting diseases which do not manifest until you are very old. So there being more older people leads for those two reasons to more demand. Is that too crude?

Professor Elisabeth Paice: I am trying to think back on the article that I read which described this. I think that I shall find it and send it to you, but there was something very powerful written about more people being fitter longer and then suddenly dying without a period of illness before it.
Baroness Blackstone: They live longer because they are fitter. My other question is about solutions. You pointed to the need for more people to help provide social care for elderly people—which is also some physical care—but surely it should not be a hospital model. Therefore, you do not need nurses to do this work; you need people who have some understanding of some of the things that you would expect a normal nurse to have been trained to do. They should surely not be transferred from acute hospitals to work in people’s homes as nurses. This would not make any sense to me.

Professor Elisabeth Paice: It would depend on what they were doing. If what they were doing at home was a virtual ward idea, where quite a lot of acute, rapid-response care can be delivered at home with the right expertise, then nurses would definitely be involved, but a lot of the care, as you say, might be at a lower level than that. The important thing would be making sure that people with the right skills are available when they are needed and ideally in a home setting where that is possible to maintain.

Q578 The Chairman: We have just 15 minutes left and there may be a Division. You have all touched on the funding question, which is fairly crucial. Baroness Tyler, could you bear it if we moved on to funding and, if we have time, come back to what would change? The funding question was Lord Tope.

Lord Tope: We have talked quite a lot today about the current situation, with different funding streams from different sources with different priorities and all those difficulties. We want to make recommendations in our report. What would you want us to recommend about a funding structure—we will never have enough funds, but the funding structure—that provides the best care or better care for older people?

Professor Elisabeth Paice: I would be very much in favour of bringing the social care and the healthcare funding streams together, so that we do not have that divide that we talked about earlier.

Tony Watts: I was going to say basically the same thing: one person, one budget and one organisation to administrate. It seems to be the logical solution.

Lord Tope: Absolutely. It seems so obvious. Do any of you have any experience of what they now call whole-place community budgeting—it keeps changing its name; it used to be Total Place?

Dr Shane Gordon: We are in a pilot for community budgeting.

Lord Tope: How is it working, or not?

Dr Shane Gordon: I have to be careful what I say here so as not to compromise my relationships back home.

Lord Tope: That tells us something.

Dr Shane Gordon: A lot of work is done. The difficulty that we are seeing is that, to see the outcome of the work, we have to ignore the people that we are accounting to. We have to turn a blind eye together to them for a moment to get together as commissioners, do the right thing and then work out how we are going to account to these two divergent streams of governance. It is quite a difficult place to be. The tendency of the system and the
Julie Foster: I want there to be a system whereby the money can follow the patient. A lot of money is tied up in acute hospital trusts and bricks and mortar. We are all talking about how we need to look after people upstream in their own home to prevent admissions. I feel that, sometimes, community trusts are hampered because of the funding streams and most of the money being diverted into the acute trusts.

Lord Tope: Is the increasing pressure on funding all the time promoting the sharing of scarce resources or is it making people more defensive to hold on to what they have got?

Dennis Holmes: Certainly, my experience is that it is driving innovation and integration.

Professor Elisabeth Paice: It is the former.

Dennis Holmes: Yes, it is definitely the former. This time, and perhaps for the first time in my experience, which goes back a fair length of time now, people have not retreated back into their organisations. In Leeds, for example, we talk with our NHS partners about the “Leeds pound”, it being a combination of public resources between a local authority and the NHS, which we will spend to attempt to improve the health and well-being of the population of Leeds. That is the kind of language that I have never heard used before.

Tony Watts: Can I mention the self-funding aspect? Obviously, Dilnot is on the table at the moment, and there is recognition that self-funders have to contribute, which is an important part of the whole package. Because at the moment it feels as though it is being pushed into the long grass—it may or may not, but that is the impression out there—once it, or something like it, is in place, financial product providers will come in and say, “Okay, we know what the top end of this is going to be. We will actually provide financial products which you can ensure yourself against”. At the moment, they are holding back, but if that came into the system, one might find more money coming in following individuals.

Q579 The Chairman: I am still struggling. We can also take Leeds as an area and think that it would be nice to have one pot for dealing with health and social care in the community, but how does that work in practice, because your councillors are responsible for the budget and the funds that they have got for social care? If, as a result of that process, things do not happen and people are fed up, which will always be the case, councils will then ask questions and there will be a challenge back into the system to say, “You’ve misallocated our funds” or “The priorities are wrong”.

Dennis Holmes: My personal perspective is that councillors in Leeds have decided that the health and well-being of adults is a priority for them, and they are prepared to invest what diminishing resources we have into that and the well-being of children in the city. So having given their commitment to do that, they have given us some latitude to have those discussions about the best way to try to spend that money collectively with our NHS partners to improve outcomes for people.

Lord Tope: Is that matched by a similar view from the NHS structure, which, as you say, is constantly changing anyway?

Dennis Holmes: It is at the moment.

Lord Bichard: Do you have shared outcomes?

Dennis Holmes: There are national outcomes frameworks.
Leeds City Council, North East Essex Clinical Commissioning Group, North West London Integrated Care Management Board, South West Forum on Ageing and Torbay and Southern Devon Health and Care Trust—Oral evidence (QQ 554–582)

**Lord Bichard:** Locally, do you have shared outcomes against which you allocate budgets and service provision?

**Dennis Holmes:** In some instances, yes. Clearly, we want to drive down the number of people who are admitted into acute hospital care and the number of emergency admissions.

**Lord Bichard:** Is this as a council?

**Dennis Holmes:** As a whole system. That is the agreement between us and the NHS. We need to play our part to divert people from acute hospital care. In the same way, the NHS needs to play its part to make sure that we are not paying for more weeks in residential and nursing care than is entirely necessary, so that is delaying the point of entry.

**Lord Bichard:** That was not the question that I was going to ask. I agree with you that we want the resources brought together better, but how exactly are we going to make this happen? I agree with what you say, which is that austerity is driving people towards innovation locally—it is slow, but we are getting on—but I see very little evidence of that nationally. Are you making any suggestions about that nationally to help you while you think about it? I know that we do not want more structural change—please, no. Australia has a Minister for Ageing; we do not have a Minister for Ageing. You have all been involved in setting up local Health and Wellbeing Boards. Have you ever wondered why we do not have a national health and wellbeing board? Do you have any thoughts around those national issues which might make it easier for you?

**Dennis Holmes:** At the risk of sounding completely off message, there is an alternative view which is that the National Health Service becomes a local health service, and the resources that are administered from Whitehall get devolved to local authorities.

**The Chairman:** Just to stay with the question, the sense that we have partly got is that it is working already in Leeds. What needs doing over and above what you are already doing? On your point about money following the patient, is that not what CCGs are meant to do? Effectively, acute hospitals get paid only if a CCG puts money in there, do they not? They get lots of top-up funding as well.

**Dr Shane Gordon:** No, about 60 per cent of their funding is under the payment-by-results scheme, which means that, for every bit of activity they do, they attract a set fee, whether or not that activity adds value to the patient’s outcome.

**The Chairman:** True, but that is the case only if you put them in an acute hospital.

**Dr Shane Gordon:** Well, people end up there without us putting them in there.

**The Chairman:** Through A&E?

**Dr Shane Gordon:** Through all sorts of mechanisms. There are many, many doors into the hospital. Only a subset of those comes from local general practitioners.

**Q580 The Chairman:** That implies the question that we are going to put to Jeremy Hunt, I am sure, at some stage. Without being too blunt about it, we have clearly got this big shift to do in terms of taking money from one part of the health system to build a different system. Elisabeth’s point was that you have probably got to do some dual funding, because you have got to build that before you close that down, but I do not understand what is therefore going to drive the shift in the shrinkage of the acute sector, either on the funding models or, bluntly, the lack of political leadership.
Leeds City Council, North East Essex Clinical Commissioning Group, North West London Integrated Care Management Board, South West Forum on Ageing and Torbay and Southern Devon Health and Care Trust—Oral evidence (QQ 554–582)

**Dr Shane Gordon:** You have highlighted the two issues. One is that the payment mechanism for hospitals incentivises them to do things to people, whether or not that helps people in terms of the quality of life or their outcomes, because they get paid for doing things. So a change in that funding mechanism to, for example, a capitated budget for the year of a patient’s care or their lifetime of care would change that dynamic.

**The Chairman:** The capitation budget would go to you at local commissioning?

**Dr Shane Gordon:** There are many different ways of doing it.

**Professor Elisabeth Paice:** We would see that as the GP having the capitated budget and deciding, with the patient—very importantly—and the carer, where that money should go.

**The Chairman:** And you take that funding almost from the base funding of the acutes?

**Dr Shane Gordon:** There is not a base funding of acutes; they are funded through what they do. By doing that, you would shift the focus from doing things to people to empowering people and supporting them in their own homes, for example. So it is a shift in the model of the way in which we support people. The second thing that you highlighted was political will, which is equally important. We know that we have colleagues like Mike Farrar in the NHS Confederation saying that we need 30 per cent fewer hospitals. My own analysis suggests that we have about 50 per cent of health spend on hospitals in the UK compared to 30 per cent to 40 per cent in other parts of Europe, so perhaps we have overcapacity in that part of the system. But we also see that, when the system tries to reconfigure hospital care, it is the politics of that that is the most difficult part of that transition. That is where, again, a public dialogue about what we want from our public services to support care in all aspects of our life is really important, because if we continue this discussion about hospital bricks and mortar, we are talking about the wrong thing.

**The Chairman:** Tell me who is making that case. Mike Farrar, who gave us good evidence, clearly was there. I asked officials from the Department of Health to let us see a list of places where Ministers had made this statement. They sent the note in and it is conspicuous by its absence. And you know why: it is because the public think that hospitals are their salvation, so it is political suicide to talk about closing a hospital. So we are completely in the wrong place.

**Tony Watts:** Politicians stand up and say, “Well, I’ve opened up so many new hospitals. I’ve got so many more nurses on the wards”. That is tantamount to success and to giving us a good NHS. As this evidence demonstrates, that is not necessarily the right way forward.

**The Chairman:** But am I right—I shall put it ever so crudely; Ilora, you know about this and I do not—that, unless we address this and talk about these things and make this shift, we are going to have some pretty dreadful services for frail, vulnerable, older people in the next decade. Is that too crude?

**Dennis Holmes:** I personally concur with that analysis.

**Q581 Baroness Finlay of Llandaff:** I want to question Dr Gordon on the statement that there are so many different routes now by which patients come into hospital, which I would agree with. But the GP used to be the gatekeeper. If the GP is not the gatekeeper and the person triaging—and the ambulance service is the other one, because, obviously, it picks up acute calls—how do you control those people who are turning up at hospital because they cannot access primary care and how do you control the referral into the system, because a telephone helpline says, “Oh, well, I think you’d better go to hospital”?
They may have a set of symptoms and the person on the end of the phone is understandably risk-averse because they do not know the person they are talking to. What is the cost of these so-called gatekeeper systems? I had an experience of this yesterday with somebody who was ill. Over three hours, multiple phone calls were made, when actually a phone call to a GP who could have said, “Yes, I’ll write a prescription. Come and collect it. That chemist is open” could have taken 10 minutes.

Dr Shane Gordon: I am at risk of inviting the censure of my entire profession with what I am about to say, but the first thing is that a good gatekeeping system is essential for the health service. I am not so sure whether that applies in social care, but general practice has had its role serially extended to, for example, long-term conditions management as a major part of its business. It is no longer focused on that as its primary role. So the question for me is: what sort of primary care service is fit for this world? It does not look like the one we built in 1948, which is roughly what we still have. So that is a really profound question for the organisation of primary care.

The Chairman: Is there somebody with a view as to what it should be?

Dr Shane Gordon: Well, a number of people highlighted the challenge. The King’s Fund did a very good report on the future of primary care earlier in the year. I know that the Royal College of GPs has particular views on it. A lot of professional organisations are saying that something must change. I am not so sure we have got to “And so, what should it look like?”

The Chairman: We shall look at those. I had not realised that we need to change primary as well as acute care in order to sort this mess out.

Dr Shane Gordon: Probably more.

Professor Elisabeth Paice: It has got to accept all this new and really quite difficult, challenging work. I would like to make a plea, if you are interested in trying to change things. One thing that is overdue for a change is the length of time for which we train GPs. The training time for GPs is actually much shorter than that for—

Lord Bichard: Presumably, the content too.

Professor Elisabeth Paice: Yes, absolutely, the duration and the content, but people would immediately come back saying there is no room for anything more, which is why the length of training would have to increase, in my view, in order to get the sort of primary care we really need.

Baroness Finlay of Llandaff: Can I concur with that, first because GPs are providing a service during training—do not forget that—and second because, taking an example at the other end of life, 50 per cent of GPs have no paediatric training. Now, you could easily construct training appropriate to care in the community in paediatrics, as you could in psychiatry, which is a large part of a GP’s work. But they are providing service during training. This is not undergraduates; it is postgraduates.

Professor Elisabeth Paice: They are, and a lot of the service they provide is in a hospital setting despite the fact that they are training for general practice.

The Chairman: You are making us faint. Keep going. Any final comments that you want to make on this terrain?
Tony Watts: Getting into hospital is only half the issue; it is getting out of hospital that is the problem. The big point is that people go in for one symptom or another, get stuck in there, pick up other conditions—urinary infections are a big one—and getting them out in order to get them assessed and get them to a safe place can delay the process. So having come in relatively healthy with something relatively minor, they end up quite ill and unable to look after themselves. This, I suggest, is a massive cost to the country.

Q582 Baroness Tyler of Enfield: Really, I want to reflect on the first bit of our discussion this afternoon, regarding what needs to change locally to create a much more joined-up, integrated, responsive system for older people. Given that we are looking to make recommendations in our report, a number of you did touch on particular things. Many would like to see half the pilots and things you are involved in implemented. But if each of you were asked what is the one key thing that would make the biggest difference locally towards creating a much more joined-up, integrated and responsive system with that focus on prevention, what would it be?

Professor Elisabeth Paice: I would have to go for education in its broadest sense; that is to say the culture change, developing the collaborative professional who communicates well at patient and organisational level.

Julie Foster: We are fortunate that we already have fairly good integrated health and social care services. What I would want to look at would be some evidence-based preventative services, perhaps with some dedicated funding. It is very easy for that sort of thing to get swallowed up and for things to stop happening when acute pressures start to come, so that is something I would like to see.

Baroness Tyler of Enfield: Just while you are speaking, I read through your very interesting presentation. You focused quite a lot on a single point of contact for health and social care. Do you think if we could get that in place, that would be one of the big game-changers?

Julie Foster: I think so. I think it has been the single biggest factor in making us more successful at integration. If you ask the GPs that we work with about our system, they think it is wonderful. They just have one number to telephone for community services.

Baroness Tyler of Enfield: And that would apply for patients and carers as well, would it?

Julie Foster: Yes, the same number.

Dennis Holmes: I concur; I do not think integrated systems can work without a single point of contact. I would like to see a standstill in the NHS so we can continue to work with the people we have just started working with in the past eight to nine months. If they could stick around for a longer period of time we would make genuine progress.

Dr Shane Gordon: We need an honest conversation on a national level about the future of the social contract.

Tony Watts: I thought my points would be covered, but I would bring the informal carer network of family and friends into the process a lot more than it is at the moment, and really support that because a small amount of assistance, a small amount of help, would go a huge way to solving all the issues we have here today.
Baroness Tyler of Enfield: And what is it precisely that government could do to support that informal network?

Tony Watts: I think if you look at the local level, the support structures are not in place that would enable a carer to go and get help, even if it is just a bit of advice, respite or sometimes a bit of cash to make a small thing happen. The community needs to be brought into the whole process, as was mentioned earlier on, because they have a big role to play here in looking after their elderly.

Baroness Finlay of Llandaff: Can I ask you about your single point of contact? Is that available to patients and their relatives?

Julie Foster: Yes.

Baroness Finlay of Llandaff: It is the same one?

Julie Foster: Yes, it is.

Baroness Finlay of Llandaff: How do you make sure that there is continuity and a sense of responsibility for the person who is face to face with whoever it is they are seeing, whether it is someone from social care or from healthcare, so that they will take whatever risks ought to be taken for that person?

Julie Foster: We have a very strong multidisciplinary team and it may be that a patient sees more than one member of the team, depending on their needs. However, the people at the front end, these health and social care co-ordinators, are precisely that—co-ordinators—so you may get several members of staff carrying out assessments, but they will co-ordinate those in order to put together a care package.

Baroness Tyler of Enfield: I think that has an awful lot of mileage. As a very frequent user of health and social care in relation to my elderly parents, that is the thing that would make a really big difference.

The Chairman: Do any other members have final burning questions? It has been a fascinating session again. Thank you very much. Thank you for shifting your diaries; I am sure all of you had to. You will see the transcript, but even before you do if there are things you would like us to reflect upon, the door is open for your ideas and further reflections on what it is that we want to say to the public—because they are also our audience—to the Government and to local authorities about what needs to change in order to address these issues.
Howard Lewis, UK Older People’s Advisory Group—Written evidence

1 Cultural Changes

Firstly the historically embedded Ageist Society in the UK needs to be replaced with a different attitude to all citizens. This should recognise the role and individual contribution made by each person to the society in which we live rather than to stereotype and separate individuals on the basis of age.

We need to look at other countries where they treat older people differently – and adopt some practices e.g. in some countries it is a legal requirement to have an ‘older person’s council’ in each Government Authority ensuring their viewpoint is considered when decisions are made.

The media – which, to a large part has contributed to the problem, can play a vital role in changing such attitudes.

Older people are generally seen as mainly ‘dependant’ on their families and the support of the NHS. In fact, current statistics show that in the region of 95% are actively involved voluntarily in their communities, bringing up and financially supporting their families, caring for older relatives and participating in local sporting and other activities.

It must be recognised that modern lifestyles could very well have an effect on reducing future longevity - and the Government, in conjunction with the NHS and the media have a responsibility to promote preventative measures by healthier living at every stage of one’s life. Education from an early age could play a major part in achieving this. A strategy for the PREVENTION of illness and disability brought about by poor lifestyles wherever possible should be Government’s main objective.

Monitoring schemes provided by local doctors’ surgeries to diagnose potential health problems in early stages should be made compulsory. This would enable the treatment and possible cure of health problems before they became more serious and expensive to the NHS. The promotion of such a scheme and its purpose should take place across the UK.

Medicine ‘user reviews’ should be promoted more extensively – including by the media, to ensure people are not taking dangerous ‘cocktails’.

Fast food outlets, something not in existence during the early years of our older people - and who don’t appear generally to be obese, should be one area requiring scrutiny and a strategy implemented to deal with them. Good eating habits learned at school should be a major consideration.

2. Costs of an Ageing Society

Costs of State and Public Sector pensions are not currently shared adequately. In addition, those working in private sector companies needing to keep costs low in order to compete
in a global market do not enjoy similar conditions on retirement. Recognition of the importance of wealth creating companies to the Treasury should be accompanied by incentives not only to entrepreneurs, but also to their production workers and staff if we are to attract people into dwindling manufacturing firms.

In addition, our State Pension is one of the lowest in Europe, and we must look again at how higher pensions are being achieved elsewhere.

It is felt by many older people that, in order to fund the NHS, care and future State pensions, individuals who, statistically, should be looking at increased longevity, should pay more. Generally speaking, the standard of living has improved considerably since the ‘Beverage’ report came into being – with many young workers enjoying cars, holidays abroad, mobile phones, i-players etc. It seems reasonable, therefore to expect a portion of their improved standard of living to go towards Government costs in supporting them for a longer life to which they can look forward.

Many older people have deep concerns about meeting daily living costs, and the poor return on their life savings has meant – for many, taking money from those savings accounts in order to do so. This has resulted in a ‘knock on’ effect to building societies who recognise that they are having to rely on more savers in order to meet the financial needs of each borrower.

A radical look at the current large differences between savings and interest rates evident on high streets should be made – and, maybe Government intervention.

The more independent people become, the less need exists to rely on benefits from the state and therefore incentives should be given to save during our lifetime. During the current period of austerity there doesn’t appear to be any.

A current disincentive is the existence of an income ‘threshold’ below which a number of benefits become available, whereas those who have saved or who have a small private pension, and are minimally just above it, do not qualify – the outcome being that the total income of those in receipt of benefit is higher. Older people are looking for a ‘fairer’ system.

The proposed introduction of a compulsory ‘additional’ working pension regulated by Government while in employment (and, hopefully not so dramatically affected by ‘market forces’) should radically reduce numbers of those beneath the ‘threshold’ in the future.

Another cost to the taxpayer needing to be addressed is associated with the supply of medicines which - although an essential part of the NHS, many are wasted. Pharmacists’ DATA bases together with GP records should play a part in ensuring duplication and unnecessary repeat prescriptions are avoided.

Government must, however, ensure that medicines are readily available to patients, and the problem of shortages eliminated if individuals are to avoid deteriorating to a worse condition – requiring yet more expensive treatment.

3. Work

We can again learn from other countries where employers prepare workers for retirement,
and encourage older workers to retire early or work ‘part time’ in order that jobs are made available for the young.

Older workers should be allowed to continue to work as long as possible in the UK if they wish, but we need to have full employment if this to be practical.

In the current economic climate and high unemployment we need to look in depth at the system in place.

When we consider our network of sewers, roads, out-of date domestic electrical wiring, flood defences, and old housing stock unsuitable for later life there is no shortage of work, but the current system to engage in it prevents it happening - with capital needing to be raised.

Unemployment currently stands at several million and costs the taxpayer several million pounds more. We therefore need in some way to marry the jobs with those out of work.

A scheme which requires those unemployed able to do part – time productive work to do so for the benefit they receive would provide experience while maintaining a regular work routine ready for a full time job when it became available (12 hours per week for a single man on minimum wage?) Individual family circumstances would need to be taken into account.

Such a scheme worked successfully during the 80’s.

We also need to ensure that it is financially advantageous to be in work rather on benefit. Again we can learn from other countries.

One of the major disappointments of the modern era has been the failure of the microchip to reduce the working week. It was forecast that everyone would be working shorter working weeks. What generally happened was the creation of redundancies instead of work ‘sharing’ and greatly improved productivity. Dialogue with the commercial world needs to take place.

4. Public Services

Should be made more efficient and meaningful consultation take place with the public to ensure Local Authorities are aware of what people need. Too often nothing materialises following Local Authority ‘roadshows’.

In addition, Government consultative documents should be accompanied by a timescale and a budget if they are to be taken seriously.

Councillors could play a better role in communities with responsibility for a definitive ‘job’ during their term of office.

Access to information about available services should be improved.
5. **Engagement**

One of the positive outcomes of the ‘Strategy for Older People’ has been bringing people together. There are, subsequently, large active groups of such people available for engagement right across the UK – with the United Kingdom Advisory Forum of Ageing (UKAFA) organised by the DWP meeting quarterly in Westminster - or Change AGEnts Co-operative’s Older Peoples Advisory Groups (OPAGs) existing in the regions and Nations. Members of the House of Lords should therefore have local access to these or other groups.

1 September 2012
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

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

1. About us

2. The Local Government Association (LGA) is here to support, promote and improve local government. We will fight local government’s corner and support councils through challenging times, focusing our efforts where we can have real impact. We will be bold, ambitious, and support councils to make a difference, deliver and be trusted.

3. The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross-party position on issues and to speak with one voice on behalf of local government.

4. We aim to set the political agenda and speak in the national media on the issues that matter to council members.

5. The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

6. We work with the individual political parties through the Political Group Offices.

7. Visit www.local.gov.uk

8. SOLACE (the Society of Local Authority Chief Executives and Senior Managers) is the representative body for senior strategic managers working in the public sector in the UK. We are committed to promoting public sector excellence. We provide our members with opportunities for personal and professional development, and seek to influence debate around the future of public services to ensure that policy and legislation are informed by the experience and expertise of our members. Whilst the vast majority of SOLACE members work in local government we also have members in senior positions in health authorities, police and fire authorities and central government.

9. The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold statutory children’s Director role.

10. A note on our submission and key messages
11. We welcome the opportunity provided by the House of Lords Select Committee to raise the profile of the impact of demographic change on public services. This response primarily focuses on the combined challenge that our aging population poses for the future of our health and social care system. We acknowledge, however, that this is only one aspect of the demographic challenge facing councils and those demographic pressures will vary across different localities. For some local authorities, the increasing number of children with learning difficulties and complex needs, for example, is proving equally challenging. Moreover, some areas will feel the impact of an ageing population more acutely than others in the shorter term.

12. Demographic pressures and continued upwards demand will not only impact on health and social care budgets. The funding gap between revenue and spending pressures, estimated to reach £16.5 billion a year by 2019/20, threatens the future viability of a range of council services. The LGA estimates that, taking out funding for social care and waste services, funding for other council spending will drop by 66 per cent in cash terms by the end of the decade.\(^\text{213}\)

13. Other factors will also exacerbate the effects of the funding shortfall for social care. Welfare reforms, for example, are likely to be most felt by the poorest in our communities and could lead to negative health outcomes, placing additional pressures on acute services.

14. There are, therefore, many interconnecting challenges that arise from, and are associated with, the shortfall in social care funding. The solution must start with a commitment from the Government to a significant real terms increase in funding for health and social care services.

15. As essential as funding is, we recognise that there are other key ingredients that are essential to delivering the full benefits of a sustainable health and social care system. Integration across health and social care is, for example, critical and will be driven by new models of collaborative leadership. Local government and its partners also need to work in new and exciting ways with and alongside communities, empowering citizens to contribute back to society.

16. This shift away from direct provision towards enabling and capacity building forms part of a wider cultural shift whereby vulnerable people, including the elderly, are no longer seen as a burden to society but rather are respected and the contribution they choose to make to family and community life is valued.

17. Our submission

18. Celebrating later life

19. People in the UK are living longer than ever before, which is a cause for celebration. But in order to add life to years, and not just years to life, we need to develop

\(^{213}\) Funding outlook for councils from 2010/11 to 2019/20, LGA, 2012
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

20. Achieving age-friendly communities requires a change to make social care a ‘mainstream’ issue in the public consciousness. Social care is at times perceived to be a poor relation to the National Health Service, when such vital services should be seen on par with it. There is a common lack of understanding as to what social care is, why it is important, and why – unlike many health services – it is not provided free of charge.

21. Social care services – their reach, cost and quality – affects a much higher proportion of the population than is probably imagined. Taking into account carers and people who use or work in social care services, disability charity Scope estimates that as many as one in six people in England and Wales are connected to social care in one way or other.214

22. Communicating the remarkable reach of social care services is crucial if we are to bring about a shift in public attitudes.

23. **Pressures on the system**

24. It is a cause for celebration that we are living longer; however, our aging population, alongside other demographic shifts and wider factors, such as the impact of welfare reform or the shortage of school placements experienced in some areas, is exerting considerable pressure on both the health and social care system and public services more broadly.

25. In terms of social care services, if these pressures are left unaddressed, increase future demand will not be met effectively – by which we mean clear, understandable, appropriately resourced care and support solutions that are tailored to the individual. This in turn, will place additional pressure on other parts of the system, such as acute care services.

26. It is our view that the care and support system needs to be urgently reformed and more money needs to be made available to meet demand. If this does not happen, the impact will not only be felt by those who rely on care and support services but users of other council services, as social care budgets eat into remaining council resources.

27. **The impact of our aging population on social care services**

28. The main focus of this submission is the impact of our aging population on social care services. The statistics are well known and do not need outlining in much detail here. In short the system is facing (and is projected to face) significant increased demand as our population ages.

29. By 2060, 40 per cent of the population will be over 50. By 2030, there is predicted to be a 64% increase in people aged 75 and over, compared to a 16% increase for all ages. The number of people with dementia is predicted to double over the next 30 years. As the

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214 This proportion is calculated using the latest available statistics on carers, social care users and social care workers in England and Wales.
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

older population grows, conversely the number of people working to support those in later life will shrink. As life expectancy increases, so do the pressures on local government.

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<td>10,328</td>
<td>10,907</td>
<td>4.26</td>
</tr>
<tr>
<td>30-44</td>
<td>10,775</td>
<td>10,634</td>
<td>11,181</td>
<td>11,920</td>
<td>12,010</td>
<td>11.46</td>
</tr>
<tr>
<td>45-59</td>
<td>10,099</td>
<td>10,886</td>
<td>11,063</td>
<td>10,559</td>
<td>10,421</td>
<td>3.19</td>
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<tr>
<td>60-74</td>
<td>7,627</td>
<td>8,075</td>
<td>8,585</td>
<td>9,074</td>
<td>9,848</td>
<td>29.12</td>
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<td>75+</td>
<td>4,119</td>
<td>4,523</td>
<td>5,112</td>
<td>6,116</td>
<td>6,756</td>
<td>64.02</td>
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<tr>
<td>All ages</td>
<td>52,233</td>
<td>54,468</td>
<td>56,606</td>
<td>58,607</td>
<td>60,408</td>
<td>15.65</td>
</tr>
</tbody>
</table>

30. Demographic pressures are increasing at a time when resources are shrinking. We need to look at the totality of services for older people and ensure that there are efficient and effective funding arrangements in place which will be fit for purpose in an ageing society.

31. LGA modelling of revenue and service demand shows that a likely funding gap of £16.5 billion a year will emerge by 2019/20, or a 29% shortfall between revenue and spending pressures. This gap reflects the difference between what local authorities across England would need to spend to maintain frontline services in their current form, and the income they will be able to raise from grants, fees and charges, business rates and council tax.

32. Spending on older people already makes up nearly half of social care spending, and as the number of over 85s increases sharply, it is set to rise. We estimate that demographic pressures for this service will cost local authorities in the region of 4% per annum.

33. We estimate that councils finance, on average, about 48% of total expenditure on social care and support through Council Tax, although some councils fund as much as 70%. It is clear that securing the future sustainability of local government must start with securing the future sustainability of adult social care.

34. Given the expected rise in the annual cost of adult social care, we therefore anticipate a funding shortfall by 2014-15. Without significant real terms increases in funding it is likely that there will be considerable pressure on councils’ ability to maintain care services on current eligibility criteria in the coming years. The Spending and Saving Survey 2011 showed that more than half of councils were seeking to protect adult social care (57%). However, Councils will have to make very difficult decisions in order to address increasing demand at a time of reducing resources.

35. The main resource councils use to fund adult social care locally is Council Tax, although as different areas of the country have populations with different levels of resource the amount that can be raised locally varies considerably. Given this has been capped, councils have to use the limited levers available to them to manage demand, principally
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

tightening eligibility thresholds and raising income via increasing fees and charges. The net result of this underfunding has been a growing level of unmet need and then a consequent increase in the number of individuals that ultimately do qualify for council-funded support by virtue of having ‘critical’ needs.

36. These, of course, are often the most costly. An ADASS budget survey reveals that 85% of councils are now operating at ‘substantial’ or ‘critical’ only which illustrates the extent to which some councils are having to ration their adult social care services to keep pace with demand.

37. This survey also reveals that £1.89 billion has already been taken out of adult social care budgets over the last 2 years, despite demographic pressures growing at 3% per year. The survey indicates demographic cost pressures across all groups totalling £425m. 17% of councils are not funding these pressures, 42% of councils are partially funding them, and 41% of councils are funding them in full.

38. The government did respond positively to some of the central arguments made by local government in the run up to the Spending Review. There is new adult social care funding of £530m in 2011-12, rising to £1bn in 2013-14, and a further £1bn funding for joint working with the NHS. These monies constitute the “extra £2bn” that government argues social care has received.

39. There has been £622m worth of NHS investment into social care in 2012-13 and councils have worked closely with NHS colleagues to maximise the use of this additional resource. £284m has been applied to offset pressures and cuts to services, £148m has been invested in new social care services, and £149m has been allocated to working budgets. However, whilst this money is certainly welcome, its impact would only be truly felt if we were in a settled state - the picture presented above with regards to general funding pressures makes clear that we are not.

40. Set against the backdrop of budget constraints on public services and the challenging and uncertain economic climate we are in, we are keenly aware that it would be rash to say that any service area should be exempt or excluded from the potential benefits of constructive re-shaping and re-provisioning. The LGA’s new adult social care efficiency programme, part of our productivity programme is explicitly about refining and developing effective approaches to efficiency to deliver the savings councils need to make to meet the challenges of reduced funding and demographic pressures.

41. Specific pressures: special education needs and education

42. An important wider implication of the pressure on adult social care budgets is the impact on other service budgets – an impact that will only increase and, ultimately, become acute for all other aspects of council services.

43. The most obvious area to highlight is children’s services and, specifically, children’s social care and school place planning, where there is evidence that demand and demographic pressures respectively are making it increasingly challenging to reduce costs (even though productivity is increasing). For example, there remains a legacy impact from the Baby Peter case, illustrated by apparently permanently raised levels of referrals to social care, increased numbers of children and young people requiring protection plans, and
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

rising numbers entering the care system. Department for Education statistics (to March 2011) show, for example, that referrals to children’s social care stood at 615,000 in 2010/11, up from 603,500 in 2009/10, and 547,000 in 2008/09.

44. Similarly, urban population growth, most notably in London (but not confined to the capital), is beginning to impact on the sufficiency of school places (primary initially), requiring councils to secure large scale investment in new school estate. Research carried out by London Councils, for example, shows that London faces a shortfall of 70,000 school places between March 2011 and 2015, with the cost of providing enough school places expected to rise to £1.7 billion by 2015.

45. It should also be noted that the role of the local authority in education generally is changing but, importantly, not diminishing – although significant resources have either been taken back to the centre or removed from the funding system as part of the Government’s deficit reduction strategy. Local authorities increasingly have championing and commissioning roles, maintaining a local overview and ultimate responsibility for performance, as well as and securing fairness in admissions, for example. Our estimate is that local government in England will see a decline in its funding for services other than schools and children’s services over the next four years. The funding reduction is estimated to be about 16% in real terms.

46. Local authorities also are having to cope with increases in numbers of children with additional (special) educational needs:

<table>
<thead>
<tr>
<th>2005-10 Percentage increase of pupils with:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour, emotional and social difficulties</td>
<td>23% (158,000)</td>
</tr>
<tr>
<td>Speech Language &amp; Communication:</td>
<td>58% (113,000)</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder:</td>
<td>61% (56,000)</td>
</tr>
</tbody>
</table>

47. It is clear, therefore, that attention to tackle the potential funding crisis for adult social care must not take attention away from other, possibly lesser but still significant demand and demographic pressures.

48. School place planning remains part of their core statutory duties. This is not a function that relates only to education and children’s services – the whole of the local authority, and public services in the area more generally, are affected by the effectiveness of school place planning.

49. Consequently, whilst meeting the needs of an ageing population is seen overall as the most significant pressure on local government resources now, and over the next 20 years, it must not be forgotten that other critical service areas are not without their own challenges. And it can be expected that these pressures will only grow as councils are charged with not just meeting the needs of vulnerable children, young people and adults, but also by delivering innovation and quality in other critical service areas such as waste collection and disposal, highways maintenance and economic development regeneration and housing.
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

50. Specific pressures: younger disabled adults

51. The incidence of disability is rising, and with it the demand for social care. At 11.5 million, disabled people represent a significant slice of the UK population.\textsuperscript{215} Broken down further, in 2010-11, some 6% of children (0.8 million) were disabled.\textsuperscript{216} Among adults of working age, the prevalence of disability is even higher – at 15% (5.4 million).\textsuperscript{217} Higher still is the proportion of adults over State Pension age who are disabled – 45% (5.3 million).\textsuperscript{218}

52. The number of disabled people in the UK is increasing – from 10.7 million in 2002-03, to 11.5 million in 2010-11), a consequence of an increasing population overall. As our population ages, so the number of disabled people is likely to rise.\textsuperscript{219} Incidence of disability increases with age: proportions range from 13 % of 16-24 year-olds to 70% of over-85s.\textsuperscript{220}

53. In fact, among adults aged 75 to 79 and over, adults with impairment form the majority (51%).\textsuperscript{221} So too are there decreasing levels of mortality among adults (18-64) with learning disabilities (critical or substantial care needs, only). This is expected to boost this particular population from 220,000 in 2010 to 290,000 in 2030 – a dramatic increase of 32.2% (to put this in perspective, the general 18-64 population is expected to grow by only 6.1% in the same timeframe).\textsuperscript{222}

<table>
<thead>
<tr>
<th>Projected number of younger adults with disabilities</th>
<th>2010 (number of people in thousands)</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>% increase 2010 - 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with a severe learning disability</td>
<td>220</td>
<td>240</td>
<td>260</td>
<td>280</td>
<td>290</td>
<td>32.20</td>
</tr>
<tr>
<td>Adults with a sensory or physical impairment</td>
<td>2,890</td>
<td>2,930</td>
<td>3,030</td>
<td>3,110</td>
<td>3,110</td>
<td>7.50</td>
</tr>
<tr>
<td>Adults with mental health needs / other</td>
<td>210</td>
<td>210</td>
<td>220</td>
<td>220</td>
<td>220</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Source: Projections of Demand for Social Care and Disability Benefits for Younger Adults in England – the Economics of Social and Health Care Research Unit (2011)

\textsuperscript{215} DWP Family Resources Survey - United Kingdom - 2010/11 (DWP: London, June 2012)
\textsuperscript{216} DWP Family Resources Survey - United Kingdom - 2010/11 (DWP: London, June 2012)
\textsuperscript{217} DWP Family Resources Survey - United Kingdom - 2010/11 (DWP: London, June 2012)
\textsuperscript{218} DWP Family Resources Survey - United Kingdom - 2010/11 (DWP: London, June 2012)
\textsuperscript{219} DWP Family Resources Survey - United Kingdom - 2010/11 (DWP: London, June 2012)
\textsuperscript{220} ODI Life Opportunities Survey - Wave one results, 2009/11 (DWP: London, 2011)
\textsuperscript{221} ODI Life Opportunities Survey - Wave one results, 2009/11 (DWP: London, 2011)
\textsuperscript{222} Economics of Social Health Research Unit (2011) Projections of Demand for Social Care and Disability Benefits for Younger Adults in England
54. In some areas, the pressure resulting from an increase in the number of people with learning disabilities is more of a pressure than that posed by increasing numbers of older people. These trends are also fueling the rising demand for social care services.

55. The transfer of learning disability funding from health to social care is being achieved through the introduction of a specific grant called the Learning Disability and Health Reform Grant. It amounts to £1.325bn in 2011-12, rising to £1.357 in 2012-13. This funding covers the transfer of costs but not the rising demand and growth which is significant.

56. Local government’s contribution and the need for a funding commitment

57. Councils have had to face extremely tough choices about which services they can keep on running. Councils continue to show that they are doing everything they can to minimise the effect of these cuts, and building on their record of delivering new and better ways of doing things differently in order to keep public services running. The Local Government Association’s Spending and Saving Survey 2011 revealed that councils have cut senior management costs while trying to protect the services that the most vulnerable rely on.

58. The Prime Minister has acknowledged that “local government is officially the most efficient part of the public sector” and that “councils achieve well in excess of the sector’s spending review targets, beating central government savings by a country mile” (Rt Hon David Cameron MP, Cutting the Cost of Politics, speech, 2009). Councils made savings of more than £3bn between 2005 and 2008 and a further £1.7bn in 2008-09.

59. Councils know that it is likely that more efficiency savings can and will have to be made, and the LGA is investing heavily in a national productivity programme to assist with this. However, what has to be saved over the next few years goes far beyond what can be achieved by conventional efficiency savings and, moreover, the level of savings achieved to date cannot be sustained.

60. As we have long argued, these difficult decisions are best made at the local level. Councils – working with their local partners – have a thorough and expert knowledge of their communities’ needs and continue to strive to ensure that scarce resources are targeted where they are needed most.

61. Despite this success at local level, the government cannot expect Councils to continue to fill the funding gap through efficiencies – this is simply unsustainable, the shortfall is too great. The government must commit to significant real terms increase in funding for social care; reform and funding for the health and social care system must go hand in hand if we are to build a sustainable system for the future. This point has not been recognised by the Government, which has failed to address the issue of funding alongside its plans for reform.

62. For this reason, the government’s progress report on funding takes us no further forward on how a modern, stable and predictable social care system can be properly resourced. We have a real sense from the sector that we are in ‘last chance saloon’ on this issue and that failure to reform now will only lead to more major failure just a short way down the line in terms of the system collapsing.
63. Addressing the future funding question encompasses a number of different issues that need to be resolved:

- Funding the interim period before any reforms are actually implemented to ensure interim increased demand can be met.
- Funding the set up and running costs of a reformed system.
- Funding any shortfall between what a reformed system covers and what costs may still remain.

64. We will shortly be conducting our own analysis of the amount needed between now and the likely implementation of any funding reform post-Dilnot to cope with demand and changing levels of service. This will be done alongside an analysis of the proposed costs of Dilnot’s model.

65. Developing an integrated system

66. Increased funding is critical to securing a sustainable health and social care system for the future but if we are to realise the full benefits of reform, we also need to secure an integrated system.

67. The relationship between health and social care is exceptionally significant – particularly given the fact that £1 spent on care services that provide help at home yields bigger savings for the NHS. There are only two options that will address the combined funding pressures on the health and care system: to increase the financial resource available for adult social care; and/or to deliver a substantial shift in resources from the acute sector to preventative work and the community service sector. Achieving the latter will require strong political leadership and new ways of working at different levels within the system.

68. At a national level, the NHS Commissioning Board, the Department of Health and Public Health England (all of whom will have substantial commissioning responsibilities), will need to ensure that their national commissioning decisions support and align with local commissioning plans. The NHS Commissioning Board, will also have an important role to play in ensuring CCGs are working effectively with local authorities through the Health and Wellbeing Board to join up the health and care system locally.

69. It is important that the integration agenda is owned by those jointly responsible for delivery, and that there is a real opportunity for local commissioners to influence a shift towards a total approach to the use of resources, and aligning budgets with strategic planning by CCGs and local government through Health and Wellbeing Boards. This requires a focus on delivering integrated health and care for individuals, underpinned by a clear understanding of the needs of patients and communities, articulated through the individual patient voice and Healthwatch.

70. Integration must not be seen as an end in itself and should instead be seen as part of the bigger goal of reform across councils and the wider health and wellbeing system and focus upon improved outcomes and efficient use of resources. It is also important to recognise that integration may be best achieved at different levels. On one level there is some work to be done on the structures and architecture within partnerships. But
more important than the mechanics is the need to foster shared cultures that see everyone involved pulling together in the same direction towards a common outcome, in a system in which differences have been continually reinforced. Local partners have to resolve at the strategic level, the tension between, on the one hand the JSNA which fosters needs-driven commissioning strategies and, on the other, the more local, asset or place based approaches to finding solutions.

71. Most councils have taken the opportunity to press on with establishing new Health and Wellbeing Boards. They see it as an opportunity to accelerate the horizontal integration of commissioning plans across local public services and to achieve better outcomes for local people. However, the reforms taking place within the health system present additional risks and opportunities for local government. On the one hand, the transfer of public health to local government, combined with a renewed focus on joint leadership through Health and Wellbeing Boards, has the potential to deliver a more joined-up and integrated health and care system that could improve outcomes and deliver increased efficiencies.

72. On the other hand, questions around the affordability of the new role for public health combined with the enormous funding pressures on adult social care, presents a huge challenge for local government and its partners in planning and delivering meaningful integrated health and care services. However, if the right links between social care, health, and public health are made, we can improve services for the people using the system and create savings for the taxpayer.

73. Finally, we must be clear that ‘integration’ and ‘interdependence’ are terms that do not just apply solely to the relationship between care and health. A true ‘wellbeing’ service must include the various interactions between care and housing, transport, leisure and skills to name a few. This is about seeing the totality of a local area’s service offer and thinking how it can join up around the individual.

74. If we are to develop more connected communities local government and its partners need to work seamlessly together, at strategic, service management and operational levels, overriding traditional boundaries and driven by new models of collaborative leadership. New systems will require leaders to work together to both improve the health and wellbeing of communities and to ensure that public resources are used in a way which avoids duplications and delivers efficiency whilst retaining an emphasis on quality.

75. **Looking to the future**

76. **The developing context in local government**

77. Particularly over the last ten years, initiatives such as Local Strategic Partnerships and Local Area Agreements have opened up local public services and encouraged much closer inter- and intra-organisational working.

78. We have also seen a concurrent shift in how we view the individual receiving services. Whereas we previously may have described things being ‘done to’ a person, we now see the individual very much as a consumer with increased expectations about the services that should be on offer and the quality of those that are. Informal carers, with their own
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

wellbeing closely linked to the quality of life of the person they are caring for, must also be seen as consumers, experiencing and supporting access to a range of services on offer.

79. The goal is now to join up the different organisations and individuals within a community that each play a part in either providing services or contributing to an individual’s wellbeing. This has further cemented the idea that achieving wellbeing is about making use of the whole range of local services, such as transport, housing (which in particular is rightly assuming greater profile in current debates about the future of care), health, leisure and training and education to name a few. A wide range of local authority functions are therefore fundamental to promoting the health and wellbeing of older people.

80. Furthermore, councils are actively extending individual choice and control through the application of personal budgets (councils are working towards all eligible adults in receipt of personal budgets by April 2013), and working with individuals in seeking improved personal health and wellbeing outcomes.

81. Developing adult social care in the future

82. These dual developments towards personalisation and joined-up services render traditional perceptions of ‘social care’ obsolete. The service should not exist solely as a ‘welfare net’ for those with the severest need or most limited means. Rather, it should be about helping people live their lives as they themselves aspire to.

83. We believe such a system should balance both national and local inputs. We summarise these broadly as follows:

- National: a portable assessment of need that is acknowledged anywhere in England, along with a portable assessment of an individual’s means.
- Local: decisions about the services to meet need, and the amount to pay for them.

84. People want choice and control over the services they receive. Taking need first, this will inevitably vary from place to place. And as patterns of need vary, it follows that the response must vary too. This will be shaped by other local factors such as the level of council and partner resources, the infrastructure that supports service delivery, the state of the local care market and local costs. This is local knowledge held, gathered or coordinated by local government. These features can only be achieved locally because they depend on a local response to local patterns of need.

85. The practical argument against a fully national system relates to the specifics of how adult social care is funded, and indeed, the way local government as a whole is funded. Despite many people thinking otherwise, funding for social care does not come solely from national taxation. Rather, as the local government finance system is based, in part, on the relative resources a council can draw on, services such as adult social care and support are funded through a combination of central and local funding.

86. Personalising services
87. That local response must look both ways; it should draw down from universal services and include, where appropriate, more specific care and support interventions. We view the universal offer comprising services that support a focus on early intervention, prevention and wellbeing that prevents people needing interventions at a crisis points and effectively keeps people out of the system.

88. The idea of improving the individual’s experience of care and support must remain at the heart of any future system. This move to personalisation must not just associated with cash transactions, as this ignores the group of users who are perhaps the greatest cause for concern: those who seek state-funded services, are ineligible for public funding, yet have very limited means to pay for the care and support they require themselves. For this group, receiving timely and accurate information and advice can be the difference between making poor, costly decisions that ultimately bring them into the state-funded system once their needs have escalated, and good decisions, which maximise their limited resources and maintain their independence.

89. With a range of assessments, means and needs tests, charges, eligibility and interactions with other systems (such as health and benefits) the adult social care system is incredibly confusing for the individual. In many cases getting this aspect of care and support right means preventing admissions to residential care, which we know can be a significant cost pressure for the system as a whole. This would involve a shared territory for local statutory and voluntary sector services, founded on quality information and advice.

90. Developing a national guarantee that is expressed locally, such as we have set out above, means we cannot predict how services will adapt and grow under a truly personalised system.

91. Providers and commissioners alike must broaden their perception of what a person may need – not just for everyday living but also for an independent, fulfilling life. We anticipate services may be smaller, more organic, and cross-cutting between, say, health, housing and care. Regulating a market that seeks to respond to the delicate balance of people’s own resources, community support, carers and statutory services may well require a different (or additional) set of standards to those we have traditionally applied.

92. Rethinking design and delivery

93. Conventional approaches begin by measuring what people need, based on problems of ill-health, disability and disadvantage, and then attempt to deploy public-sector resources to meet those needs through a process of setting priorities.

94. Councils and other public sector organisations are exploring the implications of a move away from direct provision, intervention and doing to communities, towards enabling, capacity building and doing with and for communities. This aims to discover and acknowledge the assets that individuals and communities have already.

95. There are many roles that the statutory sector can play in this. Housing with extra care options, good transport and easily accessible information about what’s available for older people are just a few examples of things which are key to helping older people live happy, healthy lives. Councils can balance meeting the most pressing needs, like
Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and Society of Local Authority Chief Executives (SOLACE)—Written evidence

expensive social, residential and nursing care, while maintaining spending on preventive activity is cut back.

96. But this place based approach to ageing starts by looking at the resources available - not simply from the public sector but also from the private sector, the community and individuals. By fully using the wealth of resources on offer, local partners can not only make their areas better places for people to grow old, but can save money too by reducing older people's reliance on social services, the NHS and care support.

97. Meaningful engagement with older people has been a thread running through this approach. This has involved supporting older people to take the lead in finding solutions, rather being seen as part of the problem, with professionals acting as enablers.

98. It also emphasises the importance of the community and its role in ensuring a sense of universality across both services and consumers who are neither advantaged nor disadvantaged by whether they are publicly of self-funded. It requires fostering a sense of collective responsibility for the society-wide benefits of living healthily and planning for the future.

99. Concluding thoughts

100. The Coalition Agreement stated that the government understood “the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face”.

101. We are under no illusions that addressing some of the issues outlined above, and securing lasting reform is a major task. Several past attempts have all failed, exposing the reality that in a debate about state funding, individual contributions and collective responsibility. We recognise that we cannot simply expect the Government to adopt Dilnot at a time when public finances are so tight. That's why we will work on an offer to central government to show how local authorities can help get us to that fairer, more transparent system.

102. The Government cannot, however, expect local government to bear the load alone. Whilst the sector has excelled in delivering efficiencies, this cannot be sustained over the long term. The Government must enter into an honest debate with the public about what kind of society they want to live in, what kind of social care system they want and how they want to fund it and find a means to deliver a significant real terms increase in funding for health and social care.

103. The Coalition acknowledges that the need for reform is now urgent and we cannot afford any further delays. We need to invest urgently for the short-term, collaborate productively for the long-term, and proceed with all-party consensus. Only this way can deliver for the here and now and for the decades ahead.

3 September 2012
Email message from Sir Merrick Cockell to the Chairman

Further to our recent conversation, I am writing to provide you with some additional information for your Committee on Public Service and Demographic Change. Our written evidence, perhaps as you may have expected, had a strong focus on the financial implications of demographic change simply because this is an issue of such paramount importance to the sector - especially in this period of sustained austerity.

I do not, however, want to give the impression that securing additional resources for social care is the sector's sole focus; as you would no doubt also expect given local government's excellent track record on planning to meet demand - and doing so creatively - councils across the country are doing a great deal to plan ahead so that the more negative impacts of an ageing society are mitigated, and the more positive impacts are maximised.

As part of this - and as part of the LGA's support to the sector - we ran an 'Ageing Well' programme between July 2010 and March 2012. The programme provided sector-led support to assist councils in meeting the challenges associated with an ageing population.

The programme was delivered by the LGA and funded by the DWP. The programme had four main themes:

1. Leadership – enabling leaders and decision makers in local government to set the vision and direction of what it means to create ‘a place good to grow old’.

2. Strategic approach – given the importance and wide-ranging nature of the agenda, and its affect across local government as a whole, ensuring a coordinated and strategic approach to ageing.

3. Involving older people – as principal ‘customers’, involving older people to help tackle poor and inefficient services. Older people also have a huge contribution to make, which can be increased significantly through strategic but low cost support from the council.

4. Joined-up approach – greater productivity and customer focus through commissioning and service delivery that are properly coordinated and were a place-based focus is adopted.

The programme followed an approach of diagnosis, improvement and information and a great deal of practical work was undertaken at each level. Products included case studies, written guides, toolkits, and videos on subjects from developing dementia-friendly communities to tackling loneliness and social isolation. More information is available on our website at: http://www.local.gov.uk/ageing-well.

I hope this is helpful and reassures you that the sector is well aware of the need to plan for an ageing population and is doing a great deal in this respect. If you would like to know any more or if I misunderstood what you were seeking, please do not hesitate to contact me.

January 2013
Low Incomes Tax Reform Group and Tax Help for Older People—Written evidence

1. Summary

1.1. To keep to a concise submission, we do not give full background for each point, but can provide more information on request. We answer only those questions of relevance to our work and experience.

1.2. Together, LITRG and Tax Help have significant experience in the problems encountered by older people in dealing with public services – most specifically, HM Revenue and Customs (HMRC). From this and other experience with tax, national insurance, tax credits and benefits system we offer thoughts in response to the call for evidence.

1.3. We cover the following:

1.3.1. Caring for other family members in various ways needs to be recognised as ‘work’ and such work is making a valuable contribution to society. Tax, national insurance and benefits rules for carers (whether paid or unpaid) could benefit from a thorough top down review.

1.3.2. Self-employment should be recognised under Universal Credit as equally valuable as employed work, thus encouraging people to contribute to society both now and to save for their future.

1.3.3. Tax reliefs can incentivise saving for the future. It is critical to consider tax rules early in the scoping of any new products and as such to design a system for the long term. Changes to the pension rules in recent years have regrettably bred mistrust in the system, discouraging people from saving in products for which the rules might change later. This creates uncertainty which should be avoided.

1.3.4. Tax reliefs could also be used to incentivise other potentially beneficial changes, for example: to increase flexibility of working from home to help employees balance work with family care needs; to help maintain the skills and qualifications of professionals who have retired from paid work but who continue to serve society as volunteers; and to increase saving by those who need to make up a shortfall in retirement funding.

1.3.5. Other population trends, such as changes in the permanence of personal relationships (marriage, civil partnership and divorce trends) need to be considered alongside the ‘ageing population’. Government policy needs to be reviewed in the context of how couples are treated in the tax and benefits systems.

1.3.6. Government needs to be wary of excluding some service users from engagement with the system by moving too fast on its ‘digital by default’ strategy. It must be remembered that a person’s ability to keep pace with technological change might, and almost certainly will, diminish as they get older (both for health and financial reasons).
1.3.7. Tax issues should be considered early in any change of service delivery to avoid unforeseen problems of the type we have witnessed with Direct Payments scheme users becoming ‘accidental employers’ of care staff.

1.3.8. Government should capitalise on the use of agents for efficient delivery of public services. End users can be better served by making it easy for agents to help them.

1.3.9. Services should always be simple to use and accessible, with communications and processes designed to be as easy as possible to follow. This is critical with an ageing population and increased numbers potentially being in need of additional support. The establishment of the Office of Tax Simplification (OTS), which is conducting a review of pensioner tax, is a helpful step towards overall tax simplification.

1.3.10. The Government could stimulate further debate by capitalising on consultations. This could be achieved by not necessarily sticking to their sometimes too-narrow scope if respondents feel strongly that a wider debate of the issues is needed or is in fact essential in order to obtain a better understanding.

2. Question 2 – Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

2.1. The definition of ‘work’ and how it is treated in the tax and benefits systems

2.1.1. We think there is a strong case for reconsidering and debating what constitutes ‘work’ for the purposes of the tax and benefits systems. This would likely prove to be very worthwhile.

2.1.2. There are many different tax and benefits rules depending on the type of work that a person does which can give the impression that certain types of work are more valued than others. For instance, certain types of carer have a specific treatment within the tax system, such as foster carers, yet there seems to be no coherent strategy more generally for recognising of the services to the state of those who care for other family members without payment.

2.1.3. It is only recently and in response to sustained pressure from LITRG and others that certain carers have been given specific exemptions from the normal working hours requirements in the tax credits system.\(^{223}\)

2.1.4. In the context of the ageing population, we also have to consider that there are various ‘in-family’ care arrangements in place which mean that other family members can go out to work. For example, a grandparent might look after a grandchild which in turn enables the child’s parent to return to work. But the system does little to recognise their significant

\(^{223}\) See [http://www.litrg.org.uk/News/2012/carers-tax-credits](http://www.litrg.org.uk/News/2012/carers-tax-credits)
2.1.5. Carer’s allowance, although taxable, is not taxed at source and is therefore a potential source of confusion for its claimants and easily gives rise to unnecessary correspondence with HMRC when there is a failure to declare the receipt.

2.1.6. Interaction with the tax system needs to be considered carefully in any review of care provisions. Over the years, there have been many variants of tax reliefs and benefits to recognise certain family situations – for example married couples and those bringing up children – and it would be useful to have a debate as to whether these are better situated within the tax or benefits system. Indeed, with child benefit, there is now an overlay of the two – a benefit paid to the main carer of a child but with a very complex claw-back via the tax system where one or both of a couple is a higher earner225.

2.1.7. But why recognise someone bringing up children differently than someone who is caring for another, such as an elderly parent? Or indeed differently than someone who is providing care for payment rather than the unpaid care provided for a family member? Tax law currently gives tax-free allowances to shared lives carers226, so why not give similar relief to children looking after their own parents – such as by making carer’s allowance tax-free? Or by giving them an additional personal tax allowance to compensate for this?

2.1.8. At present, there are myriad rules for different types of carer – tax, national insurance contributions, national insurance credits, tax credits and other benefits. A simplification review could have the benefit of consistency and fairness of treatment across the board at its core, together with clarity and certainty as further key objectives.

2.1.9. There is perhaps no clear answer as to whether additional tax allowances and reliefs or benefits are the better solution. Much depends on the situation. But often tax allowances and reliefs are complex in their design which can lead to poor understanding of entitlement and therefore failure to claim them. Clear communication and ensuring take up are therefore essential for any tax ‘incentive’ strategy. This can be helped by having simple rules (for example a universal allowance rather than one which is withdrawn by reference to thresholds) and automatic awards (rather than having to claim).

2.2. **Attitudes to work – self employment and Universal Credit**

2.2.1. LITRG is very concerned that the Government is not currently recognising self-employed work as being as important to society as employment, with its plans for Universal Credit227. Yet self-employment is a vital option for people getting into work and being able to support

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225 This is where ‘adjusted net income’ (as defined in tax law) exceeds £50,000 a year.

226 ‘Qualifying care relief’ provisions are found in Part 7, Chapter 2 of Income Tax (Trading and Other Income) Act 2005

227 See http://www.litrg.org.uk/News/2012/uc-draft
themselves both now and in terms of saving for the future. The system therefore should not discourage it.

2.2.2. The lines between working and pension age are also becoming increasingly blurred and therefore it would be helpful for the Government to have a clear strategy on benefit entitlement in this ‘crossover’ period.

2.3. **Volunteering**

2.3.1. Many older people also continue to make a valuable contribution to society after they have retired from paid employment by using skills gathered in their working life. Tax Help for Older People has some 550 active volunteers, a good number of whom fall within this category.

2.3.2. There is a peculiarity in the tax system in that, during their working life, employees can claim a deduction against taxable employment income for the cost of professional membership fees and subscriptions necessary to do their job\(^\text{228}\); yet if the same individual wishes to continue to use those skills on a voluntary basis post-retirement, no such deduction can be claimed against other income, such as pensions. This seems to be counterintuitive and a damaging disincentive to people maintaining their skills set and also making a contribution to society.

2.4. **Savings**

2.4.1. The tax system can be used to influence behaviour. If the tax system is to be used as a means of encouraging savings by providing certain tax reliefs, those reliefs need to be clear and well understood. For example, the working population is unlikely to appreciate the contribution that is made via basic rate tax relief to their pension fund when all they see is the ‘net’ pension contribution on their payslip.

2.4.2. If tax incentives are given, offering tax-preferred products (such as pensions and ISAs), they need to be designed and implemented for the long term and not changed as part of short-term government policy. Making continual changes to the system leads to mistrust. For example, the rules changed in 2006 to raise the minimum age for accessing pension funds from 50 to 55 and as such people will be dissuaded from using such products if they perceive that the Government can move the goalposts at short notice.

2.4.3. Pension tax reliefs could be made more attractive — for example, for those in the latter stages of their working lives (in their fifties and sixties, say) who need to make up a shortfall in their retirement fund. It is perhaps only at that stage, when other financial responsibilities may be easing, that people can afford to save more for retirement; yet by that stage they would have to invest proportionately more to make up for lack of earlier funding.

2.4.4. It is important to consider tax rules when designing any new incentives, schemes or products. In March 2011, LITRG responded to a consultation about Simple Financial

\(^{228}\) Sections 343 and 344 Income Tax (Earnings and Pensions) Act 2003
Products with that very message\textsuperscript{229}. It is therefore disappointing that a further consultation has now been published which says that the tax status of proposed Simple Financial Products has yet to be considered in detail\textsuperscript{230}.

2.5. \textit{Employment flexibility}

2.5.1. Care is one of the main problems discussed in the call for evidence and thought needs to be given as to how care is viewed and provided in future. Flexible working patterns could help those who have family members with low to moderate care needs or for those who are looking after someone with a degenerative condition. Some tax reliefs are available for employees working at home, but these are very limited. For example, HMRC guidance allows for a flat rate expense of £4.00 per week to cover the additional costs of working at home. The Government could consider whether there is any room for further incentives within the tax system to allow individuals to work from home more flexibly around the care requirements of other family members. This could allow those who care for a relative both to continue to work and to provide care, obviously depending on the intensity of care needed.

2.5.2. Flexible working should indeed be a more general theme in catering for the needs of an ‘ageing’ population and a world in which many people may have to continue working until at least their late sixties. Inevitably, people’s ability to continue working will vary according to health, with manual workers perhaps most at risk. Again, tax incentives could be considered as a means of encouraging employers to cater to individuals’ needs.

2.6. \textit{Recognising other population trend changes, alongside the ‘ageing’ population}

2.6.1. It is also important to consider population trends other than the ageing population.

2.6.2. The Government recently consulted on changes to the bereavement benefit system. LITRG responded\textsuperscript{231} to this consultation pointing out that the tax considerations of any redesigned benefit should be considered early on in the process. Whilst the Government’s response\textsuperscript{232} acknowledges the point, it has yet to be resolved and has been referred to HM Treasury for full consideration.

2.6.3. Alongside the tax considerations, LITRG also commented that the Government had seemingly not taken account of the increase in the number of couples living together as if they are husband and wife or civil partners without having made that legal commitment. Bereavement benefit (both currently and as is proposed under the new rules) is paid only to widows, widowers and bereaved civil partners and not to anyone who has lost a de facto spouse or civil partner.

\textsuperscript{229} See \url{http://www.litrg.org.uk/submissions/2011/Simple-financial-products}
\textsuperscript{230} See \url{http://www.hm-treasury.gov.uk/d/sergeant_review_simple_financial_products_interim_report.pdf} (para 6.8)
\textsuperscript{231} See \url{http://www.litrg.org.uk/submissions/2012/bereavement-21cent}
\textsuperscript{232} See \url{http://dwp.gov.uk/consultations/2011/bereavement-benefit.shtml}
2.6.4. This does not seem to recognise that bereavement is likely to impact similarly on a household regardless of the legal framework of the relationship and it contradicts many other benefits which are assessed on a couples basis, regardless of marriage or civil partnership. It also interestingly contradicts the new High Income Child Benefit Charge, i.e. the claw back of child benefit, in whole or in part, when one of a couple is a high earner, again regardless of marriage or civil partnership.

2.6.5. These conflicting rules for couples between tax and benefits and even between different benefits seem to us to be an obvious problem in the current system and one which is likely to be compounded in the future, as more de facto couples age and encounter bereavement.

3. Question 4 - Do we need to redesign and transform public services for these challenges? If so, how?

3.1. ‘Digital by default’ and the impact of ‘digital exclusion’

3.1.1. There has been a radical shift in service delivery in recent years, both in the private and public sector. HMRC has moved from localised services to an increasingly impersonal model of call centres and online channels; and the Government generally is now adopting a ‘digital by default’ strategy which is certainly worrying for those less computer literate or worse still unable to access IT at all due to their location.

3.1.2. As clearly stated in a recent LITRG report\(^\text{233}\), this shift has made access to services harder for some, with a significant and disproportionate impact on older people and some people with disabilities. There are various reasons for the problems, including: fear of change or making mistakes; affordability; and lack of IT access or capability.

3.1.3. With an ageing population, it is possible to foresee problems from the increase in online services coming into sharper focus. For instance, if everything is online and password-protected, how are others to step in and help if a person lacks capacity (for example, due to sudden ill-health or gradual loss of memory in older age)? This is a major concern which ought to be considered.

3.1.4. The arrival of a piece of paper by post – a bill or notice, say – alerts a helper such as a friend, family member or social worker that action is required. Intangible, electronic, mail does not do this in the same way as it may well be hidden. Many private sector services are already delivered exclusively online such as some banks no longer sending out statements and certain utilities providers sending bills by email alone. If public services are similarly ‘hidden’ online, within the Government Gateway, how will people cope? If in future a notice to file a self-assessment tax return were to be served by email, how would a helper know that such a return is required if they cannot access the online service?

3.1.5. On the back of recent developments in registration of births and deaths, there should be a general move to a joined-up ‘Tell Us Once’ service for other life events – a single

\(^{233}\) See ‘Digital Exclusion – a research report’, April 2012
notification of both private and public sector services that a person has, for example, retired or that the management and control of a person’s financial affairs has been transferred to another through grant and registration of a Lasting Power of Attorney (or similar). This would save time and effort of older people and those who are helping them, and reduce error rates in complying with official obligations. For example, if such a notification were to be sent to HMRC on registration of an attorney, this would help in some situations outlined in the paragraph above, as HMRC could then notify the representative that the taxpayer’s return is outstanding.

3.1.6. There also seems to be a perception that as people who are currently more digitally aware move towards older age, they will be more willing and able to access services online. We would register a note of caution in accepting this premise. Whilst there might be a smaller proportion of technology novices in future, it does not necessarily follow that the numbers of people keeping themselves informed of communications technologies post-retirement will increase. Indeed, if the rate of change in communication technologies continues apace, it is quite possible that the drop-off rate will increase rather than decrease. This point is likely to be exacerbated in older age as pensioners often have fixed incomes but increasing outgoings (with care needs and so forth) such that keeping pace with technology is likely to be less affordable, even if they would otherwise be willing to remain so engaged.

3.1.7. We therefore recommend that the impact of changing the way services are delivered continues to be monitored to ensure that no-one is left behind. This must include taking into account whether or not people are able to keep up with technology as it moves forward.

3.2. **Redesigning public services – always consider the tax issues**

3.2.1. The tax issues of any policy change need to be thoroughly thought through at an early stage. Over recent years, we have witnessed the tax problems encountered by those living independently who are in receipt of direct payments which are then used towards their care needs. Such people can become what we would term ‘accidental employers’, with accompanying legal and tax obligations.234

3.2.2. Therefore any other scheme of caring for disable/older people in future needs to learn from this experience and consider any tax implications from the outset.

3.2.3. VAT, with its array of provisions for disabled people235 and mobility aids for those aged 60 or over can also cause confusion236. Zero rates and reduced rates may go unclaimed as the consumer has to identify themselves as being entitled to them.

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236 LITRG commentary on the reliefs can be found on the Group’s website: [http://www.litrg.org.uk/Disabled/buying-goods-service](http://www.litrg.org.uk/Disabled/buying-goods-service)
4. **Question 5 – What should be done now and what practical actions are needed?**

4.1. **Use of agents**

4.1.1. The Government should build on the use of agents to provide efficient public services. For example, recently HMRC has been developing an agent strategy, which includes considering how HMRC interacts with various types of unpaid or tax agent, such as voluntary sector organisations and friends and family helpers.

4.1.2. In our experience, services are likely to be more efficient for all concerned if it is easy for individuals to be helped by others where necessary. Older people who are starting to lose their capacity to deal with things for themselves often need to involve another family member or friend to help them.

4.1.3. Efficiencies could be found at quite quickly in this area. For example, by giving voluntary sector organisations more security of funding and in so doing those organisations could concentrate on service delivery rather than spending huge time and effort in fund-raising.

4.2. **Simplification**

4.2.1. Much of the problem with service delivery rests with the massive complexity of the system. We therefore welcome the Government’s focus on tax simplification, with the establishment of the Office of Tax Simplification (OTS).

4.2.2. But to be successful, simplification needs to be seen through to completion and for instance, although the OTS is still engaged in its review of pensioner taxation[^1], changes were made to the tax allowances for older people in the March 2012 Budget. It would be very much better to design the tax policy in the light of a full review.

4.2.3. Nonetheless, there are still plenty of areas for debate and movement in terms of simplifying the system for pensioners and we hope that the further work of the OTS will lead to a comprehensive strategy for making pensioner taxes simpler – both as they reach retirement, and in future if they become less capable of dealing with officialdom.

4.2.4. All parts of government should commit to ensuring that all communications and processes are as simple as possible for older people to understand and comply with.

5. **Question 6 – How can we stimulate a national debate about these issues?**

5.1. **Capitalising on consultation responses**

5.1.1. Further debate on areas of policy discussed above could be stimulated if government Departments such as HMRC were to take on board comments that are submitted in response to consultations which, although outside the core issue under consultation, are nonetheless relevant. Those comments could then be fed back to the public and debated further.

[^1]: See [http://www.hm-treasury.gov.uk/ots_pensionerstaxreview.htm](http://www.hm-treasury.gov.uk/ots_pensionerstaxreview.htm)
5.1.2. But often, consultation documents are narrowly focused and can give the impression that a course of action has already been decided upon rather than first stimulating wider debate. Also, there can be too long a period between the consultation deadline and the Government’s (or Department’s) response, thus losing continuity and momentum.

5.1.3. A good point at which to debate the future of service provision and the ageing population was at the time when the first call for evidence was made on possible merger of income tax and national insurance contributions administration. LITRG had felt that a deeper look at the issues would be worthwhile, for example whether to integrate income tax and national insurance contributions more closely or to consider the possibility of having a more structured contributory principle and ring-fenced funds for provision of care and financial support to people in older age. But such fundamental debate appears to have been bypassed in favour of a narrower, administrative review.

Appendix: About us
The Low Incomes Tax Reform Group (LITRG) is an initiative of the Chartered Institute of Taxation (CIOT) to give a voice to the unrepresented. Since 1998 LITRG has been working to improve the policy and processes of the tax, tax credits and associated welfare systems for the benefit of those on low incomes. The CIOT is a charity and the leading professional body in the United Kingdom concerned solely with taxation. The CIOT’s primary purpose is to promote education and study of the administration and practice of taxation. One of the key aims is to achieve a better, more efficient, tax system for all affected by it - taxpayers, advisers and the authorities. Tax Help for Older People (Tax Help), an original pilot service by LITRG but a separate charity since 2004, provides UK-wide free, expert personal tax advice to some 24,000 older people on lower incomes annually by telephone and face to face. It also provides educational material and training courses for its client group and other advice agencies in the voluntary sector.

Neither LITRG nor Tax Help is politically driven. If this evidence appears to stray into ‘policy’ matters, we emphasise that we do not intend to make recommendations of that nature. They are ideas to contribute to the debate using the benefit of our experience and expertise, from which we have been able to spot general trends and themes.

1 September 2012

238 For example, the response to HMRC’s ‘Relief for Income Tax losses’ consultation was published in July 2012, the consultation period having closed in September 2011.

239 See LITRG’s response to that call for evidence, September 2011
http://www.litrg.org.uk/submissions/integrate-tax
Professor Les Mayhew, Cass Business School—Supplementary written evidence

1. Background

In my earlier correspondence I informed the Committee about the Brent Integrated Care Co-ordination Service (ICCS). In April 2006, this new service was established with a grant of £1.65m from the Department of Health. ICCS was one of many pilots evaluated under the previous Government’s POPPs programme (Partnerships for Older Peoples Projects).

ICCS is a service that provides early holistic assessments of health and social needs of clients referred to it. It then refers clients to a range of providers that could include the voluntary sector, service providers in the private sector such as dentists and to statutory sector organizations such as The Pension Service and the Brent Adult Social Care Department.

Two important findings were that ICCS produced significant saving to local health care costs. For example it was found that there was a saving of on average between 14 and 29 bed-days per client in the 12 months following referral and reduced the number of hospital bed-day at the end of life from around 38 days to 16 days.

Two publications based on the evaluation may be accessed at:


2. Further work

Whilst the findings of the evaluation were warmly welcomed and accepted by the Council it was concerned about taking over responsibility for the service once Department of Health funding had ceased. In particular they were concerned that the economic benefits fell to the PCT but the costs of the service fell on the Council.

This issue was eventually resolved after the PCT agreed to increase its share of future funding. However, the Council also wanted to establish whether there were savings to the Council from early intervention, accepting that if there were these would be probably be smaller than the savings to the PCT.

Provided any savings met the extra costs of providing their share of ICCS they would be

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240 Based on a workload of 500 referrals per annum ICCS produced gross health care savings of between £1.8m and £4.2m a year (£1.35m and £3.45m, net). If this was repeated throughout the UK the savings would be in the order of £0.6bn to £2.1bn a year.
happy to take over funding. This was also a key issue for the Department of Health which decided to fund second phase work on the direct and indirect impacts of ICCS on Older People’s Services (OPS) in the borough.

I attach a copy of that report (Mayhew, 2010241). The methodology involved using administrative data to track older people over time and to monitor the support provided including spells in hospital up to and including death in some cases. This enabled us to make informed comparisons of pathway costs and outcomes: either using ICCS or not.

2.1 Some specific hypotheses were as follows:

- ICCS leads to a small reduction in the number of people going into funded residential or nursing care
- Fewer A&E attendances result in fewer pseudo-emergency referrals from ambulance 999 calls and A&E
- ICCS connects people to services that substitute wholly or in part, funded packages of care (i.e. adult social services)
- ICCS connects people to services that result in delaying their need for funded packages of care
- More rapid and holistic assessments by ICCS may prevent earlier deterioration or crisis intervention and therefore prevent or at least delay the development of greater social care needs
- ICCS undertakes a number of assessments that would otherwise have to be done by social care
- People known to ICCS spend less time in hospital post assessment than those who are referred to OPS

2.2 Summary of findings

- The evidence suggests that ICCS leads to a small reduction in the number of people going into funded residential care by deferring or delaying transfer (e.g. see section 4(d))
- There was less evidence than expected that ICCS intervention would result in fewer A&E attendances than would have occurred as a result of OPS intervention (see section 6(c))
- There is evidence that ICCS connects people to services that substitute wholly or in part for funded packages of care (e.g. see section 11)
- There is evidence that ICCS connects people to services that result in delaying their

need for more expensive care services such as residential or nursing care (e.g. see sections 4(d), and 11)

- There is evidence that more rapid and holistic assessments by ICCS may prevent earlier deterioration or crisis intervention and therefore prevent or at least delay the development of greater social care needs (e.g. see sections 6 and 11)

- Based on changes in workload share there is evidence ICCS undertake a number of assessments that would otherwise have to be done by Older Peoples Services (see section 11)

- There is evidence that clients known to ICCS spend less time in hospital post assessment than clients referred via OPS (see section 6)

3. Discussion

The analysis of three years worth of detailed health and social care records for nearly 4,500 people strongly indicates that proactive care co-ordination is effective at engaging with people who are hard to reach, who, despite being at some considerable risk to their independence are nevertheless not being identified by, or referred to, mainstream adult social care services (e.g. older people living alone, in social housing and on means tested benefits).

ICCS reduces the number of referrals to mainstream adult social care services (though the combined number of referrals increases so that coverage and support across the population are greater) and reduces the subsequent consumption of social care services and their overall cost. In particular, admissions to care homes appear to be reduced or the need delayed.

There were also indications from this study about the effectiveness of earlier intervention as opposed to responding to crises (i.e. when people are identified as being at ‘substantial’ or ‘critical’ risk) which called into question the perverse effects of limiting services to these two tiers of the FACS system.

There was evidence that the presence of ICCS reduces the number of referrals to OPS; however, the combined number of referrals to both services increases (ignoring overlaps) so social care coverage and support for the local population are greater. At an annual cost of only £750k a year for ten ICCS care coordinators, a manager and an administrator, this appears to be very good value for money based on an annual caseload of ~ 600 (although there was scope to expand this to around 1200).

The evidence strongly confirmed that post-crisis interventions result in more periods in hospital and consequently more intensive post discharge social care and re-ablement costs. The evidence is particularly strong that ICCS is much more effective in terms of avoiding bed-days than are social care pathways. In addition where ICCS and social care

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242 Across health and social care the terms ‘re-ablement’, ‘enablement’, ‘rehabilitation’ and ‘intermediate care’ tend to be used interchangeably, and the boundaries between services are often blurred. The definition of re-ablement adopted by CSED (Care Services Efficiency Delivery) is: ‘Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. For more on the cost effectiveness of intermediate care see: Mayhew, L. and D. Lawrence (2006) ‘The costs and service implications of substituting intermediate care for acute hospital care, Health Services Management Research 19, p80-93.'
pathways are combined, transfers to nursing or residential care are reduced or delayed. In terms of end of life care the results of this study suggest that:

- Clients only known to ICCS consume fewer bed-days in the last 12 months of life than clients known only to OPS (16 versus 38)
- Clients referred from ICCS to OPS consume fewer bed days in the last 12 months of life than clients referred from OPS to ICCS (33 versus 41) although sample on which this finding is based is small

4. Conclusions

In terms of costs/savings based on this evaluation the results indicated small annual savings to the council of between £0.44m and £1.14m based on then current activity levels and prices. This is much smaller than the savings to health care but gave sufficient assurance to the Council that they would not lose out financially.

The savings were also pathway dependent: for example, it was found that that the cost per pathway without ICCS would be £4,520 if OPS-only, £4,801 if referred from ICCS to OPS and £2,846 if referred from OPS to ICCS, again at then current prices. If the pathway only included ICCS, the unit costs were only around £1,500, although this includes only assessment, sourcing services and monitoring.

As far could be ascertained there were no systemic adverse impacts on mortality rates, after allowing for differences in health status of individuals at the outset (see section 5 of report). Based on the previous evaluation there was also a small but worthwhile improvement in quality of life. As the report shows from the individual case studies in the appendix, the boundary between whether to social care services is finely balanced.

Not reported in the findings section above are the ‘un-costed’ benefits to users of voluntary sector providers which were substantial (e.g. odd jobs around the home, gardening and so on). The voluntary sector also benefited from ICCS because it reduced their ‘case finding costs’, extended their support to more people, and helped them to more efficiently target their services on the neediest.

In summary, the evidence is that total costs to adult social care services are reduced in the presence of ICCS because: 1. ICCS deflects some of the demand away from OPS by assessing non-urgent cases sooner, potentially preventing or delaying them from becoming urgent; and 2. ICCS substitutes to a degree for more expensive care later on (e.g. pathway costs of referrals from OPS to ICCS are less than OPS-only pathway costs).

A final word of caution is that such evaluations are necessarily complicated and that observing the costs of care and treatment and associated the impacts on quality of life over long periods are very challenging methodologically speaking. This was not a randomized control trial which would have been very complicated expensive to do and could have taken years to complete.

However, I think both evaluations taken together prove that, by targeting the right client groups, early intervention is highly cost effective. In this case the evaluation benefited from
the superb support of the Council, PCT, and local voluntary groups who were determined to get to the bottom of this important public service issue.

December 2012
Key Points:

1. A radical review of national housing, planning and development policy is required to deal effectively with the impact of an ageing population. The Committee’s Call for Evidence requests information on how reform of housing services could better support older people and this submission notes how an increase in provision of specialist retirement housing for older home-owners could significantly reduce rising public costs in two key areas of public spending – social care and health.

2. The benefits of this form of housing, which can be provided by the market with no public subsidy, are yet to be fully grasped by policy makers. Provision is currently being obstructed by the existing planning and development system, with two out of three planning applications refused by local authorities in some regions.

3. This is despite the benefits that specialist housing for older people has on public finances and its residents through improved health and wellbeing, as well as reduced isolation and loneliness. Estimates show a modest increase in provision of specialist housing for older home-owners could save the adult social care budget more than £300m per year through improved accommodation and living environments.

4. Although a third of older people would consider living in this form of housing, planning constraints mean provision lags far behind other developed states; build rates for specialist housing are lower now than in the 1980s, and just 106,000 units for ownership have been built to-date. Our key recommendation to address this is to reform the housing, planning and development system so it encourages the building of specialist homes for older people across all tenures. This would aim to give specialist housing for older people the same level of policy recognition, at a local and national level, that affordable and starter housing for young people currently receives.

5. This submission also highlights our activity to improve bespoke financial services on offer to older people and our general approach to ageing; while it undoubtedly presents challenges, there is much to celebrate in living longer. It is important that we do not lose sight of this.

Introduction to McCarthy & Stone

1. When we started building apartments 30 years ago, our aim was to make later life richer, more rewarding and more fulfilling for our customers. This is still our guiding principle. Today, we have designed and built 70% of all owner-occupied retirement and Extra Care accommodation for older people in the UK, providing more than 40,000 homes for over 45,000 customers. Our two award-winning scheme types are:
1. **Later Living** (since 1977) – Similar to traditional ‘Category Two’ type sheltered housing, but to Lifetime Homes Standards. It includes a House Manager, lounge, communal laundry, CCTV, camera entry system, guest suite and lifts to all floors. Residents have active, independent lifestyles in a safe but private environment. The average resident age is approximately 78.

2. **Extra Care** (since 2000) – We have 42 Assisted Living Extra Care schemes open or in planning and we are the largest Extra Care provider in the UK. These dwellings are as above but are designed to full wheelchair housing standards and widths, and include more services such as 24-hour attendance, a restaurant, lounge and one hour per week of domestic assistance, with care packages available. The average resident age is approximately 83. Schemes are managed by our own CQC-registered service, which is a joint venture with Somerset Care.

2. In addition to housing, care and support for older people, we provide a range of financial services including equity release, annuities, later life planning and free benefits advice. Together, our services help older people enjoy the pleasures of later life while reducing many of the challenges that it presents.

**What challenges will an ageing population pose?**

3. The Office of Budget Responsibility’s (OBR) July 2012 report\(^{243}\) stated that the proportion of the population aged over 65 will rise from 17 per cent today to 26 per cent in 2061. These changes will place significant financial pressure on public resources, adding at least £80 billion a year to state costs, widening budget deficits and putting public sector net debt on an unsustainable upward trajectory.

4. The OBR report adds that two of the three main drivers in spending will be on health and adult social care costs (the third is pensions), due primarily to an ageing population. Health spending will rise from 6.8% of GDP in 2016-17 to 9.1% of GDP in 2061-62. A major part of this increase is due to overnight stays in hospital because of difficulties in returning home. Social care costs will rise from 1.1% in 2016-17 to 2 per cent of GDP in 2061-62. According to the report, the Government would need to implement another £17 billion of permanent tax rises or spending cuts in 2017-18 to get the debt back to pre-crisis levels of 40 per cent of GDP. It is therefore clear that measures to address the impact of a changing demographic on health and social care budgets are urgently required.

5. Across the UK people aged over 65 own more than £1.1 trillion of equity in their homes.\(^{244}\) Providing the options to allow them to access this wealth through downsizing, or ‘right sizing’, could help to address many of these funding challenges.

**What strategic choices need to be addressed?**

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\(^{243}\) ORB (2012) Fiscal Sustainability report

\(^{244}\) The Financial Inclusion Centre, 2010
6. Increasing the number of specialist homes for older home-owners could have a major impact on reducing the rising costs of adult social care and health budgets as well as improving the lives of its residents. Research by the Institute of Public Care (IPC) in 2012 showed that not only is unsuitable housing bad for physical health, it also affects the mental health of an older person through the creation of feelings of isolation and loneliness. It also has a huge impact on the public purse. Housing is a major determinate of health, and half of NHS spending is on older people. The annual cost of falls among older people is £1 billion each year and almost two thirds of general and acute hospital beds are occupied by people aged over 65.

7. The IPC’s research shows that just a modest increase in provision of specialist housing for older home owners could save the adult social care budget more than £300m per year through improved accommodation and living environments.

8. Specialist housing for older people, which includes retirement and Extra Care housing, delays and prevents the need for residential or social care through better living environments, providing residents with a greater sense of well-being and improved health. Each year a resident postpones moving into residential care, the State saves on average £28,080. Research by the University of Reading shows that 75% of residents in specialist housing have not stayed overnight in hospital since moving and 60% who had stayed in hospital said that they had found it easier to return home since moving. Very few of its residents need to leave retirement housing for nursing or residential care after they move in (about 9 in 10 stay) and crime rates are also significantly reduced.

9. Other benefits include:
   
a. **No cost to the public purse:** Funding for owner-occupied specialist housing can be provided through the release in housing equity held by 75% of pensioners. Older people hold £1 trillion of housing equity.

b. **Personal:** Reduced loneliness and isolation, improved security and companionship and a better living environment mean that 92% of residents are very happy or contented. 64% said their health and well-being had improved since moving.

c. **Housing and environment:** Efficient use of previously-used land (for instance, all of our 1,000 schemes have been on Brownfield sites). It is an effective way to free-up previously under-occupied family housing. A 40 unit scheme releases 40 local family-sized homes back onto local housing markets. 51% of residents also report lower heating bills. These under-occupied homes released into the market

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245 Identifying the health gain from retirement housing, Institute of Public Care, June 2012
246 Kerslake, A (2012) Identifying the health gain from retirement housing, Institute of Public Care
247 Fit for Living Network (2010). Position Statement, HACT
248 M Ball (2011) Housing Markets and Independence in Old Age: Expanding the Opportunities University of Reading
250 Ball, M ibid
are often refurbished and made much more energy efficient by the families who move into them.

d. **Economic:** A 40 unit scheme invests around £5 million into older people’s housing and the economy. 50 people are employed during construction. 17 jobs are created from a typical Extra Care development\(^{251}\).

e. **Allows for equity release.** Dwellings bought were 10% cheaper than the properties sold, resulting in a significant amount of equity release. About 40% were able to withdraw £25,000 or more.

10. However, public policy is yet to fully grasp these benefits. This is demonstrated by the small numbers of specialist homes for older people, such as retirement and Extra Care accommodation, which are being built in the UK, and the fact that two out of three applications for this form of housing are refused by local authorities\(^{252}\). For instance, there are just 106,000 units of specialist housing for home ownership and 400,000 units for rent\(^{253}\). While both of these numbers are low, they are especially low for home ownership given that around 75% of the 10 million older people in the UK are owner-occupiers. Build rates are also lower now than in the 1980s. In 2010, just 6,000 units for rent and 1,000 for ownership were built. However, in 1989, they were 17,500 for rent and 13,000 for ownership\(^{254}\). This 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 per cent in the United States and 13 per cent in Australia\(^{255}\).

**Figure 1:** Retirement housing units built by year in the UK (source: Elderly Accommodation Counsel)

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\(^{251}\) Figures provided by McCarthy & Stone, November 2011.

\(^{252}\) Ball, M Ibid

\(^{253}\) Ball, M ibid.

\(^{254}\) Figures from the Elderly Accommodation Counsel (2012)

\(^{255}\) Sutherland, J. (2011) Viewpoint on Downsizing for older people into specialist accommodation, Housing Learning and Improvement Network
11. This is despite growing demand for specialist housing. The 2006 Wanless Review said 27% of older people would consider this form of accommodation if it was available.\(^{256}\) In February 2012, a YouGov poll for Shelter said that 33% of people over 55 are interested in it, which equates to more than 6 million people.\(^{257}\) Shelter noted that if demand for retirement housing remains constant, supply will have to increase by more than 70% in the next 20 years. This is not going to happen without reform of the planning system.

12. A greater focus in public policy would help to overcome many of the obstacles that exist when trying to deliver this form of housing. These obstacles lead to two thirds of planning applications for specialist housing being refused by local authorities, partly due to a lack of understanding of need, demand, and any due recognition of the social, economic and environmental benefits that accrue from delivering better housing options for the local older population. Other complexities include:

a. **A one-size fits all planning obligations / taxes:** Section 106 Obligations, the Code for Sustainable Homes and Community Infrastructure Levies take no account of the specialist nature of provision of this type of housing. CIL, for instance, charges a flat rate per sq m on new housing development. It does not account for the fact that a third of its floor space is shared, and therefore not saleable, unlike traditional housing. Local authority obligations are based upon gross internal floor areas and therefore specialist housing is unfairly disadvantaged. This makes many specialist schemes unviable, and it is the main threat to new delivery.

b. **The complexities of provision.** The need for specific design features and services, such as on-site care and support provision as well as the need for individual care packages, make developing this form of accommodation different from general needs housing. Developers of all tenures provide more than simple bricks and mortar – it is the “lifestyle” provided to the residents who chose or need this type of housing that ensures a successful housing scheme.

c. **Capital hungry schemes:** Schemes need to be completed before sales are made as older people are less inclined to buy ‘off plan’ without seeing a dwelling, the communal facilities and/or meeting staff. Phasing is not possible as with general needs housing. Developments with higher levels of care often receive most of their income over the life of the development rather than through the outright sale of units. A considerable amount of up-front working capital (about £5m) is required before revenues come on-stream. Few providers can operate in this market.

d. **Getting the location right:** Specialist housing needs to be near shops, services and transport links, where residents wish to live. Good sites are: hard to find; in short supply; in demand for a variety of use; and in higher value areas; and tend to have higher development costs (often in


\(^{257}\) Shelter (2012) *A better fit? Creating housing choices for an ageing population*
Conservation Areas, in need of decontamination, with archaeological interest that needs appropriate protection etc). It is therefore in competition with other traditional housing and commercial uses (such as offices or retail) that do not face the same planning obligations to provide affordable housing and higher build standards under the Code for Sustainable Homes.

e. **A lack of joined up thinking:** Many schemes receive opposition at the planning stage based on concerns relating to the impact of an increased older population on local services, such as GP practices and hospitals. Yet research shows that residents of specialist housing actually have fewer hospital admissions and spend less time in hospital, returning home faster after medical treatment. Moreover, it largely meets a local housing need so its residents have previously been reliant on such local services and support.

13. The likelihood is that limited public subsidy will be available in the future to deliver new Extra Care or retirement housing. Therefore, given the low build rates of home ownership, it is important that planning and housing policy recognises the role of the ‘owner-occupied’ sector in increasing supply of this much-needed form of accommodation for older people.

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

14. The major challenge in delivering specialist housing for older people is the challenge in getting planning consent. As stated before, around two thirds of planning applications are refused because of a failure to understand at a local level the unique nature of this form of housing, its differences to traditional housing and its need.

15. We would like to see specialist housing for older people given the same level of policy recognition at a local and national level that affordable housing and starter housing for young people currently receive. This would involve reforming the planning and development system so it encourages the building of specialist homes for older people across all tenures. Four key measures are highlighted below that could achieve this:

   a. **Evaluate the impact of planning contributions for specialist housing,** focusing on the Community Infrastructure Levy, Section 106 payments and affordable housing policies. The impact of these payments on specialist housing, which do not take account of the differences of specialist housing to general needs housing, is the major threat to delivering new schemes. Government must look at how these financial requirements on specialist housing restrict delivery and add substantial additional costs. The Centre for Social Justice has called for a pilot where the affordable housing requirement is lifted to assess its impact on the market and the prospect of increased delivery. We would support this. A simple way to address this issue would also be to provide specialist housing for older people with its own use class to distinguish it from other forms of housing.

   b. **Take a strategic approach:** Both local and national government can encourage specialist housing by highlighting its benefits in policies, strategies and needs assessments. Nationally, this could be reform of housing and
planning strategies. Locally, this could be in housing needs assessments and in Local and Neighbourhood Plans. A national policy presumption in planning in favour of this form of housing, unless material considerations suggest otherwise, would send a clear message to new providers and local councils.

c. **Removing Stamp Duty for older people downsizing into specialist housing to encourage the market.** Any loss of income for the Treasury would be recuperated through the additional housing chains created, as sales further down the chain still qualify for Stamp Duty. It would ultimately benefit first time buyers.

d. **Formation of a Ministerial Working Group** on specialist housing for older people to bring together the key decision makers in the Department of Health and the Department of Communities and Local Government to develop policies to support this form of housing. This could look at the above recommendations as well as other areas, such as the impact of building regulations on specialist housing.

**The role of financial services for older people**

16. The 2011 Dilnot Report noted the potential for stimulation of the market for financial products which older people could use to fund their contribution towards their various needs. We agree wholeheartedly with the potential for expansion in this area, and feel that older people should not have their plans for a happy and active later life compromised by concerns about cost. We have launched a range of financial services to improve access to specific products in this area for older people to address this.

17. Capitalising on our unique understanding of the needs and aspirations of the over-50s, we are aiming to provide them with tailored financial products and services. The over-50s market is generally misunderstood and under served. By leveraging our understanding and approach, we believe that McCarthy & Stone can make a real impact in financial services. Our new financial products include:

- Pension Annuities Service
- Equity Release
- Guaranteed Funeral Plans
- Legal Services (power of attorney, will writing, etc)

18. We would be pleased to meet with the Committee to provide them with more information on our new products and our experiences in this area.

**Does our culture about ageing need to change?**

19. Finally, while much of this submission has focused on the challenges of an ageing population, which undoubtedly exist, it is important to recognise that later life can be an enjoyable and rewarding experience. Our approach at McCarthy & Stone is to base everything we do around a belief that later life can be hugely fulfilling. It is an opportunity to do all the things that we would love to do, but never get round to.
Helping make the most of it is our purpose and this is reflected in all of the services and products that we offer.

20. A report by the International Longevity Centre noted that retirement is in flux\(^{258}\) and it is time to challenge the concept of what it means to be old. We support this. The report notes that, thankfully, more of us are now living happier, healthier and longer lives. Life expectancy has risen rapidly and now stands at around 80 for both men and women. Improved health has created more opportunities for entertainment and leisure pursuits in retirement, and more people have the opportunity to stay in work for longer following the end to the compulsory retirement age last year, allowing them to maintain a higher level of income than would otherwise have been possible.

21. John Hutton MP said in the Daily Telegraph on 13 February 2012: “We have designed much of our public policy concerning older people according to an image of life after 65 that is now redundant. The old notion that after this milestone in your life, all you can expect is decline and dependence is hopelessly outdated”. We believe that retirement is the opportunity to rediscover the things people love and explore new territory. A comfortable retirement should be a right for everyone; it shouldn’t mark the point where people no longer contribute to society.

22. Better housing and financial options need to be on offer, and downshifting should be encouraged by employers to promote a smooth transition to retirement and retain older people’s experience in the market place. Retirement doesn’t have to mean the end to one’s career. Linked to this, people should be made aware of how to graduate taking their state pension, and opportunities for older people to volunteer should also be expanded. Organisations that offer flexible, fun programmes can allow older people to use the wisdom and knowledge that they have developed for a wider, public good.

23. These are just some of the principles that guide our work at McCarthy & Stone and we would be happy to meet with the Committee to provide more detail.

**Conclusion**

A radical review of national housing, planning and development policy is required to deal effectively with the impact of an ageing population. Our key recommendation to address this is to reform the housing, planning and development system so it encourages the building of specialist homes for older people across all tenures. This would aim to give specialist housing for older people the same level of policy recognition at a local and national level that affordable housing and starter housing for young people currently receive. We would be happy to meet with the Committee to provide more detail on this and any other point raised in this submission.

23 August 2012

\(^{258}\) ILC (2012) Retirement in Flux
McCarthy & Stone, National Housing Federation, Joseph Rowntree Foundation, Care and Repair Cymru—Oral Evidence (QQ 159–214)

Transcript to be found under Care and Repair Cymru
Equity Release

How well is the equity release market working?
In terms of performance, the equity release market has not achieved the expected levels of growth. The market is currently valued at around £1 billion. This is despite the fact that older people hold more than £1 trillion in housing equity\(^{259}\).

Despite the slower than expected take-up levels, the concept of equity release has to be considered as a potentially significant part of the solution to the problems that our ageing population faces. If delivered effectively, equity release has the potential to be the solution to many of the challenges facing older people, including housing, pensions and care.

Trust, reputation, bad publicity, rightfully earned by some firms many years ago, has left lingering doubts, which exacerbate some cultural qualms over the idea of effectively selling part of one’s home. Naturally, parents cherish the idea of being able to hand over a degree of wealth to the next generation but, as the clear trends of longer life expectancy and shrinking private pension provision impinge, the older generation will have to put its accumulated wealth to work. The younger generation will have to come to terms with the thought of their parents spending some of what they had envisaged would be their inheritance. Most offspring would surely agree that “spending the kids’ inheritance” is a sensible thing to do if it ensures that ageing parents can enjoy an enhanced quality of life.

How can the market be improved?
- **Product innovation** – There has been some innovation in recent years (such as the introduction of the ‘no negative equity guarantee’ and enhanced plans) but there has simply not been enough to meet the diversified needs of people in later life. Further product development is required. LTV issues aside, we would like to see a product developed that would provide a guaranteed capital sum, allowing older people to release sufficient equity to both support themselves in later life and help out loved ones.
- **Bolder communications** – We believe more direct, candid communications are required. It is not acceptable that people should live below the poverty line (it’s estimated that in the UK 2 million pensioners are living below the poverty line) when they do not need to. For many, equity release could be the solution. This message needs to be brought to the forefront.
- **Policy support from central Government** – The current generation of people aged over 65 have typically been averse to taking on debt, which does not have to be a bad thing if there are clear guarantees against the money running out and having to be repaid before a person passes away. The Government has a role to play in both changing cultural attitudes but also in offering policy support. For instance, the Dilnot Report proposed a cap on what someone should pay for care before the state steps in. We feel that these recommendations, if delivered, would give older people greater assurance over their care costs and would encourage them to draw down an appropriate amount from their properties to pay for care, knowing that the state will step in when the threshold is reached. Without such policy assurance, particularly around Dilnot, there is unlikely to

\(^{259}\) The Financial Inclusion Centre, 2010
be any policy innovation in this sector and very few new providers will be encouraged to enter.

**Why did McCarthy & Stone choose to move into this market?**
- Despite recent ups and downs in property prices, property continues to remain most people’s biggest asset, and is generally worth considerably more than the purchase price. House prices have, on average, doubled roughly once every eight years since 1950 – a rate that vastly outweighs the increase in income and living costs over the same period. As a result, many millions of Britons who may have reached or are approaching retirement age now find themselves with a wealth of equity that far outweighs their savings and income.
- We also have a deep understanding of the housing needs of those in later life. Part of our corporate strategy is to grow a financial services business that is truly focused on designing and delivering products that meet the needs of those in later life. We believe no other brand is, currently, genuinely doing this.
- We also see huge potential. Our customers could move into our properties and then take out an equity release product that releases cash for them to use as they wish. This could be to fund a holiday, to pay for care or to use as a pension. It can help our customers to lead a happier, healthier and longer life.

**How does McS quality assure its products?**
- We do not use a panel of providers. Our service provides best advice; the advisers research the whole of the equity release market to ensure the recommended product is the best product available in the market to meet the needs of the client. We regularly undertake mystery shopping and monitor customer satisfaction.
- The McCarthy & Stone Equity Release service acts as the broker. It provides customers with advice and will help the customer to apply for products but they are not the product providers themselves. The equity release products themselves are provided by third parties such as Aviva, Just Retirement and More2Life.
- Whilst the service is branded McCarthy & Stone the customer will be made aware that the underlying service provider is Age Partnership Limited. All regulated activity is carried out by Age Partnership, who are regulated and authorised by the Financial Services Authority (FSA).

**What are your growth plans?**
- We have only been offering an equity release product for the past 12 months, but it is our intention to use our knowledge of the market to become one of the leading providers within a couple of years. The types of equity release products available include:

1. **Lifetime mortgage** releases a lump sum of cash or regular extra income from the value of the property. There are no regular repayments to make as the amount that is released, plus any interest, is repaid from the money made when the property is sold. Generally this is when the homeowner dies, moves into long-term care or permanently leaves the property.
2. **Drawdown lifetime mortgage** is similar to the standard lifetime mortgage. However, with the drawdown lifetime mortgage, you can get at your money more flexibly. Rather than just receiving a lump sum, there is the option to release your cash over time, as and when required. Because
interest is only paid on the cash taken, these plans can often prove to be more cost-effective.

3. **Interest-only lifetime mortgage**, again, this is like a standard lifetime mortgage. However, regular repayments are made to reduce the impact of releasing equity on the value of your estate. Some plans allow repayments to be made that are equal to or less than the amount of interest that is charged. The remaining balance is paid off from the value of the estate once the homeowner has passed away or moved into long-term care.

4. **Home reversion plan** allows the exchange of ownership of some or all of the property for a lump sum of cash, along with the right to stay in the property, free of charge, for as long as the occupier lives, also known as a ‘lifetime lease’. Because you can continue living in your home, rent-free, for life, you would generally receive an amount for your property that is lower than its market value.

**Who is it suitable for?**

- Equity release is not suitable for everybody, which is why it is so important to speak to an independent specialist before making a decision. The amount that can be raised depends on age and the value of the property. A larger percentage of the home’s value can be released the older you get. In general to be eligible to release funds customers must be:
  - Aged 55-95 (both partners if a couple)
  - The property from which the equity will be drawn against must be worth at least £75K
  - UK mainland residents.

**What are the costs?**

There is no charge for the initial advice and no obligation to proceed to the next stage. Only if the customer chooses to proceed and the case completes would a typical fee of 1.6% of the amount released be payable. As part of the service a free quotation with a full written recommendation is sent to the customer and if the customer wishes to proceed free same-day document collection service is also provided to ensure a fast application.

**What would encourage more take up?**

- **Education** – There needs to be a greater awareness and understanding of the downsides, the safeguards in place and how equity release works.
- **Government support** – The Government, in particular the Health, Pensions and Older Persons Minster (if the role ever comes to fruition) all have a role to play in encouraging people to use the equity in their properties, ensuring that access to benefits is not prejudiced as a result. Delivery of the Dilnot Report (or similar proposals) would also provide greater assurance on care costs and give people greater confidence in the level of equity that they would need to draw from their properties to pay for their care and support costs.
- **More big brands to enter the market** – Choice is currently limited, the entry (or re-entry) of big brands can only help stimulate demand and restore confidence.
- **Equity release needs to become a standard part of retirement planning** – It should no longer be seen as a product of last resort, with retirement incomes shrinking, considering equity release as a way to fund later life has to become the norm.
It is inevitable that this market will grow and it will grow rapidly because many people simply do not have the retirement income to get by.

13 November 2012
NHS Commissioning Board ("Improving the Quality of Life for People with Long-Term Conditions"), Professor David Oliver, The King's Fund, Carers UK, Care Quality Commission, Age UK—Oral evidence (QQ 215–288)

Transcript to be found under Age UK
Transcript to be found under The King’s Fund
National Housing Federation—Written evidence

Introduction
The National Housing Federation is the voice of affordable housing in England. Our members, housing associations, provide two and a half million homes for more than five million people. Approximately half of our members deliver supported housing, personalised care and flexible support services to some of the most vulnerable people in society, including people with learning disabilities, people with mental health problems, older people with care or support needs, homeless people, and women fleeing domestic violence.

1.0 Does our culture about age and its onset need to change, and if so, how?

The population is ageing fast, with almost 10m people expected to be over the age of 65 by 2015, approximately one-fifth of the whole population of England. At the same time, the economic climate for developing homes and services to enable people to continue living independently into old age is changing dramatically, with cuts being made to both capital and revenue budgets.

The positive aspects of an ageing society are well-rehearsed. People are enjoying longer, fuller retirements or continuing to work into their 70s. Older people make a considerable voluntary contribution to society, often bringing valued life experiences to bear. Age UK estimates that people aged 50+ in the UK make an unpaid contribution of £15.2bn per year as carers, £3.9bn in childcare as grandparents and £5bn as volunteers. Fifty per cent of those aged 65-74 and 38 per cent of those aged 75+ have taken part in some form of volunteering.

Many people are growing older with significant levels of wealth in terms of housing equity. In 2004, 60 per cent of people over 65 owned their home without a mortgage. Levels of owner occupation continue to rise amongst older people. In 2001, 61 per cent of those aged 85 or over were owner occupiers, but this rose to 76 per cent for those aged 65-74. This current baby boomer generation have helped to challenge age discrimination in public services, and demand a higher quality of service in all areas of public and private provision. The grey vote and the grey pound are well-rehearsed phrases, which highlights the growing political and consumerist power of this particular group.

However, while significant numbers who have benefited from stable employment and final salary pensions are growing older with wealth, in terms of both assets and disposable income, others are asset rich but income poor. Others still, have neither assets nor income. Twenty-three per cent of older people live below the official income poverty line.

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260 Breaking the Mould, National Housing Federation, 2010
263 Care services efficiency delivery. Projecting Older People Population Information system (POPPI). http://www.poppi.org.uk
264 Households Below Average Income 2006/07, chapters 2 and 6 (figures quoted before housing costs). DWP, 2008.
The negative aspects of living longer have also been well documented. Disability, illness and poor health are not inevitable as people age, but their likelihood increases. More people are living longer with more complex conditions such as dementia and chronic illness. An estimated 3.9m (33 per cent of people aged 65-74 and 46 per cent of those aged 75+) have a limiting long-standing illness; there are 700,000 people in UK with dementia, with numbers likely to increase to 1.4m in the next 30 years. A longer old age, coupled with the changing nature of family relationships means a more isolated life for many older people. Twelve per cent of older people (over 1.1m) feel trapped in their own home, with 11 per cent having less than monthly contact with friends and family.

Clearly older people are not a homogenous group. Our understanding of this dual face of ageing, as well as the impact of future generations who won’t have the same housing equity and disposable income available to them, needs to improve, and the services on offer need to take better account of the diversity of need, income and cultural backgrounds of older people now and in the future.

2.0 Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

We welcome Government’s desire to broaden our view of national and individual success beyond simply a measure of wealth, assessing a broader and more balanced scorecard around wellbeing. The Office of National Statistics is beginning to measure this and the New Economics Foundation have developed a five point model to measure wellbeing which considers aspects such as societal connectedness, how active we are in our day-to-day lives, as well as how informed we are of the choices available to us. Housing associations have a powerful role to play in positively contributing to older people’s general wellbeing.

In trying to meet the challenges of an ageing population, housing associations have had a key role in shifting the policy agenda from dependence to prevention, from paternalism to choice and independence. The National Housing Federation and its members share a vision of housing, support and care that enhances older people’s ability to live independently for as long as possible. We share a vision of support and care services, which are flexible in their delivery and, most importantly, are based on the needs and aspirations of the resident. With an older population growing not only in numbers, but also in diversity, these underlying principles are just as important as ever before.

Housing associations provide affordable homes for almost one million older people, with 5% of all older people living in sheltered housing and extra care accommodation. Set at the heart of the community, housing associations are well placed to deliver housing and services that prevent people from needing more intensive care and support for longer, providing older people with peace of mind for their own security and making it possible for them to live in a place well connected to local community networks.

268 956,773, Number of homes for older people (From RSR 31/03/2009 & Survey of Tenants 2004/05
269 CLG, Lifetime Homes, Lifetime Neighbourhoods, 2008
3.0 Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

Levels of unmet need in terms of care and support for older people are deeply worrying. Budget increases for social care have failed to keep pace with the needs driven by demographic change and rising costs of equipment and staff. Many thousands of vulnerable people are still not receiving the care or support they need. The Commission for Social Care Inspection estimated a shortfall of 1.4m hours of care in 2006/07 to 450,000 older people. Some specialist homes are being developed for older people, but as demand outstrips supply older people will find it increasingly difficult to secure a suitable property. Supply in some areas is falling rather than rising, as traditional forms of sheltered housing are decommissioned where they no longer meet current expectations. A conservative estimate by HGO consultancy for the National Housing Federation in 2010 suggests there are already around 70,000 people aged 60+ in urgent need of housing and related support services. They are effectively on a ‘waiting list’ for a suitable home and support to allow them to continue to live independently. That figure is expected to quadruple to at least 300,000 by 2019.

However, an ageing population brings new opportunities to develop housing and services which take into account the high levels of owner occupation and housing equity owned by older people. Today’s older people are wealthier than those of previous generations. Households of people over 65 collectively own around £500bn of unmortgaged property equity, while over 50s account for 40 per cent of consumer spending, 60 per cent of UK total savings, and 80 per cent of the nation’s wealth. The proposals set out in our report, Breaking the Mould: Re-Visioning Older People’s Housing, could see housing associations broadening out their services and facilities to the wider community, using any surplus from sales to continue to provide affordable housing, care and support to those who need them most. It describes a number of the business opportunities that an ageing population brings. It offers examples of how care, support and other practical services such as handyperson or ‘help at home’ services can be developed and offered to all older people in all types of tenure.

There are already significant numbers of older people who buy their own care, and this number is set to rise further as individual budgets are rolled out. Services developed for this group are free from the constraints which revenue streams such as Supporting People often impose. Our report, Breaking the Mould, also addresses capital funding, and argues that housing associations should build larger, more accessible flats and houses which are attractive to older owner occupiers who want to move to an easier-to-manage home, but are not attracted to traditional models of older people’s housing. Income from this source can then be reinvested to improve the offer to older social renters.


Government funding for social housing can no longer be taken for granted, and every income stream available must be analysed and capitalised on, if the social housing sector is to continue to fulfil its mission to provide affordable housing for those who need it most. The option of generating capital resources by providing accessible flexible housing for wealthier older people must therefore be considered seriously, not only because it helps to house this group of the population well, but also because surpluses generated can be re-invested to improve the offer to less wealthy older people.

At the same time, we need Government to set out their proposals on the funding of social care and preventative support in particular. The National Housing Federation welcomes the Government’s commitment to adopt the principles of the Dilnot Commission that an individual’s lifetime contribution should be capped. Government has also announced that from 2015, there will be a national standard which will set out a universal minimum eligibility threshold set at ‘substantial’. However, the Federation is disappointed the Government has delayed their proposals on funding until the next spending review, which does not have a clear timetable yet. Without a clear funding framework, some local authorities could struggle to meet this eligibility threshold without making further cuts to other areas such as housing related support.

4.0 Do we need to redesign and transform public services for these challenges? If so how so?

The National Housing Federation welcome the emphasis in NHS and social care reforms on integration of housing with health and social care, as well as highlighting the core principles of prevention and improving wellbeing.

Housing is essential to improving social care. Linking up with housing can reduce demand on the care system, improve the reach and outcomes of care services and harness the contribution of wider community support networks to social care.

- Settled homes with the right support services improve health, speeds recovery from illness and reduces the incidence of respiratory and other diseases.274
- Housing with care and support enables people to remain independent and receive care services in their own home rather than moving to a care home.
- Preventative services, such as housing-related support, reduce the need for more intensive care interventions, reducing overall demand on the care system by helping people live independently in the community.
- Reablement services get people home from hospital quickly; prevent hospital readmissions and helping them to recover their independence after illness.
- Timely home adaptations assist with discharge home from hospital, facilitate the delivery of care in people’s own homes, and encourage independent living.

Closer working between housing, health and social care will achieve a care system that delivers better outcomes for individuals and communities. We need to join up housing, health and care, by ensuring engagement with housing through the health and well-being boards, local strategies and needs assessments for health, care and support. A fully integrated care service would mean hospital and care staff working closely with housing providers; local authorities and the NHS commissioning a range of specialist housing, housing-related support, adaptations, handypersons services, re-ablement services and intermediate care; and individuals being made aware of and accessing these services.

5.0 **What should be done now and what practical actions are needed?**

As the new health structures and commissioning processes develop over the next year, a key challenge for the Federation will be to make sure homes and related services are at the heart of the practice.

The National Housing Federation would like to see a number of practical actions taken:

- The Government’s integration framework includes housing in its vision for integration of health and social care and the integrated outcomes framework reflects housing.
- Housing is considered as part of joint strategic needs assessments carried out by health and well being boards by influencing the content of the JSNA guidance and working with DH to produce a sector-led JSNA resource on housing.
- DH guidance on intermediate care has a strong narrative on housing, and specifically encourages local authorities to look to housing providers for intermediate care solutions.
- DH works with local authorities and health authorities to illustrate where housing intervention is required in various care pathways.
- The development of a national information system for collecting evidence on the benefits of housing in achieving social care outcomes – this will help providers of care and support services to highlight the benefits of what they do in terms that are meaningful for health and social care commissioners.

The draft Bill supports the integration of housing with health and social care by including the importance of living independently in your own home in their definition of ‘well-being’.

6.0 **How can we stimulate national debate about these issues?**

Housing needs to be one of the main issues at the next election, and the growing care needs of older people, as well as the current and future diversity of this sector, needs to be fully understood within debates on housing. There is a need for strong political leadership in this area, both in terms of providing certainty for people as they grow older that their care needs will be met and their views listened to and acted upon, as well as certainty for the housing sector to allow providers to develop business models for the future and create a thriving care and housing market.

20 September 2012
National Housing Federation, McCarthy and Stone, Joseph Rowntree Foundation and Care and Repair Cymru—Oral evidence (QQ 159–214)

Transcript to be found under Care and Repair Cymru
National Housing Federation—Supplementary written evidence

Introduction

The National Housing Federation is the voice for affordable housing in England. Our members provide two and a half million homes for more than five million people. Every year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities. Approximately half of our members deliver housing, care and support services to some of the most vulnerable people in society, including people with learning disabilities, people with mental health problems, and older people with care or support needs, homeless people, and women fleeing domestic violence. The wide range of services provided includes: help in setting up and looking after a home or tenancy, support with developing independent living skills, help to develop social networks, manage money and to stay healthy and access health services, and assistance to arrange repairs and home improvements as well as social care.

Jake Eliot, Policy Leader at the Federation gave oral evidence to the Committee on Tuesday 30 October. During the evidence session Jake committed to sending additional examples to the committee to supplement and illustrate several opportunities he cited.

Below are the examples covered in more detail, on:

- Using transitional housing to accelerate hospital discharge and save NHS money
- Making home adaptations service smooth and effective
- Using building-based services to provide improved community services
- Developing sheltered housing into a hub of local support services
- Putting housing at the centre of a better offer for end-of-life care
- Seizing the opportunity of NHS Land

Making the best use of sheltered housing stock through transitional housing

Havebury Housing Association, working in partnership with the NHS, has transformed an unused scheme manager’s flat in Bury St Edmunds into an additional sheltered housing unit and a transitional flat for people to use when they come out of hospital and are waiting for alternative accommodation or for adaptations to be carried out to their home.

The flat has an adapted bathroom and kitchen, widened doors and an access ramp for wheelchair users. Each new resident has been able to select a bed that is appropriate for their needs and have it installed for them in the flat. The remodelling was part-funded by the local authority adult social care division.

Havebury charges £155 a week to stay in the flat, which includes a service charge. The total charge is eligible for housing benefit. This is a considerable saving on the local costs of a hospital bed at around £400 a day, which presents a saving to the NHS of £2,800 a week.

The anticipated length of stay was between 1-12 weeks, but in practice only two people lived there in the first nine months of the service, since it took much longer than expected to arrange move-on.

This initiative helps Havebury Housing Association, the NHS and social services all to
achieve their goals:

- it gives Havebury income on a flat which would otherwise have been void, and provides a much needed service to Havebury tenants as well as older people living in their own homes;
- it saves the NHS money because people can be discharged from hospital earlier than would otherwise have been the case;
- it saves social services money because it reduces the likelihood that an older person may have to be placed in registered care because they are not well enough to return home.

Providing timely and effective home adaptations

Each year, the Disabled Facilities Grant (DFG) helps around 35,000 disabled and older people to live safely and independently in their homes, by funding adaptations such as wheelchair ramps, stair-lifts and downstairs bathrooms. The Grant is used by owner occupiers, private tenants and social housing tenants, including tenants from housing associations. In summary, currently everyone is entitled to an assessment and, if found eligible, entitled to use of the Grant. Otherwise adapted properties can remain empty or expensive adaptations have to be removed, even though three quarters of a million people aged 65 and over need specially adapted accommodation because of a medical condition or disability.275

However, the delivery of DFG is dependent on the availability of funds and the priorities of local authorities. The rapid increase in demand continues to outstrip funding for DFG. There are at least 145,000 people aged 65 or more whose accommodation was considered to be unsuitable due to their disability, which would require a further £975 million funding.276 Over 50 per cent of home improvement agencies have reported an increase in waiting times for DFGs and 70% are experiencing a rise in demand.277 Furthermore, local authorities are no longer required to match fund the grant and the ring-fence for the disabled facilities grant was removed in 2011.

Delivering DFGs can be complex because of the range of different partners required in the process to deliver even a basic adaptation. To reduce waste, time delays for clients and costs for all concerned, a number of housing associations have taken the opportunity to develop an agreement with the local authority to simplify the process and clarify responsibilities. The type of and content of agreement will vary according to the housing association involved, the type of stock they own or manage, and the profile of their tenants. Many housing associations and local authorities have worked together to find ways to improve the delivery of adaptations. Sometimes these are operational ways of working developed by staff, sometimes they can be formalised in an agreement.

Example of effective lettings management: Incommunities, Bradford

275 Housing in England 2006/07, Department for Communities and Local Government, 2008
276 Care and Repair England (2010), Time to Adapt. Home adaptations for older people: The increase in need and future of state provision
277 Foundations (2010), Adapting for a Lifetime
**Incommunities Group Ltd** is a stock-transfer Registered Provider based and operating in Bradford, West Yorkshire. Incommunities launched a Disabled Housing Register in 2002, one of the first 13 choice-based letting pilots in the country. The website was replaced with [www.openmoves.co.uk](http://www.openmoves.co.uk) in March 2010 and is focused on housing options and not limited to advertising availability of stock. The Disabled Housing Register is very popular and there have been many applications to the service (approximately 1000-1500 housing applications per year). The register links with Incommunities’ stock database, which holds details of all properties with adaptations, and this is how clients are matched to stock. This in turn is linked to (Geographical Mapping Systems (GIS) profiling to produce much more detailed tenant and property analysis, which helps inform housing strategy. All of Incommunities’ adapted properties are prioritised for disabled people.

Since 2002, Incommunities Group Ltd has recycled approximately 350 to 440 adapted voids every year through Able Living, their Disabled Persons Housing Service. Able Living is a specialist service offering free housing advice and needs assessments to people with disabilities or health issues. The service is the first point of contact for hospital discharge and homeless applicants with health issues, as well as for clients in need of aids/adaptations, or wishing to access general accessible or sheltered/extra care housing. The service is based on providing options to help the client stay in their home or move into accommodation that is right for them. Able Living identifies potential tenants to move into adapted stock. The recycling of adapted voids saves Incommunities £1.2 million per annum. This saving is from reduced waste by avoiding adapting stock on demand or removing adaptations once a property is re-let. Equally, there is no time lost waiting for occupational therapists or technical assessments.

**Example of effective adaptations services: South Staffordshire Housing Association**

Mrs Edna Lawton had lived in a home owned by South Staffordshire Housing Association for many years. At 94, she had become frail and gave up using the bath to wash because she felt unsafe. She was then forced to wash at the sink, which took her over half an hour every day. Soon after an assessment with the occupational therapist, a walk-in shower was fitted for Edna making her life so much easier. Throughout the process, Edna had clear information about who was responsible for the work and how they could be contacted to minimise the stress and disruption to her everyday life.

South Staffordshire Housing Association’s Project Independent Living means that the waiting list for minor adaptations has been cut from twelve months to seven days. This service has become possible because of the partnership created between the housing association, its tenants, South Staffordshire District Council and Staffordshire County Council. After assessing their service, South Staffordshire Housing Association found that delays occurred when, for both funding and medical reasons, applicants needed to be assessed by an occupational therapist before work could start. To add to the frustration, applications, assessments, commissioning work and fitting equipment were each being done by different agencies. Applicants didn’t know where they were in the system or who they should be chasing for information.
South Staffordshire Housing Association approached the local authority with the solution that they became the first and only point of call for applicants. They commissioned an occupational therapist who, as well as doing assessments for major adaptations, trains their staff in assessing for minor aids. This has cut waiting times and the partnership with the local authority has reduced costs for major adaptations from £7000 to £4,200, a 40% reduction. South Staffordshire Housing Association is also building a pool of housing stock with adaptations. They have produced an integrated register of people with disabilities and homes with adaptations. This means that where a property does not lend itself to adaptation, they can advise residents of where there is a vacancy which may suit their needs. (This case study is taken from the Federation’s report, *In Your Lifetime*, 2010.)

Providing homes with popular community amenities: Peabody Housing Trust

Darwin Court, a development by Peabody Housing Trust, is an exciting and innovative social housing scheme for people over 50, although younger family members are welcome. It has 76 units: 40 supported flats and 36 general needs flats, with 39 two-bed flats and 37 one-bed flats, which allow a flexible response to tenants’ changing needs. All properties are built to Lifetime Homes standards and are wheelchair accessible. Communal balconies (as well as individual ones) on each floor are a nice design feature.

The development was on a site already owned by Peabody, so although there was the cost of demolition, the site did not have to be purchased. Peabody was creative in securing a diverse array of capital grant funding – from the (now disbanded) Single Regeneration Budget, social housing grant, charitable trusts and foundations, banks (capital grants, not loans) commuted s106 sums from Southwark Council and by selling nomination rights to various boroughs. Planning permission was granted in 1998 and the scheme opened in 2003.

There is a resource centre on the ground floor which includes consultation rooms, an IT suite, a restaurant and a swimming pool. Several of the rooms are leased to third party service providers, including a hairdresser and a reflexologist who pay heavily discounted rents in return for providing reduced rate services to residents. Originally it was hoped that a local GP surgery might base itself within the scheme and although this did not happen, Peabody continues to look for opportunities to bring community health services within the building. Peabody has also forged good links with local education providers and the IT suite has been used by Southwark College.

The restaurant is run by Peabody and is very well used by residents and people from the local community. The restaurant runs as a separate business model with its own budget, with the aim to cover running costs while providing low-cost healthy meals from fresh ingredients.

The resource centre is a significant community amenity. It has taken time to build links with local agencies and to discover what types of services local residents are interested in. It continues to be a work in progress to ensure all aspects of the resource centre are bringing in sufficient income, but Peabody and the residents are convinced that this is progress which is well worth pursuing. As well as drawing in the local community, the scheme offers outreach services to people living in their own homes. A handyperson scheme was initially offered to people living in and near to the scheme. It has been so successful that it, along with a decorating service, is being rolled out across all tenures in Southwark. The handyperson service is £15 per hour for those on benefits and £30 per hour for others. The decorating service is £100 per room for those on benefits and £200 for others.
More information on Darwin Court is available in the Federation’s report, *Breaking the Mould* (2011)

**Extending sheltered housing services to the wider community: Methodist Homes**

Methodist Homes (MHA) is a specialist provider of housing care and support for older people. It has around 50 retirement housing and extra care schemes across the UK, as well as over 70 care homes and 50 community services. Over the last year, it has been offering an enhanced service in all its housing schemes. Each scheme manager offers a menu of services to residents, which can include cleaning services, laundry and shopping. They can also plan to offer personal care provided through MHA’s domiciliary care service. For each scheme, the price and range of services is based on what is available in the local area. Prices range from £10-£15 per hour. The income from these additional services is used to fund the extra staffing requirement and other additional costs associated with the services.

In all cases, MHA is expanding services out of its building-based provision to the wider community and it has converted nine sheltered housing schemes to extra care. This offers residents a well-being service package, which provides 24-hour staffing in the scheme, help in emergencies and a daily drop in or call, as required. There is a weekly charge for the well-being service and personal care is then purchased on top. The charge for personal care varies and some care services are sold in packages, rather than by the hour, to focus on the needs of the user. This approach has helped MHA to move away from reliance on the commissioned block-contracted model of care and support. Although these schemes have required MHA subsidy in the early stages, they are all on target to be financially viable within three years of set up. The MHA subsidy includes a one-year discounted rate for existing housing residents for the 24-hour support service, so that residents pay only 25 per cent of the charge.

There are two specialist dementia care services for people living in the wider community. Both are based in extra care facilities; one is a block-contracted service, but the other, in Leeds, is a pilot offering services for purchase by individuals in the community. MHA specialises in dementia care, with its first facility having opened in 1989 and the subsequent development of around 45 additional residential services. The association has found through the pilot that standard domiciliary care services are often not equipped to work with people with advanced dementia, signifying both a gap in the market and an acute need in the community for these services, which it is addressing through this scheme. The pilot service is only offered to people within a mile of the extra care scheme, which helps to keep the costs low by minimising travel time.

MHA uses some of the surpluses it generates in combination with contributions from its charitable income to fund a national network of 50 ‘Live at Home’ services, which bring together local people to provide services and activities for older people in the community. These are membership organisations which offer opportunities for enhancing the lives of older people and of the volunteers who get involved. MHA funds managers for these groups, but each Live at Home has a local committee which supports the work of the group. Services are provided by volunteers, who are often themselves older people; the most common age group of those volunteering is 60-70 year-olds. The services include luncheon clubs, transport to appointments, outings, befriending and lifelong learning.
The central role of housing in end of life care: Home Group’s pilot of ‘A good death’

Home’s Group’s vision is to provide homes for life and its pilot service ‘A good death’ supports this. The pilot aims to give people a positive experience in the last years of life through providing community-based services. It launched in September 2011 after Home learned that many people were unable to access the support they needed to die in their own home. One national survey, undertaken in 2009, found that 60% of people die in hospital; although 70% of people would prefer to die at home.278

Working with family and wider support networks, the service helps people to plan and prepare for their death. It also supports those with a terminal illness. It enables people to make a choice about where they will die and offers emotional and practical support.

The project explored ways of improving the support people receive through technology, including telehealth. A one-off personal budget of £1,000 can be used to achieve personal outcomes such as access to social networks through smart phones or hand-held tablets.279

At any time the service can support up to 30 people who live in the most disadvantaged areas of Tyne and Wear. Most are over 75 but it does not exclude the over 55s. Referrals come from Macmillan Cancer Support, hospital social workers, Cancer Connections (a local third sector organisation) and self-referral.

- people can express their preference for support at home, so mental and emotional wellbeing is improved for them and their families
- customers, families and friends report that Home’s support to talk about the difficult topic of dying is very useful
- practical interventions, such as support to manage personal affairs, are proving as important to people as pain relief the service is improving staff skills and coordination of care for people at the end of their lives.

In addition to significant benefits for the individual service user and their families, housing-based services reduce or slow the need for intensive nursing or residential care, delivering better outcomes at lower cost for the public purse. Savings are expected from:

- fewer days spent in hospital and avoided stays in other, more expensive services
- fewer ambulance call-outs and accident and emergency attendances
- less time spent on non-nursing/clinical inputs by nurses/clinicians
- reduced demand for GP services

More information on this service, and other examples of an improved housing, health and care offer to older people is available in the Federation’s report, On the Pulse (2012).

278 NatCen survey on attitudes towards dying, death and bereavement commissioned on behalf of Dying Matters, July - September 2009

279 This personal budget is possible as a result of funding from the Health Innovation and Education Cluster North East and Newcastle Science City - not all users of the pilot will spend this.
Taking the opportunity to make better use of NHS land

With such significant pressure on public spending and widespread cuts to preventative housing-related support services, commissioners and providers need to look to a variety of different ways of delivering new services. There are already examples of social services and local authorities providing discounted or free land in order to ensure the viability of new accommodation schemes that deliver local priorities. Flexibilities available to foundation trusts provide opportunities for real innovation and creativity in the use of existing estate. Housing associations are well placed to offer the NHS new ways of using the NHS estate creatively to deliver the facilities that local residents require whilst improving health outcomes.\(^{280}\)

The Federation recommends that NHS bodies explore opportunities to use the existing NHS estate in different ways to deliver better health outcomes. This could include for example, partnerships with housing associations to ensure Trusts have accommodation available to support speedy discharge and step-down services alongside the development of private housing for sale to generate a financial return on the land for the trust.

Examples of existing and potential joint working between housing associations and NHS Trusts are available in the joint briefing written by the NHS Confederation and the National Housing Federation Housing and Mental Health.

November 2012

\(^{280}\) NHS Confederation and National Housing Federation (Dec 2011), Housing and Mental Health
www.nhsconfed.org/Publications/Documents/Housing_MH_021211.pdf
NHS Confederation, Geoff Alltimes, NHS Future Forum joint lead Carewatch Care Services and Professor Julien Forder, University of Kent—Oral evidence (QQ 289–326)

Transcript to be found under Geoff Alltimes, NHS Future Forum joint lead
North East Essex Clinical Commissioning Group, North West London Integrated Care Management Board, South West Forum on Ageing and Torbay, Southern Devon Health and Care Trust and Leeds City Council—Oral evidence (QQ 554–582)

Transcript to be found under Leeds City Council

Transcript to be found under Leeds City Council
Nuffield Trust, Dr Chai Patel CBE FRCP, HC-One, Care Quality Commission and The King’s Fund—Oral evidence (QQ 607–638)

Transcript to be found under Care Quality Commission
Office for Budget Responsibility OBR, Professor James Sefton, Imperial College London, Dr Martin Weale and Institute for Public Policy Research (IPPR)—Oral evidence (QQ 104–158)

Transcript to be found under Institute for Public Policy Research (IPPR)
THURSDAY 5 JULY 2012

10.40 am

Witnesses: Suzie Dunsmith, Guy Goodwin, Ben Humberstone and Professor Ludi Simpson

Members present

Lord Filkin (Chairman)
Lord Bichard
Baroness Blackstone
Baroness Finlay of Llandaff
Lord Griffiths of Fforestfach
Baroness Morgan of Huyton
Baroness Shephard of Northwold
Lord Tope
Lord Touhig
Baroness Tyler of Enfield

Examination of Witnesses

Suzie Dunsmith, Head of Population Projections Unit, Office for National Statistics; Guy Goodwin, Director, Population and Demography Statistics, Office for National Statistics; Ben Humberstone, Head of ONS Centre for Demography, Office for National Statistics; and Professor Ludi Simpson, University of Manchester.

Q1 The Chairman: Welcome and thank you very much for coming. I will not go around the table; you can see our names and you may know a number of the people or be sighted on them broadly. You also, I am sure, have seen the overall scope of the issue, which we are in the process of defining and tightening up—we will be doing that over the next couple of weeks. However, the broad picture is obvious: we have an ageing society. Therefore, what does that imply for public action and what should everybody be doing about it? Hearing your evidence and understanding where we can get more is a foundation for our work.

As I understand it, Guy Goodwin will be happy to make initial responses and will then allocate among his team. Ludi Simpson will then add either an expert demographer’s perspective or qualification based on what he thinks. First, perhaps Guy Goodwin will say a word about himself and his role.
Guy Goodwin: I am Guy Goodwin and I am one of the leadership team at the Office for National Statistics. On my immediate right is Ben Humberstone, who heads up population statistics, which includes the breadth of population statistics that the office produces. On his right is Suzie Dunsmith, who leads on population projections. On the far right is Ludi Simpson, from the University of Manchester. Professor Simpson is one of the leading demographic experts in the UK.

Q2  The Chairman: Thank you. I should remind you that a verbatim transcript will be produced. You will get a draft of that, which you can tweak a bit but not transform, unfortunately. Eventually, this will be webcast and broadcast to the four corners of the world.

Let me start off. Population projections vary a lot depending on the assumptions made, particularly about fertility, mortality and net migration. Can you say a bit about that—although we understand it—and about the extent to which we can rely on projections for 10 or even 30 years ahead? Clearly, if the issue is not as we think it is and is vastly smaller, we need to be sighted on that.

Guy Goodwin: The office produces estimates and projections based on those estimates. The projections do no more than take the latest estimates and look at existing trends in mortality, fertility and migration. We use an expert panel to help us to interpret the latest evidence. Then, in what we term our main projection, we push the existing evidence and trends forward. We do that right out to 100 years, because our customers say that if you are looking at pensions, for example, you want to get a feel for how things will look quite a way into the distance. Of course, the more you push these things out, the more uncertainty there is around them. Therefore, we also produce a whole series of variant projections, which show what happens if you start changing the migration, mortality, and fertility assumptions, so that you can see what happens in a whole range of different scenarios.

In terms of accuracy, the guidance that I normally give is that the more that you can be constrained to the 10-year period, the better. Once you start pushing out to 25 years and so on, the uncertainty grows significantly. That does not mean that you cannot look ahead at such projections and see the sort of uncertainty that you will have, but 10 years is a pretty good guideline. Typically, we show data at 10 and 25 years, as that is what our users want, but 10 years is what we would advise and we are pretty accurate within that.

The Chairman: Very helpful. So 25 years gives us a view of what might happen, with some plus or minus around that, but the data for 10 years can be leaned on with some confidence.

Guy Goodwin: Yes. I ought to say that, if you are looking at the older ages, the numbers are fairly stable 10 years ahead, under any of the variant projections, simply because people are already here, in the population. Their numbers do not vary; what does vary are numbers in the working-age population and in the younger ages. Fertility and migration are the things that vary, rather than the number of people in the country in the older ages.

The Chairman: Let me ask one further question before asking for other questions from colleagues. By definition, most of the older people who will be there in 10 years are here already. However, that will fluctuate according to what medical science does and the extent to which we adopt healthy lifestyles. Clearly, it will not have been your research, but presumably you will have access to research that shows what we might expect and to the academic debate on future trends in longevity.

Guy Goodwin: Yes. Colleagues might want to comment on this in a moment, but what we actually do is to refresh the projections every two years. We look at new analyses of, say,
obesity and the effect of different things on mortality. We refresh quite regularly and keep looking at how the trends are changing and keep everything up to date.

We can say a bit about healthy life expectancy and other issues later if you wish.

**Q3 The Chairman:** We will come to healthy lifestyle expectancy later. I just want to get a broad picture of longevity. Ludi Simpson might be able to comment. Do you want to say a word about where you are from and about your specialist role?

**Professor Ludi Simpson:** I am Ludi Simpson. I spent 20 years working in local government as a researcher and then transferred to the University of Manchester, where I have an honorary post and now work on a variety of projects. I am the current President of the British Society for Population Studies.

On the relationship between planning and projections, we all, quite reasonably, like to think that projections are the best prediction, but it would be silly to think that anything even 10 years ahead will happen for sure. The trick in planning is to understand at least what is predictable—and that may be only the trend upwards or downwards or within a band—and then plan, purposefully, for what is not predictable. In a sense, the variants that we have been talking about are a measure of what, on past practice, the best people working on these things think may influence the future that are not predictable, including plans. That can give you a sense of what the influence of planning might be—one can turn it on its head and look at it in that way, positively.

Also, just to support what Guy Goodwin said, the elderly population is more predictable in its numbers, both nationally and sub-nationally, because, as he said, they are already alive, so uncertainty about the birth rates does not affect the numbers. They also move around less quickly than those of younger ages. Therefore, the population is more stable.

I may have a chance later to say other things about the relationship between planning and predictions, but I think that we should treat uncertainty not as a sad thing that we wish we did not have, but as a measure of the opportunity to influence population size and distribution.

**Q4 The Chairman:** Thank you. We will come to that.

Before I pass over to Baroness Shephard, will you send us a paper that captures how the academic position has changed and what the current research view is about the uncertainty or variability on the likelihood of us all living longer than we had expected? Clearly, if we suddenly found that we will live another five years longer than expected—whether healthy or not—that will make a big difference.

**Professor Ludi Simpson:** Yes.

**Q5 Baroness Shephard of Northwold:** I noted that Guy Goodwin says that the projections cover 10 and 25 years for reasons of accuracy. I want to ask about the number of people who came from eastern Europe at the beginning of the 2000s—was that predicted? The numbers who came took the public sector, and, in particular, local authorities, absolutely by surprise, although I do not know whether it also took the NHS by surprise. I was an MP at the time, and I know that locally there was no provision for housing, and there was certainly not enough provision for dentistry, medicine, or social services, and definitely not for schooling.

It was a wave—many people then left—but was there any way of predicting the number of migrants? The migrants were much needed in the economy and were made extremely
welcome in many constituencies, including mine, because we knew that we needed help. However, none of the authorities appeared to have noticed that such help was needed or that it would be provided in a way which then caused problems for public service provision.

**Guy Goodwin**: It was not predicted by ONS—we provide projections, rather than predictions. If you envisage that we update our projections every two years with the latest trends so in effect we would have been projecting on the basis of current trends, before the numbers of central and eastern European migrants increased. Of course, as the numbers increase, the projections take account of the change, but they do not act as forecasts and predictions. ONS was not attempting to predict the impact of government or EU changes. We do not play a political role. For example, I do not know what impact a points-based system or cap will have. We are literally rolling forward the current trends as a basis—we leave predictions to others, such as the OBR, about how things will work out in the future.

**Q6 Baroness Shephard of Northwold**: That was going to be my next question. Of course you do not make predictions, but who does?

**Guy Goodwin**: Various parties make predictions. I will ask Ben Humberstone, who may have insights into this to respond, but traditionally—to stick with the OBR—the OBR will consider the number of variants that we produce and it will make a judgment on what it foresees. I know that the OBR has used the lower migration variant in recent work, so it has clearly made a judgment in that respect. In addition, the Treasury and others have used different variants at different times. They are clearly playing a role in predicting and forecasting what might happen to the economy using a range of factors, other than just our projections.

**Q7 Baroness Shephard of Northwold**: So when they come before us, we can ask that question?

**Guy Goodwin**: Yes, you could ask why they used the low migration variant, rather than a different one.

**Q8 Baroness Morgan of Huyton**: I just want to follow on from that. We have had a conversation with the OBR, and my impression is that it did not define its role in the same way that you just have. Arguably, it is seeking to do that, but I do not think that it defines that as its role. It appeared to me that it did not have permission to think beyond the absolute tramlines of current policy, so, like Baroness Shephard, I want to know to whom we go to get predictions, rather than projections. I do not think that that is the OBR.

**Ben Humberstone**: Let me pick up on two points. One is the A8 migration from around 2004. We are much better placed to measure that now with the changes made under the migrations statistics improvement programme. If there are similar future changes, we should pick those up much quicker and that will be reflected in the projections much sooner.

The key point about the alternative views of what the future might look like is picked up with our variant projections, as Guy Goodwin said. The principal projection is the one that we think is the most likely projection of the future, but we also carry out high and low migration variants, and high and low population variants that include high fertility and the fertility driven by the migration. That gives some idea for people who think that our principal projection is a bit low on the migration side, and they can use one of our variant projections. That is not something that we do, but we produce those projections based on expert advice in order to provide some idea of what alternative futures might look like.
Q9 Lord Bichard: Just following on the same point, I am still not clear who we should be looking to for advice. Baroness Shephard referred to people coming to the UK to work as a result of European Union legislative changes. What about people coming here as a result of the eurozone crisis, particularly older people who might find the UK a more attractive place to spend their latter years? Who is picking that up? Is that a prediction or a projection?

Guy Goodwin: What happens is that we would pick that up retrospectively, so you will observe it as it comes through.

Lord Bichard: That is not too difficult.

Guy Goodwin: We would pick it up—for example, through port surveys—as it happens, but we do not predict how changes might change people’s behaviour as a consequence.

Baroness Shephard of Northwold: It is not your job.

Guy Goodwin: We do not see that as part of our job.

Q10 The Chairman: To press the point, who is looking at the impact of current policies or economic fluctuations and what effect those might have on migration or on the wider issue of longevity?

Guy Goodwin: Different people are picking that up. On the economic side, that includes the OBR, the Bank and the Treasury. Implicitly, by using, for example a low migration variant, they are making a judgment on what is the best projection to use in their work. In some ways they are not using the main projection, so the Budget Responsibility Committee is making a judgment to use a particular projection. On the economic side, clearly those discussions are happening. Net migration has been relatively high in recent years, so they make a judgment for their purposes that using the low migration variant is sensible.

Various departments are interested in ageing and longevity, and not surprisingly from the Department of Health to the Department for Work and Pensions. The latter has the departmental lead on those issues—my understanding is that it is the Government’s co-ordinator.

Q11 The Chairman: But the Department for Work and Pensions is not independent of politics, is it? I do not mean that rudely to civil servants, but it will not publish papers that might embarrass Ministers, and therefore it is unlike the OBR and it is not taking a no fear or favour view of the issues?

Guy Goodwin: Clearly, neither ONS nor OBR is in that ball park. Clearly, there are academic studies going on alongside the work that can challenge and look at the issues.

Q12 The Chairman: That has been helpful in exposing the problem, but I am not sure that we have the full answer. If it is not possible, in the time we have available, to give additional detail or witnesses have further thoughts, we would welcome a note as that will help us to get through the questions without missing out the richness of what you have to offer us.

Q13 Lord Tope: We have covered some of my questions already. You have been fairly clear on the difference between prediction and projection. However, in making your projections you also have to make assumptions about the variants. To some extent, those assumptions are predictions. Can you tell us a little bit about who agrees—and how you agree—on what assumptions you are going to make and to what extent, if at all, you take into account current policies even if you are not going to predict future policies?
Guy Goodwin: I will let Suzie Dunsmith come in on that point in a moment. The process that we go through does not include making predictions in the way that you describe. We look at current trends—literally, the recent figures on fertility, mortality and migration. We share that evidence with an expert panel of the leading demographic experts in the UK. Those experts look at the evidence with us. We then roll forward that evidence. There is no element of prediction in there in the sense of saying, “Let us make a judgment on how successful the current Government’s policy on reducing migration numbers will be”. The second we went down that path, we would be in danger of compromising our independence. Obviously, the Government and other users of our data can make judgments about how successful they think such policies will be, but we do not go down that path.

Suzie Dunsmith: As Guy Goodwin says, it is all based on the data and the latest trends. We discuss those with our expert panel—a group of academics who have expertise in each of the demographic areas. When we have set our proposed assumptions, we also consult most of our users—generally, the government departments that deal with pensions and so on—to get their input on whether those projections will meet their needs and on whether they agree with the assumptions based on our past data.

Ben Humberstone: If a policy has already had an impact on the population, it will be factored into the projection. As Guy Goodwin says, what we will not do is try to guess whether a particular policy will be successful, or how successful it will be. Policies such as the current migration limit policy will have a potential impact. That will not have been fed into the latest round of projections, but the impact might be evident in the next round, which will be 2012 based. The short term is very much set on projecting forward what is happening now. The longer term is when we start turning to the expert views, because things are less certain over the longer period. That is where the assumption setting comes in. We would ask the experts questions such as, “Is it reasonable to expect that life expectancy will continue to increase at the current rate?”

Q14 Lord Tope: That is, in a sense, what I meant by predicting. You are not predicting that it will happen, but you are making an assumption that if X happens, this is the projection and if Y happens, that is the projection. Is that right?

Ben Humberstone: I would say that it is more along the lines of asking whether it is reasonable to assume that the current trend that we are projecting will continue into the future. It is not about asking what the impact of policy X, Y or Z will be, but about asking whether current trends will tail off at some point in the future. For example, is it reasonable to expect longevity to keep increasing 100 years into the future, or do we think that there are some limits to that?

Q15 The Chairman: There is an academic controversy about whether longevity will continue to increase or whether it will plateau. Is that right?

Professor Ludi Simpson: Yes, indeed, that is right. At the moment, expectation of life at birth is increasing by something like more than two months every year, which is wonderful news. Whether it can continue to increase is something that academics study and currently disagree about.

Q16 The Chairman: And there is no consensus about that or more weight on one side of the argument or the other?

Professor Ludi Simpson: There is no consensus about what will happen in the very long term. If the trend were to continue in the very long term, we would be talking about
expectations of life well into the 100s—even the 200s. There are biological and
demographic inputs into those arguments that are unresolvable in some ways. In the shorter
term, it is easier. We know that there are unlikely to be very drastic changes in mortality
trends in the shorter term.

_Guy Goodwin:_ That is the key point. If we look at the 10-year projection, it is easy to say
that a 2 million to 2.5 million increase in people aged 65 and over is coming up. We can tell
in that 10-year period that that is right. Even in 50 years, we can tell that the number is
going to double.

Q17  _The Chairman:_ That is helpful. Our focus is on the next 10 to 20 years. We may
take a glimpse at 50 years, but the policy and political debate is about the next 10 to 20
years rather than about the long term.

Q18  _Baroness Shephard of Northwold:_ I have just a brief question, which follows on
from that. Of course you do not predict, but how clear does a trend have to be or how
likely does an event have to be before you can project? You say that nobody could have
predicted what would happen in the EU. Lord Richard went on to give an example about
the clear fallout that there will be from the eurozone problems. When does something that
is happening and being reported become worthy of your attention as something for which
you should produce projections of the implications for public policy?

_Guy Goodwin:_ We produce projections every two years. Migration statistics are collected
on a continuous basis through our international passenger survey. As changes occur, they
get reported. We produce our migration data quarterly, so signs of changes appear
relatively quickly for the Bank of England, the Treasury and other policy makers to see. If
there was a sudden shift in migration, we would start picking that up in our quarterly
reports. It is not a case of waiting for years, as it happens relatively quickly. That data feeds
into the national projections that we do every two years. We do not do projections more
frequently, because in some ways you can cause chaos by doing projections so frequently
that everyone has to keep reworking their models. I think that we probably have the right
balance.

_Professor Ludi Simpson:_ Let me just tackle that question of prediction. The ONS’s work is
based on the recent past—on past trends. In that sense, it includes the existing impact of
past policies and continues that impact forward. It would be wrong to say that there is no
sense of policy within the projections that are made. The ONS also consults with a band of
experts on future demographic rates—fertility, mortality and migration. Those people will
have in mind what is happening at the moment. They will not ignore current policy, but the
great majority—if not all of them—will be very aware of the poor record of forecasting
from current policy and economic change into later demographic change. In that sense, they
will be very conservative in their expectations of the impact of policy and economic change.

If you are looking for predictions in the sense of scenarios, an example would be to ask
what would happen if elderly people from Europe viewed the UK as an attractive place to
come. That is not a prediction of what will happen but a case of what would happen under
that scenario. That is exactly what planners do rather than the ONS. In local terms, that is
what all the local housing planning and housing land release is about—asking what would
happen if we produced less or more housing.

In the same way, the Government would find it useful to have policy-led projections—or
predictions in that sense of scenarios. As you mentioned, it would be important to do it in
such a way that it is not politically driven but science driven—in terms of what is known
about the impact of such policies or such economic changes from past examples. That does not happen at the moment to the extent that it might.

Lord Tope: Professor Simpson has just answered a question that I did not get to ask him and I am very grateful for that.

Q19 Baroness Tyler of Enfield: I should like to pursue a couple of areas which we have already started to talk about—namely, the impact of changes and assumptions and the accuracy of your projections. You have already said clearly the types of assumptions and the key assumptions that you make. It would be helpful if you could expand on the assumptions around longevity and mortality, which I think you said are at the more stable end of the assumptions that you look at. I want to understand what the impact of changes in those assumptions would be on the numbers in the population of those over pensionable age and those over 85, if for some reason those assumptions changed.

Guy Goodwin: I will let Ben come in with the specifics on this but I will give an oversight. If I concentrate on the 10-years ahead period, at the moment we are talking about an increase in the population from just over 62 million now by about just over an extra 5 million. Out of that 5 million increase, we estimate that 2 million to 2.5 million will be in the 65 and over age category. Of that, half a million will be in the over-85 category. If you roll that quite a long way forward to the 50-year mark, you clearly get significant increases in the older ages. That is because you picking up people born in the so-called baby boom years and whatever. Gradually, you are bringing in the bigger cohorts. Over a 50-year period you would be talking about doubling the population aged over 65 and a very substantial—four times or more—increase in the main projection of those aged 85 and over. You really are talking about a quite substantial increase at that end. Most of that is in the population as it currently is. Perhaps Ben can give some specifics.

Ben Humberstone: Yes. If you are thinking about the high and low life expectancy variant projections, the principal projection would give us about 18.9% of the population in 2020 aged 65 and over. We can provide a detailed table with all those figures. The high life expectancy would make that 19% and the low life expectancy would make that 18.7%. We are not talking about massive swings over the period that you are talking about. Clearly, the further you extend the projections, the greater those differences become.

The Chairman: That is very helpful.

Q20 Baroness Tyler of Enfield: That is very helpful and I would find those tables very helpful. The main point I have taken from that is that, within the timeframe we are focusing on, there is some degree of stability in these projections.

Ben Humberstone: That is a fair point.

Q21 Baroness Tyler of Enfield: Unless any other colleagues want to come in on that specific point, I will move to the accuracy of some of your projections in the short term. First, how accurate did the 2008-based projections turn out to be when compared with your most recent update, your mid-year estimates?

Guy Goodwin: Ben, could you pick up on this?

Ben Humberstone: Yes. It is an interesting time to be asking this question because, clearly, we have the results of the 2011 census coming out on 16 July, which will give us further insight into that and into how accurate the 2010-based projections were. The difference between our 2008-based projection for 2010 and the 2010 mid-year estimate is about
40,000. It is within 0.1%. So, as Guy says, within a two-year gap, the population is very much based on the current trend within a year, two years or five years. The accuracy will tail off as you extend the projection forward.

**Q22 Baroness Tyler of Enfield:** Would that be within the range that would have been expected in that timeframe?

**Ben Humberstone:** That is quite good: we are quite pleased with that. Yes, it is within the boundary that we would expect. We have been closer and we have been further away.

**Guy Goodwin:** In general, there was a fairly extensive study done of the accuracy of the projections, which I understand looked over a 50-year period. But the five-year projections are pretty good. If there are any issues, they tend to be right at the bottom end and the top end, and of course the migration element. In general, they are pretty favourable at that level.

**Q23 Baroness Tyler of Enfield:** Okay, that is extremely helpful. Finally, I want to move to when we are reaching further out. Again, we have already touched on that point as regards the difference between the work that you do and the OBR. In looking at what we have looked at already, we have seen the OBR projections showing the proportion of the UK population aged 65 and over reaching 26% by 2061, and your table showing that this will happen a good number of years earlier. Could you just tease out the reasons for this difference a bit more? We have started to talk about that.

**Guy Goodwin:** I will bring Ben in again in a moment if he wishes. When you quote the percentage of the population or when people talk about what they term as older-age support ratios and so on, the key point is that when the percentages vary, people assume that it is the numerator that is varying—namely, the number of people in those older ages—but of course in general it is the denominator that is varying; that is, the number in the population or the number of working ages. That is much more dependent on some of the more uncertain elements, such as migration and fertility rates and so on. It is the bottom bit that tends to vary rather than the top. Ben, do you want to add anything?

**Ben Humberstone:** No, you explained that quite well. Yes, migration is the area where we have the greatest uncertainty in terms of projections. We have very good registration systems for births and deaths. It is relatively stable and we can project forward. Migration is the area that is more uncertain. We rely on a survey conducted at ports to get our statistics, which we then project forward. So when other departments use our low migration variant, that creates a bit more variation in what they are covering.

**Q24 Baroness Tyler of Enfield:** Finally, on a slightly less technical question, accepting that you have a different remit from the OBR, which you have clearly thought out, do you talk to each other and compare notes on the different approaches you are taking and the different answers and implications that you might be drawing out?

**Guy Goodwin:** We have good relations with the OBR and there is that ongoing conversation. We have those discussions about whether it wishes, for example, to have specific projections run. We can run specific ones. We have run them for the Home Office and the UK Border Agency and they are all made public. We have had those discussions with the OBR and we have good relations.

**Baroness Tyler of Enfield:** Thank you very much.

**Q25 Lord Touhig:** When Robert Chote came to see us, he said that the OBR says that the population aged 65-plus will be 20% of the population in 2061. You put it at a quarter of
Guy Goodwin: We can provide the figures for you. My understanding is that the OBR uses a low migration variant. If you use a lower migration variant, you reduce the denominator, the numbers of people in the working-age population. It is using our variant—it is not a different variant—but it is just not using the main variant. It is assuming a variant that assumes migration is lower than if we just pushed forward on current trends. By doing that, you get a lower working-age population. Therefore, you reach the 26% at a different time span because, effectively, you have a lower total population. I think that it is in line.

Ben Humberstone: Yes, it is important to note that the OBR is using one of our projections but it is our low migration variant projection. It is not that it has come up with its own or that it does not agree with ours. Picking up on a previous question, we work very closely with it to make sure that what we produce meet its requirements as one of our key users.

Guy Goodwin: Varying the uncertain bit—the migration—therefore, the 26% comes because the older population stays the same but the working-age population reduces. Therefore the percentage is higher. That is the driver for it.

Q26 Lord Touhig: In terms of building blocks, as you do these projections throughout the United Kingdom, I assume that there are building blocks—regions, sub-regions and so on. I just wonder how small these building blocks are. Perhaps I may give an example: in my former constituency in south Wales, in 1993, a report was produced that showed that 15% of the population was aged 65 plus and by 2026 more than half the population would be over 65. If that is the case, it would affect the impact and demand for services. Can you tell me what sort of building blocks you use to get the overall United Kingdom picture?

Guy Goodwin: We produce subnational population projections. They are at the local authority level. We do not go below local authority level. We do small area population estimates but, with the uncertainty involved, we do not roll those forward. But we do local authority ones, which we present to the local authorities. We have a specific ageing tool where they can see how the population ages looking forward for any local authority. You can pick that up as a public tool and use it for your local authority and so on. That is the level. We do not do projections on parliamentary constituencies or some of the other geographies at the moment.

Q27 Lord Touhig: It just happened to be that the borough and the parliamentary boundaries were coterminous. So the building block to give the overall United Kingdom picture is based on each local authority area. Is that how it is worked?

Guy Goodwin: No, we work in a different way. Do you want to explain?

Ben Humberstone: We do it the other way around. We start with the national population projection and then work out the subnational, which is constrained to that national population projection. The reason for that is that the most difficult part of the projections is the migration. You can only really accurately measure the migration at the national level. That gives us the total that we then use to constrain the subnational or the local authority level population projections as we go forward.
Q28 **Lord Touhig:** In your paper, Population Ageing in the United Kingdom, its constituent countries and the European Union, of March 2012, you state: “Wales has a more aged population than England. Part of the reason is that younger people have tended to migrate out of Wales”. My perception is that that is not very great these days. I am possibly wrong if you have come up with this. But that will impact on the services that will have to be provided because some of these services are now devolved to the various nations and regions of the United Kingdom. What current information do you have that young people are moving and that it is having such an impact that you decided to note it as making the Welsh population much more aged because young people are moving out?

**Guy Goodwin:** For our internal migration estimates of people moving within the UK, we look at GP data, where people are registered and where they re-register. That is the main way in which we still judge internal migration. Literally, we look at how many people are registered with a GP in one particular place—in your example, in Wales—and where they re-register. So you get movements in that sort of shape. That is where we base it in our projections.

Q29 **Lord Touhig:** On one final point, if I may, Robert Chote also told us that we can be certain about age structure because people are already born, to which I think Professor Simpson alluded in one of his responses earlier. That is fine and I can accept that. But we have considerable regional variations as people die. In my part of the world because of, for example, chest diseases, life expectancy is not as great. How would you take account of that subregional variation to give us the overall national picture?

**Guy Goodwin:** I will bring Suzie or Ben in on that in a moment. We have detailed data at the local authority level on deaths, life expectancy and so on. Do you want to say a little on that?

**Suzie Dunsmith:** As has been said, we produce the national population projections for the UK and the constituent countries. Then we produce the subnational projections for England. Each of the devolved Administrations produces its own subnational projections. In terms of the international migration and the cross-border flows, like Guy said, we use the health records data and we consult with the devolved Administrations to agree on the cross-border flows between each of the countries. For the England subnational projections, we look at the local fertility and mortality rates. We then apply these and it all gets constrained to the England national figure.

**Guy Goodwin:** This is the important point. We are not just pushing it out, we are taking in the individual local authority.

Q30 **The Chairman:** Professor Simpson, do you want to come in on that?

**Professor Ludi Simpson:** No.

Q31 **Baroness Morgan of Huyton:** I should like to probe a little further on this. It sounds to me that you are saying that at the national level you are confident, but that it is much more patchy at the local authority level. Is that a fair assessment of what you are saying? We are interested in services, particularly looking at an increasing number of elderly in the population. I mean, the most dramatic miscalculation, arguably, in recent years has been the number of five-year-olds trying to go to school without school places. What is the dialogue that happens between yourselves and the local level that has meant that there has been such a miscalculation of that group? What conclusions should we draw about the older population going forward.
Guy Goodwin: I will let Ben come in on this a moment. The dialogue with local government in my view is good. I think that you might be overstating somewhat the situation. We have a good degree of confidence in the local level estimates. Clearly, when we get the census we will do those sorts of reconciliations again. Clearly, as you get down to local level, the uncertainties inevitably in some places will rise. We know where those main uncertainties arise from. They are areas where there is a huge amount of mobility, both in and out—not in terms of just international migrants but internal migrants where there are lots of students and so on. A lot of work has gone in to get those as tight as possible with local authorities. Ben mentioned earlier the migration stats improvement programme that has been geared towards doing that. But, inevitably, for some local authorities with huge churn, it is more unpredictable than those local authorities that are very stable. There is a greater element of uncertainty than if you are dealing with it at the national level. Do you want to add anything?

Ben Humberstone: Yes, as regards the population estimates that we carry out, as Guy said, some areas are more difficult to estimate than others; for example, areas of high population churn, high net migration, students and special populations and so on. Essentially, we benchmark those population estimates every 10 years using the census. So the population estimates for a local area—this is a grossly oversimplified view—will take account of the census base, will age the population forward, and will take into account births and deaths, international migration, internal migration.

The further forward you move from the census base, the more scope there is for uncertainty and the more uncertain the projections are likely to be. Hence, the 2010 base is as far away from a census as you can possibly get and we are looking forward to the results of the 2011 census coming out so that we can produce the next set and go back to that accurate base that we need to roll forward.

Guy Goodwin: But we do not hide from the fact that these are estimates. That is important. We look at administrative sources and reconcile. We have engaged with local government and local authorities, and looked at ways in which we can improve within the framework that we have got. But there will always be estimates and there will always be greater uncertainty in some areas, for example, in London, and wherever there is high churn and high turnover.

The Chairman: We cannot deal with this now, but we have mostly looked at data at the national level and, to a lesser extent, at the various component nations of the United Kingdom. I would like, and others might as well, a paper from you showing what we know now about the population aged 65 plus and 85 plus in various local authorities, so that we have got a picture of the variability, which I imagine is enormous.

Guy Goodwin: Yes. We have information in the public domain on that.

The Chairman: That obviously is highly relevant to the cost consequences and how central and local government work together. Secondly, could you provide something about what you know and how you try to assess, to use a neutral work, the variability of that going forward. If it is all pretty stable, it is an easier problem to deal with than if, clearly, an area of the country may suddenly have very large numbers of additional elderly people. Both of those are bedevilled by your denominator problem, of course, because you have to use ratios and the denominator fluctuates as well. Would that be possible?

Guy Goodwin: Yes. We have information in the public domain on that.

The Chairman: Thank you very much. We do not need to come back to that later.
Professor Ludi Simpson: I am happy to respond to the question about children and schools.

The Chairman: I do not think so particularly.

Baroness Morgan of Huyton: It would interesting if you could send us some information on that.

The Chairman: Why?

Baroness Morgan of Huyton: I think that it is symptomatic of an issue.

The Chairman: It is interesting in terms of understanding how the Government got it wrong and what we might reflect on from that.

Q32 Lord Griffiths of Fforestfach: This question is based on ignorance. Let us assume that you produce a projection of people who will receive state pension in, say, 15 years’ time. How much confidence should I have in the number and what would be the distribution around that? Can I have 99% confidence in it or 95% confidence or what?

Guy Goodwin: We can give you some specific background on the confidence you can have. But you should have good confidence over that sort of period. Over 10 or 15 years, you should have pretty good confidence because people are in the population currently. If there are policy changes, of course, we rework it but you should have good confidence about that.

The Chairman: Very helpful.

Q33 Baroness Blackstone: I want to ask a couple of questions about birth rates and then move on to our international position in relation to populations over the age of 65. On birth rates, it is now said that natural growth plays a bigger part in our current population increase than net migration because we have suddenly seen a bit of a baby boom. How long do you expect that to last?

Guy Goodwin: I will bring Ben in on this one. It occurs to me that one area of uncertainty, which we mentioned earlier, is what is going on in terms of fertility rates. Indeed, at the European population conference in June, it was a very hot topic of debate. As you rightly pointed out earlier, it is not just this country. A lot is being observed and analysed by academics and others on what is going on across various countries. People are looking at some of the increases in fertility rates in Scandinavian countries and observing, as these are broken down, some of the patterns. For example, in the more professional groups women are choosing, and it is looking more fashionable, to have three children. Therefore, there is an increase in the numbers of births that you would expect. So lots of different things are happening in fertility rates. Some of the obvious ones are recent changes in migration. Although we say that the biggest impact on change is natural change, by that we are talking about births and deaths. Then we look at migration separately. But, clearly, migrants who have become residents here are contributing to the fertility increases as well potentially. We have some figures on that that we can give you. In addition, in UK-born mums who are not recent migrants, you are seeing increases in fertility. It is quite a complicated picture. The message coming out of the conference and generally is that there is a bit of wait-and-see on this in terms of where this is heading. It is a genuinely uncertain area. Ben, do you want to add anything?

Ben Humberstone: As Guy says, two things affect the number of births. One is the fertility rate and the other is the number of women of child-bearing age in the population. The
former part is affected in part by women moving to the UK from other places with higher fertility rates and bringing those fertility rates with them. That is partly what is driving the fertility rate in the UK at the moment but it is mainly an increase in the fertility rate for UK-born women.

On the latter part, an increase in the number of births because of the increased number of women of child-bearing age in the population as a result of migration clearly impacts on what we think is affecting the population change in the future. So you were right to quote that it is about half and half net migration and natural change. If you take network migration out or if you look into the impact of net migration on the number of births and its effect on natural change, you get to a position where about two-thirds of the projected growth is as a result of migration that is specifically increasing the number of women having babies in this country.

Q34 Baroness Blackstone: Over what period has that two-thirds increase been due to net migration because of a higher birth rate among the migrant population? Are we talking about over 10 years or 25 years?

Suzie Dunsmith: Twenty five years.

Ben Humberstone: It would be a 25-year projection.

Baroness Blackstone: It will be about two-thirds.

Guy Goodwin: But I should really stress again the uncertainty around this because some experts at this conference were saying, “We will probably see fertility rates go back on their downward trend at some stage”, right to the other extreme, where, because of gender equity and other issues, you see it going up quite significantly where people are making active choices to have more children and so on. You are getting quite different messages, so there is a level of uncertainty around that.

Q35 Baroness Blackstone: If I can come in again, there must also be a level of uncertainty about the speed with which the migrant population adjusts its own birth rates to something more like the existing UK population.

Ben Humberstone: Yes, that is right and in the short term our projections reflect that. At the moment, the total fertility rate is about 1.98. We expect that to rise a bit in the short-term to just a fraction over 2. But in the long run we expect that to start falling again, as Guy says, to about 1.84, I think.

Guy Goodwin: But the jury is out on that one as well. Again, at the European population conference, some academics were showing examples of where, if you broke down recent migrants, some could be categorised into having no children effectively and making choices of not having children, others were very much more up to looking to the countries that they have come from and to have similar fertility rates. There is quite a mixed bag. So it is a difficult area.

Q36 Baroness Blackstone: Coming to the over-65s, which is the core interest of this Committee, we have been given some figures that in 1985 the UK was second only to Sweden in the proportion of its population aged over 65. By 2010, we had fallen to 17th in the EU. Apparently, we are projected to fall to 23rd by 2035, which is a long way ahead. Can you elaborate a little on that and tell us why you think we are now in a very different position in relation to our European neighbours?
Guy Goodwin: I will give a general response and Ben and Suzie can come in. Again, when you are talking about proportions of the population, you have to remember the two elements of it. One element is how many older people you have in the population who are over a particular age. The other is how many people you have in the population as a whole. If you are seeing expansion in terms of increases in migration and so on, you are affecting the bottom bit of the proportion. So your proportion is coming down. It does not necessarily depend on the top bit. So how you are shaping compared with other European countries, in that sense, depends not just on how many older people you have got and the rate at which you are ageing but also on how many people you have in the country. I suspect that what is happening is that that bottom bit is affecting that rating as well.

Suzie Dunsmith: That is absolutely right. It is to do with the recent trends in fertility. Over the past 10 years, the UK has aged less rapidly than in a lot of European countries. One of the contributing factors to that is the relatively high fertility rates in the UK compared with some of the central, southern and eastern European countries.

Q37 The Chairman: That is very good. For some of this, we are finding it easier to get our heads around and, more importantly, our audience might if we talk in absolute numbers rather than proportions. By which I mean, being able to say, “This is what we think is the likely number of older people aged 85 plus or 95 plus who will be with us in 10 years’ time, 15 years’ time and 20 year’s time”. That is not bedevilled by the denominator problem, which, particularly for some of the higher level figures, can look pretty scary, or exciting, depending on your point of view.

Guy Goodwin: You will notice that when I introduced the numbers I was talking in the context of 5 million extra people, of whom 2 million to 2.5 million will be over the age of 65 and half a million of those will be over the age of 85. That just gives you a feel for the scale of the issue that we have got. I did not use proportions. However, people use proportions because they are looking in many ways at the capability of being able to afford—

Q38 The Chairman: We want to get our heads around both, do we not? Sorry to give you work, but could you send us a note of what the absolute numbers look like for the next few years, so that we can get our head around that story?

Guy Goodwin: We will give you a table.

Q39 Baroness Blackstone: It would also be helpful to understand slightly better whether any of this shifting of our position in the league tables is due to a different situation in the UK in relation to ageing than in our European neighbours—Scandinavia, France, Germany, Spain and Italy.

Guy Goodwin: Yes, I think we either have a note or can do one. There is a difference in that we are ageing slightly at a different rate. So we can provide that.

Baroness Blackstone: It looks as if we are. It cannot all be about birth rates.

Q40 The Chairman: Do we know why?

Guy Goodwin: I do not know offhand. I know that there is a paper on it.

Professor Ludi Simpson: It is partly that the reduction in the birth rate happened earlier in the UK than in other European countries. So it is simply that they are catching up. If you look at Sweden, which was top in 1985, I am sure that you will find that is not top now for the same reason.
Q41 **The Chairman:** Thank you. Does anyone else want to come in on Tessa’s questioning or shall we move on to Baroness Finlay?

Q42 **Baroness Finlay of Llandaff:** Thank you Lord Chairman. I want to ask about life expectancy in particular and whether it is correct that life expectancy per se is increasing faster than healthy life expectancy or disability-free life expectancy, and whether there is a gap and how it is widening. I will want to explore that further as well, so, in answering, you might consider how you are defining and getting data on disability-free life expectancy, or health versus unhealth, in that population you are looking at.

**Guy Goodwin:** There is some smashing work and articles on this and we can probably send you something which is a very good summary of this, including how we calculate, the definitions and so on. We will do that. As a broad answer, clearly life expectancy is increasing. Within that, if I can refer to an average person—but you know that there is not such a thing—typically he or she will live not just longer but longer in good health but also longer in poor health, as a consequence of this. In an ideal scenario, people say what you would ideally like to see is the percentage increase in healthy life expectancy or disability-free life expectancy to be going up more than the percentage, or at the minimum the same, as the percentage increase in life expectancy. Ideally, you want to live in good health for preferably longer. The figures at the moment traditionally have not been particularly encouraging in that sense. The latest figures we have, which are done over a five-year period, suggest that the healthy life expectancy for women is broadly increasing at the same rate as life expectancy. But the healthy life expectancy of men is increasing at a lower percentage increase than life expectancy, which is a cause for concern. I do not know if we can give the exact figures.

**Ben Humberstone:** We do not have the exact figures that you were just talking about but we can provide the summary and the tables which indicate the position exactly.

**Guy Goodwin:** There is an element in there of concern that it is not the reverse way around. Our experts say that these figures are still quite uncertain. Looking ahead, you may see some shifts.

Q43 **Baroness Finlay of Llandaff:** In your projections, how much do you take into account the changing pattern of disease and disease management? One of the thoughts in the disease arena—breast cancer 20 years ago—had a completely different prognosis from today where it is, by and large, a chronic illness. But we are seeing earlier diagnosis and a lower age of diagnosis, so those women who are surviving will almost inevitably have less completely healthy life expectancy and will have longer when they are in some form of treatment or surveillance and so on. How much do you model for advances on medical science that may be on the horizon, so involving horizon scanning? How much do you look at things such as obesity, which are at epidemic proportions and known to adversely affect all aspects of health, not only in developing different diseases but in developing chronic disability and decreased ability to function? How much do you project and model around potential epidemics and things such as the projections around the pandemic flu that happened? In the reports from the last time around using the last lot of flu data, there may have been quite a gross underestimate. There have been changes in society as well, such as the decrease in smoking.

**Guy Goodwin:** There are lots of questions there. If I do not cover them all, come back to me. We have detailed information on cause of death. We do the processing of the cause-of-death data. So, to a degree, we have detailed figures and past figures on those. When we get
to the projections looking ahead, clearly, as things change, by doing the projections every two years we pick up recent developments in any mortality shifts. Then the expert panel clearly advises us on things that might affect life expectancy and mortality. It is done in quite a generic way, so are we trying to predict and forecast the effect of obesity on mortality looking further ahead and building that in the projection? It is a very difficult area. In a generic sense they may be advising us to look at these and to take a cautious approach, and not just assume that these rates will continue for ever. But it is done at that generic level and not really getting into detailed modelling to underpin the projections.

On epidemics, as regards the pan-flu, clearly we produced data on the cause of death. Along with the then Health Protection Agency, the General Register Office and so on, we made sure that data exchanges happened on the numbers in the short term. But, again, projecting how these things would impact on the projections is exceptionally difficult, so we did not build that into the projection base.

**Q44 Baroness Finlay of Llandaff:** Within your projections in the population groups, do you have sub-groups? I am thinking particularly of children and children with disability. We now see children surviving the neonatal period who previously would not have survived, although they often survive with quite severe disabilities. Therefore, their care requirements in the population will be significant, and will be significant for many years. We are also seeing their life expectancy extend, which again has been quite dramatic. So for conditions from which children would have died in their teens, they are now living into their 20s, 30s or even 40s.

**Guy Goodwin:** Projections are done in enough detail, looking at the various individual ages and so on, to make sure that as we are looking at the recent past, we will pick up those improvements as they happen. We are not looking at particular ages and making projections at that level of granularity about what will happen. You will be picking up in a generic sense rather than projecting by these individual ages.

**Q45 Baroness Finlay of Llandaff:** Can I pursue this a little more? With the data you have now, which is current data, are you also looking back at trends that have happened within that granularity? If we take disability among children as an example, are you producing reports and questioning as to why that has happened already?

**Guy Goodwin:** I think the honest answer is to a very limited degree. We would do some research but I do not think that we have as regards the example you have given.

**Q46 Baroness Finlay of Llandaff:** So would that be more into the community-paediatrics type of areas.

**Guy Goodwin:** Yes.

**Ben Humberstone:** But we do look into mortality and morbidity associated with the types of things that you are talking about. One of the debates you touched on that we had with the expert panel was around obesity. The argument was that, at the moment, in the sense that the experts could agree, obesity would have an impact on morbidity but not necessarily an impact on mortality.

Quite a lot of the stuff that we do around life expectancy projections and assumptions around life expectancy is based on reductions in stroke and cardiac disease and all those sorts of things, and things from which people are surviving that previously they would not have done.
**Q47 Baroness Finlay of Llandaff:** If I can pick up on something that came up earlier, you said that you are picking up trends in population movements based on GP registration data.

**Guy Goodwin:** You mean the internal moves.

**Baroness Finlay of Llandaff:** Yes, the internal moves around the country. Given the move to change the way in which people can register with GPs so that they can be registered near work rather than near home, how have you considered that for the future and what are you going to do to future-proof your data? It may appear that you have massive population shifts, particularly from somewhere like the valleys where many people will travel into the cities—Cardiff and Swansea being the two particular ones—and may well, for convenience, register with a GP who they can see at the end of work, before work or in the lunch time because they cannot get home to see their GP. So you may have a misrepresentation because it might look as if the whole working population more or less has moved. You may find that, as several people do that, more and more people would do that.

**Guy Goodwin:** It is a risk and it is a risk generally with using administrative sources. I know that we are doing quite a lot of work in looking at the future of the traditional census and whether we can do alternatives based on reusing existing data. Every time you look at using administrative sources, of course there is a risk that they can be changed or be eliminated in some cases and so on. Clearly, if there is a discontinuity, there are things that you can do, such as modelling or other things in the short term, or you can look for alternative sources.

I know that with our migration programme, we have been looking at contingency plans on what happens if some of the administrative sources do change or shift, and how we would continue to use some of the modelling we use at the moment. It is a difficult area.

**The Chairman:** Thank you.

**Professor Ludi Simpson:** It is important to know that the internal migration statistics are based on the home address and not the doctor’s address. So that particular change should have no impact.

**The Chairman:** That is what I assumed. It would be daft not to.

**Q48 Baroness Morgan of Huyton:** I may be asking a simple question and it may be that others know the answer but I am afraid that I do not. What do we mean by a healthy life? In a sense, that is fundamental to our inquiry and I do not know what definition you are using to define a healthy life. Is someone on long-term statins healthy? Or is a healthy person someone who is not on anything or someone with dementia who is not receiving treatment?

**Guy Goodwin:** There is a paper which defines it very well. Unfortunately, I do not have it in my head but we can certainly supply it. I do not know if anyone else knows the precise definition.

**The Chairman:** We all have a strong personal interest in this.

**Q49 Lord Bichard:** You dropped in one of your answer a few minutes ago something that could be quite important to us and I should like to give you a chance to elaborate. You said that many of us men are clinging on to life rather than experiencing a good quality of life. Why is there this gender difference?
Guy Goodwin: That is a good question and I do not have an immediate answer. We have a paper that describes some of these things which we will supply to you.

Lord Bichard: In no way am I being critical, but I am surprised that you do not have an answer because it really is quite important in terms of knowing what you might be able to do about it and how expensive it is.

Guy Goodwin: I do not have it at the top of my head unfortunately.

The Chairman: Lord Bichard, over to you on old age support ratios.

Q50 Lord Bichard: I have a couple of questions on old age support ratios, which I was delegated to ask you, although I think that I know the answer to at least one of them. I will none the less ask it so that you can get it on the record. We have talked a lot about increasing numbers of older people, but the old age support ratio diminishes only slightly. It goes from 3.2 now to 2.9 in 2035. I am assuming the answer to that is related to the number of people who, as a result of increased fertility and migration, are under the state pension age. Am I right in thinking that?

Guy Goodwin: Yes, I think.

Ben Humberstone: Yes.

Guy Goodwin: I thought we were about to give you some exact figures.

Q51 Lord Bichard: I just wanted to be sure that I have been awake. So I got that one right. But there are also some large differences—again, some of the reasons for this are probably obvious but I should like to hear you just talk about it—in the old age support ratio in different areas. It goes from under 2 in some areas where there is a high proportion of retired people up to 7 in inner city areas. As I say, I can imagine some of the reasons for that. But could you talk a little bit about that because those differences get larger over time, up to 2035. What are the driving factors?

Guy Goodwin: There will be considerable variations in different areas of the country: for example, somewhere on the south coast where there may be very high levels of people aged 65 and over compared with the working population would be different to some areas in London where you may have vast numbers of younger working-age people compared with old people. Really, that is just embedded by different areas. Of course, it changes over time as different cohorts go through. As the larger cohorts—there were larger cohorts after the war, the baby boomer cohorts and so on—feed into the top line and they become over 65, there are some shifts in particular areas. There is bound to be that variation. The ageing tool developed for local authorities brings out those sorts of variations.

Q52 Lord Bichard: So can we say that economically active areas attract economically active people and vice versa?

Guy Goodwin: Yes, I think we know that with internal migration and so on. If you look at London, people stay until a particular age often, which is generalising to a degree, and then might move to the south-east or the countryside and so on.

Ben Humberstone: It can be impacted very much by what we refer to as special populations, such as students. Oxford and Cambridge are good examples of where a very high proportion of the population is students of working age. Those sorts of things can have an impact.
Office for National Statistics and Professor Ludi Simpson, University of Manchester—Oral evidence (QQ 1–55)

Q53 Lord Bichard: I am not sure where this question will take me. I am just thinking aloud really. We have often been told that technology will mean that people will not move into areas of concentrated economic activity and that they can work from a distance. That has happened a bit although not as much as was predicted. If that did begin to happen, might we imagine that that could change this difference?

Guy Goodwin: I think that it could. If you went back, say, 10 years, we were probably saying then that it really could change dramatically. As you say, it has probably changed slightly but not as much as we might have guessed 10 years ago, or I might have guessed.

Professor Ludi Simpson: On that same point, for the past 50 years in Britain, there has been a trend from the cities to less urban areas both for residence and work but also because of larger distance commuting. The impact of that is to increase that divide. There are more areas with more older people and areas with fewer older people. I think that that is behind the trend. Whether that will continue for a short time, a long time or for ever, it is hard to predict but I am sure that it will continue for some time, partly because those who are able to work from home or are telecommuting in some way tend to be older and further into their careers.

The Chairman: Thank you.

Q54 Lord Griffiths of Fforestfach: I want to ask a question about the definition of poverty, particularly the problem of relative poverty and absolute poverty. If you define poverty as income below a certain percentage of median income of the population and median income rises, clearly, absolute income has risen but the number of people living in poverty will also have risen. Would you comment on that and say if you use other approaches for thinking about and for measuring poverty?

Guy Goodwin: The main measure of poverty, the main indicator, as you say, is using a relative measure based on the median. That is still the same measure. Other measures of poverty are typically used. There can be some sort of absolute measure if users and stakeholders agree a particular level. So you can say that a proportion of the population is below a particular level of income or whatever. That has not been used widely, relatively surprisingly, in this country. Part of that will be because of difficulties in agreeing on what is a reasonable level. But you can vary that level.

You can also look at measures of material deprivation. There are household surveys on everything from wealth and assets to income, and you can put together various measures and look at it in a more rounded picture of that sort. Those are the main measures but in the UK my understanding is that we have concentrated largely on that relative median measure and still do.

Q55 The Chairman: Thank you. Is there anything further on poverty. That is absolutely brilliant timing. You have got us to 12 o’clock, which is what we had thought. We have asked a lot and you have been extremely helpful on clarifying the issues. Thank you for agreeing to send all the supplementary papers. That will be very helpful.

If in the course of our work, as I suspect we will, we find that we need further information or some interpretation, can we come to you and Professor Simpson to see if you can help us with what you already know or have got? Would that be possible?

Guy Goodwin: Yes, of course.
The Chairman: That is most helpful. On behalf of the Committee, thank you very much indeed for coming. It has been most interesting.
Older People’s Commissioner for Wales—Written evidence

Introduction

The Older People’s Commissioner for Wales has four general statutory functions:
(a) to promote awareness of the interests of older people in Wales and of the need to
safeguard those interests;
(b) to promote the provision of opportunities for, and the elimination of discrimination
against, older people in Wales;
(c) to encourage best practice in the treatment of older people in Wales; and
(d) to keep under review the adequacy and effectiveness of law affecting older people in
Wales.1

The Commissioner is an independent advocate for older people in Wales. This response to
the Consultation is in accordance with the Commissioner’s general statutory functions.

1. Does our culture about age and its onset need to change, and if so, how?
1.1 Extending life expectancy and increasing the years one spends in good health should be
matters for celebration and yet increasing numbers of older people is viewed as a crisis by
some. This approach has an impact on the actions of commentators and service planners,
The challenges ahead call for a more balanced discourse led by politicians and
key social commentators and the media itself. The discourse must also take place in
local communities where key decisions are being undertaken on services affecting older
people. Older people and people approaching older age must be part of the debate including
older people whose voices are seldom heard and seldom listened to.

1.2 Stereotypes of older people and ageing abound where older people are portrayed at
either end of a spectrum between active citizens undertaking extraordinary one-off acts and
passive recipients of services. This indicates a similar approach to how society often views
disabled people. The disability movement has developed a social model to view impairments
and to challenge an over-medicalised approach. Developing a social model around
aging would be equally beneficial. The whole of society needs to be inclusive of older
people, aware of their immense contribution, and adapt itself to address the diverse and
varying requirements so that people can enjoy an active older age.

1.3 The language used about age and ageing needs to be transformed. Rather than viewing
older people as a burden and ageing as an insurmountable problem, the debate needs to
focus on the often untapped assets that older people present and the pivotal roles they
carry out as employers and employees, as carers for members of all generations, as family
members, and as volunteers. The danger of an overly negative approach to ageing is that it
can prove a self-fulfilling prophecy. Older people increasingly believe the incorrect rhetoric
that views them as a burden, and concentrates on their disabilities rather than their abilities.
This in turn can lead to the lowering of self-esteem amongst some older people The
Commission has been interviewing older people about the positives and negatives about
growing older and were struck by the numbers who saw no merits in ageing despite the fact
that many of those interviewed are utilising time to pursue hobbies, undertake volunteering
and spend more time with family members post retirement. Changing cultures should

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also involve challenging older people and how they view aging. Most of those interviewed about aging consider older age as being at least ten years older than them.

1.4 It is important not to view older people as a homogenous group. The reality is that older people are now more diverse than ever before but inequality between older people is increasing apace with gaps appearing between the 'haves' and 'have nots'. There is a wealth of diversity in the UK and we should learn from how non-western cultures look upon aging especially in terms of how some cultures celebrate the wisdom of many of its elders and utilise this to best effect.

1.5 Aging is not a matter of chronology – it relates to circumstances and functional loss with significant variation between localities on how people age. The preoccupation with age thresholds in the UK is thankfully weakening with the abolition of the default retirement age. Outlawing age discrimination in goods and services should also lead to the removal of unjustified or unfair age thresholds for health screening processes and financial products. Older people are not a group apart from society. Older people are our grandparents, parents, friends, and neighbours, and ourselves either now or in the future. Bearing this in mind tends to lead to a more honest appraisal of lives and aspirations of older people in all their diversity.

1.6 A shift in culture must improve the voice, choice, and control that older people have over all services that impact on them now and in the future. Older people must be engaged in designing, monitoring, and evaluating services that impact on them.

1.7 Whilst ageing is an inevitability, years spent in good health can be increased and improvements undertaken. 75% of the factors determining how an individual's age relate to one's environment rather than genetics. This is precisely why ageing well strategies are so critical.

The Older People’s Commission is pleased to host the Ageing Well Wales Partnership. Ageing Well is a partnership programme for collaborative action that will take forward targeted action on the physical environment within communities and action to promote the benefits to health and well being of people’s surroundings and homes. The programme will champion further action on prevention specifically preparing future environments and attitudes for ageing well. It will also promote opportunities for the over 50 – 65 population who require more support to retain optimum levels of health and wellbeing in the future as they age and the impact of demographic change specifically with regard to work, pensions and opportunities for civic engagement become a reality for an increasing number of people in this age range.
An important element of the programme is to make a specific contribution to redressing the growing inequalities across Wales so that as people age with more years free from disability and ill health that we add "life to years not only years to life.

2. Do our expectations and attitudes about work, savings, retirement, and independence need to change, and if so, how?
2.1 Attitudes to work and economic activity are inevitably changing. The welcome abolition of the default retirement age must be accompanied by growing awareness of age discrimination in the workplace. This continues to be a significant issue despite being
outlawed in 2006. **The UK Government should redouble its awareness raising efforts on countering age discrimination in the workplace.**

2.2 Distinctions are emerging between those who want to work on beyond state pension age and those forced to contemplate doing so due to their financial circumstances. We should aim to approach employment, the winding down of economic activity, and increasing levels of social activities as a consequence as a continuum. **More creative thinking is required from employers on how to approach the continuum.** Greater embrace of flexible working is required for older workers caring for parents or wishing to increase their volunteering activities whilst remaining in work.

2.3 **Particular focus is needed on those that are disproportionately affected by an increase in the state pension age** including people undertaking manual work in small companies where opportunities to diversify are scarce, women in particular who have undertaken caring responsibilities during their working lives, those on low incomes, and those ceasing to be economically active through ill health. All these groups are disproportionately represented in the Welsh workforce.

2.4 Many older people are struggling financially. One in six older people in Wales live in poverty and this is not acceptable. Spiralling food, fuel, and care bills are difficult to deal with for those on low and modest fixed incomes. Debt levels are increasing significantly amongst older people especially those entering older age at present and in the immediate future. Older people who have lived comparably frugal lives tell the Commission of their disillusionment as they receive comparable levels of social care to those that have never saved and are asking themselves whether making sacrifices to save have proved worthwhile. Many increasingly see assets dwindling to cover care costs. Low interest rates have led to diminishing returns on savings.

2.5 Action is urgently needed to incentivise saving amongst all generations. **Implementing a sustainable, transparent, and fair system of social care funding must be an urgent priority with the adoption of the caps proposed by the Dilnot Commission.** This may encourage people of all generations to save in the knowledge that doing so at an earlier stage may protect future assets.

2.6 In each of the last two years OPCW and Citizens Advice Bureaux in Wales have been scrutinising contacts by those aged 60 or over. There is a trend of increasing debt levels amongst people entering older age, and prospects for saving are poor. Commitments to increase the basic state pension will be especially important to older people facing increasing debt, and public services need to demonstrate a continuing commitment to fund debt counselling services.

2.7 More older people are expressing a preference to remain independent and to continue living in their own homes. These desires have a distinct impact on future service planning where balances need to be struck between meeting the needs of current service users and planning services around perceived future aspirations. **Transparency of decision-making and the Involvement of current and future service users is a vital component.** Managing transitions can be especially problematic such as locating health services at home or in local communities, or managing the closure of care homes. These transitions are undoubtedly difficult to manage effectively and public authorities have a patchy record in doing so.
2.8 Older people should be supported in maintaining independence despite changes of circumstances such as bereavement and personal ill health. Older people should obtain timely and appropriate adaptations to their homes, many of which are in owner occupation. **Planning for such adaptations should commence at the point of condition diagnosis or when an individual enters hospital for treatment.** In Wales, Care and Repair’s Rapid Response scheme has led to significant progress but there are some glaring inconsistencies between local authorities. **A greater focus should be placed on developing a coherent reablement framework.**

2.9 The independent living desires of the 2010s must not be treated as the community care provision of the early 80s. There will be cost savings in time as good health prevention measures lessen dependency on acute hospital services and care home placements. However **funding will be required initially to ensure that greater numbers of health and social care staff are upskilled to provide enhanced services in individual’s homes and communities.** There will also be renewed pressure on certain allied health professions and the need for smarter working across health, social care, and housing teams.

2.10 The ability to remain independent in one’s own home is no guarantor that people obtain the quality of life they desire in older age. Public services should not take for granted that social infrastructures will always be there to support individuals such as the role of informal carers and the proximity of family and friends. **Isolation and loneliness is becoming an increasing feature for many older people, and is detrimental to health and well-being.** Coherent and sustainable mechanisms must be in place to ensure that practical assistance is provided over and above personal care from local authorities. The third sector is ideally placed to provide such support and resources are needed to strengthen and deepen the provision.

2.11 To counter the threat of isolation, **a greater focus is needed on the role of befrienders and advocates.** Formal social care can prove to be extremely time limited and delivered by a plethora of individuals. Equal focus should be placed on the provision of practical assistance for older people living alone such as assistance with shopping, gardening, and changing light bulbs, as well as having a familiar face to talk to.

3. **Do the extent and nature of public services need to change? If so, how, and how should they be paid for?**

3.1 **A seismic shift in focus to improve ill health prevention and active ageing is required** without detrimentally affecting acute treatment. Identifying risks to ill health and mitigating their effect will enable active aging. Changes have to be introduced sensitively and the infrastructure needs to be well resourced and in place before any reductions in acute services take effect.

3.2 Collaboration between service types and between localities is of critical importance and in relation to developments in Wales, progress remains patchy with some excellent, and fully evaluated initiatives not generally being rolled out quickly and comprehensively enough.

3.3 **Greater consistency in provision is required** and a recognition that older people increasingly anticipate a base line of services and support.
3.4 **Greater focus on service quality and user interaction is vital when decisions are taken to commission services.** This is of particular significance in the context of domiciliary and residential care where provision is overwhelming delivered by the private and not for profit sectors.

3.5 **Impact assess decisions relating to service reductions and withdrawal** so that they do not run contrary to decisions taken by the same public service or another – for example encouraging independent living but withdrawing funding for befriending, luncheon clubs, or closure of day centres for reasons related solely to cost. Under the Equality Act there should be an expectation that policies and practices are age proofed but there is little evidence of this having the desired impact to date.

3.6 **We must dispel the myth that the amounts allocated to services predominantly used by older people are unaffordable.** The UK spends only 1.5% of GDP on social care – less than the European Union average and a third of the amount allocated in both the Netherlands and Sweden. The UK allocates less than the European average in pension provision and has higher than average levels of pensioner poverty. There is merit however in considering how increased levels of funding would be sustained in the longer term.

3.7 Promoting well-being is largely absent from the strategic agendas of statutory authorities and can be misunderstood and misrepresented.

4. **Do we need to redesign and transform public services for these challenges? If so, how?**

4.1 Too much of current approaches hinge on transactional actions. **Much more focus should be placed on transformational approaches and joined-up action between authorities and services.**

4.2 **Evidence is needed of involvement of older people in decision-making** from service design, through delivery to evaluation of policies and practices.

4.3 **Co-location of services needs to happen** together with a greater understanding of the impact of service location on outcomes for older people.

4.4 **Achieving consistency** – at present this can vary between shifts, let alone wards, offices, and trust/local authority boundaries.

4.5 **We must achieve greater leadership and personal accountability within public services** including encouragement of leadership amongst those not perceived as having authority.

4.6 **A culture of staff and others promoting improvements and reporting when services fall short** – we should stop referring to this sort of activity as ‘whistleblowing’. The focus should be on the activities reported rather than persecuting those that dared to raise a question. OPCW has commissioned research on reporting poor practice in public services.

4.7 **Whilst there are numerous examples of creative and effective practice in our localities, too many services are simply failing older people.**
5. What should be done now and what practical actions are needed?
5.1 A demonstrable increase in older people being directly involved in the design, delivery, and evaluation of the services that disproportionately impact on their lives.

5.2 Demonstrable evidence of good practice being evaluated and the learning spread more widely.

5.3 Enhanced statutory obligation for services to work together around clearly established service outcomes for older people.

6. How can we stimulate national debate about these issues?
We need a more honest, balanced, and less crisis driven debate about changing demographics and aging.

6.1 Furnish older people with greater awareness of what exemplary public services can look like in practice so that a more objective assessment can be made of local services.

6.2 Reassurance is needed to service staff and volunteers that constructive suggestions of potential improvements do not demonstrate disloyalty to the service or will not be used against an individual nor lead to service withdrawal.

6.3 There is a key role for regulators and improvement agencies in achieving greater focus on the quality of services from an users perspective.

6.4 An urgent debate is needed on striking balances between greater automation and face to face provision of services – Increasing numbers of older people are finding liberation through digitalisation and find automated telephone systems more efficient. However, of the current and next generation of older people, there is a danger that a significant number will feel threatened and increasingly marginalised by digitalisation and automation. There is the potential that an over-reliance on telecare may enhance loneliness.

31 August 2012
Professor David Oliver, NHS Commissioning Board, The King’s Fund, Care Quality Commission and Age UK—Oral evidence (QQ 215–288)

Transcript to be found under Age UK
Another point that should be made is that the geographical boundaries for health and social care different. GPs are responsible for their registered patients, and local authorities for their residents. That those boundaries are not identical is an obstacle to collaboration between health and social care. To quote a colleague in social care:

“Health and Social Care are commissioned on a different basis that does put barriers up and causes problems in terms of continuity of care. In essence, health services are commissioned via PCTs/CCG’s based on a **GP registered population** whereas social care is commissioned on a **resident** population. This is problematic from an integrated care perspective. It is quite common to have a patient **resident in your borough** which social services are “responsible” for but in fact the GP is in a **different borough** which then often means that there are different “health services” involved in the care. Equally, GP registered populations frequently means that patients extend **beyond** the borough that the GP is sited in – it is not unusual for GP patients to in fact be straddled across a number of boroughs. This means that other local authorities will be involved in these patients care (which may be different to the borough where the GP is sited) and different community health providers are also likely to be involved. All in all, it makes integrated care much more of a problem. The government policy which is pushing that patients can register with any GP of their choice in fact aggravates this even further. This is fine for a cough and cold but not good for continuity of care and particularly where other services are involved. Ideally, to support integrated models, you would want health and social care to “manage” the same population (resident would be easiest) but that would require an enormous change and reallocation of funding formulas.’

January 2013
HC-One is the UK’s third largest care home provider, specialising in Dementia, Nursing, Residential and Specialist care. HC-One began operating on the 1st November 2011. With 14,000 staff, it aims to provide the kindest care for over 10,000 residents in more than 230 homes across the country.

**Opening Statement**
In the current economic climate, it is unrealistic to expect that large sums of money will be made available to fund health and social care services to the level that will be required as the population continues to age. Nonetheless, the Government must not bypass the issues raised by the Dilnot Commission on Funding of Care and Support. It is vital that funding already earmarked for care should not be diverted to fill gaps elsewhere in the budget. Though unpopular with the Local Government Association, we believe that the only way for the optimal level of community based social care provision to be achieved is through the reintroduction of specific ring-fenced grants. These grants must be seen as the minimum level of expenditure on adult social care and not the maximum.

**Improving the Quality of Care Services**
The Government must take a new look at how care services can be more efficient and more effective, and consider overhauling the entire system of provision of care for older people. Simply tinkering at the edges of the social care system, dealing with small problems and providing only cosmetic solutions is not sufficient. There needs to be a radical rethink of how services are provided.

Many older people receive dangerous and poor quality care in long stay NHS rehabilitation wards and units. This is a misuse of NHS skills and resources. There should be a radical shift in funding from the NHS to local government to commission community care services that are better placed to provide integrated residential, rehabilitative, palliative and hospice care.

NHS resources should be diverted to community care and social care providers to allow -
- greater provision of medical oversight in community services
- greater provision of paramedical, pharmacy and occupational therapy services
- additional nursing support.

Purpose built residential services can provide better care for people at the end of life than NHS hospital acute and rehabilitation wards. Rather than cosmetic changes, a radical restructuring of the way services are provided is required.

As the system currently stands, there is little correlation between the cost and the quality of care. There are many different measures of quality of care within the system. There is also little link between the assessed needs of older people and the level of service negotiated on their behalf by commissioners.

Put simply, the amount that is spent on an individual’s care does not necessarily accurately reflect their needs.
Funding
Special projects and short-term schemes can plug the gaps in funding and care, but it is not possible to roll these out nationally in a meaningful and sustainable way.

We support the concept of choice and direct payments, which can allow individuals to manage their care pathways as best suits them, but in many local authorities there is a lack of streamlined and easily accessible guidance for individuals, families and advocates.

The NHS has many points of entry and there is a frequent failure to place older people’s health needs in the context of a suitable longer term care pathway. The benefits of excellent NHS medical care risk being reversed if older people are discharged from hospital into poor quality underfunded care provision. Allocating resources to high quality preventative social care in the community could reduce the need for expensive short term medical interventions.

Locally raised money through Council Tax should also contribute towards the cost of caring for older people in their communities.

Dementia
Dementia patients are among those who find it hardest to cope with frequent changes. Yet many patients experience several moves as their dementia takes hold, usually from their homes to assisted living and fully residential facilities.

The system should be reformed so that when dementia is identified, a detailed care plan is made with a clear care pathway allowing the older person’s care to be tracked over a longer period. From the very beginning, the older person, their families and their carers should be aware of the planned route for their care as things change and their dementia progresses.

In addition, we would recommend the imposition of a statutory requirement on Health and Social Care Trusts and Authorities to review care at least twice a year.

The impact on lower income households
There is no need for changes in legislation. Local authorities should retain the power to allocate funding for care, and continue to account for lower income households through this allocation. However, regarding the thorny issue of personal contributions to the cost of care, delays in implementing the expensive elements of the Dilnot Review should not be allowed to get in the way of other essential changes.

Current failures that should be widely recognised
The greater the financial risk in the social care sector, the less likely there is to be new investment, and the more likely it will be that existing investors and financial institutions want to remove their funds from the sector. This is particularly the case where private and also not for profit providers are seen to fail. Mechanisms should be put in place to prevent such failures and restore faith in the sector.

Risk costs money: money that would be better used providing care. Penalising providers will simply discourage investment.

Conclusion
In the current economic climate, it may not be possible for large sums of money to be made available to fund all the reforms to the health and social care system that are currently being recommended by politicians and stakeholders. Nevertheless, greater efforts must be made
to reallocate existing funding to accurately reflect the care needs of older people. As the population continues to age, the current system will no longer be fit for purpose without radical reforms to the NHS and social care systems.

December 2012
Dr Chai Patel CBE FRCP, HC-One, Care Quality Commission, The King's Fund and Nuffield Trust—Oral evidence (QQ 607–638)

Transcript to be found under Care Quality Commission
Dr Chai Patel CBE FRCP, HC-One—Supplementary written evidence

Submitted by Dr Chai Patel CBE FRCP, Chairman of HC-One following his appearance at Session 17: Public Service and Demographic Change, which took place on 18th December 2012. HC-One is the UK’s third largest care home provider, specialising in Dementia, Nursing, Residential and Specialist care. HC-One began operating on 1st November 2011. With 14,000 staff, it aims to provide the kindest care for over 10,000 residents in more than 230 homes across the country.

The Committee Chair, Lord Filkin of Pimlico, invited all witnesses from 18th December to submit a short note on the following question.

• What should our health and social care system look like in 2025? In particular, what might the fundamentals of structures and funding look like?

In the short period of time that has since elapsed, we have been pleased to pull together the following note and HC-One and I would be delighted to take part in further discussions.

The Health and Social Care System of 2025 – Funding

2025 needs to see in Britain a system funded by a number of sources. There will be greater national awareness of the differences between funding by individuals versus funding by the State. Effective and meaningful co-payment by individuals who can afford to contribute is necessary and will have ensured that there is more money in the system. From this will have flowed better quality, more personalised and more effective care. Greater overall funding and public acceptance of co-funding will also have delivered increased tele-medicine, earlier interventions and reduced admissions to hospitals. Care will be less institutionalised and more tailored and personalised.

There needs to be, by 2025, well established Government clarity on what individuals are expected to fund. Pensioner poverty will need to have been tackled meaningfully. By 2025, the State will need to have had the courage to make totally clear what individuals can be expected to provide for their own social care. The tone of the national conversation will have to have advanced, to a much more honest and grown up place. The King’s Fund paper, Transforming the Delivery of Health and Social Care published in September 2012 argues that services have failed to keep pace with demographic pressures. According to Age UK, the proportion of people aged 65+ will rise from 17.2% currently to 22.4% in 2032. With the prospect of several years of austerity still to come, the pressure on older people’s health and care services in will be severe in 2025 unless fundamental change is agreed very soon.

The Dilnot Commission established the principle of the State and individuals sharing the costs of long term care with a cap on the contribution required from individuals. The trailing today of a Government intention to implement the Dilnot recommendations with a cap at £75,000 would be an important and welcome step in the right direction. Also, with 1.7 million older people living below the poverty line and a further 1.1 million on the edge of poverty, the Government is to be commended for its commitment to maintain the ‘triple lock’ on basic pensions, reversing the decline in the real value of pensioner incomes over previous years and under Governments of all colours. As Age UK has stated, ‘Reform of
Dr Chai Patel CBE FRCP, HC-One—Supplementary written evidence

care funding would be a worthy legacy for any Government.’ It is important that this Coalition does not miss this historic opportunity to deliver meaningful reform, ideally with cross-party support.

The measures that seem to be advocated as recently as today by the Coalition are a step in the right direction if they can receive such cross party support. This is a national emergency and should be treated as such.

**The Health and Social Care System of 2025 – Structures (People)**

We also need a fundamental review of the underlying economics of the elderly care system. Currently elderly care work is considered a minimum wage, low skilled profession on a par with shelf-stacking at a supermarket. There is nothing wrong with that profession – we just think that providing care demands more. We would not treat children the way we treat the elderly, and we would never consider paying teachers at the level that we currently reward care workers. In the health and social care system of 2025, social care workers must, we hope, be recognised more highly, in terms of both salary and status for the important and skilled work that they do in looking after our vulnerable older people. 2025 must see health and social care totally repositioned as a career.

**The Health and Social Care System of 2025 – Structures (Providers)**

We are passionately in favour of a system of mixed provision as the one that will deliver the best care to the largest number of people. In 2025, our future National Health Service and social care systems will need to be more closely integrated to provide the best and most cost effective care for older people based on their individual specific needs. 2025 will need to see reduced tertiary (NHS) involvement in care provision.

The climate for the involvement of the private sector will need to have become more favourable and to have moved away from the general sense of tension that currently exists. The investment community is interested in healthcare and sees it as an opportunity. However it also sees political hostility to private sector involvement in the UK and that naturally will leave it with concerns and doubts about whether to invest in the sector. There used to be a sense that the provision of care services was open to all comers as long as the end user benefited. There is a genuine desire amongst the investment community for people who want to use their capital ‘with purpose’, to help address social concerns.

The current health and social care system is made up of many disparate facilities and services that are difficult for people to navigate, particularly older people in need of residential or rehabilitative care. Our experiences suggest that a 2025 system should see widespread use of ‘navigators’ to help elderly people choose the care pathways best suited to their needs, and help them understand and access the right services available to them. Our future health and social care system will need to have greater integration of the healthcare and the social care older people receive, where an individual’s GP, navigator and carers are all involved in the decisions made about their care.

**The Health and Social Care System of 2025 – Structures (Budgets)**

We are aware that the King’s Fund has understandable reservations about the concept of shifting resources from the NHS into the care sector. Our view is that by 2025 some of the £106 billion that is currently in the NHS 2010/ 2011 Budget must be moved to community care and the management of long-term diseases. The funding allocated to the NHS for these areas does not match the reality of day-to-day life as HC-One sees it across the country.
We believe approximately ten per cent of that budget should be moved to local authority social care budgets.

Moving budgets to where they are most needed would mean greater integration between the healthcare and social care systems and will allow advances and innovation to be shared across the system. It would deliver better, tailored and more personalised medical care as well as actual savings to the Exchequer. Currently, we see many beds in NHS long stay rehabilitation wards occupied by elderly people whose needs would be better met by community care services.

In an improved health and social care system in 2025, it would make sense to have recognised that care services in the community are better placed to provide integrated residential, rehabilitative, and palliative care. With more qualified nurses, occupational therapists and better training for care workers, there could be greater provision of medical oversight in community services. This would reduce the burden on NHS services and reduce the need for high cost hospital-based care.

Currently many residents in residential social care facilities are sent to hospitals in their final days of life. In 2010, 58.4% of people aged 75 and over died in hospital compared to 22.1% in nursing homes. Yet surveys have shown that two thirds of people would prefer to die at home, while only 3% would choose to end their life in a hospital.

The Health and Social Care System of 2025 – Structures (Where We Live)
Today’s care homes as a concept originate in the workhouse of the nineteenth century. By 2025 we hope we will see a fundamentally different perception of elderly care in the public mind. We will have invested much more into retirement living with a much wider range of care available. We will have revisited from first principles where we live when we are old, and what that accommodation both looks like and offers the user as a living environment. There will have to have been by 2025 huge strides forward in tele-medicine and the use of technology and innovation.

The Health and Social Care System of 2025 – Structures (Long Term Conditions)
We need to get to grips with how we as a country deal with long term conditions. Long-term conditions are crucial in considering the question of effective health and social care. In 2025 we hope to see a health and social care system benefitting hugely from earlier diagnosis of long term conditions, earlier and more effective intervention, more effective treatment and most crucially, better outcomes. People could, in 2025, live better for longer. By 2025 we could have redefined how the private sector, tertiary sector and the NHS work together in these areas. By 2025 we would have placed dementia where it needs to be – recognised as one of a number of the chronic conditions affecting people in later life.

Many of HC-One’s residents are admitted to residential care because they can no longer live unassisted in the community as a direct result of a diagnosable medical condition. These conditions are often related to old age, and include dementia, arthritis, Parkinson’s and many

281 Deaths in Older Adults in England 2010 – National End of Life Care Intelligence Network: http://www.nwph.net/nwpho/publications/Deaths_in_Older_Adults_in_England_FINAL_REPORT.pdf
others. Under the NHS system, all diagnosable conditions are given care that is free at the point of delivery. Our 2025 future health and social care system should recognise the reasons why capacity is reduced in old age, and where there is a diagnosable condition, people should be given long-term residential care that is free at the point of delivery. These are big changes in thinking.

The Health and Social Care System of 2025 – Innovation
The provision of health and social care in 2025 is likely to look very different from the provision that we know today. Technological change, funded in ever more creative ways, for example through seed innovation funds, will need to have become a significant driver of change in our care provision in the next decade. The private sector will continue to bring new ideas into the existing system, both in terms of technology and funding streams. Government needs to play its part. Current focus in this area is lacking. We believe that a Minister for Older People would be a hugely positive step.

Already we are seeing the potential benefits for the health and social care of telemedicine - the use of telecommunication and information technologies in order to provide clinical health care at a distance. Telemedicine enables medical and care professionals to collaborate in the process of monitoring, diagnosing and treating of patients from remote locations, causing less disruption to the lives of patients who no longer have to travel to receive their care and reducing the cost of providing care.

Such technological innovations, while still in their infancy, have the potential to transform the provision of social care, and if embraced can help us achieve the more closely integrated health and social care systems that will allow for the cost effective delivery of the best care to the largest number of people. Government has shown in other areas of policy that it is prepared to embrace seed funding of innovation. Health and Social care, and in turn the public finances could benefit greatly from such focus.

Conclusion
By 2025, we should aim to end discrimination against older people so that the conditions that incapacitate the elderly are recognised as medical issues and that that care is provided free at the point of use for those who need it. There should be a rebalancing of the system whereby more care is delivered in community care services and less in hospitals, by a more highly trained, better valued profession of care workers with integrated medical oversight.

The potential for what we can achieve by 2025 is huge.

The time for talking is over. The time for doing has arrived.

7 January 2013
As Parliament’s Ombudsman, I very much welcome the Committee’s inquiry into the impact of demographic change on public services and I value the opportunity to submit written evidence to the Committee.

As you will know, my role as Ombudsman is to consider complaints that government departments, a range of other public bodies in the UK and the NHS in England, have not acted properly or fairly or have provided a poor service. We aim to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvements in public services and informs public policy. We assist Parliament in scrutinising the actions of the Executive.

Last year, we received 23,846 enquiries from members of the public wishing to complain about their experience of public services. The demographic breakdown of our complainants is available in our recent Annual Report 2011-12, Moving Forward, which is available on our website (www.ombudsman.org.uk).

The broad remit of my office means that our expertise covers a wide range of public services and the complaints we receive cover citizen’s experiences at all stages of life: from maternity services to pensions. Through our casework we can help Parliament in scrutinising the delivery of public services and support an understanding of the impact of demographic change: we can identify trends in complaints and share our unique insight into the often serious consequences that poor public services have for individuals.

In my submission I do not address the wide range of issues raised in the main call for evidence of your inquiry. Instead I would like to highlight the role my office can play in helping Parliament understand the impact of demographic change on public services. Already, a fifth of our customers are 65 years or older and a significant proportion of the complaints made to us about the NHS every year are about the care of older people. This reflects the growing importance of this group.

In particular, I would like to bring to your attention a report, Care and compassion?, which we published in February last year. The report provides an overview of our work on complaints about the quality of care for older people in the NHS and the lessons to be learnt from that work.

I believe that the findings of Care and compassion? are relevant to your inquiry: the report demonstrates that the NHS is failing to treat older people with care, compassion, dignity and respect. It highlights the gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS in England. The report presents a picture of NHS provision that is failing to meet even the most basic standards of care.

I welcome that the report has led to a number of important initiatives that aim to improve the care of older people: the Commission on improving Dignity in Care was set up to develop a better understanding of how and why older people’s care is failing on dignity. The
UK Parliamentary Ombudsman and Health Service Ombudsman for England—Written evidence

Commission has identified a range of practical measures to drive improvements in the care of older people and is currently drawing up an action plan for implementation. Care and compassion? was also a driving factor in the publication of the Dignity Code by the National Pensioners Convention in February this year, which sets out minimum standards for the dignified treatment of older people. The Code has been endorsed by the Government. These are just two examples of the wider impact and system wide improvements that we can achieve by sharing the learning from our casework.

Against this background, the NHS will need to spend increasing amounts of time and resource caring for older people with multiple and complex needs and long-term conditions. Our casework suggests that there is often a link between age and disability. Together with the Local Government Ombudsman we published a report, Six Lives (available on our website), in March 2009, which illustrated serious service failures across both health and social care that meant that people with learning disabilities experienced prolonged suffering and inappropriate care.

The nature of the failings identified by Care and compassion? and Six Lives suggests that extra resource alone will not be sufficient to help the NHS fulfil its own standards of care. Instead, the NHS will need to close the gap between the promise of care and compassion, as outlined in its Constitution, and the injustice that many older people experience in reality. The key to that is an attitude – both personal and institutional – that recognises the humanity and individuality of every patient and responds to them with sensitivity, compassion and professionalism.

When I became Ombudsman in January this year I launched a project to refresh our corporate strategy, with the aim of identifying ways in which we can deliver more benefit to a greater number of people. As part of this exercise, we are looking at how we can become more useful to Parliament, and in particular to select committees in both Houses. I would therefore welcome the opportunity to work with your Committee in the future.

I appreciate that my comments relate to only a few aspects of your broad inquiry. Nevertheless I hope that you find them and the enclosed publication useful. If I can assist you further by expanding on these observations either in oral evidence or in further written evidence, please do not hesitate to contact me.

Yours sincerely

Dame Julie Mellor DBE

5 September 2012
**Pensions Advisory Service—Written evidence**

**About The Pensions Advisory Service**

We are an independent voluntary organisation that is grant-aided by the Department for Work and Pensions (DWP). We provide free information and guidance to members of the public on all pension matters, covering state, company, personal and stakeholder schemes.

We also help any member of the public who has a problem, complaint or dispute with their occupational or private pension arrangement. We do not deal with problems, complaints or disputes relating to state pensions.

Over the last year we received 2.5 million visits to our website (projected to increase to in excess of 3 million visitors in this financial year), handled over 68,500 calls to our helpline and responded to over 20,000 questions by post or email – an increase from 2010/2011, showing that demand for our service continues to grow.

**Our response**

While we do not have the evidence base to put forward a detailed response to the questions asked, we have recently collated the responses to surveys we collected from employees who attended one of our presentations about saving for retirement. One aspect of this data may give an insight into the action that can be taken to change attitudes about retirement saving.

During the financial years 2010/11 and 2011/12, we surveyed 9,350 employees who attended seminars we hosted in their workplace about saving into a pension. Forty two per cent (3,938 people responded) to our survey.

More people in 2011/12 thought their retirement was too far in the future to take any action to save or save more for their retirement (an increase of 4.2% of respondents from 2.8% in 2010/11 to 7.0% in 2011/12) and more people thought they would not live long enough to see their retirement to warrant saving (an increase of 1.2% from 0.7% in 2010/11 to 1.9% in 2011/12). This could be as a result of media coverage of the rising state pension age, particularly alarmist tabloid headlines capitalising on state pension reform. This suggests to us that whilst people are more aware of increases in longevity, this awareness has had an adverse rather than a positive effect on their savings behaviour.

Based on the analysis of our survey, there appears to be a growing minority who are becoming discouraged from considering saving for retirement which we believe may be linked to messages about improvements in longevity having an adverse, rather than a positive effect.

In addition, anecdotal evidence gathered from calls to our helpdesk suggests the same trends in people’s attitudes towards retirement planning:

- It is apparent that people do not think that they will live long enough post retirement to get back what they’ve saved.
Pensions Advisory Service—Written evidence

- There is a feeling that the concept of retirement is getting further and further away, meaning that people do not think they will be retiring soon enough to make saving now worthwhile.

It may therefore be necessary for the messages about increases in longevity to be changed, particularly those emanating from central government and the pensions industry.

**Concluding remarks**

DWP research into attitudes towards the Pensions Advisory Service has demonstrated that we are seen as a trustworthy source of independent and unbiased information and guidance about pensions. We would like more people to know about our free service and to expand our role in helping people understand the need to take greater personal responsibility for planning for later life. We would welcome any support the Committee can give us in making our technical specialist pension service better known to the public.

August 2012
The Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) has produced projections of future public and private long-term care expenditure. We have developed models under a programme of research funded by the Department of Health and other funding agencies to produce projections of future demand for long-term care and associated expenditure to assist decision-makers considering policy developments on long-term care funding, including in particular the funding of care and support.

We believe that it is essential that decisions on the funding of care and support should be based on robust analyses of the likely future costs of different approaches in view of expected socio-demographic changes. Demographic change will impact more substantially on social care than on health care and pensions. The reason is that social care for older people is so heavily concentrated on the oldest old, that is on the very group whose numbers are rising the most rapidly. Around 54% of older publicly funded home residents are aged 85 and over, and around 34% of publicly funded older home care users are aged 85 and over (Darton et al 2007). While the numbers of people aged 65 and over are expected to rise by 51% between 2010 and 2030, the numbers aged 85 and over are expected to rise by 101% over the same period (ONS 2010-based principal population projection).

Our most recent PSSRU projections are those we produced, in collaboration with the University of East Anglia, funded by the Department of Health, for the Commission on Funding of Care and Support. They are published in the Commission’s report (CFCS 2011) and in two PSSRU discussion papers (Wittenberg et al 2011, Snell et al 2011).

We prepare projections on a set of base case assumptions, which we then vary in sensitivity analysis. Our main base case assumptions for older people are:

- The number of people by age, gender and marital status changes in line with the Office for National Statistics (ONS) 2008-based population projections;
- Prevalence rates of disability by age group (65-69, 70-74, 75-79, 80-84, 85) and gender remain unchanged, as reported in the 2001/2 General Household Survey;
- Home-ownership rates, as reported in the 2002/3 to 2004/5 Family Resources Survey, change in line with projections produced by the University of East Anglia;
- Health and social care unit costs remain constant in real terms to 2015 and then rise by 2% per year in real terms (but real non-labour non-capital costs remain constant);
- Patterns of care and the system of funding care are unchanged.

Under these base case assumptions, the numbers of disabled older people, defined as those unable to perform at least one instrumental activity of daily living (IADL) or having problems
with at least one activity of daily living (ADL), would rise by 61% between 2010 and 2030, from around 2.5 million to around 4.1 million. The number of older people with moderate or severe disability, that is, needing help with one or more ADL tasks, would increase by 66% from around almost one million in 2010 to just over 1.6 million in 2030.

We project that public expenditure on social services for older people would need to rise under the current funding system from around £7.7 billion (0.6% of GDP) in 2010 to £15.4 billion (0.8% of GDP) in 2030 in constant 2010 prices. Private expenditure we project to rise from £6.8 billion in 2010 to £16.7 billion in 2030, but this needs to be treated with caution.

Our analysis shows that 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. It is not clear however that the supply of informal care will rise to keep pace with demand (Pickard et al 2012). In particular, informal care provided by the adult children of older people with disabilities may not rise in line with demand. Demand for informal care from children is projected to rise by over 50% between 2007 and 2032, whereas the supply of care to older parents is projected to rise by only 20%. If the supply of informal care does not increase to meet demand, the need for formal services will rise faster than under the base case set of assumptions.

Sensitivity analysis shows that projected future demand for social services for older people is sensitive to assumptions about future mortality rates and future prevalence rates of disability among the older population. For example, if rates of chronic conditions changed in line with continuation of recent trends, net public expenditure on social services for older people would need to rise to £18.3 billion (0.95% of GDP) as opposed to £15.4 billion (0.8% of GDP) if disability rates remained constant. Projected future public (and private) expenditure on care is also sensitive to assumptions about future rises in the real unit costs of services, such as the cost of an hour’s home care or of a day care session.

We also produced for the Commission projections of future public expenditure on social care for younger adults. These were prepared using the same base case assumptions, except that prevalence rates of learning disability by age and gender are assumed to change in line with the ‘middle’ projections of the future need for social care services among adults with learning disabilities produced by Emerson and Hatton (2008; Table 4). Net public expenditure on social care (net of user contributions) is projected to rise by 67%, from £6.8 billion (0.54% of GDP) in 2010 to £11.3 billion (0.58% of GDP) in 2030. This is on the basis that the real unit costs of care rise by 2% per year from 2015 onwards but that user contributions remain constant in real terms.

Sensitivity analysis shows that projected future demand for social services for younger adults is sensitive to assumptions about future prevalence rates of learning, physical and mental health disability. For example, if the numbers of people with learning disabilities requiring care rose in line with Emerson and Hatton’s lower or higher variant projections, net public expenditure on social care for younger adults is projected to rise to £10.5 billion (0.54% of GDP) or to £12.9 billion (0.66% GDP in 2030) respectively, as opposed to £11.3 billion (0.58% of GDP) under their ‘middle’ projection. Projected future public expenditure on care is also sensitive to assumptions about future rises in the real unit costs of services, such as the cost of an hour’s home care or of a day care session.
Our base case projections for public expenditure on social care for older people and younger adults together are that it will need to rise from around 1.15% of GDP in 2010 to around 1.4% of GDP in 2030 to keep pace with socio-demographic pressures and expected real rises in the unit costs of care. This is comparable with the recent projections by the Office for Budget Responsibility (OBR 2012). They project public expenditure on adult social care rising from around 1.1% of GDP in 2016/7 to around 2.0% of GDP in 2061/2. Their analysis takes account of projected changes in the population by age and gender, assumes that unit costs of care rise in line with per capita GDP and assumes unchanged policy.

We would stress that our projections of future public expenditure on adult social care are based on a specified set of base case assumptions. This set of assumptions seems plausible but is clearly not the only possible set. Moreover, our projections do not take account of changes in expectations about quality of care, which may prove as important as demographic change. This means that our projections should not be regarded as forecasts of the future.

References

5 September 2012
PolicyFen—Written evidence

1. Introduction to evidence
1.1 This is a submission of evidence to the House of Lords Committee on Public Service and Demographic Change, in response to their call for evidence “to consider public service provision in the light of demographic change, and to make recommendations”.

1.2 It is from Policy Fen, an informal network of organisations committed to improving the link between policy and information. It operates as a Special Interest Group of Cambridge Network283.

1.3 Policy Fen is steered by members of the following organisations:
   - Analytics Cambridge
   - Cambridge City Council
   - Cambridge Network
   - Cambridge Past, Present and Future
   - Cambridge University
   - Cambridgeshire County Council
   - David Simmonds Consultancy
   - Rand Europe

1.4 The submission is based on a conference organised by Policy Fen and entitled: ‘Older but fitter? Policy challenges of a changing older population’. The conference was held on 20 April 2012.

1.5 This submission takes the form of a note of the conference and follow up action, since the topic is close to that of the House of Lords Committee on Public Service and Demographic Change.

1.6 In the context of the document please note that all presenters were presenting their own views, not necessarily those of the organisations they are affiliated to.

2. Background
2.1 It is well known that the population of the UK is becoming an older population. Official projections for Cambridgeshire, for example, suggest an increase of 69% in the number of persons aged 65+ from 2011 to 2031, compared with an increase of 19% in the total population; on that projection, persons aged 65+ will increase from 17% to 24% of the county population over those two decades. The problems arising from growth in the older population is a focus of much concern, particularly as regards the implications for funding pensions and the issues of providing medical and social care. But the situation is complicated by changes in how healthy and active people are at any given age. 65-year olds are in general healthier and more active now than in previous generations (which is partly why the government expects them to go on working); if this kind of trend continues, the significance of having an “older population” may change dramatically.

283 The Cambridge Network is a membership organisation based in the vibrant high technology cluster of Cambridge, UK. It brings people together - from business and academia - to meet each other and share ideas, encouraging collaboration and partnership for shared success.

845
2.2 The purpose of this event was to consider:

- the evidence about trends in health and activity of the older population - 'is there a problem?'
- the implications for both private and public sectors - 'how does that affect what we do?'
- the possible responses of local government and service providers – in planning, transport, social care and housing - 'what are we doing / how are we planning to solve the problem?'

3. Introduction to Older but fitter Conference

3.1 In opening the event, David Howarth (University of Cambridge, chairman for the event) observed that we know that improvements in health have led and will lead to significant changes in the numbers of elderly people. In 1961 in the UK there were 600 people aged 100 or over. There are now estimated to be 14,500 centenarians. In 2060 (less than 50 years, or a half-life, away) the latest projections from the Office for National Statistics say there might be 456,000.

3.2 David quoted David Sinclair, Head of Policy and Research at the UK International Longevity Centre, who in considering these figures painted the picture that “we will be older, but in worse health, and at high risk of living alone in unsuitable accommodation”. And that “… we are very poor at forward planning, as politicians and individuals”.

3.3 David Howarth explained that we structured the day into three parts:

- Firstly, the demographic and health background: 120 years ago, people aged 70 were considered to be “disabled from work by age”. Is that still the case? Will it be the case in the future?

- Secondly, we will take a business perspective. For businesses there are many implications. There are new products to be developed around health, transport and living. But how will old people (however we define old) buy or use these products? Who will make them? – will it be a young workforce of 60 year olds?

- Finally, implications for public policy. Will the health service cope? What will it cost? What will the role of the voluntary sector be? What are the implications for social care with the increase in vulnerable people?

4. Demographic and health background

4.1 Alan Fitz (Research Manager – Demography, Cambridgeshire County Council) opened the presentations with some further detail of population projections for Cambridgeshire, summarised in the population “pyramids” shown below. These are for 2010 and 2030 – the 2010 graph itself being much less of a “pyramid” than in previous centuries. These projections imply that the proportion of over-65s in the population is expected to grow from around 15% to around 25% over 20 years.

4.2 Abhijit Bagade (Consultant in Public Health Medicine, NHS Cambridgeshire) continued, pointing out that these over-65s already account for nearly half of expenditure on hospital admissions, and a similar proportion of other health expenditure; the majority of the County Council’s budget for adult social care is spent on older people. He summarized the picture as one of:
PolicyFen—Written evidence

- an increasing number of older people
- People are living longer
  - In increasingly healthy states but also in poor health
  - Increasing life expectancy, decreasing mortality
- most older people live independently
- many 65+, including those over 85 continue to be involved in community groups including local councils.

4.3 He summarised the effect of advances in healthcare as “adding years to life and adding life to years”.

4.4 More detailed info on the topics covered by Fitz and Bagade is available at:
http://www.cambridgeshirejsna.org.uk/ and
http://www.cambridgeshire.gov.uk/business/research/

Figure 1: Population pyramids – projected changes
4.5 Jane Fleming (Institute of Public Health, University of Cambridge and Cambridgeshire &
Peterborough CLAHRC - Collaboration for Leadership in Applied Health Research and Care) discussed what population-based research can tell us about disability in (older) old age. The strong association of ill health with age has led to concerns that as the population ages so will the burden of ill health. There are limited data on the overall effect of longer life spans on time spent in ill health. The worst case scenario is that with increased life expectancy a greater proportion of time is spent in ill health.

4.6 Between 1981 and 2001 in the United Kingdom, both life expectancy and healthy life expectancy have increased but life expectancy has increased faster. The result is that the expected time lived in poor health from age 65 onwards for men increased from 3.1 years in 1981 to 4.3 years in 2001. For women in 1981 the corresponding figure was 5.0 years, rising to 5.8 years in 2001.

4.7 Jane presented results from analysis of the MRC Cognitive Function and Ageing Study (www.cfas.ac.uk) which has looked at:

- 18,304 individuals
- Aged 65 and above in 1991
- Rural and urban sites
- Population sampling including care homes
- ~ 80% response rate at each stage
- Interview capturing key areas relevant to mental health and disability
- Followed up as far as possible over 10+ years

4.8 There is no doubt that the increasing numbers of the very old are at considerable risk of dementia. These data are from the major MRC funded study examining dementia in the population. This part of the research has provided estimates for planning, the commission
into long term care, forward projections in reports at LSE and local planning. There is no escaping that age is the greatest risk factor for dementia.

**Figure 3: Prevalence of dementia by age**

4.9 Jane continued with results from analysis of the data collected on problems in daily living, based on questions about:

- Locomotion: “Are you able to go up and down stairs?”
- Reaching: “Are you able to reach an overhead shelf?”
- Dexterity: “Are you able to tie a knot in a piece of string?”
- Vision: “Do you suffer from poor eyesight which interferes with day-to-day living?”
- Hearing: “Do you suffer from hearing problems which interfere with day-to-day living?”
- Thinking: Mini-Mental State Examination (MMSE)

4.10 The data illustrates the tendency for different abilities to be lost at different ages, with locomotion being typically the first of the abilities considered to be lost, and dexterity the last:
4.11 A key finding for local policy-making is that “lack of locomotion ability may exclude regardless of vision, hearing, thinking, reaching or dexterity ability”. A new round of similar survey work should provide valuable data on how the incidence of problems at each age is changing over time – though there remains considerable uncertainty about how this will change in future, seen in different scenarios:

Figure 5: Compression of morbidity

4.12 Jane also presented some results from analysis of the Cambridge City over-75s Cohort (the CC75C study). A key result for the “Older but fitter” theme is that >1/2 in their late 80s needed no help in basic ADLs (independently bathing/showering, dressing and getting to
the toilet on time). Note that this relates to the whole Cambridge population including those living at home in the community, and those living in institutional care homes.

4.13 Ellen Nolte (RAND Europe) discussed the role of care coordination to address the complex needs of chronic health problems. She pointed out that:

- the proportion of older people in the population is growing...
- … and so is the likelihood of developing a potentially disabling chronic condition
- ‘Compression of morbidity’: decline in disability but an increase in health problems among survivors
- Some of this is because of healthier lifetime experiences, but a substantial amount is due to more effective healthcare
- Population ageing will not automatically make healthcare more expensive, but it will make it a lot more complex.

4.14 As a result of the “compression of morbidity”, the number of people with chronic illness is growing:

- ~20% to over 40% of population in EU aged 15 years and over report a long standing health problem
- Growing number of people with multiple health problems
- ~ 2/3 of those who have reached pensionable age have at least 2 chronic conditions
- People with chronic diseases are more likely to utilise health services
- Account for ~80% of consultations with a GP; ~15% of those with 3 or more problems account for ~ 30% of inpatient days (UK)
- Individual chronic diseases (e.g. diabetes) account for 2-15% of national health expenditure in some European countries

4.15 She went on to discuss the requirements for chronic illness care, which few if any health systems are well equipped to provide, in particular because of the requirement for, and difficulties of, coordination between different services. She illustrated this with data from a range of countries, and concluded that successful implementation of chronic care management process requires understanding of:

- the inefficiencies in healthcare delivery
- disincentives for the patient or provider to receive or deliver the highest quality care (access and cost)
- relative cost-effectiveness of alternative treatments
- success of different interventions in modifying individual behaviour (e.g. adherence).

5 Business perspectives
5.1 David Rimmer (Critical Data Ltd) discussed the role of technology in care for the elderly, with examples from the products and services which his company sells under the “Canary” brand. He argued the need to change the way care is delivered...

- Philosophy: Prevention, not cure
- Keep people independent for longer
- Transformation of service delivery
- Accept that technology can help (but not replace)
- Self monitoring, self diagnosis, self medication
- Resource multiplier, access voluntary sector
5.2 He noted the significance of a mentally active elderly population! Retirees of tomorrow use technology in their everyday & working lives......today, including PCs Laptops, Smartphones, Tablets, social media (Facebook, Twitter, Linkedin, Skype), ubiquitous Broadband connectivity.

5.3 The King’s Fund - W.S.D. trial. Headline findings: Telehealth could deliver...
- 20% reduction in emergency hospital admissions
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs.
- 45% reduction in mortality rates.

5.4 David saw the role of the private sector as:
- Innovating new ideas – ‘Imagineering’ a future that doesn’t yet exist
- Considering markets: Who are customers? What need?
- Adapting, evolving, developing new business models
- Educating the market; awareness & communications
- Risk Taking
- R&D new products & services
- Capital Investment
- Technology roll-out / implementation
- Making a profit/return: Financial and Social!

5.5 The target market for Canary is not the elderly themselves, but the “guilty children” of elderly parents and other relatives who are willing to use cutting-edge technology to remotely monitor the activities of those they are attempting to care for from a distance, in order to allow those cared for to remain independent living at home for longer than would otherwise be possible. The system consists essentially of:
- monitoring devices (eg movement detectors in specific rooms)
- communications reporting the “caree’s” activity to an expert system which seeks to detect worrying situations (eg no visit to the bathroom by 10h00) and reports these to designated family, friends or carers by email, text or voice call.

Figure 6: System overview
5.6 How can Public Sector help?
- Take the attitude of “just do it” (experiment rather than analysis)
- accept the “survival of the fittest” – not every experiment will succeed
- consider technology as service multiplier (not a substitute for service).

5.7 Catherine Clapton in charge of Customer Care/Education at Patients Know Best (PKB) presented a different use of information technology in managing and complementing patients' health records. PKB’s approach is based on the proposition that the patient is the only practical and legal link across all healthcare providers (one answer to the points about coordination of care made by Ellen Nolte). The products they offer integrate the clinical records created by doctors and hospitals with a range of features which can be used by the patient including:
  - recording self-monitoring eg peak flow monitor results
  - recording symptoms
  - making appointments
  - on-line discussion as an alternative/addition to a conventional appointment

5.8 Various organizations have produced smartphone apps to complement the PKB system either to help patients in managing particular problems (eg asthma – with links to air quality information) or to gather particular data from specific groups of patients for research projects.

6 Policy perspectives
6.1 Marion Bailey (Programme Co-ordination at Future East) discussed the role of housing in relation to the older population. She quoted figures indicating that 65-85 year-olds spend 85% of their time at home, so conditions, safety etc there are extremely important. Older people show a strong preference for remaining in the houses where they have lived for some time (perhaps for decades), particularly to retain contact with friends and neighbours in the immediate area. The main reason why they do move is “not being able to manage” – “not being able to manage” often occurring suddenly as a result of a crisis, leading to a less-than-ideal outcome. Future East has been working on what can be done to make sure that people are able to manage. This centres on lifetime design standards e.g.
  - the capacity to have a bedroom at entry level
  - a bath which can be converted into a walk-in bath
  - power sockets at waist level.

6.2 The added costs are estimated at only a few hundred £ if incorporated into the design of new housing from the outset of the design process (see http://www.lifetimehomes.org.uk), and the standards have already been adopted in Greater London.

6.3 In addition to the suitability of the dwelling itself, maintenance is an increasing issue especially with higher proportions of owner-occupiers among the elderly. Implications include:
  - the need for a trusted equity-release scheme
  - help with finance for and practicalities of arranging/commissioning adaptations - Disability Grant helps in some cases, but tends to be very slow because of cumbersome appraisal/assessment procedures.
6.4 Housing issues are connected to loneliness which is a major health issue for a significant proportion of elderly people – whilst a great deal of voluntary activity is supplied by over-65s, one in 10 see family or friends less than once a month.

6.5 Lawrence Ashelford (Assistant Director, Planning and Development, Cambridge University Hospitals NHS Foundation Trust) discussed Addenbrookes as a factory for dealing with illness and injury, facing an inexorable rise in the demand for its services due substantially, though not wholly, to the growth in the elderly population. The fragmentation of healthcare may mean that care will be more difficult to manage – hospitals currently look after the health of the whole body. If healthcare becomes fragmented between services this could increase difficulties in care, especially rehabilitation. Patient self-management is important but can be very resource heavy though this has to happen. Co-ordination with voluntary groups is also crucial. One surprise for many of the audience was the relatively short-term nature of the management planning process - typically 3 years in advance with first year the best elaborated - “30 years is for policymakers”. Bringing policy-making back to the local arena will surely have implications for Addenbrooke’s.
Richard O’Driscoll (Head of Commissioning (Older People), Cambridgeshire County Council) reviewed the challenges for Cambridgeshire:

**Figure 7: The Challenge for Cambridgeshire**

<table>
<thead>
<tr>
<th>2012</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 96,000 Older People</td>
<td>• 135000 +Older People</td>
</tr>
<tr>
<td>• 7,000 have Dementia</td>
<td>• 14,000 have Dementia</td>
</tr>
<tr>
<td>• 8,600 have Depression</td>
<td>• 14,500 have Depression</td>
</tr>
<tr>
<td>• 32,000 (over 65’s) fall x1</td>
<td>• 44,800 (over 65s) fall x1</td>
</tr>
<tr>
<td>• 48,000 unable to manage single domestic task</td>
<td>• 74, 500 unable to manage domestic tasks</td>
</tr>
<tr>
<td>• 12,000 older people carers</td>
<td>• 16,800 OP Carers</td>
</tr>
<tr>
<td>• Economy-15,000 in fuel poverty</td>
<td>• Economy ?</td>
</tr>
</tbody>
</table>

**Figure 8: Other Challenges**

- Workforce-recruitment, retention, skills
- Cost: Residential and Nursing Care
- Choice: personalisation, direct payments
  - "More Mick Jagger less Vera Lynn"
- Safeguarding
- Organisational Silos

6.7 On the more positive side
- Older people will be fitter for longer
- Older people volunteer
- Older people contribute to the economy
- Older people provide care to others e.g. unpaid child minders
- Only 15% of older people receive social care support
Figure 9: Where should we focus?

Where should we focus?

• Prevention: primary, secondary, tertiary
  E.g. Reablement / intermediate care
• Work with communities-asset model
• Supported Housing-extra care sheltered hsg, outreach
• Telecare, Telehealth.....more of
• Service Integration / Collaboration-whole system
  (not just health and social care)
• Support Carers. E.g. Respite care
• Workforce strategy. E.g. training, pay etc

Cambridgeshire County Council social care page is:
http://www.cambridgeshire.gov.uk/social/

7 Organiser’s post-meeting comment:
7.1 The speakers have given us a clear idea of the health and other problems raised by the aging of the population, and of some of the ways in which these can be addressed by the public and private sectors. Are things worse or better? Are we just piling on pressure to existing systems until they break? Should we revisit the original goal of the health service and find new ways of addressing it? Policy making is now in the local arena so much is new.

7.2 The presentations did however concentrate very much on the first adjective in our title “older but fitter?” – this is probably our own fault for inviting speakers who are specifically involved in researching and addressing the problems of older age. Whilst it was noted that many of the over-65 population are in reasonably good health and highly active, we didn’t discover how much the fitness and activity of (say) the 65-70 group has improved, and whether it may be expected to improve further in future. Further work is needed on the original question of whether the boundary of “older age” for planning and policy purposes should move from 65 to a later age.

Report by David Simmonds, David Simmonds Consultancy Ltd.

Note: all presenters were presenting their own views, not necessarily those of the organizations they are affiliated to.
Acknowledgements: Policy Fen is very grateful to all the speakers, to Louise Rushworth (Policy Fen) for her work on the organization of the event, and to Professor Peter Landshoff and the Centre for Mathematical Sciences, University of Cambridge, for hosting the event.

8 Current Work

8.1 Following on from the event Older but fitter? Event the presenters and other interested parties came together to discuss follow up actions. Those present were from:

- Analytics Cambridge
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire County Council
- Cambridge City Council
- Cambridge University (including Institute of Public Health)
- Arthur Rank Hospice Charity

8.2 The following actions were agreed:

- Consult the County’s Health and Wellbeing Board about requiring all new homes to conform to Lifetime Home standards and influencing the design of new communities
- Ask Policy Fen to consider organising an event on social networks and volunteering, with possible topics:
  - facilitation process to recruit and organise volunteers to do things, such as
  - reducing people’s social isolation by getting them to help the community
  - help people navigate round the health and care system and put them in contact with other organisations that might help them (eg to remove damp in home)
  - recognise signs of health threats
  - examples good volunteering practice
  - how to maximise impact and sustain the effort
- Circulate research proposal on integrated patient care and invite participation
- Arrange a date for the group to meet again September/October (Richard Potter). Likely topics for further discussion (in addition to those listed above):
  - severe future lack of NHS resources
  - involvement of patients and carers in the complex system
  - patient self-management and tele-health
  - risk enablement

31 August 2012
Population Matters—Written evidence

1. About Population Matters

Population Matters is the leading population charity in the UK. Our vision is of a global population size providing a good standard of living for all, a healthy environment and environmental sustainability.

2. Does our culture about age and its onset need to change, and if so, how?

Yes, it does need to change. With increasing longevity, people are and will be spending a greater proportion of their life as older people. With improved health and limited resources, our culture must adjust by enabling older people to continue to participate in and contribute to society and their own upkeep.

3. Do our expectations and attitudes about work, savings, retirement and independence need to change, and if so, how?

Yes, they do need to change. We should expect and enable people to work later in life than in the past. Employers and the government should consider what changes to employment practices are required to enable people to work longer. This may include changes to work premises and equipment, encouraging people to work from home and being more flexible with regard to sick leave. Given the pensions shortfall, a flexible labour market should enable the ‘fit old’ to work as many or few days per week as they feel necessary to top up their own pensions, notably providing a work-force to care for the ‘unfit older’. At the same time, society and individuals must prepare for a longer period of retirement and care support as longevity increases.

4. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

Public services should adapt and increase in scale to meet the increasing need. The changes should be paid for partly through increasing taxes and through moving from universal to means tested provision. We should also consider reducing expenditure in other areas, particularly by limiting child benefit and child tax credit to the first two children. Encouraging people to have smaller families would lower education and child care costs, helping to meet the rising cost of older people. Limiting net migration would also reduce the pressure on public services, now and in the future. As Sir David Attenborough says, the idea that ever more old people need ever more young people - who will grow old in turn - to look after them is an ecological Ponzi scheme. In any case, as pressure on all public resources increases, and the costs of prolonging ever more lives of ever diminishing quality into ever more extreme old age rise, it may become necessary at some point to re-consider a transparent scheme of health service rationing with democratically agreed priorities, Oregon-style, to replace the current ad hoc system. All societies must ultimately face the implications of the fact that £1 spent on x is £1 not spent on y.

5. Do we need to redesign and transform public services for these challenges? If so, how?
It may be that public services can rely more on volunteers and encourage the employment or unpaid help of the ‘young old’. Public services should also be provided in lower cost ways through the use of communications technology and community based services.

6. **What should be done now and what practical actions are needed?**

Growth of the older population is due both to the growth in the proportion of the population that is older and the growth in the population as a whole. The growth in the proportion of the population that is older is due to growing longevity and that the current birth rate is lower than it was for much of our recent history. The growth in the population as a whole is also due partly to growing longevity but also to net migration, which is high relative both to historical levels and other European countries, and to the birth rate, which has risen significantly in recent years and is high relative to other European countries. As the 1973 Population Panel said: ‘Our analysis… leads us to the conclusion that Britain would do better in future with a stationary rather than an increasing population.’ We can reduce the future number of older people by reducing the level of net migration and by encouraging people to have smaller families. First class family planning services and sex and relationships education should be among the very highest priorities.

7. **How can we stimulate national debate about these issues?**

The changing age profile of the population is part of a wider debate about sustainability in a world of limited resources. England is the most densely populated country in Europe. The resultant pressure on resources is evident in debates over affordable housing, planning pressure, pollution, loss of biodiversity and amenities, traffic congestion, transport overcrowding, carbon emissions and water, energy and food security. Responding to ageing is thus only part of the issue of sustainability. National debate about ageing could be stimulated by talking more widely about the sort of society we want in the UK, how we can live within our resources and what a sustainable population size would be. We support the principal recommendation of the 1973 Population Panel — the last time an official body considered UK population policy — that population should become an additional responsibility for a senior Minister, with a central coordinating unit.

16 August 2012
Thank you for your correspondence dated 28 November 2012 in which you invited Reform to present oral evidence to the Committee on Public Services and Demographic Change on 11 December 2012.

As I noted in my reply to you, as I was overseas on this date I was unable to attend the evidence session and so this letter provides Reform’s response as written evidence. I would be happy to provide further information or an oral briefing on any of the issues raised in this letter if the Committee requests.

The Committee outlined six questions that it saw as fundamental when exploring the implications of an ageing society for public services. Of these six this submission focusses on the following four:

- Do the extent and nature of public services (including welfare payments) need to change? If so, how, and how should they be paid for?
- Do we need to redesign and transform public services for these challenges? If so, how?
- What should be done now and what practical actions are needed?
- How can we stimulate national debate about these issues?

In answering these questions this submission draws on the recent Reform report Entitlement Reform. The findings of this report were presented at a conference on the long term fiscal outlook held in Wellington, New Zealand, on the 10th and 11th of December. This conference was jointly organised by Victoria University of Wellington and the New Zealand Treasury.

The key points that this letter raises are, in summary:

- Although population ageing is a long term trend, urgent action is required. While there is uncertainty over the precise scale of the increase in costs (given inherent uncertainty in long term fiscal projections), early action would be consistent with a “least regrets principle.” Early action reduces the overall fiscal cost of adjustment required, minimises disruption to families and allows a clear direction of travel to be set before the political barriers to change rise.
- There is a need for an honest conversation regarding the length of working lives and the need for families to contribute more to the cost of public services. These changes can be positive – there is nothing wrong with older cohorts being increasingly independent from the State.
- Reform should not just look at the “public pillar,” but must also consider how private products (such as savings vehicles, insurance and equity release) can play a role in helping families accumulate assets and make the most of these assets when they retire (decumulation).

Background information on this conference, including an agenda and copies of presentations, can be found at: http://bit.ly/PJ0S59 (last accessed 19 December 2012).
Jurisdictions like New Zealand highlight the benefits of having a public process that can shape the preparation of long term fiscal projections and assessment of policy responses. The process surrounding the New Zealand Treasury’s preparation of the most recent long term fiscal outlook (due in 2013) could provide useful lessons on how to stimulate constructive national debate.

The long term challenge of funding public services highlights the need to strengthen the government’s fiscal management. Measures of the sustainability of UK government debt show a long history of unsustainable borrowing: the surplus has been great enough to reduce public debt in only six of the past 34 years.\(^{285}\) Demographic changes will make maintaining a sustainable fiscal policy harder. The Office for Budget Responsibility will help in this regard, but a more binding fiscal mandate is needed.

Background materials outlining Reform’s work on addressing the fiscal costs of population ageing are included with this letter. This background material is:

- Copies of Reform’s reports *Entitlement Reform* and *Old and Broke*.
- A copy of a Reform research note on fiscal rules.
- A copy of Dr Nolan’s PowerPoint presentation at the recent Victoria University of Wellington and New Zealand Treasury conference on the long term fiscal outlook.

**Implications for the extent and nature of public services**

1. Demographic change provides benefits, with people entering retirement now healthier, wealthier and more active than previous generations of retirees.\(^{286}\) But there are costs too. Population ageing increases the cost of many of the existing features of the welfare state. Prudent fiscal management requires considering how these increasing costs will affect the public finances and what this means for the future welfare state.

2. Changes to the extent and nature of public services should not be considered in isolation from tax burdens and the level of government debt.

3. This submission emphasises entitlement reform as the scale of the fiscal challenge means revenue changes cannot realistically be seen as the sole answer. There is also a limit to which tax burdens could rise without damaging international competitiveness and leading to an erosion of living standards (particularly as shrinking working age populations mean that to even just hold revenue constant (as a proportion of GDP) average tax rates on workers could have to rise or tax bases expand in any case).

4. Further, public debt is already high in the United Kingdom (net debt is expected to reach 80 per cent of GDP by 2015-16) and the long term outlook is for debt to fall to around 57 per cent in 2031-32 but then rise again to 89 per cent by 2061-62.

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\(^{286}\) Population ageing is likely to be permanent. This ageing does not just reflect the “temporary effect” of the bulge of “baby boomers” reaching retirement age but also more permanent trends such as increasing longevity and decreasing fertility rates.
Reform—Written evidence

These long term estimates assume the economy faces no major economic shocks over this period.

5. As Zuccollo notes there are real costs associated with increasing levels of public debt.\(^\text{287}\) High debts may encourage pro-cyclicality of fiscal policy (which can exaggerate the economic cycle and prolong recessions), decrease growth (debt levels exceeding 90 per cent of GDP could decrease growth rates by up to 1 per cent) and restrict the government’s ability to respond to crises with fiscal policy.

6. When considering entitlement reform it is important to consider structural changes not simply salami slicing budgets. Salami slicing would mean that the costs of change would be likely to reflect political influence and the principles (case) for reform would be seriously weakened.

7. Also, while attention is often given to changes taking place to public programmes, such as increases in the state pension age, it is also important to not lose sight of how the environment for “the private pillar” is changing. More focussed public programmes mean that many people will need to make a greater contribution to their own living standards during retirement through accumulating greater assets during their working lives and more effectively converting these assets to income at or during retirement (decumulation).

8. Specific recommendations for entitlement reform in the areas of pensioner benefits, health and long term care are discussed in greater detail in the section below. This section also discusses recommendations for reform of the private pillar.

The need to redesign and transform public services

Public programmes – pensioner benefits

9. The primary objective of the core state pension should be poverty reduction. This programme is not an effective policy tool for pursuing other goals, such as smoothing incomes over time. Occupational and voluntary pensions are more suited to this second goal.

10. A focus on poverty reduction requires a mature debate on the role of means-testing. In Australia, for example, means-testing benefits has been seen as a key strategy for reducing poverty and was a feature of the 2009-10 “Secure and Sustainable Pensions” package, which increased the value of benefits while tightening the income test rules to fund this. Yet there is also concern that means-tests weaken incentives for people to participate in the labour market and to save and support themselves.\(^\text{288}\)

11. New Zealand’s universal pension provides an alternative case. The New Zealand experience highlights that it should not be assumed that a universal system would

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\(^{288}\) This effect of means-testing (especially asset testing) on savings is likely to have been dampened by the system of compulsory savings, as this compulsion reduces scope for behavioural change (although some scope remains and there would, nonetheless, still be a “utility loss”). The impact on the labour market has, however, been of concern.
automatically improve incentives to save and work. The New Zealand system also illustrates how in a universal system the pension must be set at a minimum level (which is subject to cost constraints). This means that as fiscal constraints increase there will be greater pressure to erode the real value of pensions for all pensioners. The options in this case are to face large increases in the cost of transfers, allow pensioner poverty to increase or to more effectively target resources to poorer pensioners.

12. As well as the reliance on means-testing, the other policy variable that can influence the poverty reduction effectiveness of state pensions is the approach to indexation. In the long term changes to the indexation of the state pension can have very significant fiscal and distributional implications. If the state pension is indexed in line with prices only (and there is no floor), while the purchasing power of the benefit will be retained the relative income of pensioners will be likely to fall relative to people in work. The consequence is that pensioner poverty could increase over time when measured against poverty measures based on relative incomes.

13. In the United Kingdom the Coalition Government has introduced a more generous system for indexing the state pension called the triple lock. This change to the way in which the state pension is indexed will more than erode the fiscal savings from recent changes to bring forward the increase in the pension age. Bringing forward the increase in the pension age only provides medium term fiscal savings and no long term fiscal benefit (as the age will eventually return to its previous track). Indeed, in 2011 Reform estimated that by 2041 the increase in the costs of pensions will be around 0.7 per cent of GDP higher under the Coalition’s reforms than under the previous Labour government’s plans. This was equivalent to (with rounding) £10.9 billion in 2011.

14. As a simplification measure entitlement in the United Kingdom should also be based on residence rules not contribution histories. The Government has proposed to move to a flat rate pension of £140 a week. The proposed level of £140 is consistent with the current level of the Guarantee Credit, which provides a minimum pension income for people above the pension credit qualifying age (which is currently below the State Pension age). The Government has proposed maintaining the contributory principle, but as the Guarantee Credit would also lift

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289 When considering the effect of means-tested pensions on financial incentives to save, for example, it is necessary to consider both income and substitution effects: One incentive for people to make provision for their retirement is to gain a financial return from that investment (the substitution effect). These incentives reflect the amount of extra income in retirement produced by each dollar in contributions. A positive real payback means that the investment has returned more (in real terms) than the individual contributed. By reducing the return from saving a means-test could reduce this payback and weaken incentives to save. Yet while a means-test may mean that people lose some of their income from saving, the decision to save is also influenced by a desire to reach a certain income in retirement. An income smoothing model suggests that if the level of government entitlement is below the desired income at retirement, then individuals would be encouraged to save while still working to increase their income and living standards in retirement. Incentives to save are reduced when people know that they will receive a benefit even if they make no preparation for their own retirement.


291 The triple lock means that where wage growth is lower than price growth, the retirement pension will grow with the higher of price growth or 2.5 per cent.

292 Cawston et al. (2011), Old and Broke: The Long Term Outlook for the UK’s Public Finances.
the retirement incomes of retirees without contribution histories to this level, assessing contribution histories makes little practical difference.

15. In the United Kingdom there is a pillar of supplementary pensioner benefits that is particularly costly and poorly targeted, especially the universal pension benefits like the Winter Fuel Allowance, free bus passes and free TV licences. Even a small increase in the generosity of poorly targeted programmes comes at a very large financial cost, meaning that resources have to be spread thinly and less is available for poor families. Political incentives mean that the wrong type of support tends to increase in value. This can be shown in the contrasting recent histories of the Winter Fuel Allowance and the Pension Credit. This poorly targeted spending may also weaken the welfare system as a whole by undermining legitimacy. As data from the British Social Attitudes Survey has shown, the increased spending on poorly targeted middle class welfare in the United Kingdom from 1997 onwards was associated with a fall in public support for benefits to people in need."

Public programmes – health and long term care

16. Addressing age related spending requires reform to spending on services as well as spending on transfers.

17. Health is the largest departmental budget and will continue to dominate departmental spending. As Reform noted in 2011, in England the costs for the NHS were forecast to rise by £20 billion over the course of this Parliament. These cost pressures are not a short term problem. According to the OECD, UK public health expenditure will rise from 7.9 to 9.7 per cent of GDP by 2050. The OBR, IMF and the Bank of International Settlements have also highlighted the need to make the costs of healthcare sustainable.

18. The NHS has particular importance for the population over state pension age. As Reform showed in 2011, the major benefit in kind that this group receives is healthcare, with other benefits in kind accounting for low shares of the services received. This can help explain the opposition of much of this cohort to reform to and involvement of private firms in services such as the NHS, which contrasts with the attitudes towards reform of younger cohorts.

19. As the population gets older the NHS will need to further re-orientate its services to focus on the management of long term chronic conditions. This means the service will increasingly need to turn to technology to help deliver public services, support an older workforce and improve productivity. Reform has collated a number of case studies of where health services have used both established and future technologies to improve value. These include:

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294 Cawston et al. (2011), *Old and Broke: The Long Term Outlook for the UK’s Public Finances*.

295 Cawston et al. (2011), *Old and Broke: The Long Term Outlook for the UK’s Public Finances*.
Citizens in the Valencia region of Spain can access both primary and secondary care via one system. The easy and quick access to patient information afforded by the new technology has also led to high employee productivity.\(^\text{296}\)

The use of information and technology has delivered real quality improvements at University Hospitals Birmingham. Medication errors have been cut by 66 per cent, preventing up to 450 individual errors a day. Information and strong management have changed the culture of clinical staff.\(^\text{297}\)

20. These changes present challenges to the traditional, labour-intensive model of public service delivery. In particular, these changes should support the transfer of care from hospitals to the community, as this would deliver significant savings and improve outcomes.\(^\text{298}\) There has, however, been too little progress made in this respect. A major reason for this is the unpopularity of hospital reconfigurations and closures, with Ministers and MPs often leading efforts to block changes at their local hospitals.

21. Private contributions are already required for services such as long term care. This must continue. For this reason Reform has been supportive of the Dilnot proposals to cap the costs of care, as the certainty that a cap could provide may help support the growth of private products to help families manage the costs of care. Yet any cap would need to provide clear value for money for the taxpayer. A cap would also need several things to make it work. The first is honesty and clarity about what is included. The cap also needs to be free from political whim. The cap should not change unnecessarily and any changes must be clear, based on principle and reflect a transparent and open process. The political desire to tailor the cap to attract votes must be resisted. Expectations for the cap must also be realistic.

\textit{The private pillar}

22. As the Chartered Insurance Institute has shown, the private welfare market is undergoing significant change.\(^\text{299}\) With increasing numbers of baby boomers now retiring the focus is moving from “accumulation” (building up financial and other assets) to also include “decumulation” (converting these assets into income streams). The result is that market solutions to help families make the most of the equity in their assets are becoming more important. Releasing equity tied up in housing stock, for example, is playing a greater role in lifting living standards of income poor but asset rich retired households, extending the time families can comfortably live in their own homes and funding care.

23. Yet these markets face challenges. One challenge is public attitudes. As Lord German has noted, in the United Kingdom there is a perception that a “home is a family asset to be valued as a statement of personal freedom, and intended for

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\(^\text{298}\) Bosanquet et al. (2010), \textit{Fewer Hospitals, More Competition}.

passing on to other members of the family.” As hard as this is to say, this perception cannot last. Population ageing will create a real hole in the public finances and the large amount of equity tied up in family homes should play a part in helping plug this gap. People over 65 hold 29 per cent of owner occupied homes, 93 per cent of which are owned outright without a mortgage.

24. Governments must also consider how to improve value for money of policies that aim to support accumulation. There is little doubt that the current system of pension tax relief is expensive (equivalent to around 2 per cent of GDP) and poorly targeted (much of the relief goes to people who would have saved anyway). The system needs reform.

25. Yet the Chancellor of the Exchequer risks scoring an own goal with plans to cut pension tax relief following the Autumn Statement. Rather than a naked tax rise on the rich, any changes should be part of a coherent package that aims to increase saving and lower the cost to the taxpayers.

26. Decisions regarding savings and the purchase of private income support policies are by their nature long term ones. The more uncertain the environment, the harder it will be for families to make the decisions that are in their long term interests and for private providers to complement State programmes.

What should be done now?

27. As the section above discussed specific options for reform, this section outlines why the direction of travel and a timeframe for implementation need to be set now.

28. Reform should not be put off. The political challenges of reform are high (powerful vested interests) and many members of the public are anxious about change. Yet an early start to reform would provide real benefits. Even just in fiscal terms putting the welfare state on a more affordable footing sooner rather than later would be beneficial. As a quick illustration, the Office for National Statistics has estimated that in the United Kingdom net government debt will increase from 74.3 per cent of GDP to 89.0 per cent between 2016 and 2061. If the government is assumed to have a target for debt to be no higher than 80 per cent of GDP in 2061, achieving this through reform in 2016 would cost 1.5 per cent of GDP, or £23 billion, less than if reform was put off until 2061 (ceteris paribus).

29. The argument for early reform is much more than a fiscal one. The temptation for governments will be to put off dealing with these challenges but this will limit future governments’ options. This is not just a challenge for the distant future but will be felt as political parties start to develop manifestos for their next general elections (baby boomers are retiring now). Looking forward this is going to intensify, so that by 2050 the share of the voting population over 65 in the United Kingdom, for example, will have increased from 1 in 4 now to 1 in 3.

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300 German (ed) (2012), Making the Most of Equity Release: Perspectives from Key Players, Smith Institute.
30. There is also a potential personal cost to delaying change. In any change there will be a group of people who are likely to “lose out” or be relatively disadvantaged by the transition from one system to another. Governments are likely to want to protect current recipients and younger people should have sufficient time to change their plans to adjust for any loss of government support. But there is a group of people closer to retirement who will face losing their support and who may not have enough time to, say, significantly build up their private savings. Over the next 10 years this group of people is going to make up an increasing share of the population, and so the potential disruption from reform (and the costs of the transition) will rise.

How could national debate be stimulated?

31. Jurisdictions like New Zealand highlight the benefits of having a public process that can shape the preparation of long term fiscal projections and assessment of policy responses. The process surrounding the New Zealand Treasury’s preparation of the most recent long term fiscal outlook (due in 2013) could provide useful lessons on how to stimulate constructive national debate.

32. The long term challenge of funding public services also highlights the need to strengthen the government’s fiscal management. There is cross-party support for long term action to bring down the government’s debt levels. Even among economists who favour fiscal stimulus in the short term there is broad agreement that debt levels need to come down in the long term.

33. Fiscal rules can play an important role in helping governments commit to a sustainable plan to deal with debt. Yet their previous use in the UK has not been a success. From 1998 to 2008 the UK had two rules: a golden rule to ensure budget balance, and a sustainable investment rule to constrain total debt. These rules did not prevent the increase in government debt in the UK between 2003 and 2008, even before the global financial crisis. Measures of the sustainability of UK government debt show a long history of unsustainable borrowing: the surplus has been great enough to reduce public debt in only six of the past 34 years.301

34. A better approach is required. International experiences with fiscal rules show a range of approaches can work, so long as they are appropriate to the situation. No one size fits all. However, key features that determine the success of fiscal rules include: comprehensive coverage of the government’s accounts to avoid gaming, the flexibility to deal with unexpected contingencies, and supporting institutions that hold the government to account.

19 December 2012

Professor Philip Rees, University of Leeds—Written evidence

This response to the Call for Evidence focuses on the clarification of demographic questions raised by the House of Lords Committee in its Hearings on 5 July 2012 (House of Lords 2012) which ONS staff Guy Goodwin, Ben Humberstone and Suzie Dunsmith and Ludi Simpson (Chair, British Society for Population Studies) attended as witnesses. The response says something about (1) how population ageing is measured, (2) about the degrees of confidence we can have in official projections of the older population, (3) provides an estimate of the contribution of increasing longevity and cohort replacement to future increases in the older population of the UK and (4) assesses the impact of ageing on health, labour force, households and dementia drawing on a study of Northern England populations.

1. How population ageing is measured

The discussion at the Hearing was confused here. The Committee Members properly recognized that the absolute numbers of older persons do matter because local agencies (health or local authority) need to deliver services and care to frail older people. Guy Goodwin focussed on relative measures such as the Old Age Dependency Ratio (ODR) almost exclusively while Committee Member Lord Bichard talked about the Old Age Support Ratio (the reciprocal of the ODR). Lord Bichard said “We have talked a lot about increasing numbers of older people, but the old age support ratio diminishes only slightly. It goes from 3.2 now (2010) to 2.9 in 2035” (House of Lords 2012, Transcript Q50), quoting ONS (2011, p.6). It should have been pointed out that the OSR was measured using a different numerator and denominator in the two years and so the two figures are not comparable. These measures are ratios of the population aged 16 to pensionable age to the population of pensionable age and over. Under the Pensions Act of 2011 pensionable age thresholds will rise decade by decade and there is a note that the timetable may be speeded up. So the smallness of the fall on which Lord Bichard remarked is a direct consequence of legislation and implementation of policy. 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 (computation based on the NPP2010 principal projection).

2. How confident can we be in the projections of the older population of the UK?

Lord Griffiths of Fforestfach asked “How much confidence should I have in the number and what would be the distribution around that? Can I have 99% confidence in it or 95% confidence or what?” (House of Lords 2012, Transcript Q32). Guy Goodwin answered this question in very general terms. Earlier (Q2) he had referred to the Variant projections produced by ONS as part of the National Population Projections suite as an indicator of the uncertainty in future populations but suggested it was up to the user of projections to choose the variant s/he was most comfortable with.

How should the question on how confident can we be in the NPP projections have been answered?

Methods have been developed by researchers for computing confidence intervals around a principal projection. These involve the estimation of error distributions of the leading indicators that drive a projection (e.g. total fertility rate, mortality rates by age and total net migration at a minimum) and the sampling of those error distributions hundreds of times to
produce a distribution of projection results from which confidence intervals around a principal projection can be defined.

The pioneers of probabilistic population projections are Wolfgang Lutz and his colleagues in Vienna. They have published probabilistic projections at the world scale (e.g. Lutz et al. 1996, Lutz et al. 2001, Lutz 2006) and for many country populations. They are currently engaged in producing probabilistic projections about 194 countries covering most of the world’s population (Nikola Sander, personal communication). At the heart of their methodology is the use of surveys of demographic experts who were asked to judge the confidence intervals around leading indicators for each demographic component.

Alternative methods of estimating errors have been proposed including comparison of projection series with later published estimates (Shaw 2007, Keilman 2007, 2008) and time series forecasting using auto-regressive moving average (ARIMA) models (Alho 1992) as in the Uncertain Population of Europe project (Alders et al. 2005). There have been two sets of probabilistic projections produced for the UK: the projections by Coleman and Scherbov (2005) use normal probability methods of error specification while Abel et al. (2010) use Bayesian probability methods of error specification (though their projections do not include age and sex). Wilson (2004) and Wilson and Bell (2004a, 2004b) provide very transparent accounts of probabilistic projections of the populations of Australia and New Zealand, again using time series models to derive error estimates. There is work in progress at the University of Southampton which recognises model specification error as well as empirical errors (Abel et al. 2010, Forster and Ou 2012 and Smith and Raymer 2012). The Southampton authors use Bayesian methods for estimating and applying error distributions. At the June 2012 European Population Conference in Stockholm there were many presentations on the topic including one by Corsetti and Marsili (2012) that indicated that the Italian Statistical Office was already publishing probability ranges for its National Population Projections.

The Office for National Statistics has, in the past, developed methods for computing confidence intervals around their principal projection. Chris Shaw (former GAD and ONS member of staff responsible for national projections) and colleagues carried out a programme of error estimation using both a historical database (Shaw 2007) and expert panel surveys (Shaw 2008). He consulted with and adapted an argument based expert survey from Lutz (2009). Chris Shaw and colleagues used these error estimates to produce probabilistic confidence intervals using the 2006-based National Population Projections. Progress reports were produced on these probabilistic projections (ONS 2009, Rowan and Wright 2010) but the numeric results have not been published. Figure 1 reproduces two population age structure graphs from the Rowan and Wright (2010) paper. We can see from the graphs that the confidence bands are widest for the youngest ages and diminish towards the older ages though bands widen in the 80s. When we compute the ratio between the confidence intervals and the projected populations, we find that the percent error diminishes from 27% for ages 0-4 in 2031 to 4% for ages 75-79 but then increases considerably at very old ages to be 81% for ages 100+ (Table 1). Errors we make in forecasting mortality rates/survival probabilities pile up in the oldest old ages.

[Figure 1 about here]

[Table 1 about here]
How confident can we be in the projected populations? Table 2 summarises the evidence for three broad age groups and the total population. The confidence intervals generated from the graphs in Figure 1 seem encouraging small, though wider in 2056 than in 2031 because error accumulates over time. However, when we compare these 2006-based projections with a more recent projection based on mid-2010 populations, we see that the 2010-based projected populations fall well above the upper confidence level. We cannot therefore be very confident in the confidence intervals. The calculations use errors for the driver components averaged from those provided by members of the National Population Projections Expert Panel. The sample is very small and therefore the estimate of the errors very uncertain. What this discussion indicates is that ONS needs to invest further in methods for estimating confidence levels in their projections.

There are more uncertainties that have been estimated by current methods. Consider the population trajectories under a series of projection scenarios shown in Figure 2 (Rees et al. 2012a). The solid black line shows ONS’s NPP2008 principal projection and the black pecked line shows the sum of 355 local projections aligned to the NPP2008 assumptions overall with the lighter pecked line using slightly higher assumptions. The bottom pecked line shows what might have happened if all of the component drivers had been kept at their values measured around the 2001 Census. This projection is much lower than the ONS Principal or the TREND or UPTAP EF projections; the difference is due to a combination of increasing net immigration flows, higher fertility rates and lower mortality probabilities. This assumption uncertainty certainly lies behind the gap between the upper confidence limit for the 2006-based projections and the 2010-based projections. But there is also model uncertainty shown by the middle trajectory (UPTAP ER) which adopts a different model for projecting emigration. A quick check of our 2011 projections against 2011 Census population estimates showed that an average of the TREND EF and UPTAP ER was close to the census estimate.

3. An estimate of the contribution of increasing longevity and cohort replacement

The Committee asked several times about the degree of confidence that one could have in continuing reductions in mortality and associated increases in life expectancy and the witnesses made reference to an ongoing debate. There is a huge and continually developing literature on this topic. There are two polar views on this issue. The first, put forward by Jay Olshansky and colleagues (e.g. Olshansky 2001) is that we are approaching the limits to life expectancy and that a number of disease trends (e.g. 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. The second, put forward by James Vaupel and colleagues (e.g. Oeppen and Vaupel 2002) is that the historical record of the countries with the best life expectancy records suggests no limits to improvements driven by progress in well-being and medical science. Translating these optimistic views into future forecasts, Christensen et al. (2009) suggest very high proportions of current birth cohorts in a sample of advanced countries surviving to be centenarians. The evidence on the impact of obesity trends was debated by the National Population Projections Expert Panel with no clear consensus. The Foresight Report on Obesity (Government Office for Science 2007a, 2007b) suggested that there will be a subtraction of circa 1.5 years to set against an
expected increase in longevity of about 8 years from 2010 to 2050. It should be stressed that these trends depend on current policy of investing in better survival but on continuing failure to stop the increase in obesity.

However, the increase in the number of old people is not just a function of improving mortality before and during old age, but it also depends on the size of new (birth) cohorts entering old age (e.g. having their 65th or 70th or 75th birthdays) compared with those who went before them. Does the future population of the old grow because mortality is declining or because the birth cohorts entering old age in the future are larger than they have been in the past? This is quite a difficult question to answer because it involves designing the correct scenario projections that provide an estimate of the effect. Neither the ONS Variant Projections nor the Scenario or Demographic Driver Projections designed by Rees et al. (2012a, 2012b) quite deliver the right scenarios. Given the correct scenarios (what if projections) there would also need to be a careful age-period-cohort analysis, which has not been done. However, the question is an important one to answer and it is worth making an informed guess using the ETHPOP projections.

Figure 3 shows a set of scenario projections carried out in order to estimate the impact of component assumptions on the future population (Rees et al. 2012b), extending and adapting a method proposed by Bongaarts and Bulatao (1999). The fourth effect on the projected population is that of reduced mortality, which adds 5.9 million to the UK population between 2001 and 2051, of which 3.3 million are added by 2026. Let us assume that all these extra persons are old people (aged 65+). Let us assume also that international migration does not impact the older population. Then we can subtract the mortality effect from the total population effect to give an approximate estimate of the cohort replacement effect of 2.8 million in 2001-2026 and 2.3 million in 2001-2051. This implies that the replacement cohort effect is negative in the second quarter of the 21st century because in the 2040s smaller cohorts from the mid-1970s to mid-1980s are attaining age 65. In the bottom panel of Table 3 we compute the percent contribution of improving longevity (54% to 2026, 72% to 2051) and of cohort replacement (48% to 2026, 28% to 2051).

4. The impact of ageing on health, labour force, households and dementia
The House of Lords Committee Hearing touched on the impact of population ageing on the numbers of people with health problems or disabilities, who would need health and social care. There is a lot of research going on into this topic across Europe currently. The critical question is whether age-specific rates of disability of different degrees are remaining constant or if they are declining in parallel with mortality rate decline. There are difficulties establishing trends in age specific disability rates from sample surveys. The results also depend on exactly what measure (degree of disability) is used. In research commissioned by Central Government Departments (DWP, BIS and DCLG), Rees et al. (2011c) and Buckner et al. (2011) attempted to answer the following question: what impact does population ageing have on health, holding prevalence rates by age, sex and local authority constant at 2001 Census levels, for Northern England? Table 4 sets out some of the results for local authorities grouped into Local Enterprise Partnerships.
The first column of Table 4 shows the modest growth in total population in Northern areas from 2011 to 2013, only 12% in total. The second column presents the projection results for households, assuming “household representative rates” by age and sex remain constant. Households still grow by more than the population because population ageing leads to smaller households. The third column shows declines in the labour force, most marked in the depressed city regions of Liverpool, Tees Valley with a few low increases in North Yorkshire, Leeds City Region and Cumbria. The next column which reports the projected number of people with self-reported limiting long-term illness shows the impact of population ageing. The age curve of LLTI resembles that of mortality (though there are important differences) with the highest rates in the oldest ages. A 25% increase is projected for Northern England as a whole. We could expect that age-sex specific prevalence of LLTI might decline in future and that these increase were pessimistic. However, the final column shows what a challenge our society faces: it show the projected growth in numbers with dementia (e.g. Alzheimer’s syndrome). To date there has been only a little progress in postponing the onset of dementia. An 83% increase in persons with dementia in Northern England will demand considerable care by relatives and society.

5. Conclusions
It is useful to draw out lessons from the observations made in this contribution and make some suggestions. There is a need to revise population projections frequently to take into account the latest trends. There is a need to develop better ways of assigning confidence levels to the projections. A policy goal should be to push ill health to older and older ages. We need a National Health and Social Care Service not just an NHS. There will be a continuing need to raise the pension age threshold to preserve the viability of public and private pension schemes. But this means enabling older people below those rising thresholds to work and to be active in contributing to society. People and organizations will need to re-think life careers in new ways.
Table 1: Confidence intervals for the projected population, by 5 year age group, United Kingdom, 2031 and 2056

<table>
<thead>
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<th>Ages</th>
<th>2031 populations (thousands)</th>
<th>2056 populations (thousands)</th>
<th>95% Confidence Interval</th>
<th>Cl as % of Population</th>
<th>95% Confidence Interval</th>
<th>Cl as % of Population</th>
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<td>57</td>
<td>168</td>
<td>5</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>75-79</td>
<td>71</td>
<td>112</td>
<td>4</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>80-84</td>
<td>143</td>
<td>168</td>
<td>6</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>85-89</td>
<td>143</td>
<td>253</td>
<td>11</td>
<td></td>
<td>11</td>
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<tr>
<td>90-94</td>
<td>114</td>
<td>337</td>
<td>23</td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>95-99</td>
<td>57</td>
<td>168</td>
<td>28</td>
<td></td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>100 &amp; over</td>
<td>29</td>
<td>140</td>
<td>81</td>
<td></td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>All ages</td>
<td>3414</td>
<td>8814</td>
<td>13</td>
<td></td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Note: The confidence bands were estimated by manual measurement from the graphs in Figure 1.
Source: Rowan and Wright (2010), Figures 6 and 7
## Table 2 Confidence intervals for the projected UK population, 2031 and 2056

<table>
<thead>
<tr>
<th>Projection Year</th>
<th>Age groups</th>
<th>2006 Based projection</th>
<th>2010 based projection minus UCL</th>
<th>2010 based projection</th>
<th>CI as % of Projected Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Confidence Level (LCL) (95%)</td>
<td>Upper Confidence Level (UCL) (95%)</td>
<td>Confidence Interval (CI) (95%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2031 0-19</td>
<td>14,399</td>
<td>13,656</td>
<td>15,141</td>
<td>1,486</td>
<td>16,525</td>
</tr>
<tr>
<td>20-64</td>
<td>37,275</td>
<td>36,632</td>
<td>37,918</td>
<td>1,286</td>
<td>39,404</td>
</tr>
<tr>
<td>65+</td>
<td>15,340</td>
<td>15,018</td>
<td>15,661</td>
<td>643</td>
<td>15,837</td>
</tr>
<tr>
<td>Total</td>
<td>67,013</td>
<td>65,306</td>
<td>68,720</td>
<td>3,414</td>
<td>71,766</td>
</tr>
<tr>
<td>2056 0-19</td>
<td>14,188</td>
<td>12,743</td>
<td>15,859</td>
<td>3,116</td>
<td>17,426</td>
</tr>
<tr>
<td>20-64</td>
<td>37,156</td>
<td>35,135</td>
<td>39,247</td>
<td>4,112</td>
<td>42,665</td>
</tr>
<tr>
<td>65+</td>
<td>18,236</td>
<td>17,380</td>
<td>18,966</td>
<td>1,586</td>
<td>20,210</td>
</tr>
<tr>
<td>Total</td>
<td>69,580</td>
<td>65,258</td>
<td>74,072</td>
<td>8,814</td>
<td>80,300</td>
</tr>
</tbody>
</table>

Source: Computed from the graphs shown in Figure 1 in Rowan and Wright (2010) and from the 2006-Based and 2010-Based National Population Projections (ONS). The populations are in 1000s.
Table 3 Estimates of the effect of increasing longevity and cohort replacement on the population of the United Kingdom aged 65 and over, 2001-2051

<table>
<thead>
<tr>
<th>Projection/Variable</th>
<th>Population 2026 (millions)</th>
<th>Population 2051 (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHPOP Replacement V2</td>
<td>65.3</td>
<td>67.2</td>
</tr>
<tr>
<td>ETHPOP Momentum V2</td>
<td>62.0</td>
<td>61.3</td>
</tr>
<tr>
<td>Increase due to increasing longevity</td>
<td>3.3</td>
<td>5.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHPOP Trend V2</td>
<td>6.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Net effect (increase due to cohort replacement)</td>
<td>2.8</td>
<td>2.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Change due to:</th>
<th>2001-2026</th>
<th>2001-2051</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longevity</td>
<td>54</td>
<td>72</td>
</tr>
<tr>
<td>Cohort Replacement</td>
<td>46</td>
<td>28</td>
</tr>
</tbody>
</table>

Sources: Computed from various ETHPOP projections, [http://www.ethpop.org/](http://www.ethpop.org/). See Rees et al. (2012a) for an account of the model and assumptions used for the Trend projection and Rees et al. (2012b) for an account of the scenario projections used to measure the effect of increasing longevity.
Table 4: Projected percentage change in total population, households, labour force, people with limiting long-term illness (LLTI) for Local Enterprise Partnerships, Northern England, 2011-2036

<table>
<thead>
<tr>
<th>Local Enterprise Partnership</th>
<th>Population 2036</th>
<th>Households 2036</th>
<th>Labour Force 2036</th>
<th>People with LLTI 2036</th>
<th>People with dementia 2036</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester</td>
<td>9.5</td>
<td>13.7</td>
<td>-4.3</td>
<td>27.9</td>
<td>85</td>
</tr>
<tr>
<td>Liverpool City Region</td>
<td>1.0</td>
<td>6.5</td>
<td>-11.8</td>
<td>18.3</td>
<td>81</td>
</tr>
<tr>
<td>Leeds City Region</td>
<td>15.4</td>
<td>19.8</td>
<td>2.1</td>
<td>34.3</td>
<td>92</td>
</tr>
<tr>
<td>Sheffield City Region</td>
<td>9.4</td>
<td>13.3</td>
<td>-2.7</td>
<td>26.8</td>
<td>79</td>
</tr>
<tr>
<td>Cheshire and Warrington</td>
<td>8.1</td>
<td>11.6</td>
<td>-3.9</td>
<td>29.5</td>
<td>82</td>
</tr>
<tr>
<td>Tees Valley</td>
<td>6.7</td>
<td>12.3</td>
<td>-6.6</td>
<td>19.5</td>
<td>89</td>
</tr>
<tr>
<td>Cumbria</td>
<td>13.9</td>
<td>15.5</td>
<td>2.8</td>
<td>31.2</td>
<td>78</td>
</tr>
<tr>
<td>Hull City Region</td>
<td>8.2</td>
<td>11.6</td>
<td>-3.1</td>
<td>28.3</td>
<td>78</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>16.6</td>
<td>19.1</td>
<td>5.9</td>
<td>28.7</td>
<td>76</td>
</tr>
<tr>
<td>North East</td>
<td>14.2</td>
<td>17.4</td>
<td>1.8</td>
<td>24.5</td>
<td>82</td>
</tr>
<tr>
<td>Lancashire</td>
<td>12.1</td>
<td>15.9</td>
<td>1.0</td>
<td>32.2</td>
<td>79</td>
</tr>
<tr>
<td>Northern England (sum of GORs)</td>
<td>11.7</td>
<td>14.7</td>
<td>-4.1</td>
<td>25.0</td>
<td>83</td>
</tr>
<tr>
<td>Rest of England</td>
<td>18.2</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>England</td>
<td>16.5</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

Notes: The percentage change = 100 × [projected population of group 2036/projected population of group 2011]
Some LEPs overlap. The Northern England total is the sum of the former North East, North West and Yorkshire and the Humber Government Office Regions. na = not available.
Source: Rees et al. 2011c, Buckner et al. 2011
Figure 1: Provisional probabilistic projections (medians and intervals) of the United Kingdom population using the 2006-based National Population Projections
Source: Rowan and Wright (2010), Figures 6 and 7
Figure 1 Trends in the UK population, ONS 2008-based projections and five ethnic group projections, 2001 to 2051
Source: Rees et al. (2012a) based on ETHPOP Version 1 projections (http://www.ethpop.org/).
**Key**

<table>
<thead>
<tr>
<th>Projection</th>
<th>Effect</th>
<th>Formula</th>
<th>Population differences (millions)</th>
<th>Population multipliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$P_s$</td>
<td>TREND (Standard)</td>
<td>$P_s^{2051} - P_n^{2051} = 75.8 - 61.0 = 14.8$</td>
<td>$75.8/61.0 = 1.24$</td>
<td></td>
</tr>
<tr>
<td>$P_n$</td>
<td>Natural increase-1 (no international migration)</td>
<td>$P_n^{2051} - P_i^{2051} = 61.0 - 61.1 = -0.1$</td>
<td>$61.0/61.1 = 0.99$</td>
<td></td>
</tr>
<tr>
<td>$P_i$</td>
<td>Natural increase-2 (no migration)</td>
<td>$P_i^{2051} - P_r^{2051} = 61.1 - 67.2 = -6.1$</td>
<td>$61.1/67.2 = 0.91$</td>
<td></td>
</tr>
<tr>
<td>$P_r$</td>
<td>Replacement</td>
<td>$P_r^{2051} - P_m^{2051} = 67.2 - 61.3 = 5.9$</td>
<td>$67.2/61.3 = 1.10$</td>
<td></td>
</tr>
<tr>
<td>$P_m$</td>
<td>Momentum</td>
<td>$P_m^{2051} - P_0^{2001} = 61.3 - 59.1 = 2.2$</td>
<td>$61.3/59.1 = 1.04$</td>
<td></td>
</tr>
<tr>
<td>$P_0$</td>
<td>Base (2001)</td>
<td>$P_s^{2051} - P_0^{2001} = 75.8 - 59.1 = 16.7$</td>
<td>$75.8/59.1 = 1.28$</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3** Projection results for the UK, 2001-2051, for all ethnic groups combined

Source: Authors’ computations from ETHPOP Version 2 projections (http://www.ethpop.org/).

Source of Figure: Rees et al. (2012b)
References


4 September 2012
Memorandum on Confidence in Projections of the Older Population

Abstract

This document responds to two requests by the Committee Chair, Lord Filkin, during the 16 October Hearings: (1) to supply an assessment of confidence in the projected numbers of older persons for the UK and (2) to supply an assessment of the projected numbers of people with disability for the UK. To estimate the confidence in the projected numbers of the older ages some nineteen different population projections for the UK were pooled and used to compute confidence bands around a median projected population for each age group. The population aged 65+, 10.2 millions in 2010, is projected to 18.3 million in 2050, with a 95% confidence that it will lie between 21.3 and 15.7 million. We can be more confident about the numbers for the younger elderly (aged 65-84) than for the older old (aged 85+). We cannot be very confident about the future numbers of centenarians. The population of centenarians is projected to be 242 thousand in 2050 compared with 12 thousand in 2010 but the 95% confidence interval stretches from 426 thousand to 59 thousand. The results of projections of the disabled population of local areas in Northern England and of the whole UK are reported, along with projections that use constant and declining trends in disability prevalence so that the effects of “pure” ageing and possible future health improvements can be estimated. We find that population ageing will increase the population with 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%. However, we cannot currently assess the degree of confidence around these projections.

Acknowledgements

The following provided valuable advice in the preparation of this memorandum: Ludi Simpson (University of Manchester) encouraged me to volunteer as a witness; Steve Smallwood (Office for National Statistics) suggested that I needed to look at old age support ratios; Pia Wohland (University of Newcastle) provided a healthy life expectancy tool for experimentation; Alan Marshall (University of Manchester) made available his disability projections for the UK population.

CONFIDENCE IN PROJECTIONS OF THE OLDER POPULATION

The House of Lords Select Committee asked “How much confidence should we have in projections about the ageing of the UK population?” in both its July and October 2012 Hearings and did not receive satisfactory answers. Lord Filkin, Chair of the Select Committee expressed surprise that precise statements could not be made about this important matter and challenged the witnesses at the 16 October Hearings to produce a memorandum that answered the question. The first part of this paper delivers the answer, while the second part provides some answers about how many people will be disabled in the future, though without the same confidence bands.

302 The questions are taken from the Calls for Evidence of the Committee.
We can be very confident that population ageing will continue for two reasons: (1) survival chances both to old age and within old age are highly likely continue to improve, even through our current economic difficulties although the pace of improvement may be slower than before; (2) the baby boom generations of the 1950s and 1960s which were larger than their predecessors in the 1930s and 1940s have begun to retire and most of them will have done so by 2040 under present plans for raising the State Pension Age. The improvement in survival chances we believe will continue because that has been the experience of the previous century and because there are populations which have already achieved the improvements anticipated for the UK (e.g. the populations of Japan, Iceland and Australia or of the county, Dorset, in the UK with the highest life expectancy). The cohorts who will move into the older ages have already been born. These cohorts will age and mostly survive to old age in the UK, unless there is a huge increase in emigration on retirement.

**Confidence bands for projected populations by age**

The conventional method to determine confidence in a statistic is to compute probabilistic confidence intervals, using the formulae based on the normal distribution and the viewpoint that our observations are the product of unbiased sampling from a bigger universe. For example, the UK population, aged 65 and over, can be estimated as 10.5 million at mid-year 2011, and a consensus projected value might be 18.3 million in 2050. We would want to be 95% confident that the true value in 2050 lay between 21.3 million and 15.7 million, for example. There is a methodology, called probabilistic projection, which emulates the strategy of sampling and inference and makes possible such statements. However, ONS have only experimented with this methodology (Rowan and Wright 2010) and not published comprehensive findings. The results, based on estimates by members of the National Population Projections Expert Panel (Shaw 2008) about future confidence intervals for the main driver variables in a projection to have, were not encouraging. The experts, including myself, were not expert enough. I explain later why none of the probabilistic projections of the UK population, available in the literature, are yet suitable for such use.

An alternative approach is to re-define what we mean by expert views. Here we define an expert view as a projection carried out by statistical agencies or academic project teams. The justification is that the teams of researchers can give a lot more thought and carry out a lot more analysis that an expert asked to fill in a questionnaire in a short period of time. The main projections and variants for which there are plausible arguments can be included in a set of projection results, the probability distribution of which can be described. The data for projected populations by age and sex from these projections need to be in the public domain and accessible for download. This meant that many academic projections could not be used as their full results were not immediately accessible. Table 1 lists the details of nineteen deterministic projections which have a recent starting base or “jump-off” population, between 2005 and 2010. There are six academic projections from the DEMIFER and ETHPOP projects, four projections by international agencies, EUROSTAT and the UN, and eight projections produced by the Office for National Statistics (ONS). These projections are independent in design and implementation but connected in that all the necessary input data for the base population and base period components are produced by the Office of National Statistics. It is also possible that the staff responsible for the projections could have exchanged views about component assumptions. It was decided to exclude from the pooled set reference projections that assumed constant component rates because they can be regarded as highly unlikely. We also excluded conditional projections.
whose main purpose was to isolate the effect of the assumptions made for one component. The projections listed in Table 1 differ in their assumptions about future fertility, mortality and international migration and they also differ in some aspects of the projection model used, particularly in the way international migration is handled.

In order to use the projected populations from the nineteen projections as one statistical dataset, it was necessary to carry out some harmonization. All projections except EUROPOP2010 reported the projected populations by five year ages to 95-99 with a final age group 100+. The EUROPOP2010's final age group of persons aged 85+ was distributed to ages 85-89, 90-94, 95-99 and 100+ using the breakdown in the 2011 UK population estimate based on ONS data to achieve constant age groupings across all projections. The time reference of the projections was standardized at mid-year (reported as either 30 June or 1 July depending on source). The DEMIFER and EUROSTAT projections reported start of year populations. Linear interpolation between successive start of year populations was used to estimate mid-year populations with a small extrapolation from SY2050 to MY2050. For all projections a MY2011 population was interpolated and compared with a UK MY2011 estimate based on the 2011 Census for England and Wales and 2010-based National Population Projections for Scotland and Northern Ireland. The differences were then added to the projection series so that all projected populations were re-based, reducing “jump-off” differences to small numbers.

Full results are available from the author (in a file called “Combined Projections.xlsx”). Table 2 reports selected results for summary ages and Table 3 reports selected results for five year ages. The tables report five statistics for each age group. The median is used to represent the consensus projection because the distribution of the projections is skewed from the normal, with the average value over the nineteen projections slightly higher than the mean. Then we used the percentile function to interpolate for each age a population 97.5% through the distribution and a population 2.5% through the distribution. These two limits enclose 95% of the distribution. The 95% percentile interval is reported and finally expressed as percentage of the median. Note that we label the percentile intervals derived from this analysis as Confidence Bands to signal that they were derived in a different way from “normal” confidence intervals.

Table 1: The set of deterministic projections of the United Kingdom included in a confidence analysis

<table>
<thead>
<tr>
<th>Projection Set</th>
<th>Projection</th>
<th>Base Year</th>
<th>Model</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMIFER</td>
<td>GSE</td>
<td>SY2005</td>
<td>Multiplies: Hierarchical multistate cohort-component</td>
<td>Growing Social Europe: optimistic, equality driven</td>
</tr>
<tr>
<td>DEMIFER</td>
<td>LSE</td>
<td>SY2005</td>
<td>Multiplies: Hierarchical multistate cohort-component</td>
<td>Limited Social Europe: pessimistic, equality driven</td>
</tr>
<tr>
<td>DEMIFER</td>
<td>EME</td>
<td>SY2005</td>
<td>Multiplies: Hierarchical multistate cohort-component</td>
<td>Expanding Market Europe: optimistic, competition driven</td>
</tr>
<tr>
<td>DEMIFER</td>
<td>CME</td>
<td>SY2005</td>
<td>Multiplies: Hierarchical multistate cohort-component</td>
<td>Challenged Market Europe: pessimistic, competition driven</td>
</tr>
<tr>
<td>ETHPOP</td>
<td>TREND</td>
<td>MY2001</td>
<td>Bi-regional cohort-component</td>
<td>Trends in components</td>
</tr>
</tbody>
</table>
updated to MY2006 component model for ethnic group populations and local areas with gross immigration and emigration flows Bi-regional cohort-component model for ethnic groups populations and local areas with gross immigration and emigration rates

<table>
<thead>
<tr>
<th>ETHPOP</th>
<th>UPTAP</th>
<th>MY2001, updated to MY2006</th>
<th>LIPRO: Multistate cohort-component</th>
<th>Trends in components specified by research team. Local differentials maintained at 2000-1 or 2005-6 levels</th>
</tr>
</thead>
</table>
| EUROS   | EUROP | SY2010                   | Cohort-component, Principal Projection | Trends in components assumed
| ONS     | PRIN  | MY2010                   | Cohort-component, High Fertility Variant | High fertility assumptions
| ONS     | HFERT | MY2010                   | Cohort-component, Low Fertility Variant | Low fertility assumptions
| ONS     | LFERT | MY2010                   | Cohort-component, High Life Expectancy Variant | High life expectancy assumptions
| ONS     | HLE   | MY2010                   | Cohort-component, Low Life Expectancy Variant | Low life expectancy assumptions
| ONS     | LLE   | MY2010                   | Cohort-component, High Migration Variant | High migration assumptions
| ONS     | HMIG  | MY2010                   | Cohort-component, Low Migration Variant | Low migration assumptions
| ONS     | LMIG  | MY2010                   | Cohort-component, High Population Variant | High assumptions all components
| ONS     | HPOP  | MY2010                   | Cohort-component, Low Population Variant | Low assumptions all components
| ONS     | LPOP  | MY2010                   | World Population Prospects, Cohort-component model | Medium variant
| UN      | UNMD  | MY2010                   | World Population Prospects, Cohort-component model | Low variant
| UN      | UNHI  | MY2010                   | World Population Prospects, Cohort-component model | Low variant
| UN      | UNLO  | MY2010                   | World Population Prospects, Cohort-component model | Low variant

Projectio
n Set Databank sources Reports, Papers


ETHPOP [http://www.ethpop.org](http://www.ethpop.org)

<table>
<thead>
<tr>
<th>Source</th>
<th>Website</th>
<th>Notes</th>
</tr>
</thead>
</table>

Notes: SY = Start of Year, MY = Mid-Year
Table 2: Confidence bands for populations by summary ages, UK, 2010, 2020, 2035 and 2050

<table>
<thead>
<tr>
<th>Year</th>
<th>Ages</th>
<th>Median</th>
<th>Percentile 97.5</th>
<th>Percentile 2.5</th>
<th>95% Percentile Interval</th>
<th>PI as % Median</th>
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<tbody>
<tr>
<td>2010</td>
<td>All ages</td>
<td>62771</td>
<td>63287</td>
<td>62243</td>
<td>1043</td>
<td>1.7</td>
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<tr>
<td></td>
<td>0-19</td>
<td>15065</td>
<td>15220</td>
<td>14947</td>
<td>273</td>
<td>1.8</td>
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<tr>
<td></td>
<td>20-49</td>
<td>26072</td>
<td>26300</td>
<td>25889</td>
<td>411</td>
<td>1.6</td>
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<tr>
<td></td>
<td>50-64</td>
<td>11394</td>
<td>11467</td>
<td>11330</td>
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<td>8872</td>
<td>8904</td>
<td>8758</td>
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<td>1382</td>
<td>1307</td>
<td>75</td>
<td>5.5</td>
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<td></td>
<td>100+</td>
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<td>13</td>
<td>11</td>
<td>1</td>
<td>10.9</td>
</tr>
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<td></td>
<td>65+</td>
<td>10240</td>
<td>10300</td>
<td>10077</td>
<td>223</td>
<td>2.2</td>
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<tr>
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<td>85+</td>
<td>1369</td>
<td>1395</td>
<td>1319</td>
<td>76</td>
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<tr>
<td></td>
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<td>3.67</td>
<td>3.69</td>
<td>-0.03</td>
<td>-0.7</td>
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<tr>
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Notes: Computed from 19 recent projections listed in Table 1. All populations are in thousands.

OSR = Old Age Support Ratio = Population aged 20-64/Population aged 65+
VOSR = Very Old Age Support Ratio = Population aged 50-64/Population aged 85+
The median and percentile values for OSR and VOSR are computed from the corresponding population values rather than from OSR and VOSR values for each of the 19 projections. In one case, OSR in 2035 this leads to the median lying outside the confidence band as defined where the band is very narrow.
Confidence in the population aged 65+

On the basis of this analysis, we can make statements about our confidence in the projected numbers of older persons as a whole (aged 65+): (1) in 2020 we can be 95% certain that the population aged 65+ lies between 13.3 million (upper limit) and 11.3 million (lower limit) with a median value of 12.1 million, a relative uncertainty of 17%; (2) in 2030 we can be 95% certain that the population aged 65+ lies between 16.0 million (upper limit) and 14.4 million (lower limit) with a median value of 14.6 million, a relative uncertainty of 18%; (3) in 2040 we can be 95% certain that the UK population aged 65+ falls between 18.7 million and 15.0 million with a median value of 17.2 million; (4) in 2050 we can be 95% certain that the population aged 65+ lies between 21.3 million (upper limit) and 15.7 million (lower limit) with a median value of 18.3 million, a relative uncertainty of 31%. These projected values compare with a central value in 2010 of 10.2 million.

Confidence in the population aged 85+

Table 2 reports the confidence band for the older old population, aged 85 and over, a sub-group which will be more infirm, disabled and dependent than the older population in general. The population aged 85+ grows substantially from a 2010 median size of 1.4 million to a median value of 1.6 million in 2020, 2.2 million in 2030, 3.4 million in 2040 and 4.3 million in 2050. The confidence bands around these median values are around twice as large, in relative terms, as those for the 65+ population as a whole. In 2050 the upper confidence limit for the population aged 85+ is 5.8 million, while the lower limit is 3.3 million.

Confidence in the population aged 100+

The relative confidence bands for the number of centenarians are much larger than for the 85+ age group. We can be two to three times less confident in the future number of persons aged 100 and over than in the numbers of the older old (aged 85+) and five times less confident than about the old as a whole (aged 65+). So by mid-century the median projected number of centenarians will be 242 thousands lying between an upper confidence limit of 426 thousands and a lower confidence limit of 59 thousand, all compared with a median estimate for MY2010 of 12 thousand. Most of the MY2050 population of persons aged 100 and over will have been born between MY 1949 and MY 1950. The UK birth cohort was about 793 thousand so the median survival rate will be about 31%, ignoring the effects of international migration, though these computations are approximate.

How confidence varies by age and over time

Table 3 reports the confidence statistics by five year age groups for 2010, 2020, 2030, 2040 and 2050. Uncertainty is high for the youngest ages, reflecting uncertainty about future fertility; uncertainty declines in the middle age groups because these people are already in the population at the start.
Table 3: Confidence bands for five year age groups, United Kingdom, 2010, 2020, 2035 and 2050

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<td>627</td>
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</tbody>
</table>

**Notes:** Computed from 19 recent projections listed in Table 1. All populations are in thousands.
Uncertainty is at a minimum in the “younger” old ages, 65-84, and then rises steeply from age 85 onwards, reflecting the cumulative effect of uncertainty about mortality/survival. The uncertainties also rise steadily with time elapsed from the start of the projection from 2 per cent for the total population in 2010 to 13 % in 2020, 13 % in 2030, 28% in 2040 and 38 % in 2050. These results resemble closely the analysis of historical errors in UK population projections since the early 1950s by Chris Shaw (Shaw 2007).

Two factors explain the increasing width of confidence bands as age increases at older ages. The first factor is the accumulation of errors in mortality from age 65 to age 100. The second factor is that projections differ in their assumptions about the future rates of mortality decline in the future. Some projections are very optimistic about likely future improvements. Others assume relatively little improvement.

Confidence in old age support ratios

In Table 2 old age support ratios are reported. As the population ages, the ratio of older people to people in the working ages reduces. The median Old Age Support Ratio (OSR) decreases from 3.66 in 2010 to 2.27 in 2050 or by 38%. This will raise viability issues for the Pay As You Go funding model for the basic state pension, which has prompted the planned rises in age of pension entitlement over the next four decades. Note that the confidence intervals across the 19 projections for the OSR are very narrow for all the selected years, varying between -6.5% and +2.2%. In effect, the uncertainties in the working and older age populations cancel out.

The second support ratio attempts to capture the availability of carers for the older old population that has a high need for care. The Very Old Age Support Ratio (VOSR) divides the number of people at ages 50-64 by persons aged 85+, whose children will be mostly in the younger age group. The VOSR decreases from a median of 8.32 in 2010 to 3.11 in 2050, a decrease of 63%. The uncertainty for the VOSR is much higher than for the OSR, rising steadily from 4.5% to 32.8% (as absolute measures). The implication is that more care will need to be provided by persons outside of the late middle age group of children of the very elderly.

Can we make these confidence bands into confidence intervals?

In answering the question “how much confidence can we have in the projected numbers for the UK population of the elderly?” we have used the term “confidence bands” rather than the conventional “confidence interval”. This flags up that the method for computing the statistics is based on an observed distribution of projected populations rather than a representative sample from a much larger set of possible projections, generated by a probabilistic methodology. In Table 4 are listed candidate probabilistic projections of the UK population which could also be pooled in order to compute a consensus view about confidence intervals.

Table 4: United Kingdom projections for the confidence analysis: probabilistic projections not used

<table>
<thead>
<tr>
<th>Projection</th>
<th>Model</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONS</td>
<td>Cohort-component probabilistic using expert estimates of driver confidence</td>
<td>Rowan and Wright 2010</td>
</tr>
</tbody>
</table>
The Office for National Statistics produced probabilistic projections of the UK population, using expert estimates of future confidence ranges of the total fertility rate, life expectancy and net migration drivers of the principal projection of the 2006-based projection (Rowan and Wright 2010 based on work by Shaw and colleagues). The reliability of the confidence intervals reported was called into question in previous evidence (House of Lords 2012, pp.261-263) because the 2010-based projection generated populations outside the 95% upper confidence limit of the projection in 2031 and 2056. Coleman and Scherbov (2006) produce a probabilistic projection of the UK population divided into main ethnic groups. However, the published account does not provide confidence levels for age groups. Southampton demographers (Abel et al. 2010, Raymer et al. 2012) have produced experimental probabilistic projections but neither uses a cohort-component model so confidence intervals for age groups are not produced. European Demographers (Alders et al. 2005) in the Uncertain Population of Europe (UPE) project do implement a probabilistic projection, based on a cohort-component model, for a set of European countries including the UK, with a “jump-off” population at SY2004. They provide in their UPE database a small set of sample projections by age from which confidence levels and intervals could be computed. American demographers (Raftery et al. 2012) have implemented probabilistic projections for the countries covered in the UN World Population Prospects (WPP) projections but unfortunately apply the methodology only to fertility and mortality, leaving the net internal migration component as set in the WPP. For the UK this cannot provide reasonable results as the most important source of future variation in population are the international migration assumptions (Rees et al. 2012c). So although considerable experience in probabilistic projection is being acquired, a fresh project is needed to generate the confidence intervals for age groups required by the House of Lords.

CONFIDENCE IN PROJECTIONS OF LIFE EXPECTANCIES, DISABILITY FREE LIFE EXPECTANCIES AND POPULATIONS WITH DISABILITY

The House of Lords Select Committee also asked “What are the major disagreements among demographers about ageing? How far do they disagree, for example, on projections of expectation of life; on projections of the length of disability-free life; and on projections of the numbers of people who will become disabled?”

Projections of expectation of life

There is a spectrum of opinions about how much life expectancy will improve in the future. Demographers Oeppen and Vaupel (2002) demonstrated that life expectancy ceilings for the future regularly declared by researchers had been broken through. At the other end of the
spectrum are demographers, such as Olshansky et al. (2001), who point to the slowdown of improvements in survival as a result of new diseases, e.g. those caused by obesity. He and his colleagues estimated a claw back in US life expectancy of about one and a half years by mid-century. However, in the UK the Foresight Report on Obesity has a much lower estimate of the reduction, no more than a half a year by mid-century. This is against a projection of increase in period life expectancy of about 8 years by 2050 by ONS and between 10 and 12 years in the DEMIFER project, which had more optimistic assumptions.

To measure the degree of uncertainty in the projections of mortality for the UK population, we assembled the mortality assumptions for the projections listed in Table 1 that reported different mortality variants or scenarios. The mortality assumptions are most usefully reported as assumptions about life expectancies at birth. Many projection models project the age-sex mortality rates directly, having examined recent trends and having considered future developments in medical science and health policy. So life expectancies for these projections are summary diagnostic indicators. Other projections forecast life expectancies directly and then use a method for converting the summary forecasts back into projected mortality rates or their complement, survival probabilities. In Table 5 we report fewer life expectancy projections because many variants produced by the Office for National Statistics in Table 1 share mortality assumptions as do the UN variants and ETHPOP variants, yielding a set of 10 rather than 19 projections to analyse, to which we have added a projection assuming a continuing linear increase in life expectancy based on ONS reported life expectancies changes for 2000-2010 (ONS EXTRAP).
Table 5: Combined life expectancy projections, United Kingdom, various years

<table>
<thead>
<tr>
<th>Set</th>
<th>Projection</th>
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<th>Female</th>
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</thead>
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<tr>
<td></td>
<td>201 202 203 204 205</td>
<td>201 202 203 204 205</td>
<td></td>
</tr>
<tr>
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<td>GSE</td>
<td>76.6</td>
<td>79.9</td>
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<td>LSE</td>
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<td>EME</td>
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<tr>
<td>DEMIFER</td>
<td>CME</td>
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<td>79.0</td>
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<td>ETHPOP</td>
<td>TREND</td>
<td>80.5</td>
<td>81.7</td>
</tr>
<tr>
<td>EUROST</td>
<td>AT</td>
<td>78.7</td>
<td>79.9</td>
</tr>
<tr>
<td>ONS</td>
<td>PRIN</td>
<td>78.5</td>
<td>80.8</td>
</tr>
<tr>
<td>ONS</td>
<td>HLE</td>
<td>78.5</td>
<td>81.5</td>
</tr>
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<td>LLE</td>
<td>78.5</td>
<td>80.2</td>
</tr>
<tr>
<td>ONS</td>
<td>EXTRAP</td>
<td>78.5</td>
<td>82.5</td>
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<tr>
<td>UN</td>
<td>UNMD</td>
<td>77.9</td>
<td>79.2</td>
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<td>97.5</td>
<td>76.6</td>
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<td>2.5</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>95% PI</td>
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</tr>
<tr>
<td></td>
<td>PI as % of</td>
<td>4.5</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Sources: Computed from the projection databases listed in Table 1, using linear interpolation where necessary.

Notes: EXTRAP = extrapolation of life expectancy at 0.4 year per year.

In the DEMIFER project we used four policy driven scenarios. The starting values for 2010 in these projections look rather low compared with the estimate for ONS, an extrapolation of the latest 2008-2010 life expectancies. However, all scenarios were quite optimistic about the degree of improvement in life expectancy. These were based on measuring the rate of improvement in age-specific mortality across Europe between 1992 and 2005. This was a 2.7% per annum decline over the 14 years which was increased in the GSE and EME scenarios and decreased in the LSE and CME scenarios. The most optimistic DEMIFER scenario (Growing Social Europe) envisages a life expectancy increase of 12.8 years (men) and 11.8 years (women), while the most pessimistic DEMIFER scenario (Challenged Market Europe) projects a 9.1 year increase for men and a 7.8 year increase for women.

The ETHPOP TREND assumptions for life expectancy are quite close to the principal ONS assumptions for the principal projections but start at higher levels in 2010 and end at lower levels in 2050. The EUROSTAT assumptions are close to the ONS principal projections in 2010 but assume less improvement by 2050. The ONS high variant assumptions are as optimistic as the DEMIFER GSE projections while the ONS low variant sets a floor on improvements in life expectancy and assumes none from the 2030s onwards. The ONS EXTRAP trajectory, which resembles the pattern found by Oeppen and Vaupel (2002) for the top country life table is, in fact, not quite as optimistic as the DEMIFER GSE and EME
scenarios or the ONS High variant. The UN uses only a single mortality assumption for the three variant projections and it is at the pessimistic end of the range.

In the bottom panel of Table 5 we report the same set of statistics as were used for the projected population by age. The median trajectory is close to the ONS PRIN projection and projects an increase of 7.2 years by 2050 for men and 6.4 years for women. All projections assume this common pattern that men will make greater gains than women and that therefore the gender gap will shrink. The 95% confidence band expands as the projection horizon increases, roughly doubling between 2010 and 2050, with uncertainty for male life expectancy being about a third higher than that for women.

Projections of the length of disability-free life

There are no official projections of disability-free life expectancy for the UK nor are there projections of persons by disability status, except for projections which assume recent prevalence rates continue into the future (Snell et al. 2011 for the Dilnot Commission, Rees et al. 2011 for DCLG, BIS and DWP) with the exception of work by Marshall (2009a, 2009b and 2009c) discussed later. There has been work on Disability Free Life Expectancy and Healthy Life Expectancy in the last decade and on the methods that should be used. For example, Khoman et al. (2008) compare the conventional prevalence rate method with a multi-state transition method but unfortunately the questions used in the two datasets used are different so we can’t tell whether the differences are due to method or question. Similarly, ONS changed the question used in the GHS when it became the GLS when subsumed into the Integrated Household Survey, but in this case Smith and White (2009) were able to simulate a full series from 2000-02 to 2008-10 using assignment probabilities based on 2005-07 surveys which contained both questions. Table 6 assembles Healthy Life Expectancy and Disability Free Life Expectancy estimates for various years between 1992 and 2008.

What does Table 6 tell us?

Healthy Life Expectancy and Disability Free Life Expectancy computations are based on self-reported health measures. We therefore need to take care when comparing survey results between years because of changes in the question about health or long term illness used. This affects the level of health/illness. Disability Free Life Expectancy (DFLE) at age 65 based on a yes or no answer; Healthy Life Expectancy (HLE) is based on a 3 part question in the GHS between 1992 and 2005-07, on a 5 part question in the GLS from 2005-07 to 2008-10; a 5 part question in the BHPS is used in 1992 and 2002. In addition, the method used with the BHPS data is not the conventional prevalence method (Sullivan method) but a method based on transition probabilities and a multi-state transition model. So HLE based on a 3 part question is higher than HLE based on a five part question which corresponds with the level reported for DFLE. There are also more detailed measures of the Activities of Daily Living (ADLs) (in surveys such as the Health Survey of England and the English Longitudinal Study of Ageing) which are also important in measuring disability and these can give different signals. In general, HLE at age 65 using the 3 part health question is higher than when the 5 part question is used. DFLE at age 65 is lower than both HLE measures in 1992 but has closed with the 5 part HLE measure by 2008-10.

Life expectancy at age 65 is improving for both men and women, more for men than women, as has been found for life expectancy at birth (Table 5). Healthy life expectancy is also improving for both men and women. HLE at age 65 for women is greater than for men but
men’s HLE is improving more. HLE as a percentage of LE tends to decrease when comparing 1992 with 2002 or 2000-02. This suggests that morbidity is expanding. HLE tends to increase as a percentage of LE when the years 2005-07 are compared with 2008-10. However, there are exceptions to both generalisations in the earlier and later periods. This suggests that morbidity is compressing.

Trends in limiting long-term illness

Table 7 reports directly on the age-sex specific prevalence rates of limiting long standing illness (LLSI) derived from use of the same question in successive years of the General Household Survey and its successor the General Lifestyle Survey (part of the ONS Integrated Household Survey). The years have been grouped and averages computed to reduce noise in the annual series. Between 1981-1985 and 1991-1998 LLSI rates mostly increase for both men and women; between 2000-2004 and 2005-2010 the rates decrease or remain stable with the one exception of women aged 75 and over. In all age-sex groups apart from women aged 75+ the GHS/GLS reports that prevalence rates of limiting long-standing illness declined in the decade 2000-2010. We cannot be certain about these trends because they are based on a sample survey and the numbers of respondents in each age-sex group are not large enough to establish that all changes were statistically significant. The trends for women aged 75+ may reflect compositional effects: i.e. women are getting older within the age group and so the weight of higher LLSI prevalence rates may increase. Nevertheless they may be evidence that our society is achieving a reduction in illness.
### Table 6: Recent estimates of healthy life expectancy at age 65, UK

<table>
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<tr>
<th>Author, Gender</th>
<th>Data sets used</th>
<th>Measure</th>
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<th>2000-02</th>
<th>2005-07</th>
<th>2008-10</th>
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<tr>
<td>Men Deaths, populations</td>
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<td>16.1</td>
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<tr>
<td>GHS</td>
<td>HLE65(P3)</td>
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<td>12.0</td>
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</tr>
<tr>
<td>% LE65</td>
<td>76.1</td>
<td>74.5</td>
<td></td>
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<td>BSPS</td>
<td>HLE65(T5)</td>
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<td>12.2</td>
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<td>% LE65</td>
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<td><strong>Women</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td>Deaths, populations</td>
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<td>14.2</td>
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<td></td>
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<td>% LE65</td>
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</tr>
<tr>
<td>Men Deaths, populations</td>
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<td>14.2</td>
<td>15.9</td>
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<tr>
<td>GHS</td>
<td>HLE65(P3)</td>
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<td>11.9</td>
<td>12.9</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>% LE65</td>
<td>76.1</td>
<td>74.8</td>
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<td></td>
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<tr>
<td>GHS/GLS</td>
<td>HLE65(P5)</td>
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<td>9.9</td>
<td>10.1</td>
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</tr>
<tr>
<td>% LE65</td>
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<tr>
<td>GHS/GLS</td>
<td>DFLE65(P2)</td>
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</tr>
<tr>
<td>% LE65</td>
<td>55.6</td>
<td>55.3</td>
<td>58.1</td>
<td>58.4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Women</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Deaths, populations</td>
<td>LE65</td>
<td>17.9</td>
<td>19.0</td>
<td>19.9</td>
<td>20.4</td>
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<tr>
<td>GHS</td>
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<tr>
<td>% LE65</td>
<td>72.6</td>
<td>73.7</td>
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<tr>
<td>% LE65</td>
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<tr>
<td>% LE65</td>
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**Sources:** NIESR: Khoman et al. (2008), ONS: ONS (2002), Smith and White (2009), ONS (2012). 1992 data are for GB.

**Notes:**
- LE65 = life expectancy at age 65, HLE65 = healthy life expectancy at age 65
- P3 = prevalence rate method based on three response category question using “Good” Health
- P5 = prevalence rate method based on five response category question using “Very Good” and “Good” Health, T5 = transition rate method based on five response category question using “Very Good”, “Good” and “Fair” Health
- DFLE = disability free life expectancy based on question about limiting long standing illness
- GHS = General Household Survey
- GLS = General Lifestyle Survey, BHPS = British Household Panel Study
Table 7: Limiting long standing illness rates, GHS/GLS surveys, 1981-2010

<table>
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<tr>
<th></th>
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<tbody>
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<td>4.4</td>
<td>3.0</td>
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<td>26.5</td>
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<td>26.6</td>
<td>24.0</td>
</tr>
<tr>
<td>45-64</td>
<td>36.5</td>
<td>38.8</td>
<td>37.4</td>
<td>35.5</td>
</tr>
<tr>
<td>65-74</td>
<td>43.5</td>
<td>46.3</td>
<td>45.4</td>
<td>45.0</td>
</tr>
<tr>
<td>All ages</td>
<td>16.0</td>
<td>18.8</td>
<td>18.0</td>
<td>17.2</td>
</tr>
<tr>
<td>Women</td>
<td>3.0</td>
<td>3.8</td>
<td>3.8</td>
<td>3.2</td>
</tr>
<tr>
<td>0-4</td>
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<td>7.3</td>
<td>7.8</td>
<td>5.5</td>
</tr>
<tr>
<td>5-15</td>
<td>11.0</td>
<td>13.3</td>
<td>12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>16-44</td>
<td>26.0</td>
<td>28.0</td>
<td>26.0</td>
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</tr>
<tr>
<td>45-64</td>
<td>39.5</td>
<td>37.5</td>
<td>36.2</td>
<td>36.2</td>
</tr>
<tr>
<td>65-74</td>
<td>53.5</td>
<td>51.8</td>
<td>48.0</td>
<td>49.2</td>
</tr>
<tr>
<td>All ages</td>
<td>18.5</td>
<td>20.5</td>
<td>19.6</td>
<td>19.2</td>
</tr>
</tbody>
</table>

Source: Computed from GHS and GLS Surveys, ONS (2012)

Projections of the numbers of people who will become disabled

There are, to my knowledge, no official projections of the numbers of people who will become disabled. There are some academic studies commissioned by central government or by local authorities.

The Personal Social Services Research Unit (Universities of Kent, LSE, Manchester) has produced a detailed report on *Projections of Demand for Social Care and Disability Benefits for Younger Adults in England* for the Commission on Funding Care and Support (Dilnot Commission 2011). This work is focussed on younger adults and applies assumptions of constant rates in its projections. A Northern Universities Research Consortium reported on *The Impacts of Demographic Change in the North of England* for three central government departments (BIUS, DCLG and DWP) (Rees et al. 2011b, Buckner et al. 2011). This work used the assumption that recently estimated prevalence rates by age and sex will continue unchanged into the projection future. These prevalence rates are multiplied by the national or subnational projected population in each age and sex group to arrive at the projected numbers. Table 8 shows how the population reporting limiting long term illness might grow in future.
Table 8: Projected populations with limiting long term illness (LLTI), Local Enterprise Partnerships, Northern England, 2011 and 2036

<table>
<thead>
<tr>
<th>Local Enterprise Zone</th>
<th>Population with LLTI</th>
<th>Time Series</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
<td>2036</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>582</td>
<td>744</td>
</tr>
<tr>
<td>Liverpool City Region</td>
<td>386</td>
<td>457</td>
</tr>
<tr>
<td>Leeds City Region</td>
<td>624</td>
<td>839</td>
</tr>
<tr>
<td>Sheffield City Region</td>
<td>458</td>
<td>581</td>
</tr>
<tr>
<td>Cheshire and Warrington</td>
<td>120</td>
<td>155</td>
</tr>
<tr>
<td>Tees Valley</td>
<td>139</td>
<td>166</td>
</tr>
<tr>
<td>Cumbria</td>
<td>92</td>
<td>121</td>
</tr>
<tr>
<td>Hull City Region</td>
<td>68</td>
<td>87</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>201</td>
<td>258</td>
</tr>
<tr>
<td>North East</td>
<td>579</td>
<td>720</td>
</tr>
<tr>
<td>Lancashire</td>
<td>271</td>
<td>358</td>
</tr>
<tr>
<td>Leeds City Region</td>
<td>513</td>
<td>700</td>
</tr>
<tr>
<td>Sheffield City Region</td>
<td>316</td>
<td>396</td>
</tr>
<tr>
<td>Northern England (GORs)</td>
<td>3268</td>
<td>4163</td>
</tr>
</tbody>
</table>

Note: Populations are in 1000s. The time series starts at 2011 = 100.

Note the considerable increases, averaging 25% in 25 years, varying between 18% (Liverpool City Region) and 36% (Leeds City Region). However, these projections reflect only the impact of population change, mainly ageing, on the numbers of people with disabilities and do not factor in change in the disability prevalence rates.

Work at the Cathie Marsh Centre for Census and Survey Research by Marshall (2009a, 2009b and 2009c) has taken the projections one step further and developed four projections:
• a Static LLTI projection which assumes that LLTI rates remain at their 2001 for each year of the projection (as in Rees et al. 2011b, Buckner et al. 2011);
• an Inter-census change projection in which district changes in LLTI between 1991 and 2001 censuses continue;
• a Pessimistic projection in which increases in LLTI rates are projected based upon the highest rates observed in GHS (1991-04); and
• an Optimistic projection in which decreases in LLTI rates based upon the lowest rates observed in GHS (1991-04).

The projected populations under these four scenarios are reported for the UK in Table 9. The projections were carried out for all UK local authorities as part of a project supplying information for users of POPGROUP, a suite of population projection routines developed by Ludi Simpson and Luc Anselm and now managed by the Local Government Association and Edge Analytics.

Table 9: LLTI projections by Alan Marshall (CCSR)

<table>
<thead>
<tr>
<th>Area</th>
<th>Static LLTI 2001</th>
<th>Pessimistic LLTI 2021</th>
<th>Optimistic LLTI 2021</th>
<th>Inter-census change 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbe</td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
</tr>
<tr>
<td>2021</td>
<td>2021</td>
<td>2021</td>
<td>2021</td>
<td></td>
</tr>
</tbody>
</table>
The static (no change in LLTI prevalence) projection is close to all but the Pessimistic projection. The static projection for the UK posts a 25% increase with people with LLTI for 2001-2021 (20 years), compared with a 25% increase for the North of England for 2011-2036 (25 years) in the N8 Research Partnership project.

Is there any evidence of trends in age-sex prevalence rates that would enable us to produce a better projection? Table 10 sets out projections of the trends in limiting long standing illness set out earlier in Table 7. We fitted various models to the 2000-2010 time series and selected a simple exponential model that extrapolates the change of the last decade forward. We see that substantial change will occur by 2050, if these trends continue. These observations, though not as certain as we would like and not as detailed (e.g. in reporting on separate older old ages), give some basis for an optimistic projection.

We can combine the prevalence rates in Table 10 with the median projected populations from Table 3 aggregated into corresponding age groups in Table 10 to project the numbers of person with limiting longstanding illness. In the left panel of Table 11 we assume that the LLSI rates will remain constant at their 2010 GLS values. In the right panel of Table 11 we use instead the trended rates given in Table 10 to project the numbers of persons with LLSI. In Table 12 we compute the ratios between the constant and trended numbers with LLSI. Using prevalence rates held constant at 2010 levels, Table 11 reveals the full impact of population ageing and population growth. The numbers with LLSI expand from 11.2 million in 2010 to 15.5 million in 2050: the numbers are 39% higher. If we believe the trends in LLSI rates over the past decade and extrapolate them, we obtain the projected numbers of persons with LLSI shown in Table 11’s right panel. The downward trends in LLSI prevalence rates almost completely compensate for the increasing numbers of older people and there are only 11.8 million persons with LLSI in 2050, an increase of just 6%.
**Table 10**: Trended LLSI prevalence rates (%), persons, UK

<table>
<thead>
<tr>
<th>Ages</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>2.8</td>
<td>1.9</td>
<td>1.3</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>5-15</td>
<td>5.6</td>
<td>3.7</td>
<td>2.5</td>
<td>1.8</td>
<td>1.2</td>
</tr>
<tr>
<td>16-44</td>
<td>10.8</td>
<td>10.1</td>
<td>9.6</td>
<td>9.0</td>
<td>8.6</td>
</tr>
<tr>
<td>45-64</td>
<td>23.2</td>
<td>19.6</td>
<td>16.5</td>
<td>13.9</td>
<td>11.7</td>
</tr>
<tr>
<td>65-74</td>
<td>35.1</td>
<td>32.2</td>
<td>29.6</td>
<td>27.2</td>
<td>25.0</td>
</tr>
<tr>
<td>75+</td>
<td>47.1</td>
<td>47.4</td>
<td>47.8</td>
<td>48.2</td>
<td>48.7</td>
</tr>
<tr>
<td>All ages</td>
<td>17.8</td>
<td>16.6</td>
<td>15.5</td>
<td>14.4</td>
<td>13.4</td>
</tr>
</tbody>
</table>

Source: Computed from GHS and GLS Surveys, ONS (2012)

Model: Using 2000-2010 Exponential Regression Intercept and Slope and 2005-2010 intercept

**Table 11**: Projected populations with LLSI using constant and trended prevalence rates, UK, 2010 to 2050

<table>
<thead>
<tr>
<th>Ages</th>
<th>Base 2010</th>
<th>Model using constant LLSI rates</th>
<th>Model using trended LLSI rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020 2030 2040 2050</td>
<td>2020 2030 2040 2050</td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>107 115 113 111 120</td>
<td>78 53 40 35</td>
<td></td>
</tr>
<tr>
<td>5-15</td>
<td>399 425 474 459 467</td>
<td>283 213 149 105</td>
<td></td>
</tr>
<tr>
<td>16-44</td>
<td>2761 2765 2861 2933 3016</td>
<td>2593 2540 2440 2393</td>
<td></td>
</tr>
<tr>
<td>45-64</td>
<td>3711 3954 3872 3987 4145</td>
<td>3330 2750 2386 2087</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>1892 2290 2525 2772 2536</td>
<td>2101 2131 2150 1807</td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td>2284 2646 3503 4369 5206</td>
<td>2662 3552 4467 5382</td>
<td></td>
</tr>
<tr>
<td>All ages</td>
<td>11153 12195 13348 14630 15491</td>
<td>11047 11239 11631 11809</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Populations in 1000s.

**Table 12**: Ratios of projected populations with LLSI using constant and trended prevalence rates, UK, 2010 to 2050

<table>
<thead>
<tr>
<th>Ages</th>
<th>Base 2010</th>
<th>Ratios of trended to constant LLSI projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020 2030 2040 2050</td>
<td>2020 2030 2040 2050</td>
</tr>
<tr>
<td>0-4</td>
<td>100 68 47 36 29</td>
<td>68 47 36 29</td>
</tr>
<tr>
<td>5-15</td>
<td>100 67 45 32 22</td>
<td>67 45 32 22</td>
</tr>
<tr>
<td>16-44</td>
<td>100 94 89 83 79</td>
<td>94 89 83 79</td>
</tr>
<tr>
<td>45-64</td>
<td>100 84 71 60 50</td>
<td>84 71 60 50</td>
</tr>
<tr>
<td>65-74</td>
<td>100 92 84 78 71</td>
<td>92 84 78 71</td>
</tr>
<tr>
<td>75+</td>
<td>100 101 101 102 103</td>
<td>101 101 102 103</td>
</tr>
<tr>
<td>All ages</td>
<td>100 91 84 80 76</td>
<td>91 84 80 76</td>
</tr>
</tbody>
</table>

Notes: Ratios computed by dividing trended rate projections by constant rate projections, expressed as percentage.
SUMMARY AND CONCLUSIONS

This document has supplied the answers to two questions posed by the Committee Chair, Lord Filkin, during the 16 October Hearings: (1) how confident can we have in the projected numbers of older persons for the UK and (2) how many people with disability will there be in the near future in the UK. To estimate the confidence in the projected numbers of the older ages we adopted the strategy of pooling nineteen different population projections for the UK produced by two academic teams, the UK’s national statistical agency and two international statistical agencies. The resulting database of 5 year age group populations for 2010 to 2050 was employed to compute confidence bands around a median projected population for each age group. For the population aged 65+, a median estimate of 10.2 millions in 2010 was projected to become a population of 18.3 million in 2050, with a 95 confidence that it would lie between 21.3 and 15.7 million. We can be more confident about the numbers for the younger elderly (aged 65-84) than for the older old (aged 85+). We cannot be very confident about the future numbers of centenarians. The population of centenarians is projected to be 242 thousand in 2050 compared with 12 thousand in 2010 but the 95% confidence interval stretches from 426 thousand to 59 thousand. The results of projections of the disabled population of the local areas and the whole UK are reported, along with projections that use constant and declining trends in disability prevalence so that the effects of “pure” ageing and possible future health improvements can be estimated. We find that population ageing will increase the population with 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%. However, we cannot currently assess the degree of confidence around these projections.

Some caveats must be attached to this analysis. The paper reports the results of a review of the literature and some original analysis but has not been peer reviewed (necessary to provide confidence in the conclusions). The paper will be submitted to a demographic journal for such a peer review but it might take some time to be accepted. Currently, my papers seem to need three challenging revisions before acceptance. There is also a need to build a fully specified probabilistic projection model of the UK population, building on the work that has already been done but subjecting the results to validity tests. Such validation will mean starting the projection 10 to 20 years in the past so that we have a population estimate series grounded in two censuses (2001 and 2011) against which to validate the confidence intervals. This is important because the previous attempt by ONS was problematic. The key ingredient for such a set of projections is well found estimates of errors in the main projection drivers: total fertility rate, male and female life expectancies and net immigration numbers, if the same model is used as that currently employed by ONS for National Population Projections. The errors should be derived from time series analysis, from historical projection error analysis and from using expert projections, as we have attempted here. However, we should allow as well for model specification errors which apply to the ways in which immigration and emigration are modelled. Pooling of the probabilistic projections using different component error estimates might be a further step to establish confidence in the confidence bands.
REFERENCES


December 2012
Professor John Philpott, Economist and Labour Market Analyst, Trades Union Congress (TUC), BT and Chartered Institute for Personnel Development (CIPD)—Oral Evidence (QQ 514-536)

Transcript to be found under BT
The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 27,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

**The implications of an ageing society for public services**

There is no doubt that the changing demographics of the UK population are having a profound effect on health care services. On the 13 September 2012 the RCP published *Hospitals on the edge? The time for action*, which highlights the magnitude of the challenges currently facing acute care services, including the ageing population. I enclose a copy of the report for your information.

The report highlights some dramatic changes to the demographics of hospital inpatients:

- Nearly two thirds (65%) of people admitted to hospital are over 65 years old.
- People over 65 occupy more than 51,000 acute care beds at any one time, accounting for 70% of bed days.
- Hospital Episode Statistics (HES) show a 65% increase in secondary care episodes for those over 75 during the past 10 years, compared with 31% for those aged 15–59.
- People over 85 years old account for 25% of bed days – increased from 22% over the past 10 years. This equates to more than five bed days per annum, compared to only one fifth of a bed day each year for those under 65.
- People over 85 tend to spend around eight days longer in hospital than those under 65 – 11 days compared to three.

Despite patients over 65 making up the larger share of the hospital population, the system continues to treat older patients as a surprise, at best, or unwelcome, at worst. Much more can be done to prevent unnecessary hospital admission and readmission, shorten length of stay and ensure the smooth and effective transfer of care for patients ready to leave hospital. Areas with integrated services for older people have lower rates of bed use; these hospitals also tend to have lower admission rates and deliver good patient experience.

However, there will always be a cohort of patients with acute medical illnesses requiring admission to hospital. Hospitals, and those who work in them, have a responsibility to ensure that the needs of these patients are met. Research shows that medical and nursing staff often feel that older patients ‘shouldn’t be there’. Being perceived as the ‘wrong patient on the wrong ward’ has been shown to reduce the quality of care, building attitudes of resentment from both medical and nursing staff. Older people must have equal access to healthcare services; it is not acceptable to view older people in hospital as being in the ‘wrong place’. Hospital services must adapt to ensure that older patients, including those who are frail and have a diagnosis of dementia, have access to safe, high-quality care in settings that meet their needs.

In the report, the RCP makes a number of recommendations to address the current challenges facing acute hospital services. These include:
• promote dignity and patient-centred care
• redesign services and change the way we organise hospital care so that patients have access to efficient, high-quality expert care regardless of their age or day of the week
• review medical education and training, renegotiate the New Deal and ensure the right mix of medical skills – including ensuring that all medical professionals have the skills and knowledge they need to care for older patients with complex conditions, frailty and dementia
• ensure the availability of primary care services whenever they are needed, including at the weekend and at night
• revolutionise the way we use information to support high quality patient care
• embed quality improvement across the system
• show national leadership.

To address these issues, the RCP has launched the **Future Hospital Commission**. The Commission will undertake a radical review of the organisation of hospital services, releasing its recommendations in spring 2013.

We look forward to the outcome of the Committee’s inquiry and please feel free to contact us if we can provide further information to inform your deliberations.

20 September 2012
The Saga Group—Written evidence

1. Does our culture about age and its onset need to change and, if so, how?

Our culture and attitudes to age are significantly out of date. Medical advances in the past few decades mean that people are living much healthier and longer lives, and are fitter and stronger in later life than ever before. People now recover from, or live well with illnesses that would have disabled them in the past. Heart problems, diabetes, cancer, bronchial problems - all of these conditions often associated with older people, will no longer prevent them from living active lives.

In short, people are not necessarily 'old' at 50, 60 or even 70 any more. In the past, those in their fifties or beyond would often be physically less strong than younger generations, would have short periods of life left and often suffered from ailments that impaired their daily lives significantly. This is not generally the case any more.

Saga, for example, has changed the range of its holidays to suit the active older person. We know that just because someone has reached a particular chronological age, there is no reason to stereotype them as only fit to undertake limited activities. Sixty and seventy-somethings these days are going on our holidays to Borneo, trekking to Everest Base Camp, exploring the Amazon and much more.

Chronological age is no longer a barrier to being active and healthy. Running marathons, swimming the channel, taking up new sports and interests are open to people of all ages, and the old stereotypes are breaking down.

Changing this culture of age requires a change of attitude: overcoming age discrimination, ensuring older people are not 'written off' just because of their age, embracing the opportunities that are now available. The media has a large role to play here. Far too often, when there is a story about older people, the media show an image of someone nearer 100 than 60!

The media also tends to glamourise youth, with older people considered 'past it' (whatever 'it' is) while steering away from showing images of men - and especially women - in their later years. Grey hair is out, smooth wrinkle-free skin seems to be essential.

However, things are slowly starting to change. The Government has rightly outlawed age discrimination and also abolished the default retirement age. Both of these are important steps in the right direction.

It would be helpful to think of people as people, and take them as they come, rather than pigeonholing them into a certain 'box' just because of their chronological age. There are enormous variations between individuals at all ages and later life - from ones 50s, 60s or 70s onwards still constitutes many different phases.

Even retirement itself is now being rethought. There are opportunities for working part-time, rather than suddenly stopping altogether. This is a whole new phase of life - 'bonus years' - which previous generations could not normally enjoy. The successes of medical practices and work practices, which now mean work is physically less demanding and people
are no longer incapacitated by diseases in later life, allow people to stay actively engaged in
the workplace as they get older, rather than having to stop altogether. Helping people
embrace these bonus years, with Government encouragement, would be really helpful in
promoting the cultural change that we need.

2. Do our expectations and attitudes about work, savings, retirement and
independence need to change and if so, how?

The government's decision to abolish the default retirement age is an excellent first step in
moving towards the new future for work and retirement, with retirement becoming a
process, rather than an event. It is very unhealthy for people to be working full-time one
day, then suddenly not working at all the next day. Indeed, many people find it difficult to
adjust to life without any work at all. Some people define themselves by their work, or
enjoy the social interaction and feeling of usefulness in doing a job. Indeed, there is a
condition known as 'sudden death retirement syndrome' where older people who retire
suddenly lose the will to live and die soon after retirement.

Attitudes to work and retirement are very outdated. Having become prevalent in the 1980s
and 1990s, the concept of 'early retirement' led to unrealistic expectations for the next
generation that economic progress should entail people retiring earlier than previous
generations.

This notion of 'early retirement' being something to aspire to needs to be abandoned. It is
not good for individuals, for society or for the economy. The idea that people should
expect to stop working and have good pensions from their early 50s onwards for the rest of
their life (which could be another 40 or 50 years!) does not fit twenty-first century realities -
it is financially unaffordable for the vast majority of the population.

Early retirement was convenient during the period when the baby boom generation was
entering the labour market and the older generations at that time had experienced dramatic
change in the workplace, with traditional industries closing down and many were in poor
health due to industrial strains. They often needed to stop working due to physical
limitations and lack of modern skills. Meanwhile, there were so many younger people (baby
boomers) coming into the jobs market looking for work and ready to embrace new
technologies and working environments, that it made sense for older people to retire. And
because they often had very generous final salary pension schemes which were all thought to
have big surpluses, company management could easily offer people good early retirement
pensions, thinking it was all going to be paid for by strong future investment returns from
the stock market, which most pension funds were relying on.

So, until a few years ago, most people were already retired before state pension age.
However, the trends are once more moving in the opposite direction. As final salary
pension schemes have closed, as life expectancy has continued to rise, as people have
realised that the costs of providing good pensions is actually far higher than previously
realised, and as the baby boomers themselves are approaching traditional retirement age,
people are realising that old attitudes to retirement and to pensions need to change.

As regards retirement, people are now thinking about working longer than they would have
previously intended - although many would prefer to work part-time if they can. Some of
those who did retire early ended up going back to work, or doing voluntary work, because
they were bored. Some have returned to work part-time or retrained to do other things. This is the way of the future in my view.

As regards saving for retirement, the previous assumptions that small amounts of saving can lead to large amounts of pension have proven unsustainable. In the past, private pension saving relied on strong investment returns, mainly from the stock market, to forecast generous future pensions, which would grow from relatively small contributions. The magic of compounding was supposed to deliver good pension income, but this has not materialised in private defined contribution schemes and has proved unaffordably costly for most employers running defined benefit schemes.

When thinking about saving overall, it is very important that the concept of pensions is clarified. At the moment, there is confusion between the role of the state and role of private saving. The state pension system relies on mass means-testing, which penalises people who have saved for their retirement. That is not a sustainable way forward.

It is important, in my view, that the state pension should provide just a minimum social welfare base, payable to older people (but the age from which this starts to be paid cannot be set in stone and must be adjusted to fit developments in society over time). If people know there is just this minimum level, and if they want to have more than that in retirement, they will know they need to find extra money from somewhere. Whether that comes from their own savings, employer savings plans, housing, a business, an inheritance or some part-time work at older ages, they will know they need more money and should not be penalised by the state for providing for themselves. Therefore, we need to rid the state pension system of the reliance on means-testing and ensure that people recognise the need to save.

However, we should not have unrealistic expectations of the returns that savings can deliver, nor be misled into thinking that returns can be guaranteed, even in the long-run. People need to understand that saving alone will not guarantee a good pension.

As people are living longer and longer, the amount of savings either needs to rise sharply, or people must retire later in order not to keep extending the number of years their pension has to last for.

Investment return forecasts have, in the past, been far too optimistic. Saving for retirement requires saving a sum of 20% or more of salary every year for many years, in order to have a chance of a good pension. For a final salary type pension, the sums are more like over 30%. This means that most people will simply not be able to save enough for a good pension and will need to either think about working longer so the pension lasts fewer years, or having a lower income in later life, or a combination of the two.

As regards independence, many older people can live well on their own nowadays. With advances in telehealth and telecare, as well as people being stronger and healthier, many older people can now stay independent in later life. Housework is much less physically demanding and care in the home will provide a much better lifestyle, if help is needed, than moving into a residential care setting unless this is absolutely necessary.
3. **Do the extent and nature of public services need to change? If so, how and how should they be paid for?**

Public services are not always quick to adapt to demographic realities. In fact, the care of children has improved significantly over the years, however care for older people has actually very often deteriorated recently. Council budgets are being cut and, as increasing numbers of very much older people need some care, councils are having to cut back the amount they spend on each person's care, and on the services they provide.

It would be enormously helpful if councils and Government were to plan over the longer term for the needs of the aging population. Councils are not required to produce 5-year or 10-year plans as to how they will cope with increasing numbers of older residents in their area. They do plan for rising numbers of children, but that is not sufficient to adapt to demographic developments.

Social care is the biggest problem in local public services for older people. The country has not prepared people for supporting themselves well in later life and the welfare state does not really cover care, because it was designed over sixty years ago, when the two big problems for older people were considered to be health and pensions. In those days, people died younger and, if they were ill, they did not live for years in chronic ill-health. As life expectancy has risen and the baby boom generation has grown older, we should have been preparing for the new future which is rapidly approaching. Sadly, we did not.

There is almost no money set aside for social care of increasing numbers of frail older people. Whether at public sector or private sector levels, funding for care happens on an ad hoc basis, rather than being budgeted properly and planned accordingly.

It is important that we start to fund care needs, in combination with consideration of our health spending, and also that we encourage private individuals to realise the need to have some money set aside by each family, in case one of them needs costly care. If there is money put aside, then should care needs arise, this will be less of an emergency expenditure need and more of a planned purchase. Incentives for care saving plans, with families being encouraged to join together to fund care in a tax free savings environment such as an ISA, would be a good start.

We need a partnership between the state and the individual family, so people know what they can expect the state to provide and what they need to do for themselves.

4. **Do we need to redesign and transform public services for these challenges? If so, how?**

Greater emphasis on care in the home, rather than in hospitals or residential care homes is required. Building more retirement villages, community housing that older people may want to move to but can still live in on their own. Housing developments suited to older people, who like having gardens, need entertainments, clubs, medical or fitness facilities as they get older are not really being built, but are much needed. Public health services should be redesigned to focus on preventing people from needing long-term care, staying fit and healthy in their own homes. Checking people's homes for safety, as well as having medical check-ups can be equally important to prevent ill-health. Handrails, fixing loose carpets,
ensuring there is proper lighting - all minor items that can prevent falls and hospital admissions or broken bones which end up costing so much to the health service.

5. What should be done now and what practical actions are needed?

We need to ensure there is a national debate around how to deal with the aging population. This could include:

- Highlight examples of people who are finding fulfilment working in later life, but in a part-time capacity.
- National awards for those helping others to cut down their working life, plan to work part-time or retrain.
- Encourage employers to keep older workers on part-time if they want to.
- Start a national plan for how to ensure suitable housing and adaptations for housing to become age-friendly
- Start a national information and education campaign to encourage people to take the small steps needed to age well and to explain the social care system
- Introduce incentives to help people save for their later life care needs
- Consider a cross-departmental approach to helping improve older people’s lives
- Provide free information via the NHS on benefits of adapting homes for safety to prevent falls and benefits of some care in the home as preventive measures
- Incentivise financial and lifestyle planning from mid-life onwards, to help people fulfil their own potential, plan the future that fits their own lives best and understand all the options that might be open to them, so they can make the best personal choice for themselves.

6. How can we stimulate national debate about these issues?

The Committee inquiry itself is very welcome in this regard, to help focus media attention and debate on this important issue.

Saga is trying to do what it can too, to lead the debate on the issue of healthy aging, and demographic change. We are holding our Saga Thought Leadership seminars, our Quarterly Reports which form a ground-breaking research series helping to shape the debate around how the lives of Britain’s 21million over 50s are developing. We also regularly issue other public information materials, as well as conducting research and engaging with the media.

9 September 2012
The Saga Group, Professor Noel Whiteside, University of Warwick, The King’s Fund and National Association of Pension Funds—Oral evidence (QQ 463–495)

**The Saga Group, Professor Noel Whiteside, University of Warwick, The King’s Fund and National Association of Pension Funds—Oral evidence (QQ 463–495)**

*Transcript to be found under The King’s Fund*
The Saga Group—Supplementary written evidence

Public policy adaptations and argumentations to help the shift to part-time work in later life.

There are many ways in which public policy can be adapted to help people recognise and embrace the potential for working later in life. These social shifts take time to evolve, and people will take time to understand the benefits to themselves of having higher income than a state pension can provide. But the process is already underway and there are also, of course, benefits to the economy of people having more money to spend too, especially as this is a rapidly growing demographic group.

Public policy for many years has positively discouraged later life working. This Government has made a major step to overcoming some of the disincentives, but many remain. The removal of the Default Retirement Age is a major reform for the labour market, which opens the way for workers to be able to stay in employment to older ages. The policy is an excellent first step. Much more needs to be done to remove the other disincentives as well as introducing new incentives.

As later life working becomes more of a reality, the next stage is to plan for a part-time career after full-time work, so people can ease into retirement, as a journey, rather than suddenly stopping working altogether. This is not about a policy of 'work till you drop' or 'work till you die', it is about taking advantage of extra years and less physically demanding work practices that can allow people to cut down their working hours, without stopping altogether and help improve their own lifestyle, if they want to. If they do not want to, then they will receive state old age support, but if they are able to keep working they can supplement that state pension income with more money for themselves. This can also help them be better prepared for later life care needs, if they arise.

Here are some of the policy areas that the Committee can consider to accelerate and facilitate this process.

1. Remove disincentives to working in later life that are inherent in the mass means-testing of the state pension system. This includes changing the earnings disregard in Pension Credit. The lowest earners are more likely to be eligible for Pension Credit and, if they claim, the £5 a week earnings disregard is a significant disincentive to later life employment.

2. Ensure that older workers are offered opportunities to re-skill just as younger workers can - this can be in the form of subsidised training courses perhaps run by local colleges or funded by JobCentres for those who are unemployed.

3. Ensure that the unemployed older workers are offered back-to-work help, retraining and mentoring as intensively as younger workers with timely interventions, rather than only helping after they have been unemployed for more than 12 months. Unemployment at older ages can lead to permanent exclusion from working life, which cuts people's lives and opportunities too short. At the moment, older unemployed workers are not helped as much as younger ones.
4. Offer employers tax incentives to help workers with later life financial planning, so they can go through opportunities for combining saving and earnings to achieve a better work-life balance at older ages, with more money and more leisure time, but planned ahead in advance. Current tax incentives for employer help are minimal.

5. Reform the State Pension to remove the mass means-testing in the current system and then review the state pension age is revised regularly, to keep up with rising life expectancy. Pay a basic minimum state pension, one flat rate payment, but the age at which it starts could not be predicted many years in advance. This would mean people do not become fixated on one particular age beyond which they do no more work and will not expect to suddenly stop working at a particular age. These signals take time to filter through social consciousness, but will eventually occur.

6. Public policy needs to make clear that the state 'pension' age, is not considered to be a state 'retirement' age. The state pension for many can be considered as a replacement for declining earnings power, with people perhaps preferring to keep working part time even when they start taking their state pension. This is up to the individual and, of course, some will not be able to, but then they still get the minimum basic state pension to support them.

7. Establish a permanent Commission to consider aspects of later life income, which will include the state pension, state pension age and later life care support.

8. Public policy change on the issue of part-time work after a full-time career in later life could be assisted by measures such as encouraging the ONS or the OBR to publish data on later life working, which could quantify the benefits to society and individuals of working beyond pension age. For example, calculating the average income of those who work in later life, average hours worked, how much the total revenue to the economy from their income is and publish these figures regularly. This could highlight how much the economy benefits from part-time work in later life, as well as how much individuals themselves can benefit.

Once public policy has removed the disincentives to working part-time in later life, and once the state pension is clarified so that people understand how it works, their own self-interest will help direct them to work longer. In the current system, where people do not understand what they will get from the State, where they have been encouraged to think that retirement at state pension age is the 'norm' and where the state pension system itself disincentivises those who work longer while receiving pension credit, the self-interest cannot operate as it should. Public policy needs to remove the disincentives, clarify the system and free people to make decisions for themselves. There is a limit to what public policy can do, and in general people will do what is good for them, once they understand what they are facing. Public policy can facilitate that.

**Family Care Saving Plans**

**Almost no private savings for care:** Currently, there is virtually no private savings provision for social care needs. Almost all later life saving is concentrated in the 'pension' product. Pensions are the most inflexible form of saving, with money not accessible until later life and then subject to restrictions in terms of income provision through retirement. This makes no allowance for the potential expense of social care, whether before or after retirement.
Pension saving does not cover high care costs which are inevitable result of demographic change: Even if we do encourage more pension saving, this will not address the looming social care funding crisis that is the inevitable result of demographic change. As the Committee considers the public policy implications of demographic changes facing the nation with increasing numbers of much older people comprising a growing proportion of the population as the baby boomers live into their 80s and 90s over the next 20-30 years, now is the time to plan ahead for the costs of care that will obviously arise. Having a pension income will not be sufficient to meet these costs.

Rethink saving beyond just pension income: Therefore, we need to rethink later life saving plans to broaden beyond just the one product. Pensions will not solve the crisis of later life financial adequacy and public/private care pre-funding is long overdue.

Incentivise care saving: Public policy needs to urgently engage with the incentivisation of care saving plans and help the population as a whole recognise the requirement to have money set aside to pay for care needs, should they arise. The difference between pension saving plans (that are designed to provide a level of income through retirement to help meet general living costs) and care savings (which need to provide a much higher level of income than normal living costs) is that nearly all of us will probably need a pension income during the early part of retirement, while only one in three or one in four people will actually experience the very significant costs of later life care. Some will die without ever needing care, some will only have care for a very short time, but none of us is likely to be able to predict with certainty whether we, ourselves, will be ones who will have large care costs.

Only one in four likely to need expensive care, whereas most will need pension: So, if social care needs will only be faced by a proportion of the population, rather than all, there would seem a strong case for insurance arrangements that can help mitigate the costs of setting aside sums for care. A national insurance system would make sense, with society contributing to a central fund that will meet care costs, should they arise, for those members of the population unlucky enough to need looking after. However, the National Insurance system has never considered covering care costs. Social care has been funded locally, not nationally. National Insurance contributions go towards state pensions, but not a state-funded care system. Given the current fiscal constraints, it is unlikely that we can expect a state-funded system to emerge in time to cater for the needs of current older generations, therefore it will be important to clarify what individuals will need to pay and how the state and individual responsibilities for care can be divided.

Pooling resources can help mitigate individual saving burden: Can we find ways of mitigating the individual costs of providing for later life care one by one and organise a group arrangement for care saving that will significantly reduce the costs for each individual. We need to find an ‘affinity group’ who can club together to insure against one of the group needing care. For example, if one out of every four people will eventually need expensive social care, but they do not know in advance which one, then if the four people save collectively for care, it should only cost around a quarter of the amount when all four club together, than it would if they each saved individually. A family would be an ideal unit to start this social insurance grouping.
Care is not just about old people, it's about families: That is where it is important to try to change the terms of the debate about social care funding. Care costs are not just about old people. They are about families.

Families are important affinity group: If a family member needs then the responsibilities and costs of that care will often impact the whole family. If ones parents need care and cannot fund it, children may be called upon to either do the caring themselves, or help pay for it. If ones children need care, parents will often have to pay.

Encourage Family Care Saving Plans: So there is a role for the state to encourage Family Care Saving plans. The Government could announce that it will provide incentives for care savings plans.

If four family members save together, costs much less than each saving individually: If there is a cap on the amount that the individual will have to pay to meet care costs, for example £50,000, then a family would know they will need to ensure there is a family pot of £50,000 available, should one of them need care. Members of a family could all save together to provide for those who will need care. Perhaps four family members could save for one person's care needs at a cost of around £15,000 each, instead of each one individually needing a pot of £50,000. If there are eight family members, they could save for two people's needs in a similar way.

Family Care Savings plans should be ISA-style tax-free: I would suggest that such Family Care Saving plans should be in an ISA format, where the money being saved accumulates tax-free and can be withdrawn tax free, as long as it is used to pay for care. The care could be for oneself, or for someone else, but the tax-free nature of the savings vehicle would encourage saving. These care saving plans would also need to have a 'catastrophe' insurance element added, which would provide extra cover if more than one member of the group needed care, so that there would be sufficient money in case that particular group faced a higher than normal probability of needing care.

Could extend current ISA limit even before Dilnot-style reform: In fact, with or without the Dilnot-style care reforms, the Government could begin to incentivise care saving. The current ISA limit could be increased to allow an additional limit to help people saving for care. If someone is going to need care for one year, they will need a pot of around £30,000 to pay for it. Currently, families do not realise they need to save for care, but if there is a public policy signal that this is required, at least some people will begin to put money aside for that eventuality.

People need to know they need to save for care, takes time to get message across: It will take time to build up a care savings culture, but the sooner we start, the better. Many people are saving their full ISA allowance each year, but not earmarking the money for anything in particular. Families could benefit from allocating some of this money for care and this would start the process of making care saving the norm for the future, rather than families suddenly having to find money at the point of need, which can be distressing and difficult if not advance provision has been made.

Information could help many start saving for care now, to give peace of mind: Some families will start doing this as soon as they realise the need. There will be people who want to give themselves and their families peace of mind to know that, if they suddenly
become incapacitated (perhaps following a stroke, or accident) the money is set aside to pay for at least one year’s worth of care. Just as people take out life insurance, to give their family peace of mind should the worst happen, some people will make provision for care needs, if they realise they need to. The sooner policy helps this realisation, the better. With or without Dilnot reforms, of course, this savings culture could start, but it would be more effective if public policy leads the way.

December 2012
Professor Ludi Simpson, University for Manchester and the Office of National Statistics (ONS)—Oral evidence (QQ 1–55)

Transcript to be found under Office for National Statistics
Social Finance, Alliance Boots, Professor Martin Knapp, London School of Economics, Personal Social Services Research Unit (PSSRU) and Professor Les Mayhew, Cass Business School—Oral evidence (QQ 327–372)

Transcript to be found under Alliance Boots
Social Institute for Excellence—Written evidence

1. Introduction

1.1 The challenge that demographic change poses for public services is far-reaching in both extent and effect. As the Social Care Institute for Excellence (SCIE), our particular focus is on one aspect of this challenge, but social care can never be considered in isolation, not least because it touches almost all other public services at its edge. Demographic change poses a huge challenge for social care. Already facing reducing budgets and the associated drive for greater efficiencies, rising levels of both demand and expectation, and the need to support individuals with increasingly complex health conditions, social care has to change. It may therefore offer a useful case study for public service reform, having a role as it does in the lives of people from all ages, backgrounds, and situations.

1.2 Social care is already affected by a number of issues that contribute to the complexity of wider public service reform and emphasise that it is about much more than just numbers:

- There is often no request for support from individuals nor appropriate response from public services until a crisis occurs
- There can be a sense from both individuals seeking public service support and those working within the services that it is important to be offered something
- Support is delivered by a number of different services often working separately
- There is little sense of community support and involvement
- There can be a reliance on family support which is under threat itself, from pressures associated with working, financially supporting adult children, and relationship breakdown.

1.3 In our response to the questions below we have drawn on various strands of our recent work that may offer a helpful contribution to understanding and moving forward on this issue.

2. Do the extent and nature of public services need to change? If so, how, and how should they be paid for?

2.1 Traditionally, it has been the nature of public services to operate on a large-scale, taking a standard approach to all, and being widely criticised for bureaucracy and duplication. Some of the biggest challenges facing public services are about the need to move to a position of age equality and a personalised approach.

2.2 SCIE’s guide *Age equality and age discrimination in social care: An interim practice guide* acknowledges that although there have been many improvements in service provision and practice in recent years, within the current debates about demographic change there is a “...strong undertone implying older people represent an unaffordable burden on society”. This underlying belief needs to change, with a move towards a position where older people are seen as citizens with a positive contribution to make, and the right to support from public services when required. Following the Equality Act 2010 our guide highlights three broad principles underpinning an age
equality strategy for adult social care, which are equally applicable to other public services:

- Citizenship – each individual as a full and equal citizen
- Equity – people with the right to expect fairness in access to services and opportunities
- Sustainability – systems in place to maintain the quality of service provision and practice

And personalised services, leadership, a well-equipped workforce, and improvement targets are identified as key aspects of these over-arching principles.

2.3 Public services that understand and strive for age equality will contribute to the challenge of the demographic changes by supporting older people to play a full and active role in shaping local services, maximising their social inclusion and sense of well-being. And in turn, such localities will benefit from the knowledge and experience of an often untapped source.

2.4 Personalisation is worth exploring in more detail. A cornerstone of both social care policy and SCIE’s own work, public services more broadly could see this as an alternative to large-scale service provision and standard approaches. Personalised services understand that easy access to information, advice and advocacy enables individuals to more accurately assess their own needs and devise plans for support that will work in their particular circumstances. In its simplest terms it means fitting the service to the individual, rather than the other way round. Starting from a position that acknowledges the value of information and advice, and the ability of people to work out what will best help them would also open up the possibility of more positive outcomes for individuals, and help services avoid reinforcing decline and dependency. As the demographic pressures build, this will be essential.

2.5 In the SCIE report ‘People not processes: the future of personalisation and independent living’ recommendations for action to ensure truly personalised services become possible include:

- Taking a holistic approach that addresses all aspects of a person’s life
- Pooling and co-ordinating resources that are currently divided between a number of different government departments
- Better and closer collaboration between policy makers and service providers
- Clear and independent evidence of what is and is not working
- The introduction of co-production

The report also includes a statement of what personalisation can mean when done well, which is applicable to public services beyond health and social care:

‘Personalisation for me is about: flexibility, choice and control.
To make it work for me it needs: peer support, information and advice.
If it’s working well, it is: liberating with positive outcomes.
I will be included and valued.
No decision about me, without me.’
3. Do we need to redesign and transform public services for these challenges? If so, how?

3.1 There is a clear need to redesign and transform public services, to support a move from the traditional approach where Local Authorities and others are the assessors and decision-makers and those needing support are passive recipients. SCIE’s work suggests that a move to a co-production approach, where all involved are focused on the strengths and resources of the individual and work together to determine how these can be used to enable them to live the life they want to live, is needed. This will mean looking beyond individual needs being the responsibility of health, or social care, or the benefits agency and starting from the individual, their life, and what can be harnessed from themselves, their families, local communities and public services to best support them. And more broadly than individuals co-producing their own support, this approach assumes that harnessing the expertise and assets of the people using services is essential to ensuring services are effective and based on good practice.

3.2 An evaluation of the evidence base for co-production (SCIE Research Briefing Co-production: an emerging evidence base for adult social care transformation) highlights the strengths of co-production models applied in a range of services:

- Value for money
- Incorporation of expertise from the people who use services
- Health benefits and prevention
- Practical skills
- Social capital

The same report also suggests that there are different levels of co-production, and that at its most effective it can involve the transformation of services. At this level it requires a relocation of power and control, new structures of service delivery, and a coming together of professionals and those using public service to work together at all stages of service development and delivery. The authors of this report acknowledge that this model of co-production is ‘...challenging to realise’ and emphasise that it will be different depending on the type of public service. In social care, the elements of personalisation are strongly reflected but it is more than that too. Co-production has the potential to create new relationships, including peer support, and to position the person using services as an expert with assets to offer. It takes a whole life focus, and involves people using services to influence the ethos of care and empower frontline staff. But individuals will vary considerably in their ability to take advantage of these opportunities, and staff in public services would need to be open to a very different way of working, one in which they become collaborators rather than rationers.

3.3 The demographic pressures also make it absolutely critical that we strive to deliver integrated services in the public sector. This has been a consistent concern for many years, amid a belief that public services could be improved if agencies worked together more efficiently, but has proved extremely difficult to achieve. Anecdotally, individuals and their carers using health and social care services report bewilderment at the number of different professionals they come into contact with and the number
of times they are asked for the same information. And yet efforts to address this through changing organisational structures have not always produced more positive results.

3.4 In a recent report (SCIE Research Briefing *Factors that promote and hinder joint and integrated working between health and social care services*) the evidence base for an integrated approach in health and social care was explored. The authors of the report found that the evidence base is still weak, despite more joined up and collaborative working being a policy theme for many years. The evidence does however provide some guide to what needs to be done in order to move forward:

- It is essential that everyone involved in new partnerships and integrated services understands the aims and objectives of the initiative. This can be achieved through involving operational staff at every stage of discussion, joint development of policies and procedures, and an agreed forum for the resolution of problems and reviewing practice.
- Transparent and appropriate management arrangements appear to be associated with staff feeling secure and confident in their new role.
- Practitioners need to be able to reconcile their professional values and roles with the aims and objectives of the joint initiative. This can be achieved through a focus on the improved outcomes for people using the service and their carers, so that staff can see what their joint efforts will achieve.
- Being willing and able to share information is fundamental, but is also often a particular problem.
- The effectiveness of the approach must be considered from the perspective of the people using the service and their carers, as their desired outcomes will be different to those from a policy and practice perspective. Those using services appear to value timely assessment and services, partnership, trusting relationships with named staff, and improved communication and co-ordination between different agencies. They are less concerned with how services are organised.

3.5 Given that health and social care have struggled to move towards more joint and integrated working, despite having areas of common interest and significant numbers of people using both services, it is not surprising that other public services continue to operate very separately. But the most vulnerable groups in society use a wide range of public services and must be involved in developing solutions to the challenge of delivering more efficient, joined up services that can still respond to individual needs and circumstances.

4. What should be done now and what practical actions are needed?

4.1 In addition to the areas outlined above, there is also a clear need for public services to move away from a focus solely on high levels of need and crisis intervention, and to an approach that is preventative.

4.2 A recent series of films (SCIE Social Care TV *Avoiding unnecessary hospital admissions*) explored what actions health and social care can take together to reduce the numbers of older people requiring hospital admission, a particularly challenging
aspect of the changing demographics. Some of the more effective actions portrayed in the films include:

- The value of people having a full understanding of their health conditions, what steps they can take to avoid deterioration occurring and what actions to take if the condition is worsening
- The contribution that telehealth can make to monitoring health conditions and keeping people in their own homes
- The value of a joint health and social care team (including full GP involvement) taking a holistic approach to supporting people with complex health and social care needs in their own homes
- The contribution care homes can make to keeping older people out of hospital, through building strong working relationships with community health professionals and focusing on effective management of medication, falls prevention, mental health, good nutrition and supportive end of life care.

4.3 Where illness or deterioration of ability has occurred for an individual, the focus should be on reablement. Traditionally it has been assumed that frail older people are unlikely to regain any loss of functioning, particularly if they also have a degree of cognitive impairment but the evidence suggests that this is not the case and that it can achieve cost savings.

4.4 SCIE’s work on reablement (SCIE Research Briefing Reablement: a cost-effective route to better outcomes) has shown that the improved independence achieved as a result of such services is welcomed by individuals and in some cases is also associated with increased confidence for carers. As with a number of the possible new approaches outlined in this submission, reablement requires the workforce to do things differently – to stand back and provide the encouragement and support that people need to regain or relearn how to do things for themselves. This can be a difficult change, but will deliver better outcomes for people and reduce the need for ongoing service provision.

5. **How can we stimulate national debate about these issues?**

5.1 There may be opportunities here to learn from the example of dementia, an issue closely associated with the demographic change, and one where the public have been equally reluctant to engage.

5.2 The change in public interest in, and perception of, dementia has been building since the publication of the National Dementia Strategy in 2009. Since then the strategy has been refreshed by the current coalition government to highlight priority areas, and given new impetus by the Prime Minister’s Challenge earlier this year. With the additional profile offered by a series of All Party Parliamentary Group enquiries, the National Dementia Declaration and subsequent formation of the Dementia Action Alliance and the press coverage linked to high profile campaigners dementia is no longer the hidden disease. This has been helped by the fact that dementia increasingly touches all of our lives – most people now know someone affected in some way by the disease.
5.3 Stimulating national debate about the challenges associated with demographic change is likely to need a similarly diverse approach. Government needs to make clear that it considers it to be a priority for action, and outline how this should be approached; other mechanisms for bringing it to people’s attention need to be found; and the public need to be shown why demographic change is important and how it will affect them individually. Then it will be possible to debate the issues and explore possible solutions with an engaged audience.

29 September 2012
South West Forum on Ageing and Torbay, Southern Devon Health and Care Trust, Leeds City Council, North East Essex Clinical Commissioning Group and North West London Integrated Care Management Board—Oral evidence (QQ 554–582)

Transcript to be found under Leeds City Council
Addressing Social Inequalities among Older People

1. Demographic change affects different social groups in different ways. This note focuses on ageing and inequality.

2. Housing, employment and income differences through the life-course contribute to health inequalities in old age. The Marmot report calculates that disability-free life expectancy varies by nearly a quarter between those living in the most deprived tenth of neighbourhoods and those in the most advantaged, from 55 to 68 years. If those 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. Income inequalities among over-65s have increased since the mid-1990s, as they have for other age groups: those nine-tenths of the way up the distribution receive over three and a half times as much as those one-tenth of the way up. The corresponding incomes ratio for those in the preceding decade is higher, at just under five to one. Since retirement ages will increase to 68 after 2026, those who can will work longer and this is likely to increase inequalities.

3. These statistics show that disadvantaged older people are likely to have much greater needs in old age and fewer resources with which to meet them. Current indications are that the proportion of older people in the population will rise, that the inequalities in disability will remain and that incomes in old age will become more unequal.

4. The problems in financing public provision described by OBR are likely to become more severe. A wide range of measures have been pursued to improve the cost-efficiency of public services. ONS research on public sector productivity indicates no overall gain over the period from 1995 and a slight deterioration in the area of health care. There are some indications of greater cost-efficiency in the use of labour but these are more than compensated by changes in the cost of other inputs and increases in staffing.

5. Services relevant to health and disability are largely delivered by a combination of the NHS and local government and some by the Third Sector. Third Sector resources are unevenly distributed with more in more advantaged areas, most provision is directed at needs that do not relate to the most disadvantaged groups and much of

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304 Ibid, Figure 1.1


307 See the most recent reports by ONS on public sector productivity: http://www.statistics.gov.uk/hub/government/central-and-local-government/public-service-productivity
the provision that does is substantially financed by the state, mainly by local
government.308

6. Under these circumstances it is desirable that the various state services be co-
ordinated to take account of inequality and to ensure that the least advantaged are
included.

7. Recommendations:
   a. Resource allocation mechanisms within NHS and local government that take
      into account neighbourhood disadvantage and proportion of lower income
      people;
   b. Targets for provision that include inequality in outcomes by income group and
      neighbourhood disadvantage;

Annual monitoring of outcomes and publication of the statistics.

13 August 2012

http://www.britac.ac.uk/policy/Demographic-futures.cfm
Ten Professional Support—Written evidence

Intelligent support in delivering elder care

Proposal
Ten Professional Support (hereafter ‘Ten’) proposes developing a new user-led service to empower older people in managing their care needs and maintaining independence and quality of life. An overview of the proposed service is set out in this paper. This radically different model of support is proposed as a solution that the House of Lords Committee on Public Service and Demographic Change may find helpful to review in the context of their explorations into how public services must change in order to meet challenges facing the country in delivery of elder care. This paper does not seek to answer all the many questions posed by the Committee, but simply to share one powerful idea for a new type of support.

Rationale
The ageing population in Britain brings considerable challenges which the House of Lords Committee on Public Service and Demographic Change have outlined in their call for evidence. At the same time that these serious challenges are emerging and growing, expectations for care are changing, such that individuals demand respect for their relationships and participation, with dignity and control being of paramount concern. In seeking new solutions, the individual must be placed at the centre of service design and delivery.
Ten’s problem-solving model does exactly this, putting the individual user at the heart of how its services operate. The model has been proven to deliver highly efficient information sharing and support, and can be applied to any group of individuals facing similar challenges. Within the area of elder care, the power of Ten’s model can be harnessed to support two groups: firstly the service users themselves, and secondly the managers or volunteers who facilitate the development of services.
The importance and value of letting the individual lead in the area of elder care has already been demonstrated in the development of Elder Power in Maine, US. This proposal seeks to bring together the insights of the Elder Power project and the strength of the Ten model in order to suggest the creation of an innovative new service.

Service proposition
Responses to the question, “What do you need?” drive everything in Ten’s service delivery. In this proposed service, older individuals will be able to ask any questions about their needs. The service will aim to be the first point of call for information and guidance relating to the needs and questions of older people. It will support these individuals by providing them with access to accurate and clear written responses to their questions.
By creating a focal point for this type of support, it will both gather and disseminate authoritative information and examples of innovative or effective practice. Furthermore, the data generated by the service will create valuable insights for health professionals and other stakeholders seeking to understand and support those affected by ageing.
Ten Professional Support—Written evidence

The proposed new service will operate along similar lines to Ten’s existing support services, making full use of Ten Group’s technologies, systems and operational expertise. It will need to be tailored according to the specific sector needs, developed with input from relevant stakeholder organisations.

How does Ten’s model work?
The model is best evidenced in Ten’s flagship professional support service, The Key, which is used by over 17,000 school leaders. Originally commissioned by the Training and Development Agency for schools, The Key provides school leaders with information, ideas and case studies in direct response to their questions. Members can ask unlimited questions on any aspect of school leadership and management. Each answer is published as an article on The Key’s website, and is then available to all members.

In this way, The Key is both transactional (I ask a question - you give me an answer) and communal (my question serves the interests of the wider professional community). The service only provides information that is requested, at the time it is required, in a form that can be put to use straight-away. Its knowledge base is therefore an organic, real-time reflection of the problems school leaders face.

What are the benefits of this sort of service?
The 'user-determined' model is elegantly simple and highly cost efficient. A school leader contacts The Key and asks for ideas to reduce staffing costs. The first time this, or any such question is asked, the initial cost of producing an answer is high. The second time the production cost is much lower. The more frequently an answer is requested and accessed, the more diluted the initial production cost becomes. Of all the requests for information The Key now receives, over 99% have been previously made and answered.

Benefits of The Key
- Time saving for professionals: The Key saved an estimated 602,000 working hours over the 2009/10 academic year for the 5,000 professionals using the service. That is equivalent to 120 hours per individual, averaging at 555 hours per school, which in turn equates to £16,650 of deployed resource per school.
- Better decision-making: The Key empowers education professionals to make quicker, better decisions. Members have easy access to the latest information, guidance and ideas. Decisions are taken quickly and confidently - underpinned by accurate information and inspirational practice from across the wider education community.
- Cost savings: The Key works in partnership with over 40 local authorities delivering better education outcomes for less. Local authorities involved in block-buying, subsidising or supporting The Key have significantly reduced their schools' advisory budgets. Partnership also enables LA advisers to spend less time researching and repeating information, and more time in schools.

Benefits within elder care
Similar efficiencies and impact are projected within the context of elder care:

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309 FDS International, an independent research company, consulted 1,000 users of The Key. It found that school leaders saved an average of 3.5 hours when they accessed an answer on The Key’s website; and an average of 5 hours when asking their own question.
310 At an average estimated hourly equivalent school leader rate of £30
Ten Professional Support—Written evidence

- Better decision-making based upon accurate and relevant information
- Improved awareness of and access to a wide range of support services, groups, technologies and products
- Reduced feelings of frustration and isolation
- Sharing of useful intelligence to the sector based on data and insights created by the service

30 August 2012
Professor Pat Thane, King’s College London and Fellow of the British Academy, Age UK, International Longevity Centre and Joseph Rowntree Housing Trust—Oral evidence (QQ 72–93)

Transcript to be found under Age UK
Do you ‘get change by scaring people’?

Baroness Greengross raised this in the context of discussing poor, even discriminatory, health care for older people, and poor quality social care, both of which worsen the quality of life of older people and can lead to increased costly demands on the health service.

The question is: scaring who to do what? Baroness Morgan repeated Baroness Greengross’ analogy with AIDS advertising. That was directed at the public and was designed to scare those for whom it was relevant into taking relatively simple and cheap action to protect themselves from AIDS: use condoms. It seems to have been effective.

There is no clear analogy with protecting oneself from poor health and social care in later life because change doesn’t solely lie in the hands of users of these services. It isn’t easy to persuade health professionals to drop their discriminatory practices or to persuade local authorities to improve care services especially given current cuts. And it certainly isn’t cheap, or within the means of very many people, to buy better services privately.

It may be possible to scare the public by telling them clearly about the effects of poor services, so that they make a fuss and campaign about it on behalf of the current generation of older people and in their own interests as they age. Who would organize the scare? Unlikely to be the government, who promoted the AIDS campaign. Voluntary organizations can do it, though a big campaign would be costly. The experience of the gradual shifts since the 1970s against gender, race, disability discrimination, judging from work I and colleagues carried out for the equality and Human Rights Commission, is that such campaigns work, but slowly and they need government support, and they depended on persuasion and legal sanctions, not scare tactics.

Or should the scare tactics be directed at the professionals? If so, again, by whom? And what are they to be scared about? As Caroline suggested, it may be more constructive to persuade health professionals of the dangers of making assumptions about older people purely on the basis of age and to treat older like younger people, on the basis of their actual physical and mental condition. Government has the resources to do this more effectively than most voluntary agencies. The poor quality of much social care seems to have as much to do with inadequate funding, leading to poor training and low pay for care workers, as with discrimination. Hard to see what to do about this, unless government can be scared into realizing that low-cost, inadequate social care leads on to expensive health care, so is short-sighted.

Or are we talking about scaring people into saving more to help themselves in later life? People should save as much as they can and there were constructive suggestions earlier in the discussion about creating tax-effective savings products and alerting people to the existence of safe equity-release schemes; and auto-enrolment should help. But do we have clear evidence of how many people really can save more? How many are actually spending money they could and should save? Given how many younger people are paying off student loans (likely to rise in future), paying high housing costs, whether rent or mortgage, raising
families and paying higher everyday living costs, what do we know of the actual savings potential of the population? Especially when a good pension and a comfortable old age requires a lot of saving. It may not be surprising that many people close their minds to the costs of growing older, when other costs loom so large in their lives, not to mention the fear, or reality, of unemployment. Scaring them might just reinforce this tendency. And the costs of old age are uncertain because no-one knows whether or not they will suffer prolonged ill-health, so saving is hard to judge, though insurance could be provided in a way that overcomes that. Then we have to overcome mistrust of such products after so many experiences of mis-selling.

The reality of their own likely experience in old age must also be difficult for younger people to comprehend because they keep being told that they will have to work to ever later ages, the implications of which cannot be clear to them. Younger people need to be better informed and given more opportunities to debate, the diverse realities of ageing, with its many positive possibilities with the aim of encouraging them to prepare realistically. Who can best do this? Again, the relevant voluntary organizations in association with the government.

Getting better information across to the media about the realities of later life would help, so that they present more positive images. It was irritating this morning (Oct 26) listening to Evan Davis discussing the care of older people with Diana Athill and the senior researcher at AgeUk on Today. He kept expressing surprise at their very positive comments about the respect in which very many older people are held in this country, the support they receive from their families and their positive, substantial, inputs into society and the economy. It’s a pity he hadn’t noticed a discussion between Diana Athill and myself on this subject on Today on this very subject in July 2011 which also reached positive conclusions. Davis seems, as many people do, to accept that because people in ‘other countries’, often in Asia, share homes with their older relatives, the older people are necessarily better cared for. The work of Dr Mayumi Hayashi (Institute of Gerontology, Kings College London) on care for older people in Japanese families and the sadly high level of elder abuse, may suggest otherwise. It would be good if media figures could stop reciting negative stereotypes about older people and their treatment by others and think more carefully about the issues, but its hard to know how to change them. I doubt that scare tactics will work with them or with other sections of society.

26 October 2012
Current patterns in civic engagement by age group

1 Context and Summary
1.1 Demographic and fiscal pressures are currently forcing consideration of existing arrangements for meeting social needs. In this context, there has been discussion of the place of voluntary action. Oral evidence focussed on whether or not more might be expected of post-retirement age-groups, and our submission examines this issue, but the same question could equally be raised in relation to other groups in society.
1.2 In this paper we provide evidence on current age patterns in civic engagement. We consider evidence in relation to formal volunteering (that is, voluntary action that takes place through an organisation such as a charity, community centre or place of worship), informal volunteering (voluntary action taking place other than through the medium of an organisation) and donations of money to charity. The survey data we analyse asks questions about whether or not people engage in these activities (the rate of engagement), and if they do, the level of engagement (e.g. how many hours they have given, or how much money they have given, in a four-week reference period). In summary, the evidence shows that:

1.2.1 There is a large amount of variation in engagement within age groups. Two people of the same age can differ greatly in their civic engagement, depending variously on their education, their social class, their working lives and so forth. In examining patterns of civic engagement for different age groups it is crucial to take account of these other factors that affect engagement.
1.2.2 All age groups are currently civically engaged, to a greater or lesser degree. There is not a major problem of non-engagement but the patterns for different age groups vary by type of civic activity.
1.2.3 Rates of formal volunteering: accounting for socio-economic factors, there is generally an equal likelihood of engagement in formal volunteering across the age groups. The over 70’s age group does, on average, have a lower likelihood of engagement, however, there is great variation within this group.
1.2.4 Levels of formal volunteering: accounting for socio-economic factors, the amount of time dedicated to volunteering is higher in the higher age groups, although we find more diversity in levels amongst older groups than amongst younger groups.
1.2.5 Rates of informal volunteering: accounting for socio-economic factors, there is a dip in the propensity to be involved in informal volunteering around middle age, followed by a higher rate of engagement in the older groups. In contrast to patterns of formal volunteering, the over 70’s age group, on average, has a higher, rather than lower likelihood of engagement in informal volunteering. However, we find great variation around the average.
1.2.6 Levels of informal volunteering: accounting for socio-economic factors, similarly to what was found in relation to formal volunteering, the amount of time dedicated is higher in the higher age groups, although here again we find higher diversity amongst older groups than amongst younger groups.
1.2.7 Incidence of charitable giving: accounting for socio-economic factors, we find progressively higher rates of charitable giving across the age groups, from youngest to oldest.

311 See Transcript of evidence taken before the House of Lords Select Committee on Public Service and Demographic Change, Evidence Session No. 5, Tuesday 23 October 2012.
1.2.8 Levels of charitable giving: accounting for socio-economic factors, and unlike what was seen with formal or informal volunteering, there is no significant difference in levels of giving across the age groups, although here again we find higher diversity amongst older groups than amongst younger groups.

1.2.9 Overall, when various forms of civic engagement, including informal ways of contributing to the community and contributions in the form of donations of money rather than time, are taken into account, it is clear that, on average, older groups in British society are currently already participating in civic engagement to a high degree.

1.3 The patterns presented here are based on a representative sample of the populations of England and Wales in 2009-10, found in the Citizenship Survey. These data are publicly available through the Economic and Social Data Service website. The Citizenship Survey provides cross-sectional data. This means that the evidence presented here is snapshot of engagement by age group in 2009-10. It is not able to reveal trends over time, or trends by birth cohort (people born at or around the same time measured at different ages).

1.4 The 3 types of civic engagement examined here are:

- Formal volunteering: an individual’s participation in one or more groups in the last month.
- Informal volunteering: an individual’s provision of unpaid help of various types to non-relatives outside of their household in the last month.
- Charitable giving: an individual’s monetary contribution to various causes over the past month.

1.5 Many discussions of civic engagement focus only on the first type of engagement, namely formal volunteering. We argue for the inclusion of the other two types of engagement on the grounds that, in the context of public service provision, it is the addressing of various needs that is pertinent. That these needs are met, whether by formal organisations staffed by volunteers, by informal groups of individuals within communities, or by organisations that employ individuals who are funded by charitable contributions, is the primary concern here. It follows, then, that all three types of contributions are valid, and that any discussion of the engagement of one group in society, relative to another, should recognise all three forms of contribution.

2 Results

2.1 Our discussion of civic engagement by age groups examines both differences in individuals’ propensity to engage and their levels of engagement. For each of the set of results we present figures of the following:

2.1.1 the population distribution of engagement by age group, along with evidence of how much variation there is likely to be around the average (shown by a grey band around the central line)

312 http://www.esds.ac.uk/

313 Please see the Appendix for a list of the groups included. Please note that ‘participation’ does not require membership of these organisations.

314 Please see the Appendix for a list of the types of help included.

315 Please see the Appendix for a list of the causes included.

316 The different types of engagement have been argued to be more or less valuable in the creation of social capital and increased social mobility (see Mascherini, M., Saltelli, A. & Vidoni, D. (2007) The Characteristics of social participation in Europe: Evidence from ESS 2002, JRC Scientific and Technical Reports, European Commission. Putnam, Robert D. (2000). Bowling Alone: The Collapse and Revival of American Community. New York, NY: Simon and Schuster). However, in the context of a discussion of what is currently being done by different groups in the population with a view to identifying potential additional sources of engagement, a discussion of the advantages and disadvantages of particular forms of participation is less relevant here.
2.1.2 The predicted population distribution of engagement by age group, when relevant socio-economic factors are taken into account, along with evidence of how much variation there is likely to be around the average (shown by a grey band around the central line).

2.2 The socio-economic factors included in the analysis were chosen because of their established relevance for levels of civic engagement generally.

2.3 Propensity to engage in formal volunteering by age group

2.3.1 Figure 1 shows the predicted population distribution of the propensity for formal volunteering by age group. This indicates that the likelihood of engagement in formal volunteering fluctuates slightly for groups between 20 and 60. The likelihood tails off for groups that are older. Additionally, the band around the regression line shows the variation around the average likelihood.

Figure 1 Predicted probability of engaging in formal volunteering by age (Citizenship Survey 2009-10)

2.3.2 Figure 2 shows the predicted population distribution of the propensity for formal volunteering by age group, when relevant socio-economic factors are taken into account. It shows that controlling for relevant socio-economic factors further flattens the distribution. The chances of someone being engaged in formal volunteering remain relatively steady between the ages of 20 and 70. The chances of someone being engaged drop off in the groups that are over 70 years old. The Figure also shows us that the variation around the average likelihood of engagement in formal volunteering is larger in the age groups over 70. This indicates that these older age groups are quite different in terms of their composition. There are factors

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317 Socio-economic factors included: gender, marital status, social class, education, respondent’s income, employment status, ethnicity, religious participation, self-reported health and social trust.

that are differentiating between levels of engagement of these groups that are not covered by the socio-economic factors which have been taken into account. Some individuals in these groups are just as likely to contribute to formal volunteering as individuals in the younger age groups (indicated by the top of the shaded area) but others are less likely to contribute to formal volunteering. This variability in the older age groups is notable. It indicates that suggestions about the feasibility of getting more older people to be involved in formal volunteering need to be tempered by an appreciation of the fact that these older individuals are a very diverse group.

Figure 2 Predicted probability of engaging in formal volunteering by age taking into account relevant socio-economic characteristics (Citizenship Survey 2009-10)

2.4 Levels of engagement in formal volunteering by age group

2.4.1 Figure 3 shows the predicted population distribution of the hours of formal volunteering by age group. The shape of the distribution indicates that the number of hours of formal volunteering increases marginally by age group, with a hiatus among the 60 year old group, and a gradual decrease in older (70+) groups. Again, the band around the regression line represents the margin of error. The wider that band, the more variation there is in the corresponding age group in terms of numbers of hours of formal volunteering provided in the past month.
2.4.2 Figure 4 shows the predicted population distribution of hours of formal volunteering by age group, when relevant socio-economic factors are taken into account. Crucially, when we compare individuals of the same socio-economic situation, the amount of hours of formal volunteering an individual has done is higher the older they are. Older people are giving more hours of formal volunteering than younger people. This means that much of the apparent relationship between age and hours of formal volunteering done (as shown in Figure 3) is actually due to differences in socio-economic factors between the age groups. Again, there is increased variation around the group average for older groups, indicating that there is more diversity in formal volunteering levels within this group.
Figure 4 Hours of formal volunteering in the last 4 weeks by age, taking into account relevant socio-economic characteristics (Citizenship Survey 2009-10)

2.5. Summary of formal volunteering and its relationship to age

2.5.1 Figures 1 through 4 have shown that looking at the association between formal volunteering and age without taking account of other socio-economic factors can be misleading. Some of what at first looks like age variation in engagement is in fact due to variation in socio-economic factors within age groups. When we compare individuals of similar socio-economic backgrounds there is generally an equal likelihood of engagement across the age groups. The over 70’s age group does, on average, have a lower likelihood of engagement, however, it is also a diverse group. Looking beyond likelihood of formal engagement to levels of formal engagement, it is apparent that the amount of time dedicated is higher in the higher age groups, although here again we find higher diversity amongst older groups than amongst younger groups.

2.6 Propensity to engage in informal volunteering by age group

2.6.1 Figure 5 shows the predicted population distribution of the propensity for informal volunteering by age group, as inferred from the data. It suggests that there is a slight decline in likelihood of informal engagement in consecutive age groups, however the band around the regression line indicates that this decline is not significant.
2.6.2 Figure 6 shows the predicted population distribution of the propensity for informal volunteering by age group, when relevant socio-economic factors are taken into account. Again, it is interesting how the association between age and engagement changes once socio-economic factors are taken into account. Additionally, and contrary to what was seen in relation to formal volunteering, likelihood of informal engagement is lower among younger groups and increases among older groups. Variation in likelihood of engagement is highest amongst the older groups, suggesting, again, that the group is diverse. Some individuals in their 80’s are as likely to be engaged in informal volunteering as individuals in their 20’s, whilst others are far more likely.
Figure 6 Predicted probability of engaging in informal volunteering taking into account relevant socio-economic characteristics (Citizenship Survey 2009-10)

2.7 Levels of engagement in informal volunteering by age group

2.7.1 Figure 7 shows the predicted population distribution of numbers of hours of informal volunteering by age group. This shows that, on average, the youngest and those in their 70’s report more hours of informal volunteering. There is a dip amongst those in their late 30’s, and those over 70 year old.

Figure 7 Hours of informal volunteering in the last 4 weeks by age (Citizenship Survey 2009-10)

2.7.2 Figure 8 shows the predicted population distribution of the number of hours of informal volunteering by age group, when relevant socio-economic factors are taken into account. Younger and older individuals are likely to provide more hours of
informal volunteering than those in middle age. The highest levels are, on average, provided by the over 80’s. However, as seen previously, there is more variation as individuals get older, so whilst on average the over 80’s are very active in terms of how many hours of informal volunteering they provide, the group is very diverse, with some individuals providing much lower levels.

**Figure 8 Hours of informal volunteering in last 4 weeks by age, taking into account relevant socio-economic characteristics (Citizenship Survey 2009-10)**

2.8 Summary of informal volunteering and its relationship to age

2.8.1 Figures 4 through 8 have shown that, similarly to what was seen with formal volunteering, looking at the association between informal volunteering and age without taking account of other socio-economic factors is misleading. Some of what at first looks like age variation in engagement is in fact due to variation in socio-economic factors within age groups. Comparing individuals of similar socio-economic backgrounds indicates a dip in propensity to be involved in informal volunteering around middle age, followed by a higher rate of engagement in the older groups. This pattern is in contrast to what was seen in relation to formal volunteering where results showed an equal likelihood of engagement across the younger to middle-aged groups. Also in contrast to patterns of formal volunteering, the over 70’s age group, on average, has a higher, rather than lower likelihood of engagement in informal volunteering. However, the above 70’s section of the population is also a diverse group with respect to informal volunteering, with great variation found around the average. Looking beyond likelihood of informal engagement to levels of informal engagement, it is apparent that, similarly to what was found in relation to formal volunteering, the amount of time dedicated is higher in the higher age groups, although here again we find higher diversity amongst older groups than amongst younger groups.

2.9 Propensity to engage in charitable giving by age group

2.9.1 Figure 9 shows the predicted population distribution of the propensity to engage in charitable giving by age group. This indicates that individuals tend to higher rates of charitable giving the older they are. This trend reverses in the 55+ age
groups. Additionally, the band around the regression line indicates that variation
around the average is similar across the age groups.

**Figure 9 Predicted probability of engagement in charitable giving**
(Citizenship Survey 2009-10)

2.9.2 Figure 10 shows the predicted population distribution of the propensity to
engage in charitable giving by age group, when relevant socio-economic factors are
taken into account. The change in the shape of the distribution is stark. When
comparing individuals from similar socio-economic backgrounds, we observe a steady
increase in the likelihood of giving to charity across the age groups. As with other
estimates, we see the level of intra-age group diversity increasing in the older age
groups, underlining that older people are a more diverse group than younger age
groups when it comes to propensity to give to charity.
Figure 10 Predicted probability of engagement in charitable giving taking account of relevant socio-economic characteristics (Citizenship Survey 2009-10)

2.10 Levels of engagement in charitable giving by age group

2.10.1 Figure 11 shows the predicted population distribution of levels of charitable giving by age group. It indicates that levels of giving are higher by consecutive age group between 20 and 50 and that they then drop off in the older age groups, yet this is prior to taking into account the relevant socio-economic factors that have been shown to underpin levels of giving.

Figure 11 Pounds given to charity in last 4 weeks by age (Citizenship Survey 2009-10)

2.10.2 Figure 12 shows the predicted population distribution of the propensity for charitable giving by age group, when relevant socio-economic factors are taken into account. This graph indicates that socio-economic characteristics other than age
account for all significant differences in amount given to charity across the population, as indicated by the flat regression line across all the age groups.

**Figure 12** Pounds given to charity in past 4 weeks by age, accounting for relevant socio-economic characteristics (Citizenship Survey)

2.11 **Summary of charitable giving and its relationship to age**

2.11.1 Figures 8 through 12 have shown that, similarly to what was seen with both formal and informal volunteering, looking at the association between charitable giving and age without taking account of other socio-economic factors is misleading. Much of what at first looks like age variation in engagement is in fact due to variation in socio-economic factors within age groups. Comparing individuals of similar socio-economic backgrounds indicates a progressively higher rate of charitable giving across the age groups, from youngest to oldest. Looking beyond likelihood of charitable giving to levels of charitable giving it is apparent that, unlike what was seen with formal or informal volunteering, there is no significant difference in levels of giving across the age groups, although here again we find higher diversity amongst older groups than amongst younger groups.

3 **Discussion and further evidence**

3.1 This paper has provided evidence to inform the discussion on current age patterns in civic engagement. Evidence indicates that rates and levels of civic engagement must be seen in the context of a range of socio-economic factors, not just age. Taking these factors into account, engagement of different age groups varies across forms of civic engagement. When these different forms of contribution are taken into account it is clear that, on average, older groups in British society are currently already participating in civic engagement to a high degree. We do, however see substantial variation around average engagement, particularly in older groups. This indicates that individuals differ in their engagement behaviour for reasons other than the socio-economic factors that are taken into account here. Section 3.2 explores what some of these might be.

3.2 In considering the wider impact of an ageing society on public service, the Third Sector Research Centre suggests that the following are important considerations for the Committee:
3.2.1 Regional differences in deprivation: If social needs are to be met to a greater
degree by voluntary effort, one question is whether communities vary in their
capacities. Earlier work by the TSRC has identified a "civic core": groups of the
population who collectively provide the great bulk of hours volunteered, or money
given to charity. Analysis suggests that around 30% of the population contributes
between 80% and 90% of charitable giving and volunteering.\textsuperscript{319} These very active
groups tend to be overrepresented in the most prosperous parts of the country, and
underrepresented in more deprived areas. Approximately 14% of them live in the
most prosperous 10% of neighbourhoods; conversely, only 6% live in the most
deprived 10% of areas. The survey data do not provide a perfect guide as to exactly
where and for which organisations and individuals are volunteering. Thus it is possible
that volunteering might be taking place near a workplace, a church, or a point on
someone's journey to work. Nevertheless the general point is clear: there are
considerable variations between communities in levels of volunteering. Thus it is
possible that there is a mis-match between the areas of highest social need and the
areas in which individuals engage highly. Thus, the focus on localism and people
participating in 'their square mile' may in fact exacerbate social inequalities, rather
than diminish them.

3.2.2 Cohort differences in civic engagement: Reviews of historical statistics show
that rates of engagement and voluntary activity within the UK have remained broadly
constant. However, can we assume that this will remain the case in the future? To
investigate whether that assumption is valid, we need to compare the level of
engagement of individuals now with the level of engagement of their counterparts of
the same age in previous decades. A study of cohort variations in participation in
voluntary organisations suggests that there are reasons to be cautious in assuming
that generations will continue to participate at the same rate as their predecessors.
Individuals are asked, at two-year intervals, to estimate the number of types of
association in which they participate. If we compare cohorts observed at the same
ages, it is found that the postwar generations -- especially those in the cohorts
defined by years of birth in 1955-64 and 1965-74 - are not as active in associations as
was the case for their predecessors observed at the same ages.\textsuperscript{320} There is similar
evidence from surveys of charitable giving over time. A recent report\textsuperscript{321} analysed
three decades of survey data on charitable giving and argued that there are
generational shifts in giving behaviour. Those born in the 1970s were less likely to
give to charity than those born in 1960s, who in turn were less likely to give than the
1950 cohort, who themselves were less likely than those in the 1940s.

3.2.3 The implications for policy of our evidence are as follows. Firstly, there is
considerable stability in rates of engagement. Attracting those who are not currently
engaged will not be straightforward. It is unlikely that there will be a sudden
"Olympic effect", based on experience of previous one-off and events such as Live
Aid on charitable giving. Secondly, if the evidence for a cohort decline in participation
in associations also holds for volunteering then it is clear that we cannot presume
future generations will engage to the same degree as their predecessors. Thirdly, we

\textsuperscript{319} J Mohan and S Bulloch (2012) The idea of a “civic core”: what are the overlaps between charitable giving, volunteering
and civic participation in England and Wales? TSRC WP-73, available from www.tsrc.ac.uk

\textsuperscript{320} A. McCulloch, 'Cohort variations in the membership of voluntary organisations in Great Britain, 1991-2007', paper
presented to the Annual Conference of the Social Policy Association, available at www.social-
policy.org.uk/lincoln2012/McCulloch%20P7.pdf

\textsuperscript{321} Mind the gap: the growing generational divide in charitable giving (2012) Charities Aid Foundation / University of Bristol
have stressed the variations that exist between communities in the distribution of the most civically-engaged members of the population. There are two questions which arise here. Firstly, we find very high rates of engagement indeed in the most prosperous part of the community, implying that there will be limits to the capacity of those communities to rely on voluntary effort unless levels of engagement are also simultaneously increased. Secondly, in communities where the "civic core" is less prevalent, there are challenges in raising both rates and levels of engagement, and these communities are also likely to be hard-hit by current economic circumstances.

Given these apparent disparities between communities, creative thought is required in terms of improving the connections between communities, in order to match social needs with provision. The localist emphasis of current policy could have as one outcome that divisions between communities are further entrenched: not only are there gaps between them in socio-economic terms, but there are also widening gaps in terms of the distribution of volunteers and voluntary resources.

4 Appendix
4.1 Groups covered by formal volunteering measure:
(A) Children's education/schools
(B) Youth/children's activities (outside school)
(C) Education for adults
(D) Sport/exercise (taking part, coaching or going to watch)
(E) Religion
(F) Politics
(G) The elderly
(H) Health, Disability and Social welfare
(I) Safety, First Aid
(J) The environment, animals
(K) Justice and Human Rights
(L) Local community or neighbourhood groups
(M) Citizens' Groups
(N) Hobbies, Recreation/Arts/Social clubs
(O) Trade union activity
Other

4.2 Activities covered by informal volunteering:
(1) Keeping in touch with someone who has difficulty getting out and about (visiting in person, telephoning or e-mailing)
(2) Doing shopping, collecting pension or paying bills
(3) Cooking, cleaning, laundry, gardening or other routine household jobs
(4) Decorating, or doing any kind of home or car repairs
(5) Babysitting or caring for children
(6) Sitting with or providing personal care (e.g. washing, dressing) for someone who is sick or frail
(7) Looking after a property or a pet for someone who is away
(8) Giving advice
(9) Writing letters or filling in forms
(10) Representing someone (for example talking to a council department or to a doctor)
(11) Transporting or escorting someone (for example to a hospital or on an outing)
(12) Anything else
(13) No help given in last 12 months

4.3 Activities covered by charitable giving variable

(A) Money to collecting tins (e.g. door-to-door, in the street, in a pub, at work, on a shop counter, etc.)
(B) Sponsorship
(C) Collection at church, mosque or other place of worship
(D) Collections using a charity envelope
(E) Buying raffle tickets (NOT national lottery)
(F) Buying goods from a charity shop or catalogue
(G) Direct debit, standing order, covenant or debit from salary, payroll giving
(H) Giving to people begging on the street
(I) Occasional donations by cheque or credit/debit card
(J) Fundraising events (e.g. charity dinners, fetes, jumble sales)
(K) Other method of giving

Did not give to charity

November 2012
Introduction
1. One of the main demographic changes is concerned with older people. There will be older, especially very old, people and there will be a decline in the proportion of those in the working population to support them. Between 2009 and 2050 in the UK the percentage of people over the age of 60 will rise from 22% to 29%, the percentage of those over the age of 80 as a percentage of all aged 60 and over will rise from 21% to 30% and the potential support ratio (i.e. the number of people aged 15-64 per older person aged 65 and over) will decline from 4 to 3 ((United Nations, 2009). As the Office for Budget Responsibility (OBR) has pointed out an ageing population will affect health spending and costs of the state pension and social care. (OBR, 2012, p. 8). In addition there are implications for professionals and for older people and their families.

2. This submission argues that housing needs much greater attention than previously. This is because it is of fundamental importance in both preventing entry into institutions and in maintaining people in homes of their own when they have long term conditions. Most previous Inquiries have focussed much more on how health and social care should be provided and funded. However, attention to housing conditions might prevent deterioration in health so that a smaller degree of support is needed.

3. It is suggested that the following would help:
   • More emphasis on the role of housing;
   • Encouragement of public and private health and social care organisations to work more closely with housing;
   • Public (central and local), private and voluntary organisations publicising the ways in which housing can contribute to health and well-being and have a role in long term care;
   • Priority in funding to go to policies which are known to be successful in keeping people in homes of their own;
   • Recognising the importance, but also the limitations, of technology.

More emphasis on the role of housing
4. While there is acknowledged to be a need for more housing in all tenures some strategic decisions about the provision of certain types of housing would be helpful. There is a forecast growth in one person households with 60% of the projected growth to 2033 in England among those aged 65 and older (HMG 2011 Annex B). More small homes in any tenure, especially if designed to lifetime standards (DCLG et al, 2008), would help the growing number of small households. It would also allow older and disabled people to move out of homes that may be too big for them. This would help with the demand for bigger houses from other groups such as families.

5. There is growing evidence about the links between housing and health (Lowry, 1991, Wilkinson, 1999, Taske et al, 2005, British Medical Association, 2006). Poor housing can cause many health problems. Damp housing can cause and/or exacerbate breathing and other health problems, inadequately heated homes can cause hypothermia, badly maintained homes can cause accidents. There are implications for mental health too. ‘Anxiety and depression increase with the number of housing problems’ (Wilkinson, 1999). All of these
have costs for the health service. Housing that is warm, well maintained and secure can help keep people out of long term care. As the All Party Parliamentary Group on Housing and Care for Older People put it ‘safer, more accessible homes can help the NHS with fewer accidents, fewer patients in hospital, early discharge and fewer expensive re-admissions’.

(p.3).

6. One of the key services for the maintenance of good housing is repairs and maintenance. The contribution of home improvement agencies has been well researched and its value in monetary and other respects proved (for a summary see Centre for Social Justice, 2010). Similarly the National Evaluation of the Handyperson Programme stated that ‘they offer an important safety net for older people, and they also enhance the effectiveness of health and social care through the delivery of often very simple and very low cost interventions’ (Croucher et al, 2012, p.1). While many people with long term conditions can pay for these services the role of grants has proved invaluable. However, although the Department for Communities and Local Government (DCLG) will continue to allocate specific funds for Disabled Facilities Grants and Handyperson services to local authorities, these will not be ring fenced and there are no planned sanctions if councils use the monies for other purposes.

7. In The billion dollar question: embedding prevention in older people’s services - 10 ‘high impact’ changes Allen and Glasby emphasise two important areas where housing has a role. One is housing adaptations and practical support where they point to the role of these polices for both primary ((by providing safer and more comfortable living environments) and secondary (such as after accidents or illness) (Allen and Glasby, 2010). The other is Technology (see paras 12 – 14). The same two initiatives are among those chosen by the author of a study by the Centre for Policy on Ageing for the Joseph Rowntree Foundation How can local authorities with less money support better outcomes for older people?. (Clark, 2010).

Encouragement of public and private health and social care organisations to work more closely with housing

8. An analysis of policy documents from government show that the majority are concerned with the need for closer links between health and social care. For example while emphasising the need for integrated care neither the Department of Health (DH) in Our NHS Care Objectives: A draft mandate to the NHS Commissioning Board (DH 2012a) nor the Secretary of State’s Annual report The National Health Service and Public Health in England (DH 2012b) touch on housing. Housing may be brought in as an afterthought. While these links are clearly of fundamental importance in both assessments and treatment housing should be central. However, the Chair of the All Party Parliamentary Group on Housing and Care for Older People said ‘in discussions on the Government’s forthcoming White Paper on social care, and the legislation that will follow, we hope this report will stimulate greater understanding of the all-important housing dimension’ (p. 3). But the subsequent interim report by DH this July Caring for our future: progress report on funding reform merely states ‘we will publish a framework for improved integration between health and care’ with no mention of housing. (DH, 2012 c). It may be that the new Health and Wellbeing Boards to be set up in each locality will be a vehicle. They are planned as ‘A Forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area’ (DH Press release 19.10.11).
Public, private and voluntary organisations publicising the ways in which housing can contribute to health and well-being and have a role in long term care

There is great need for organisations and people to have more knowledge about all the housing options including grants, equity release etc so that informed choices can be made before a move to an institution seems inevitable. The Housing Learning and Improvement Network (Housing LIN) is an excellent example which gives this kind of advice. For example the recent Strategic Housing for Older People Resource Pack was produced in association with the Association of Directors of Adult Social Services (ADASS) (HLIN/ADASS, 2011). Older people in need of long term care, families and professionals would also benefit from advice. Similarly more information specifically about technology would help (McCreadie et al, 2006, 2007).

Priority in funding to go to policies which are known to be successful in keeping people in homes of their own

There are many other initiatives which have been shown in research to be valuable both as a preventive service and to keep people out of institutional care. However, while there are many case studies such as the HAPPI report Housing our Ageing Population: Panel for Innovation (DCLG, DH, Homes and Communities Agency, 2009) and On the Pulse: Housing routes to better health outcomes for older people about housing associations (National Housing Federation, 2012) there is need for evaluations which include costings. This was done for the Royal Commission on Long Term Care (Tinker et al, 1999).

One of the most important evaluated initiatives is extra care housing where older people have their own self contained accommodation with communal spaces and usually 24 hour care and some meals. First evaluated in 1989 (Tinker, 1989) and subsequently more recently (Netten et al, 2011) this has been shown to be a popular and cost effective option for many older people. While this should not be the only option is has the potential to allow people to remain in a home of their own but also to have care and support. As well as new build there are ways in which unpopular sheltered housing (which provides little in the way of support) can be remodelled to provide extra care housing (Tinker et al, 2007, 2008, Wright et al, 2009, Wright et al. 2010) A recent report for the Homes and Communities Agency Financial benefits of investment in specialist housing for vulnerable and older people concludes ‘We find that investment in specialist housing results in a net benefit for all client groups except those groups relating to young people. ………Our analysis suggest that the total benefit of specialist housing (under our central case scenario) is about £1.6 billion but……..the largest single benefit is estimated for the older people client group (Frontier Economics Ltd, 2010, p.3). However, the case for specialist housing has to be seen as a solution that will probably affect a small proportion of people who need long term care (currently less than 5% of people aged 65-69 live in sheltered housing and the figure only rises to 19% for those aged over 85 years (Department for Communities and Local Government et al, 2008, p. 31). The needs of a small amount of help to a larger number of people may be considered fairer. See paras 6 and 7 for help with home improvements.

Recognising the importance, but limitations, of technology

Of growing importance is the role of technology. A major research project which focussed on adaptations and technology was ‘Introducing assistive technology into the existing homes of older people: feasibility, acceptability, costs and outcomes’. This showed that quite small changes to the home were cost effective and improved the lives of older people (Lansley et al, 2004a, Lansley et al 2004b, McCreadie and Tinker, 2005, Tinker and Lansley, 2005). More sophisticated technology such as telemedicine and telecare have the
potential to allow people who need long term care to remain out of institutional care. For example by monitoring their own conditions, being alerted to services and through surveillance such as fall monitors.

13. Allen and Glasby show that evidence from early evaluations reveal striking savings around emergency and hospital and residential care admissions and reduced bed days (Allen and Glasby, 2010, p. 10). The results for the first randomised control trial (Whole System Demonstrator) by the Department of Health shows that ‘Telehealth is associated with lower mortality and emergency admission rates (Steventon et al, 2012). However the trial only included people with diabetes, chronic obstructive pulmonary disease and heart failure. It involved the remote exchange of data between patients and health care professionals. A critique in the British Medical Journal has commented ‘Telehealth does not just ‘work’ or ‘not work’. Particular interventions may be successful but this depends on many factors’ (BMJ 20.7.12). Another critic has cast doubts on the generalisibility of the findings (Greenhalgh, 2012).

14. For many older people it is not the sophisticated technology which may be needed but simple aids and devices to support both themselves and their carers. For example small easy to lift kettles, easy to use tin openers, Velcro on clothes etc. And the growing use of mobile phones will be of inestimable value without having the stigma of an alarm.

Wider issues
15. In addition there in one wider issue I would like to include:
• The need for public debate about the funding of long term care. The assumption is often made that people will have to make more provision for themselves. I agree that in the current climate this is right but, nevertheless, I would like a discussion on what services, such as nursing and social care at home, should be a shared one to be paid for out of taxation. I do not feel that this debate has been held. How much would the public be prepared to pay for such services for themselves and/or their elderly or disabled relatives or for unrelated people (on the grounds that this might be them in the future)? Would the voters be prepared to pay more in taxes for long term care?

In conclusion
16. There should be more emphasis on housing. More funding on housing, whether it comes from people themselves, or government is likely to save on more expensive services.

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Please note that some of the above material was submitted to the Dilnot Commission but was not published.

30 August 2012
Torbay Unitary Council—Written Evidence

Ageing Coastal Communities – Torbay

Torbay is known as an area to retire to. Its older population is diverse in terms of its cultural background, skills, lifetime experiences, health, and mobility.

Torbay along with many Coastal resorts also has high levels of deprivation. This presents the local authority with a number of challenges, in particular cuts in funding for local government mean that the local authority has to make difficult choices between investing in the economic future of the area and meeting the needs of a vulnerable aging population.

Current government policy seeks to protect older people from reductions in public spending, with potential for the burden to be shifted to those of working age. Examples include:

- Localisation of Council Tax benefits – Areas with a high population of pensioners are adversely affected by the government decision to cut benefits by 10% whilst protecting pensioners.

- Concessionary fares – costs of free bus travel for pensioners is not covered by government funding. The gradual increase in age for receipt of this benefit is of some assistance but this continues to be present a strain of the council’s budget.

Adult Care Services are likely to increasingly stretched and to continue to consume a larger proportion of the council’s budget. This despite reducing the numbers of people in nursing homes, enabling people to live in their own homes for longer, and implementation of personalised budgets.

Areas like Torbay, in the past would expect to see an influx of more wealthy retired people, with many in their fifties moving to the area. A number of changes may result in a reduction in this type of migration and further work is required to understand the impact of:

- Current problems in the housing market, slack market, reduction in prices.

- Increasing the retirement age.

- Reduction of people retiring early on final salary pension schemes.

A reduction in inward migration could result in other economic impacts, as it is these people who may be more able to remain economically and socially active. While some wish to remain in full- or part-time employment, others may wish to start up their own businesses, work on a flexible basis from home, provide care for grandchildren, elderly parents and friends, or engage in learning opportunities.

Levels of participation in voluntary and social enterprise activities are increasing among those in later life, and many older people are active in community groups, churches and schemes such as Neighbourhood Watch. An opportunity exists to encourage a greater role in supporting the delivery of public services.
Older people who have lived in Torbay for most of their lives particularly, those from deprived areas are less likely to enjoy good health, are reliant on low incomes, live in inadequate housing, lack access to essential services, and do not have good social networks – and thus find themselves excluded from society.

December 2012
Introduction

The TUC is the voice of Britain at work. With 54 affiliated unions representing more than 6 million working people from all industries and occupations, we campaign for a fair deal at work and for social justice at home and abroad.

This document represents our submission to the inquiry of the House of Lords Committee on Public Services and Demographic Change into the impact of demographic change on public services. The TUC welcomes the inquiry, and is grateful for Lord Filkin’s invitation to submit evidence.

Our submission focuses on three specific issues: inequalities in life expectancy, older workers, and the funding of care and support services. We recognise that the inquiry is broader in scope, but have chosen to concentrate on the issues most relevant to the TUC’s core concerns. We maintain of course that each of these is profoundly important in its own right.

Life expectancy inequalities

The TUC accepts that the population has aged and, in all likelihood, will continue to age over coming decades. This is due in large part to increases in life expectancy. However, health inequalities mean that longevity increases have not been experienced uniformly across all groups within the population.

For example, the difference in life expectancy at 65 between the most and least deprived local authority areas in England is 3.8 years for men, and 4.6 years for women. The difference in life expectancy at 65 between those from the highest and lowest social classes is 3.5 for men, and 3.2 for women. These variations mean that more affluent groups spend a greater proportion of their life in retirement than more deprived groups.

Those who are more affluent also spend a greater proportion of their retirement in good health: geography-based inequalities in disability-free life expectancy are even more pronounced than life expectancy in general. The difference between the local authority areas with the highest and lowest levels of disability-free life expectancy (DFLE) at 65 is 12.1 years for men, and 12.3 years for women.

The conclusion that must be drawn is that any attempt to reform public services and the welfare state to take into account longevity must be mindful of life expectancy inequalities. Most importantly, eligibility ages for age-related services and benefits must not rise faster than the life expectancy of the worst off. The sections below explore the implications of this position, and more broadly, health inequalities based on income and wealth, for two specific areas of policy.

Older workers and state pension age

One of the main implications of population ageing is the ageing of the workforce. The TUC believes that individuals should be enabled to stay in work for as long as it is possible for
them to choose to do so. As such, we campaigned successfully for the abolition of the default retirement age.

We also welcomed recent evidence published by the Office for National Statistics (ONS) on greater numbers of people working beyond SPA, insofar as this demonstrates the capacity and willingness of many older people to remain active in the labour market. However, it may also be a sign of the financial pressures many older households are facing. Furthermore, there are strong reasons to assume that the current rate of increase will not persist. Most obviously, more than 60 per cent of those working beyond state pension age are women – it is unlikely that this many women will continue to work beyond SPA as female SPA rises rapidly over the current decade from 60 to 66.322

TUC analysis of the group of people aged just below current SPA (men aged 60-64 and women aged 56-60) suggests that society is a long way from establishing working in later life as a norm.323 People in this group have relatively low employment rates, especially men.

There are of course also very low unemployment rates, especially for women. This is accounted for, however, by a very high relative economic inactivity rate of around 40 per cent for both men and women. Long-term sickness and disability is the main reason for economic inactivity among people just below state pension age. This reason accounts for over a third of those inactive for both men and women.

This is much more likely to apply to some occupational groups than others. Those economically inactive due to long-term sickness or disability are more likely to be from skilled trade or process/plant/machinery operation occupational backgrounds, especially among men, or from elementary occupations. In contrast, those from professional occupations, and to a lesser extent those from manager/director/senior official or associate professional/technical occupations, are far more likely to be inactive due to early retirement.

Caring responsibilities are also an important part of the explanation for economic inactivity, especially for women. Around one in eight economically inactive women aged just below state pension age are inactive because they are taking care of their family and/or the home.

It is not the case that all of those inactive in this group are happily retired. Almost one in five, among both men and women, who are economically inactive would like to find a job. But over half of men in this age group, and just under half of women, who would like to work are unable to do so due to long-term sickness or disability.

Among those classed as unemployed, many have been out of work for a considerable length of time. Over half of men and over 40 per cent of women unemployed aged just below state pension age have been unemployed for more than a year. Furthermore, over a quarter have been unemployed for two years or more, and over one in ten have been unemployed for four years or more. This problem is more pronounced among men. Among those unemployed just below state pension age, almost a third have been unemployed for two years or more, and almost one in eight have been unemployed for four years or more. We know from extensive evidence that the likelihood of returning to work in later life after a sustained period of unemployment is remote.

Although it is logical to assume that population ageing must lead to extended working lives, this assumption is based on the false notion that the labour market is already operating at  

full capacity. This is not the case; ensuring that older workers are able to work up to the existing state pension age should be the government’s priority, while enabling those who are able to work beyond state pension age to do so. The increased tax revenues and lower public expenditure levels that would result from higher employment rates among the existing working-age population would go a long way towards funding the kind of services required to enable a decent standard of living in retirement, even as the population ages.

The economic boost that the government expects to arise from increasing SPA will only occur if people are actually staying in work for longer. But the evidence suggests that increasing SPA alone will not lead to extended working lives. Clearly, the current SPA does not guarantee that people will stay in work until SPA, so it seems unlikely that increasing SPA to 68, for instance, means they will work until 68, particularly given the current evidence on unemployment and economic inactivity among those aged just below state pension age.

Of course, the TUC does not believe that older people, even with health problems and disabilities, are inherently less able to contribute to the labour market. Rather, a combination of contingent social and economic practices, and flaws in the physical environment of some workplaces, make it more difficult for them to do so. Greater attention to the following areas would greatly enhance the ability of people to stay in work for longer:

- **Flexible working.** The cliff-edge between work and retirement for many workers is too steep. Arrangements that allow workers approaching retirement to reduce their hours or alter their responsibilities may help many to stay in work for longer, and government should help employers to establish good practice in this regard, as well as ensuring that the welfare and pensions systems do not penalise workers who retire ‘gradually’ rather than as a one-off event. In particular, the TUC supports the extension of the right to request flexible working to all workers – such an entitlement would be, among other things, beneficial to older workers approaching retirement. The government has indicated its support for this change, and we have called for this right to be implemented as soon as possible.

- **Health and safety.** A stronger commitment to good occupational health may enable many people with health problems to stay in work for longer, and indeed help to prevent or delay the onset of work-related health problems. This could range from attention to workplace ergonomics and exercise programmes, to developing a more tolerant approach to mental health issues.

- **Retraining.** Technologies prevalent in the workplace change over time, inevitably transforming the nature of work and the functions of particular employment roles for many workers. Too often, we believe, older workers are excluded from the training opportunities that would enable them to adapt to new working practices as they get older – indeed Department for Education statistics demonstrate the age divide on job-related training, with the likelihood of being offered training declining significantly with age. The government’s decision to introduce full fees for many further education courses, for people aged 24 or over, is also likely to discourage older workers from taking up opportunities to retrain. We believe the government should

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establish stronger entitlements to training irrespective of age, and encourage employers to understand the value of increasing the skill levels of their entire workforce. Somebody aged fifty, for instance, may in the future be expected to remain in the labour market for another two decades. This is far longer than the typical employee stays with a single employer.

- **Discrimination and age management.** The evidence base on the importance of the above areas is already well-established. However, too often employers fail to instil good practice in the workplace because of discrimination against older people. Direct age discrimination has rightly been outlawed, but a more general tendency to view older workers in negative terms is arguably still a significant problem. Employers should be encouraged to establish ‘age management’ procedures whereby they assess at a much earlier stage the age profile of their workforce, and how the needs and capabilities of particular employees will change as they age.

The Committee is right to question whether the UK is ready for an ageing workforce. Progressive change across the areas listed above will not only be beneficial for the individuals able to work for longer, but also vital to the country’s future prosperity.\(^3^{26}\) We believe that any changes to SPA must be determined by an independent commission, with trade union representation, which would have a duty to consider both the impact of health inequalities, and the actual circumstances of older workers, on the fairness and utility of SPA changes.

**Care funding**

The TUC’s main interest understandably lies with employment and workplace issues. However, we also recognise the growth in care needs among the older population as one of the most profound challenges facing society as it ages. We must expect in the future to spend a greater portion of national wealth on care services for older people. Decent social care provision, in fact, will be a key means to enabling older people to work for longer, by relieving the burden on unpaid carers.

Crucially, this should not be seen as a burden related to demographic change, but rather an opportunity to reorient the UK’s economic resources towards addressing changing individual needs. Increasing longevity, although experienced unequally, is testament to the success of welfare provision, and it is right that welfare services evolve to meet new challenges.

Social care provision in England is already suffering as a result of cuts in expenditure by local authorities. Often these cuts, whether decided locally or effectively imposed by central government, are justified on the basis that the fiscal implications of population ageing inevitably lead to a degree of welfare retrenchment. However, these cuts are self-defeating. Withdrawing care services often leads eventually to greater pressure on more expensive NHS care – as well as harming the economy by increasing the pressure on relatives to provide more informal care.

Reducing the burden on unpaid and informal carers, and ‘joining up’ the delivery of health and care services for older people, are therefore two of the TUC’s key objectives in the development of a new approach to care funding.

\(^{326}\) The Committee is invited to read the TUC’s reports *Ready, Willing and Able* and *The Eighty Per Cent Solution*, where these issues are discussed in more detail. See [http://www.tuc.org.uk/extras/over-fifties-unemployment.pdf](http://www.tuc.org.uk/extras/over-fifties-unemployment.pdf) and [http://library.fes.de/pdf-files/jurni/00007.pdf](http://library.fes.de/pdf-files/jurni/00007.pdf).
More generally, our approach is underpinned by the principles of equality, respect and independence. In terms of equality, it is paramount that the ‘postcode lottery’ of care provision is eradicated. Significant local variations in provision remain evident – exacerbated by the differential impact of spending cuts. Some local authorities will only offer services to residents with ‘critical’ care needs, while others will offer services to those with ‘substantial’ and even ‘moderate’ needs. Hourly charges can range from £21.66 in Surrey and £198.80 in Cheshire East (and neither has a weekly maximum charge), to zero in Derbyshire, Tower Hamlets and Newham. Widespread ‘rationing’ of care services has been reported by Which? as budgets tighten.

We also maintain that care funding reform must not be based on the notion that older people tend to be wealthier than younger people. The decline of occupational pension provision in the private sector, a reduction in the generosity of public sector pensions, and changes in the housing market mean that it is not reasonable to assume that the proportion of older people able to pay for their own care will continue rising. Furthermore, even among today’s generation of older people, significant inequalities mean that many are unable to afford decent care provision.

It would be much fairer to design an approach to social care based on taxpayer-funded services. There is evidence that this is the overwhelming preference of society in general. The idea that this approach is intergenerationally unfair, as the government has claimed, is extremely short-sighted. Future generations will benefit from the establishment today of taxpayer-funded services, free at the point of use, in several ways: when they reach later life in the future, as the burden on informal or unpaid carers is reduced in the short-term, and as the economic benefits are realised.

As such, the TUC supports a National Care Service based on the NHS model. This would provide a minimum standard of care for all those in need, funded through general taxation. Local authorities may retain an important role in a National Care Service, with responsibility for delivery and quality. We believe, however, that a national framework for assessment and eligibility would be at the heart of a National Care Service and that local authorities should not be able to deviate from such a framework. We believe that a National Care Service, providing care at such a standard that only a small minority would want to use an alternative (and have the money to afford it), could generate support for the level of taxation necessary to fund it.

This issue is not of course entirely distinguishable from issues around the future workforce in an ageing society. Greater investment in social care, especially through a National Care Service, would lead to higher skill levels and better conditions within the care workforce. This will lead to better and more effective care, as well as the creation of high-quality job opportunities which would boost both individual welfare and economic growth.

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330 More detail is available in the TUC’s submission to the Dilnot Commission, available upon request.
Interestingly, there is evidence that the care sector is more amenable to older workers.\textsuperscript{331}
Investment in the care workforce may therefore help to achieve extended working lives in a direct sense, as well as indirectly through enabling unpaid carers to work more.

20 September 2012

\textsuperscript{331} Shereen Hussein and Jill Manthorpe (2011) ‘Third age workers caring for adults and older people in England: findings from secondary analysis of the National Minimum Data Set for Social Care’ in Diversity in Health and Care, 8(2), pp. 103-112.
Trades Union Congress (TUC), BT, Chartered Institute for Personnel Development (CIPD) and Professor John Philpott, Economist and Labour Market Analyst—Oral Evidence (QQ 514–36)

Transcript to be found under BT
**Vale Older People’s Strategy Forum—Written evidence**

**Introduction**

The Vale of Glamorgan Older Peoples Strategy Forum (OPSF) was established in 2005 as part of the Welsh Government Strategy for Older People. It has been active in promoting positive ageing in the Vale of Glamorgan; with five subgroups dealing with Age Discrimination, Housing, Health, Art Craft and Leisure, and Transport issues that affect people aged 50+. We have positive links with local and national voluntary organisations, the Wales Senedd, and the Wales Older Peoples Commissioner’s Office. The OPSF as part of its work for older people has responded to important consultations on Paying for Care, consultations in Dignity in Care, Health services in Wales, Equality issues, etc.

**Question 1. Response**

It has long been recognised that people can perceive themselves as young or old, as defined by themselves, or by society as a whole. The UK culture about age appears not be to a positive one. With the onset of the financial crisis throughout the world, and cuts in resources available for public services, older people have appeared to have taken the brunt of the criticism on future cost of service provision for an ever growing older population; older people are perceived as a threat to them it comes to ‘monopolizing’ public services for example. Older people can be left feeling disempowered, isolated, and with negative feelings of self-worth. The media etc frequently give the impression that all older people are frail and out of touch with what are happening in the wider society. There are many older politicians, sports personalities, actors, writers, artists, and good neighbours whose achievements do not receive the same recognition as their younger counter-parts. Youth and body image seems to be of major importance. The negative attitudes need to change to positive about the value of the contributions that older people give and do within society. For example; *A national survey stated that older volunteers provide either formally or informally to their local communities over ten billion pounds per annum to the national economy.*

There is also the contribution that older people make to revenues via national, devolved, and local government through income from employment, savings, VAT and exercise duty, council tax, and inheritance tax is not highlighted enough.

*The economic contribution of older people will increase to around 82 billion by 2030.*

*taken from the Gold Age Pensioners Valuing the Socio-economic contribution of older people in the UK, March 2011.*

**Question 2. Response**

We do not believe that our expectations and attitudes about work, savings, retirement and independence need to change. The vast majorities of people expect to find work and therefore hope to save, hope to have financially viable and stress free retirement and hope to remain independent into their old age. We believe it is the role of Government to provide the framework and systems to allow this to happen. Attitudes do however need to change towards opportunities and the role of the older person. Older workers in manual work can not be expected to do the same amount of physical toil as their younger employees; older people could be useful as a mentor for younger people coming into the workforce. This creates a feeling of respect towards older people in the workforce and an understanding between the two generations.
Question 3. Response
The forum believes that the extent and nature of public services need to change to reflect the changes within society as a whole. The reports by the Joseph Rowntree Foundation in their study ‘How can local authorities with less money support better outcomes for older people?’ January 2011, make the point that ‘There needs to be imaginative, affordable and effective ways of supporting older people’s health, well-being, social engagement and independence, with projects with some local authority involvement whether as lead commissioner, subsidiary partner, or through small grants or seed-funding. Greater emphasis on the assistance that older people need and choose, and their experiences rather than on conventional social care and/or services; this model is endorsed by the forum who often tell us they want full involvement in service delivery and development, and that high standards of care, dignity and respect are maintained. Older people are major users of health services in their 80’s and 90’s. The extension of life expectancy is a cause for celebration rather than regret. The health service has predominantly focused on treatment rather than prevention and health promotion and there is an urgent need to redress this balance and to recognise that health in old age is dependent upon social determinants i.e. adequate income, good quality housing, opportunities for mental and physical stimulation and activity and participation in community life. There is an urgent need to reform social care, establishing models as already described in response to question 5.
Older people with chronic health conditions need to be attributed the same health care, for if their conditions are managed properly, many will not reach ‘crisis point’ and need more expensive health care.
The forum feels that payment for services should initially be free at the point of delivery, and further costs gathered from tax contributions by society as a whole.

Question 4. Response
The forum feels that public services need to change to reflect the changes within society. Services need to reflect the needs within a person’s life in a more cohesive way; with greater emphasis on the assistance that older people need and choose, and their experiences rather than on conventional social care and/or services.

Question 5. Response
Council run services, businesses, Health boards, and voluntary organisations need to work in a more cohesive way. An example is of many older people rely on public transport which can be patchy and non-existent after ‘peak periods’. This inhibits, older people attending adult learning courses, going to libraries, volunteering, attending hospital appointments etc. This is despite the fact that the important of prevention and promoting the social inclusion of older people is widely accepted, as it avoids isolation and loneliness. Projects which involve older people within the community where they live, and joint working with local authorities can only of benefit to everyone living in that community. There could be more uses for community centre’s to provide low level support for vulnerable people within their area. This is endorsed by research by Allend and Glasby, 2010. ‘Overall, low-level practical support initiatives can have dramatic outcomes-both in terms of increased quality of life and in terms of lower use of formal services and institutional forms of support’. If should be remembered that a small proportion of older people use formal social services and most remain very independent well into their seventies and eighties.
Different generations and cultures need to be encouraged to learn from each other. There needs to be more funding and opportunities for local community enterprises; like community cafes, luncheon clubs, friendship clubs, etc. where groups can meet and share experiences.
Question 6. Response
There needs to be cultural shift in how older people are viewed within our society. Older people should not be seen as a burden or a drain on public resources. This can only be achieved via a far more positive and pro-active approach by the media, government, public services, and businesses on the achievements and contributions that older people put into their communities and society. People need to recognise that living longer can have benefits to individuals, businesses, and family life.

August 2012
Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010-11, Michael Johnson, Centre for Policy Studies and Paul Johnson, Institute for Fiscal Studies—Oral evidence (QQ 583–606)

Transcript to be found under Michael Johnson, Centre for Policy Studies
Thank you for your kind invitation to give evidence to the House of Lords Select Committee on Public Service and Demographic Change. Unfortunately, due to long-standing diary commitments, I am unable to attend either of the meeting dates that you suggest.

I am heartened by your interest in the groundbreaking work that has been taken forward in Wales since 2003, when we launched our Strategy for Older People. I have, therefore, prepared the attached written evidence paper that I would appreciate your sharing with the Committee.

I apologise for not being able to participate in the debate, but I am happy to field any requests for further or more detailed information that may arise from the paper.

Introduction

1. The Welsh Government welcome the opportunity to submit written evidence to inform the Committee’s consideration of future public service provision in the light of demographic change.

The scale of change

2. The impact of demographic change will have particular significance for Wales, which has the highest concentration of older people within the UK nations; and is a place where people come to retire. In 2011, 18.5% of people in Wales were aged 65 or over. The population in Wales is becoming older in terms of absolute numbers of older people as well as structurally. The causes are lower fertility, greater longevity or life expectancy, and lower birth rates. 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. The number of people aged over 100 is also growing quickly. There is a substantial geographic variation across Wales, evident in the cohort of people over 65. In 2011, the percentage of people aged over 65 was highest in Conwy (24.6 %), Powys (22.9%), Anglesey (22.5%) and Pembrokeshire (22%). In the same year, it was lowest in Newport (16.4%), Merthyr Tydfil (16.7%) and Caerphilly (16.7%). These figures highlight the issues about ageing in a rural environment including isolation and high service costs.

3. The Office of National Statistics reported (2012) that in Wales, life expectancy and proportion of life spent in good health is increasing. However, of the UK nations, Wales has the lowest healthy life expectancy, the highest levels of deprivation, and the highest incidence rate of chronic disease. There is also a wide variation in the number of
disability-free years across Wales – differing by as much as 9 years for a man, and 7 years for a woman. Of people aged over 65 in Wales, two-thirds reported having at least one chronic condition, and over three-quarters of people aged over 85 in Wales reported having a limiting long-term illness. Many of these people are also likely to have mobility problems, so the financial, staffing and management implications for the provision of health and social services to a growing, and potentially needier population, are clear.

4. Mortality rates, however, vary considerably (which may reflect differences in personal wealth). For instance, in 2008, Newport and Caerphilly recorded an age-specific mortality rate (ASMR) of 100 deaths per 1,000 males for males aged 75 and over, whilst Ceredigion registered an ASMR of only 71 deaths per 1,000. For females in the 75 and over group, Blaenau Gwent registered 92 deaths per 1,000 females, whereas Ceredigion recorded only 65 deaths per 1,000.

5. Current estimates suggest that about a third of all men, and half of all women over 65 will need support from social care services as they get older, creating potentially significant additional demands for services. These rising demands, together with increasing expectations of service breadth and quality, make the challenge of providing greater quantity of support for longer periods of time extremely challenging. Against the financial challenges in the public sector, balancing need and provision will be difficult.

6. It is self-evident that good quality and sufficient public services are critical to older people, now and in the future. Services need to be responsive to the diverse requirements of individuals. They also need to provide strategic response to these wider structural changes in society and demography, as well as improving the independence and well-being of older people. In Wales, the Welsh Government has developed a coherent and long standing policy agenda to address these challenges which originated in 2003, and will continue for the next decade.


Response to Demographic Change in Wales

8. The main policy to address the implications of our ageing society and its impact on public services has been ‘The Strategy for Older People in Wales’. It was launched in January 2003 and proposals for a third phase of the approach, covering the next ten years until 2023, are currently out to public consultation. The Strategy provides a clear and structured foundation on which the Welsh Government and its public service partners can develop policies and plans which better reflect the needs of older people and recognise the effects of changing demography and social circumstances. The policy is based on comprehensive research evidence and wide-ranging consultation. Older people and their representatives have had a strong role in developing the Strategy.

As a result of the first and second phases of the Strategy, we have introduced a range of programmes to address the needs of older people in Wales. There has been strong Ministerial commitment and cross-party support for the Strategy over the last decade.
9. The context for this Strategy – which was the first of its kind in the UK – was the need to respond to projected demographic change. Our Strategy is set in a ten-year framework and provides an implementation programme with more detailed objectives and programmes flowing from it. These include a range of measures to keep the elderly active and living independently, for example, by enabling them to travel and exercise (e.g. free bus passes, free swimming, £50 maximum weekly charge for home care); and provide preventative care (e.g. free prescriptions).

Some other key elements of the Strategy are:

- Clear political responsibility through a Deputy Minister with specific responsibility for older people (currently, Gwenda Thomas AM);
- Continuing and expanding awareness of the issues through the National Partnership Forum for Older People which provides a focus for debate about ageing and a source of expert advice on policy and programme development to the Welsh Government;
- Local engagement with policy and delivery through an elected member champion for older people in each council, together with a co-ordinator who is a paid officer and local forums. This has been a driver for locally focussed Strategy Plans, supported by Welsh Government project funding. There has been over 200 wide-ranging projects - see [http://www.wlga.gov.uk/english/older-people-and-ageing/](http://www.wlga.gov.uk/english/older-people-and-ageing/);
- Over 70 Forums for Older People exist across Wales. This unique arrangement and has been a major contributor to ensuring engagement in developing local plans, as well as informing Welsh Government Strategies, giving older people a voice. Close and meaningful involvement of older people directly in developing and implementing our Strategy has been at the heart of the progress we have made;
- Our Intergenerational Strategy for Wales (2008) seeks to break down the barriers between the old and the young and improve community cohesion. We fund the Beth Johnson Foundation to support its implementation. Examples of Projects include:
  - Skills swapping in **Denbighshire** where generations pass on their skills such as confidence building or using a mobile phone to practice;
  - In **Rhondda Cynon Taf**, there are now 120 older volunteers actively going into primary and secondary schools across the county;
  - In **Bargoed**, local older people and school children came together to create a sculpture trail in a local park and reclaim the park for community use following anti-social behaviour in the area;
  - In **Denbighshire**, older people and younger people with behavioural problems came together to identify solutions to local issues and work together to resolve them;
  - In **Swansea**, older and younger people came together to form an intergenerational forum. This forum considered and influenced the local Community Plan and offered an opportunity to have dialogue with Cabinet members;
  - In **Ceredigion**, older and younger people came together to quiz the Local Authority finance representatives and make proposals for future budget expenditure.

10. While our policy approach aims to mitigate the public service impact of ageing through all Welsh Government programmes, we have, nevertheless, invested more than £20
million in the Older Persons Strategy to ensure it is implemented effectively at a local level and, in particular, in strengthening the capacity of the Third Sector to respond to this agenda.

11. Research by the WRVS, challenges the widely-held view that older people represent a net cost to society. Their research found that, in Wales in 2010, over 65s through taxes, spending power, provision of social care and the value of their volunteering, made a net contribution of £1 billion to the Welsh Economy. The contribution of older people is equivalent to almost £3 million per day, even allowing for costs of pensions, welfare and health services. During the next 20 years, as the overall number of people over 65 increases and people remain healthier for longer, over 65s will contribute an estimated £27 billion to the Welsh economy. In this time period the over 65s population in Wales is set to increase from 558,000 to 828,000.

12. The Strategy for Older People in Wales has received significant positive evaluation and recognition nationally and internationally. For example, the Institute of Public Policy Research (IPPR) found in its report ‘Policies for Peace of Mind? – Devolution and older age in the UK’ (2009) that:

“The Welsh approach seems to be the most coherent long term commitment to improving the position of older people of any administration in the UK in the last decade… the Welsh Strategy appears the most likely of any to ensure a continuing high profile for older people’s issues across many policy areas and at a local level.”


Some of the main themes will be:

- The Strategy for Older People is based on the United Nations Principles for Older People (2002) and this is enshrined in the primary legislation that created the Commissioner for Older People in Wales. The Welsh Government has signalled its intent to explore whether a specific ‘Wales Declaration of Older People’s Rights’ would help us in our ambition to protect and enhance the rights of older people. Whilst a declaration in itself would have no binding legal effect, it would send very clear signals to statutory bodies and service providers, as well as to older people themselves, about our expectations and would strengthen our ability to ensure that older people receive the support and services they need to lead independent and full lives. The Deputy Minister for Children and Social Services announced on 11 December 2012 that the Commissioner for Older People will work with the Welsh Government to undertake further consideration of the parameters and impact of a Welsh Declaration;
- We are committed to work with a range of partners in developing a 5 year ‘Ageing Well’ programme that will support implementation of our Phase 3 Strategy for Older People which will commence in 2013. This programme, which will be led by the Commissioner for Older People in Wales, will support our thinking and planning for age-friendly communities and inform our thinking on how we deal with the “wicked”
issues like Dementia, frailty and falls and fractures, as well as broader issues such as intergenerational links and employment of older people. This represents a collaborative legacy commitment to the European Year 2012 of Active Ageing and Intergenerational Solidarity. The Programme will actively engage with the European Innovation Partnership, leading innovation with partners in Europe and be an EC Reference Site;

- The Welsh Government White Paper on the Social Services transformation programme will place a greater focus on re-ablement, early intervention and preventative care, and the opportunities that exist to support independent living;
- The 50+ Health Checks programme will aim to provide people aged over 50 with information and advice on a range of issues relevant to their overall health and wellbeing;
- We are looking at the built environment, the services that individuals need, putting the person at the centre, and the economic and financial climate in which our population is ageing. We are also looking at how we can take a more holistic life-course approach to ageing and take account of the impacts of accumulated disadvantage over a lifetime that can lead to poverty and poorer health in old age.

**Public service reform**

14. Dealing with the consequences of ageing is a theme of the Welsh Government’s Public Service Leadership Group (PSLG) and, in particular, the workstream that focuses on Effective Services for Vulnerable People. This places an emphasis on prevention and earlier intervention to support independent living at home for as long as possible, and on integration as a model for sustainable services. Given that an older person experiences a range of services, the programme is engaging with a range of public partners to develop solutions; including links with housing providers and the third sector, as well as Local Authority Social Services and the NHS.

15. The Promoting Independent Living project aims to understand the best ways to integrate service delivery to promote and sustain independent living and wellbeing. We are developing an evidence base of effective practice, identifying and sharing common ‘ingredients’ of effective integration, and building the capability to assess the impact of service integration on service efficiency and wellbeing of older people.

16. Evidence suggests that integrated models of service can:

- Provide immediate savings or cost avoidance;
- Deliver immediate and longer term improvements in service outcomes;
- Provide an environment for radical and creative thinking about solutions to challenges such as demographic change; and
- Encourage a ‘whole system’ mindset rather than blaming other parts of the system for pressures/implementing changes without considering impacts.

17. These are critical outputs to manage services in the future context and to deliver the outcomes for older people to which we are committed. Recent qualitative reviews showed that:
Derek Jones CB, Permanent Secretary, Welsh Government—Written evidence

- The actual impact (including outcomes for service users and cost-effectiveness) of integrated approaches to working was not always known; and
- There is more to be done to share and apply effective practices beyond the organisations with which they were developed.

Consequently, we have supported organisations to become more effective in understanding the impacts of their approaches and have commissioned a Knowledge Transfer Partnership with the Centre for Innovative Ageing at Swansea University, that will develop the means to assess the quality and costs of integrated services for older people. We have also recently commissioned research on social isolation and loneliness, and have identified re-ablement as another key area which is important for independent living and wellbeing.

The Older Persons Commissioner

18. In 2012, the second Older People’s Commissioner for Wales took up post. The functions of the Commissioner, as set out in the Commissioner for Older People (Wales) Act 2006 and subsequent Regulations are:

- Promoting awareness of the interests of older people in Wales;
- Promoting the provision of opportunities for, and elimination of discrimination against, older people in Wales;
- Encouraging good practice in the treatment of older people in Wales;
- Keeping under review the adequacy and effectiveness of law affecting the interests of older people in Wales;
- Considering, and making representations to the Welsh Government about any matter relating to the interests of older people in Wales;
- Reviewing the effect on older people in Wales of the discharge of, or failure to discharge, functions by the Welsh Ministers or by prescribed bodies;
- Reviewing the arrangements made by the Welsh Ministers and prescribed bodies for whistle-blowing, advocacy and handling complaints, and monitoring the operation of those arrangements;
- Examining individual cases, and assisting individuals in making a complaint;
- Issuing best practice guidance to the Welsh Government and prescribed bodies;
- Making reports, including an annual report, on the exercise of his functions to the First Minister.

19. The post is independent of Government and protected from inappropriate political influence. The Commissioner can, therefore, deal directly with difficult issues and directly challenge Government Ministers and other public bodies. The Commissioner, we believe, the first of its kind in the world, has been a vital advocate and supporter for the Strategy.

Next Steps

20. The next decade will present substantial challenges to public services as they deal with growing demand, tighter finances, the impact of Welfare Reform and other socio-demographic changes. The foundation laid in Wales by the Strategy for Older People provides an established basis on which to:
• Establish that full participation in all aspects of society is within the reach of all older people and that their contribution to that society is recognised and valued;
• Develop communities that are age-friendly, while ensuring that older people have the resources they need to live, be part of their communities and experience individual wellbeing;
• Ensure that future generations of older people are well equipped for later life by helping them to recognise the changes and demands that they will face, and enabling them to take action early in preparation.

Population ageing is a permanent and inevitable feature of the future. The Welsh Government recognises that all public service partners must work collectively and embrace this reality for the opportunities and challenges it brings. A high priority has been given in Wales to the impact of demographic change on public services and the responses needed for the future as these trends continue. The next 10-year phase of our Strategy for Older People will require increasing attention to this issue by Welsh Government, Local Government and its partners.

December 2012
Welsh Local Government Association—Written evidence

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities, the three fire and rescue authorities, and four police authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. The WLGA welcomes the inquiry and is pleased to offer written evidence on behalf of the 22 councils in Wales.

4. We live in an era of global ageing of unprecedented levels. This presents significant unknown challenges and potentially a wide range of opportunities but only if strategic action is taken now. A fundamental challenge is that older people are not an homogenous group and policy responses need to be set within this context. Individuals age very differently and they have variable aspirations and expectations from services now and in 15-20 years time. A balance is needed between effective responses for the immediate, particularly those who are frail and vulnerable, those facing retirement and strategically preparing and re-shaping communities for people who are in their 50s now and wish their needs and expectations to be met in 15-20 years.

5. Using chronological age is increasingly redundant as a strategic and service planning tool and approaches that look at the life course of an individual are proving far more effective. In Wales 50+ is the broad benchmark for policies and practice but increasingly agencies and government are concentrating their efforts on designing policy and practices that are integrated and holistic and places the needs of the individual irrespective of age at the heart of the process rather than using a medical diagnosis or age related criteria. We are thus moving away from age related policies to those that have shared outcomes that can be delivered through effective partnerships that fully reflect the connectivity between agencies, the community assets in the widest sense and the individuals themselves.

6. We advocate that a twin track approach for the immediate and the future generations is required each with specific and different outcomes and responses. Local Government lies at the heart of achieving all of these changes through its knowledge and proximity to local communities and its wide range of functions. Housing, the built environment, social services, education and public protection are key functions of local government and have a huge impact on how an individual ages. However, many factors are set in place at an early age.

7. There is an increasing gap between monies available to the public sector and the costs of running services even to stand still. Local Authorities for example have implemented a range of mitigating actions to address and manage budget cuts and overspends which include action plans to control and reduce spend and use of reserves. However whilst transformational change will generate some savings, the scale of change and the
necessity to balance “up stream preventative work” with the immediate pressures of providing services for the vulnerable and elderly is currently a circle that cannot be squared.

8. This challenge will be compounded if central government policy continues to advocate protection for some services and this restricts the flexibility of internal resource allocation and reduces their ability to make significant change. The prioritisation of services to meet statutory targets will continue to prevail and the transformational change needed regarding for example, housing, planning, transport, leisure and the built environment will not be feasible. These are precisely the services that require investment to transform and shape the changes needed for the future. Similarly we are aware that very little of the overall NHS budget is spent on preventative services with the bulk spent on meeting immediate health needs for a specific group of people.

9. Tackling many of the long standing resource pressures facing local government remains a difficult but necessary immediate priority even though the financial outlook is severe for many years.

10. The European Union designated 2012 as the European Year of Active Ageing and Intergenerational Solidarity and has set targets for increasing quality of life by 2020. Local Government in Wales with its partners is actively engaged at the European level. We advocate that learning from other parts of Europe and beyond can be helpful to understand potential solutions for the UK.

11. In summary, Ageing well and supporting people to remain and participate in society is an agenda for everyone. Joined up strategic action across government departments at national and local level needs to underpin and drive change.

**Welsh Context – an even greater challenge**

12. The scale of the demographic change is well known and we do not propose to rehearse these again. We in Wales face the same pressures as elsewhere in the UK particularly for the over 65 and over 85 age groups.

13. The WLGA considers the following factors to have considerable significance so that we wish to bring these specifically to the attention of the inquiry:

- Wales has a higher proportion of people of state pensionable age than other nations of the UK and the UK as a whole.

- the proportion of people over the age of 80 is also higher and within rural areas the ratio is generally higher and will increase significantly

- Wales has the highest number of people claiming incapacity and other state welfare benefits

- Around 80,000 pensioners in Wales rely entirely on the state pension and other benefits as their only source of income
Welsh Local Government Association—Written evidence

- 1 in 4 working age people over the age of 50 have no qualifications: for the under 40s it is 1 in 10
- Wales has high levels of people with chronic diseases that impact significantly upon healthy years and disability free years
- Wales has some of the highest unemployment rates in the UK. For example, the rate of older people claiming jobseekers allowance for more than 2 years has almost doubled in the last year showing a trend of increasing numbers becoming stuck in the system
- A significant proportion of Welsh communities are rural in nature with isolation and high costs of providing services a major challenge.

14. The picture is not entirely bleak and needs a balanced perspective. Wales can demonstrate many positive examples in response to the challenge of an ageing population, but the pace and focus of action needs to be increased arguably at a greater pace than in other parts of the UK. For example, increased life expectancy and proportion of life spent in good health (Office for National Statistics 29th August 2012) is increasing and great strides to reduce the incidence of heart related conditions are positive. However the table below demonstrates many people living in Wales have a significantly less positive outlook than others across key indicators. This difference between areas is stark and the gap is widening in some cases.

Figure 1 Projected Increase in population in Wales aged 65+, 2008 to 2033

Office for National Statistics.
15. Many of the councils also face the additional challenge to demographic change because they are rural in nature thereby compounding the challenge and prompting the need for a concerted strategic response to transformational change where delivery services in rural areas requires specific responses. Welsh Local Government has a strategic, political led WLGA Rural Forum which will help at the strategic level to take forward this agenda. We suggest that similar strategic forums should be established where rurality is a key challenge and solutions can be found collectively.

Wales: Health indicators across councils. 2012

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<td>male</td>
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<td>Life expectancy(LE)</td>
<td>77.0</td>
<td>81.4</td>
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<td>Health LE</td>
<td>63.5</td>
<td>65.3</td>
<td>57.1</td>
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<tr>
<td>Disability Free</td>
<td>59.1</td>
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Source: Public Health Wales Observatory 2012.

16. The table illustrates that on average males living in one area of Wales will live with good health approx 11 years more than those living in another area. For females the range is over 10 years. Similar inequalities exist for disability free years. The range being 9 years for males and 7 years for females.

17. The real challenge for Wales when examining trends and national statistics is to ensure that positive movement occurs across all the indicators not merely life expectancy for example, so that extended life can be coupled with extended years of healthy and disability free years. If not and life expectancy continues to move at a faster pace, the impact of the increase in numbers will inevitable put an even greater disproportionate burden on statutory services and we will fail to capitalise on the benefits of an ageing society.

18. Therefore, if we consider the projected increase in population over the next 15 years, the challenge to fund and respond to this trend makes this one of the most important challenges facing Wales and local government.

The impact of Devolution

19. As devolution deepens and devolved governments develop distinct policies and legislation, Wales is continuing to implement bespoke strategic responses to address this challenge. Cross party support continues for the Older People’s Strategy for which local government has consistently led the implementation at local level through strong political leadership (Older People’s Champions in all councils and Equality Champions) and facilitating inclusive User 50+ Forums in each of the councils supported by strong partnerships with its stakeholders such as the NHS and third sector.

20. However for several key areas Wales remains subject to UK policy and legislation. This is particularly the case for welfare reform where we have repeatedly
demonstrated that the affects of the wide ranging reforms will have a disproportionate effect upon the people in Wales.

**Divisive policy priorities**

21. Policies and targets can have the unintended consequence of dividing generations at the expense of another. The work to promote greater inter generational cohesion and mutuality needs to be adopted universally as well as more lifestyle approaches. It can be unhelpful for specific policies to target one section of the population at the risk of the alienation of others so that policy and action becomes a “them against us”. This is particularly sharp for example regarding recent poverty initiatives that frequently target children but do not recognise that poverty levels or unemployment rates of the over 50 is similarly high and needs action.

**Part two: Specific responses to Inquiry questions**

22. Conceptually the agenda for change can be considered across three dimensions:

- Attitudes to ageing and how they need to change
- Societal and governmental principles, policy and practice
- An Individual’s role and responsibilities and this relationship with society and local communities

Does our culture about age and its onset need to change and if so how?

**Public Attitude**

23. Positive approaches to ageing need to be promoted within an overall framework of minimizing discrimination for all. Public attitudes appear predominately negative. Portraying an ageing population as a ‘burden’ misses the point and does older people a great injustice - they make a major contribution to society, both financially and in other respects. Switching attitudes and expectations onto the benefits of ageing should be a major focus for action together with the use of more positive language. This is particularly needed for the younger older person who often struggles with the concept of “being old” and who will require a very different response from government and services when they reach 65 or 70 plus. We support the need for further national initiatives to change attitudes so that as the population ages, attitudinal change is firmly embedded into our culture.

**Lack of Awareness of their contribution**

24. It is widely recognized that older people are the primary providers of care in the UK, through the unpaid support they provide to spouses, other relatives and friends. Statutory services would implode if this contribution is not sustained. Carers over the age of 60 have been estimated to provide up to £50 billion in unpaid family care allowing children to return or continue to work. Increasing numbers of older people are also continuing in paid work and have also been estimated to be providing £4bn in unpaid volunteering. The spending power of older people, the so-called ‘silver pound’, has also been estimated to be worth over £100 billion per year to the economy.
25. Therefore if we harness and value more and maintain their existing contribution, as the numbers of over 50s increases so does the potential for mitigating spiraling demand on statutory services and crucially we enhance the prospects of achieving sustainable communities and productivity.

26. We draw your attention to this increasing focus by the European Union on the value of older people in the context of global financial trends and suggest that the UK focuses more on this perspective and engages a much wider debate about ageing. More strategic programmes that take a longer view and learn from practice elsewhere in the UK and Europe are needed. For this reason, local government and its partners are supporting a forward looking collaborative programme – “Ageing Well in Wales” to help reshape the environment for future generations, prepare for the increase in people with dementia and tackle some high impact areas to mitigate pressure on services. Local government would be happy to provide further details of this collaborative strategic programme which it is taking forward in collaboration with the Older Peoples Commissioner in Wales and the European Union.

**Media Reporting**

27. There are generalized myths about ageing, all rather negative, that need to be challenged. Media reporting appears particularly negative and stuck in a narrow perspective centered on the burden and rising cost of care homes. This is at the expense of portraying more positive images and role models of people who have achieved some of their greatest work and achievements whilst over the age of 60. Media reports that are concerned with the rising cost of caring for the disabled and frail whilst significant in their own right in the absence of other perspectives only fuels negative images and the anxiety of ageing. We applaud the recent development of the Older People in the Media Awards, known as the Roses which celebrates the best examples of coverage across all media in TV, film drama and press.

**Individual expectations**

28. Individual expectations vary considerably on how they approach ageing with some people reporting very low expectations and almost an acknowledgement that “things will decline with negative consequences” whilst others are actively embracing and enjoying the benefits of increasing age.

29. The goal should be to move everyone along the continuum of longer years of healthy expectations and life, to minimize the fear of ageing and foster greater confidence and control over their individual ageing process. An important element is that we provide people with options and effective signposting to services and help them to manage their own health. For this reason the Welsh Government has announced the development of a free annual health and wellbeing check for all people over the age of 50 by 2014. The aim is to compliment statutory advice and support on healthcare and offer the individual more ways in which they can over time manage their ageing process.

30. Planning for later life should become an essential consequence and responsibility for all. To achieve this people need earlier and better information about how this can be achieved. People need greater security about pensions, paying for care and flexible
release policies from assets to underpin peoples’ decisions and planning. The proposals by the Dilnot Inquiry on the future of residential care in our view offers the most acceptable and pragmatic solution to the iniquitous current arrangements and whilst costly should be pursued.

**Do our expectations and attitudes about work savings, retirement and independence need to change and if so how**

31. We believe that people strongly wish to remain independent whilst requiring only minimum assistance to do so from statutory services. Often people report that a little bit of help provided earlier on would have prevented more costly interventions and negative consequences later on.

32. Maintaining independence is a central theme of policy and practice in Wales but balancing the pressures on all services that can contribute remains a considerable challenge. Reductions in funding for specific schemes, sometimes of modest amounts, have a disproportionate impact. Conversely Wales benefits from the Care and Repair scheme that offers cost effective early support. Maintaining high impact early intervention schemes remains a considerable challenge for councils within its diminishing resources and has become acute in recent years as partners also make cost savings. This situation is further compounded by the loss or reduction in targeted schemes, for example, supported housing, and health and wellbeing programmes at the very time more investment and focused action is needed.

33. Many older people are struggling financially. One in six older people in Wales live in poverty. Spiralling food, fuel, and care bills are difficult to deal with for those on low and modest fixed incomes. Debt levels are increasing, interest from savings diminishing, significantly amongst older people who are entering older age at present and in the immediate future.

34. Attitudes to work and economic activity are inevitably changing. The welcome abolition of the default retirement age must be accompanied by growing awareness of the need to continue efforts to overcome age discrimination in the workplace.

35. The public sector in Wales has a higher proportion of older people working in the statutory sector than in other parts of the UK so has a vested interest to maintain stability and productivity levels by supporting more flexible working practices whilst also and supporting employees to manage and maintain optimum levels of health and wellbeing as they age. As an example of challenges to public sector employers, nurses over the age of 50 make up the greatest proportion of the nursing workforce in Wales and in local government although we only have England and Wales figures as of 2012, 28.9% these show that employees between the age of 45-55 and 17.5% are between the ages of 55-64. Collectively this equates to 46.4% of total workforce). Local government as a whole employs a higher proportion of DDA and / or work limiting disabled staff than both the private sector and the economy as a whole ( 15.7% compared to 14.1% as a whole) with slightly higher proportions than other public sector employers ( 15.7% compared to 15.4%)

36. Taking a life course approach would bring major benefits to individuals and to the public finances by: supporting individuals to make plans and save for their later life and
encouraging employers across all sectors to make the most of the skills of an ageing workforce;

Do we need to redesign and transform public services for these challenges. If so, how?

37. The challenge facing local government is the pace by which service integration across health and social care can be achieved against a backdrop of spirally demands on care budgets. Councils all report relentless pressure on social care budgets that restrict their ability to fund other schemes. It is imperative that a solution is found to providing adequate funding for social care.

38. Some solutions will require stronger intergovernmental, cross party and integrated joined up policy agreements with outcomes that can be realised in the medium and longer term. There needs to be a sharper emphasis on targeted action and continued commitment over a longer period of time. We commend the continued commitment of the Welsh Government to the ten year strategy for Older People in Wales. We urge the UK government to make progress on determining their response to the Dilnot proposals for funding residential care and to work with central and local government in Wales to address the shortfall in funding for social care.

39. We have already stated the case for a greater focus and investment on earlier prevention, greater acknowledgement of the role and contribution of universal services to health and well being underpinned by shared outcome agreements endorsed by national government in collaboration with local agencies.

Stronger links between research and policy

40. Research priorities often do not inform policy and practice in a timely manner. There is a lot of research but it can be difficult to locate and interpret in a systematic way when formulating policy.

41. There is strong argument for greater integration alignment of research priorities between research councils and government at all levels so that more opportunities exist for research to inform policy and practice and that evaluation and evidence based practice can be used to monitor the impact of policy change.

Part three: Specific Action

42. We suggest that action across the following areas would be beneficial particularly within the context of the recession and severe financial constraints on public services.

A joined up asset based approach – age sensitive communities

43. Achieving wellbeing is about making use of the whole range of local services, such as transport, housing (which in particular is rightly assuming greater profile in current debates about the future of care), health, leisure and training and education to name a few. A wide range of local authority functions are therefore fundamental to promoting the health and wellbeing of older people.
44. Councils across Wales with their partners and older people are moving away from intervention and paternalistic policies towards more collaborative participatory approaches that seek to enable, build capacity and empower people to shape their own lives and the communities within which they live.

45. This partnership approach to deliver objectives and use all available assets of a community has considerable merit. Local government has some examples across Wales that are forging ahead with this approach but capacity to drive this consistently is not in place.

**Dementia Friendly communities**

46. We consider this a priority as previously stated. The Welsh Government has highlighted a commitment to support local government and partners transform attitudes, the built environment and early assessment and support services to enable more people who will experience early stages of dementia to remain active and participate in society. This is an area we recommend for further investment and collaboration.

**Falls prevention**

47. Preventing falls and injury to the frail elderly has a significant evidence of benefits to individual, and health and social care services. We consider interventions that reduce the incidence of falls to be a priority area which could yield large benefits.

**Social Isolation**

48. An increasing number of people report high levels of social isolation. This is not exclusive to rural communities but is exacerbated by location. Transport and out of hours services are long standing challenges reported by older people.

**Promoting Equality**

49. The Public Sector Equality Duty, and the specific duties introduced in Wales under the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011, requires public bodies in Wales to set equality objectives in tackling inequality and discrimination. The purpose of the objectives and Strategic Equality Plans is to enable the delivery of measurable equality outcomes which improve the lives of individuals and communities. This allows Authorities to be more proactive, in developing planning, performance monitoring and reporting arrangements which meet local needs, and in achieving equality improvements which make sense locally. Many local authorities have adopted equality objectives relating to older people and the ageing agenda and this offers another opportunity to address discrimination and promote equality for older people.

**Conclusions**

50. Local Government welcomes the focus on examining how the UK can adopt a strategic approach to demographic change. Wales together with other parts of the
UK share a common challenge and our evidence shows some of these challenges are particularly acute in parts of Wales. Solutions that reflect challenges facing rural areas are a priority together with reducing the widening gap in health inequalities.

51. Ageing well and supporting the growing number of people to live longer, age well, remain independent and participate in society is an agenda for everyone. Joined up strategic action across government departments at national and local level needs to underpin and drive immediate change. Strong political leadership is essential with local government at the heart of the transformational agenda.

52. Attitudinal change to ageing is urgently required so that we use language and promote images of the positive benefits from ageing and the increased value of older people in general to society. Policies that are divisive and age specific are unhelpful.

53. Across the UK bespoke solutions and initiatives exist and there is merit in harnessing and share this learning at a UK government level. We would welcome further dialogue on the merits of establishing a UK wide task force drawn from central and local government with other partners to oversee and facilitate greater sharing of innovation on Ageing across the UK and help to identify further intergovernmental and inter agency action.

54. The legacy of the European Year of Active Ageing and Intergenerational Solidarity needs to be harnessed and not lost. The closing event to be hosted by Wales in November 2012 on behalf of the UK devolved governments will articulate further opportunities for joined up government action. We would be happy to report on this at a later date.

55. It is critical that investment in preventative health and well being in the widest sense is a priority and that the contribution local government makes to this agenda is fully acknowledged and supported by central government. Wales and local government has been at the forefront of putting many initiatives aimed at improving the health and well being of older people into place but concerted action, resources and support is required across all agencies if we are to capitalise on these foundations and get ahead of the curve. This is a significant challenge that now faces all parts of Wales and the UK.

24 August 2012
Wiltshire Council, WRVS, English Community Care Association and Laing & Buisson (Consultancy) Ltd—Oral evidence (QQ 373–462)

Transcript to be found under English Community Care Association
Dr Lynne Mitchell, WISE, University of Warwick, Len Street, University of the Third Age (U3A) Building Societies Association, Nick Leon, Royal College of Art—Oral evidence (QQ 496–513)

Transcript to be found under Building Societies Association
WISE, University of Warwick—Supplementary written evidence

Overview
1. How are your respective sectors responding to the changing market resulting from an ageing population? What Government policies would support the private sector to respond effectively?

The WISE (Wellbeing in Sustainable Environments) research group at the University of Warwick conducts research into the impacts that the built environment has on mental health and wellbeing of older people, including those with dementia. However, without Research Council funding there is little we can do to address gaps in knowledge and to test existing knowledge. Prior to the Government Spending Review the chances of winning research council funding was, on average, 10% but this is even less now. The EPSRC EQUAL (Extending Quality Life) Initiative funded some extremely good research on the design of environments for older people, both at the housing and urban design scale, and of products. Since the end of the EQUAL initiative there has been little funding apart from the cross council Lifelong Health and Wellbeing programme of which design of the built environment is a relatively small part so competition for that funding is huge.

2. What does your experience show that people want from older age? What affects the experiences and expectations of older people?

Firstly, it is important to focus on quality of life rather than quantity of years; the majority of older people want to lead active healthy lives, preferably in their own homes, and to continue to be useful members of and contributors to society. Secondly, older people are often viewed as a homogenous minority group with special needs. The term ‘older people’ covers a huge age range and people with many different lifestyles, attitudes and capabilities. People generally staying fit and healthy for longer than in the past and, at least in their 60s and 70s, their lives generally do not change much apart from retiring from work, having more leisure time and possibly less disposable income. However, a number of people, especially as they reach their mid-80s, do experience age related impairments and illnesses that impact on their quality of life and independence, which design and policy need to address.

3. Is there a need to improve the way that society perceives ageing and older people and, if so, in what respects? How do or can your organisations contribute to this? What contribution should the Government make?

Older people are affected greatly by the underlying ageism inherent in our society and they worry greatly about ‘being a burden’. In the past, older people have tended to be what I refer to as the ‘mustn’t grumble’ generation and there has been much talk of how this is beginning to change as the more educated and articulate baby boomers grow older. But it is questionable whether this will change for those who do become frail or who struggle to cope with living from day to day with physical, cognitive or sensory impairments.

Older people seem to bear the brunt of the blame for the housing shortage, being accused of ‘family house blocking’ in much the same way as they are accused of hospital bed blocking. Anecdotally, I have recently also heard of older people who move to smaller dwellings being blamed for preventing first time buyers from being able to buy those dwellings! Both the 2012 National Planning Policy Framework and the 2011 Housing Strategy for England suggest that providing a choice of age-specific housing can ‘free up much needed local family
housing’. Even if this is genuinely viewed as secondary to providing older people with the housing that best suits their needs, such statements do little to reduce stigmatism and ageism and could make older people feel pressurised into making unwanted or inappropriate moves. The dwelling a person has lived in for many years and brought their children up in is a home, not a house with empty bedrooms. The majority of older people wish to remain in their home and in their street and neighbourhood where they have built up a network of friends and neighbours over the years.

Research has disproved the assumption that people want less space as they grow older, many wish to have just as much space to maintain their lifestyles, for example to accommodate the elements of ‘normal’ life, such as visitors, possessions or hobbies or to cope with changing needs, for example to store mobility equipment or a second bedroom for a carer. Housing for older people needs to be easy to access, use and adapt. If these features are designed into all housing at the planning stage there will be less need for people to have to move house as circumstances change providing, of course, their health and social care needs are also being met.

Planning and urban design
4. What are the key issues that urban planning should address in responding to the needs of an ageing population?

To achieve wellbeing we need to make sure people not only feel healthy but also happy and satisfied with life. If people live in a supportive environment they are more likely to be physically active, healthy and satisfied with life. Cities, places, spaces and buildings are currently designed with the fit, young healthy adult in mind. An age friendly city (or any place, space or building) is one that has been designed so people can access and enjoy it over the course of their lifetime, regardless of ability or circumstance. They should be attractive, welcoming, safe, easy and enjoyable for everyone to visit, access, use and find their way around and, therefore, inclusive for all.

The key issues are ensuring that those older people who do have health or mobility problems do not become literally housebound due to environmental barriers present at the threshold between their dwelling and the outdoor environment, and in their street and neighbourhood and beyond. They are not housebound due to their health problems but by poor design. By barriers I mean anything that stops or restricts normal activity such as steps, steep inclines, a lack of pedestrian crossings in the right places, a lack of appropriate public seating and toilets, clear, concise signage with large text in clear colour contrast to the background, good quality smooth, plain paving, drop kerbs, no trip hazards and so on. These are all sensible features, most of which are already in the sustainable urban design guidelines but which are so often missing in our cities and neighbourhoods. Research by the I’DGO Consortium (Inclusive Design for Getting Outdoors, funded by EPSRC EQUAL) found that people living in supportive environments, and within 10 minutes walking distance of open space, are twice as likely to achieve the recommended levels of healthy walking (2.5 hours/week) than others.

Even if people with mobility or other health problems can still go out they often have to change their normal patterns of behaviour to adapt to their changing abilities, such as only going to places they can walk to easily or where they know they can park very close to the shops, where there are no steep inclines or steps, and where there are seating and toilets. They often find public transport difficult, for example, when:

- there is no bus shelter or seating at the bus stop
• they cannot read the bus stop signs or the numbers and text on the buses
• bus journeys are unstable and they fear falling over as the bus pulls away or lurches to a stop
• bus journeys are uncomfortable, for example as they go over speed humps or pot holes
• they worry that they will not be able to push past standing passengers and get off in time

Due to these barriers many older people dread the time when they will no longer be able afford to drive or are told they must stop driving. Those who cannot drive or take buses are restricted to their local neighbourhood within walking distance of home and are reliant on others to take them to places further afield, such as to hospital appointments. All this impacts greatly on their physical and mental health and wellbeing and puts an unnecessary strain on formal and informal carers.

As well as detailed design issues, there is also much that can be done at the urban form level. It is generally assumed that older people are better off living in high density areas where public transport and shops and services are more likely to be easily accessed. However, our research has found that high densities tend to cause fear of crime and traffic, stress caused by crowds and noise, and dissatisfaction due to dirt and poorly maintained or damaged footways, buildings, street lighting and other street furniture. For this reason many older people prefer to live in small towns and villages despite the lack of good local facilities and services. However, high density living for older people can be positive providing the environment is clean and well maintained, there are quiet areas away from crowds and traffic and there is a great deal of greenery, such as local green open spaces, street greenery (trees and verges) and front gardens.

**Do city design and city transport systems need to adapt and, if so, how?**

There is much that design can do to make places old age friendly both when designing new places and when regenerating existing ones. Inclusive design should not be seen as an optional extra, it should underpin all aspects of planning and design, be taught to urban designers, planners, engineers and architects and be part of the accreditation of courses by institutions such as the Royal Town Planning Institute and the Royal Institute of British Architects.

There are many relatively easy interventions that would help a great deal, such as providing more appropriate public seating and toilets. Many of the existing sustainable urban design guidelines such as locating new housing within walking distance of shops and other services, making change small scale and incremental and providing attractive, green environment are old age friendly.

**Who is responsible for ensuring this happens?**

**Lifetime Neighbourhoods**

The impact of demographic change is often compared to that of climate change yet it is not being addressed with the same urgency as climate change. The National Planning Policy Framework makes just two references to demographic changes/trends and three references to older people, in comparison to over 20 relating to achieving a low carbon future and the Government’s zero carbon buildings policy. The housing strategy for England notes, rightly, that climate change requires urgent action and wants all new homes coming through the planning system from 2016 to comply with their Zero Carbon Homes standard. But the
government has chosen not to pursue a similar policy or standard for future proofing housing or cities to address the equally pressing issue of the ageing of the population. If it is acceptable to regulate to increase housing provision and reduce carbon emissions why is it not also acceptable to regulate to meet the equally pressing needs of the ageing of the population?

The 2008 Lifetime homes, lifetime neighbourhoods: a national housing strategy for an ageing population was the first cross-departmental strategy on housing, neighbourhood, health and wellbeing for older people. It not only set out a housing strategy within the context of an ageing society but also stressed the essential link between housing and neighbourhoods in supporting healthy, active, independent lives as people age. It recognised the need to provide more housing choice and to enable people to stay in their own homes. New housing was to be built to Lifetime Homes standards and new communities to Lifetime Neighbourhoods standards. It also raised the importance of addressing the needs of the growing number of people with dementia and their right to remain part of their communities.

None of the current housing and planning policies and strategies is specifically aimed at the needs of the ageing population in such a direct way. Planning and designing for an ageing population and lifetime homes and lifetime neighbourhoods are being left to the discretion of local authorities rather than being a requirement. The National Planning Policy Framework makes no reference to lifetime neighbourhoods but does require local planning authorities to:

- deliver a wide choice of high quality homes and create sustainable, inclusive and mixed communities
- take into account current and future demographic trends and the needs of different local community groups, including older people and people with disabilities
- promote local distinctiveness and character and provide mixed use developments with strong neighbourhood centres, active street frontages and clear, accessible, pedestrian routes that are safe from crime and traffic.

The current housing strategy reiterates the importance of designing attractive, inclusive neighbourhoods to support people’s quality of life and independence as they age. It requires neighbourhood design to be locally distinctive, reflecting local character and identity and views the 2011 Lifetime Neighbourhoods report as a tool for sharing good practice to ‘enable local partners to create age-friendly, inclusive neighbourhoods’.

Health and Wellbeing Boards
For some time government has been stressing the need to strategically link housing, health and social care and this is now being promoted as a means of providing a joined-up approach towards provision and funding. The 2011 public health strategy for England and the National Planning Policy Framework both refer to the links between planning and housing and health and wellbeing. But unless design of the outdoor environment is included people can live in the perfect dwelling with all the care and support they need but if they can’t get outside their health and wellbeing will be seriously affected. The health strategy aims to empower local communities to create healthy places by giving local authorities control of public health resources and requiring them to develop new partnerships in areas such as housing, environment, planning, transport and social care, and with key partners, such as the NHS, police, business and voluntary organisations. However, the National Planning Policy Framework makes no reference to strategically linking planning, or even just housing, to health and social care.
It is difficult to see how these links are to be strengthened and maintained unless all relevant government policies and strategies see this as a major objective. At the moment Health and Wellbeing Boards only bring together health and social care representatives - to ensure the built environment, housing, health and social care are strategically linked these Boards should include housing and inclusive urban design and housing representatives.

5. Are planning authorities able and willing to respond to such needs?
The brief and generalised references to older people in policies and strategies raise more questions than they answer. However, many local authorities have been working towards making their towns and cities age friendly by developing ageing strategies and age friendly action plans which set out their visions for ensuring that their local housing and neighbourhoods are age friendly, often including lifetime homes and neighbourhoods criteria. They often use the World Health Organisation’s 2007 Global Age Friendly Cities guide as a starting point for assessing what needs to be done. Addressing the issues of a changing demographic is now at the discretion of local government but a recurring question that emerges from talking to stakeholders is: ‘How is it all to be done when there have been so many staff and budget cutbacks?’ However, examples of where it is happening include Edinburgh, Manchester and the Greater London Authority and there are also smaller local authorities working on this, often lead by their local Older People’s Forum.

Design Review
Local Planning Authorities are required to prepare a Strategic Housing Market Assessment to assess their full housing needs and to identify the scale and mix of housing and the range of tenures needed locally that meet household and population projections. This involves taking account of migration and demographic change and addressing the need for all types of housing and the needs of different groups, including older people and people with disabilities. Apart from major projects, which should be referred to Design Council Cabe for a national design review, Local Planning Authorities are expected to make their own design review arrangements. But consultees of the 2011 Bishop Review, which looked at new approaches to providing built environment design support for communities, expressed great concern about the increasingly small numbers of local authority staff with design evaluation skills. Furthermore, the design codes the National Planning Policy Framework suggests Local Planning Authorities use do not refer to lifetime neighbourhoods or inclusive design apart from ‘access’, which is just one, albeit very important, aspect of inclusive design. It is essential that Design Council CABE’s new single design review network includes experts in inclusive design and designing for an ageing population and dementia.

Neighbourhood planning
Initiated by the National Planning Policy Framework, neighbourhood planning empowers communities to develop a neighbourhood plan setting out the location and design of local new homes, facilities, shops and businesses and to submit Neighbourhood Development Orders. Neighbourhood planning teams will be made up of residents, employees and businesses led by parish or town councils or neighbourhood forums. While giving local communities, who are after all the local experts, a greater say in what happens in their local neighbourhoods is a positive move, both they and their supporting Local Planning Authorities will need a huge amount of skills, time and commitment to do this. A big challenge will be ensuring that they have the knowledge and expertise to guarantee that all local people’s needs are considered and addressed, including older people and people with dementia. It is essential to ensure that
research findings and evidenced based design guides are disseminated to Local Authorities and neighbourhood planning teams.

December 2012
Professor Noel Whiteside, University of Warwick—Written evidence

Forward This evidence looks at general principles currently guiding public service provision and their appropriateness for older people. It focuses on current savings trends (notably of women) and the problems and costs of using commercial markets for personal savings (notably pension saving) as this is now a public service. Historical and comparative evidence suggest a few recommendations.

A) Introduction

1. The evidence offered here adapts Sen’s capability perspective to view the purpose of public services as the promotion of socio-economic co-ordination, to promote social integration and participation for all along collectively agreed lines. This challenges assumptions on which much recent public service reform has been based: that commercial market competition generates efficiencies. On the contrary, market competition creates additional costs for both service providers and their users because of the co-ordination problems it creates, the auditing requirements needed to secure public accountability, the expensive, repeated competitive tendering it frequently entails and the uneven (unjust) results it necessarily generates. The alternative is not necessarily public provision. On the contrary, in the UK and Europe single private providers work on contract to a public authority. Market competition may drive down costs, but it commonly does so at the price of service quality and job security (which means that potentially good workers will avoid this type of employment). Whether this is desirable for services for older people, who rely strongly on familiarity and personal relationships to foster confidence and trust, seems dubious.

2. The paper focuses chiefly on the desire of the Committee to address expectations about work, savings, retirement – to promote income security and independence at the end of working life. In contrast to other European countries, British state pensions remain among the lowest in the developed world and therefore saving for old age is imperative. As the population ages, this imperative grows ever stronger. Yet pension markets in Britain are extraordinarily fractured and complex – arguably the consequence of growing competition between providers as well as policy initiatives that have sponsored new schemes. Regulatory requirements have increased complexity, not diminished it (see Turner Commission Reports, 2005-6). Two additional introductory points need to be made.

   a. We forget how recent the concept of a retirement pension is: until the late 1940s, both public and private pension systems were designed primarily to supplement falling earnings consequent on old age. Once ‘retirement’ became a requirement for receipt of a pension, a much larger sum of money was needed. We have now reverted to the earlier concept of a pension as a supplement to private savings.

   b. Since the late 1950s, governments have, through fiscal initiatives, sought to ‘nudge’ employers and workers towards voluntary private pension provision, to supplement the state scheme: a drive peaking in 1967 with c. 50% of the workforce contributing to an occupational scheme. Ever since, coverage has declined – we might conclude it is high time to stop flogging this distinctly dead horse.
B) Work, savings, retirement and independence: the changing working lifespan

1. Women: work and savings. Historically viewed, the nature and distribution of employment has changed radically since the 1940s, particularly for women. The ‘good mother’ used to leave the labour market to look after hearth, home and family dependents old and young. (today she abandons them to take waged work). Her future income security rested on her working husband’s savings and his contributions to a social security system that supposedly offered a subsistence level pension for both on his retirement. A few points arise:

   a. The notion of a subsistence level state pension was always an illusion. From its inception, the post-war British state pension required supplementation; those without additional savings applied for National Assistance (now Pension Credit).

   b. In the 1940s, most people entered the workforce at 15 and men commonly completed 50+ years on a standard work contract (5-6 days per week) before retiring for 6-8 years (the wife a few years longer). Under full employment, both public and privately funded retirement systems were thus financially viable. Later labour market entry and earlier exit (especially in the 1980s) coupled with soaring life expectancy have undermined the financial foundations of such schemes.

   c. Women’s working lives have always differed from the ‘standard’ male counterpart. Although today’s mothers are expected to work (and save for their own pension) the key years during which such savings are expected to accumulate are frequently spent in part-time work looking after children. In consequence, women’s savings are a fraction of men’s. There is absolutely no sign of this changing, even though female life expectancy remains higher and most elderly and frail (and poor) are female.

**Figure 1: Median wealth held in private (occupational or personal) pension plans by gender and age (2006-8)**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Median Wealth Held (£)</th>
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<tbody>
<tr>
<td>Men</td>
<td>Women</td>
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<tr>
<td>16-24</td>
<td>10k</td>
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<td>25-34</td>
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<td>65-74</td>
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<td>75+</td>
<td>70k</td>
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<td>all</td>
<td>80k</td>
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</tbody>
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d. As this figure charts median savings, it disguises enormous variation. Female savings are pitifully low (and have declined since the 2008 financial crisis). As even £80,000 does not create a viable income supplement at current annuity rates, these figures indicate the general paucity of savings in the UK working population.
   i. The data illustrate private pension savings and thereby largely reflect contrasting female and male labour market participation.
   ii. There is some sign of cohort effects: however these are slight and plainly insufficient to bridge the gap between women and men.
   iii. Even if female habits were to change today, it will take decades before cohorts of women with no or very low savings die out (well beyond 2040).
   iv. As professionals marry professionals, there is little probability that higher male savings compensate for lower female ones at household level.
   v. Other evidence shows that the poorest elderly are divorced females.

e. Private pension systems have changed from Defined Benefit (DB) to Defined Contribution (DC). DB schemes require a survivor’s benefit: DC schemes do not. Most retirees do not understand annuity markets and buy single life products, leaving survivors (usually women) with a falling income when very old and frail.

2. Retirement and pensionable age. As indicated above, the idea of complete retirement on the attainment of a specific age is of relatively recent origin and has reshaped our understanding of what pensionable age implies. The first pensions (military), commonly lump sums, enabled those leaving state service to establish another means of earning a living. Early twentieth century state pensions were to help the impoverished elderly; they were supplemented (in 1925) by a contributory scheme for blue collar workers whose incomes declined with failing physical strength. An extended scheme, introduced after the Second World War, retained a pensionable age first specified in 1925 but required withdrawal from the labour market to claim it. [Today, this idea of ‘retirement’ is anyway a misnomer: waged work among those over state pension age is rising – in consultancy (usually men) or in cleaning, catering and retail (usually women, because they have to).]
   a. Higher Pension Ages. Although highly unpopular, there is no justification for keeping the same state pension age as in 1925: life expectancy is now substantially higher.
   b. Single Pension Age. Retaining a single pension age for all penalises those entering the labour market at 16: they work more years than those entering at 25+, pay more contributions, receive the same level of benefit and probably die earlier. In France, those entering the labour market young can claim their pension earlier.
   c. Partial Retirement. Currently most retirement schemes assume that full-time employment ceases on a specific day to be succeeded by full retirement. In line with more flexible employment and in order to achieve a healthier work-life balance, partial retirement should be encouraged. This would allow employers to retain experienced people while also allowing those aged 60+ to continue in work. Savings can be retained until very old age when frailty undermines working capacity. These options are starting to take hold but need encouragement
d. Employment of older people. Encouraging the elderly to continue in work requires encouraging employers take them on: there is little evidence that this happens.

C) Savings Management: private agencies and public purposes.

The Beveridge Report documented why commercial agencies should not be involved in the delivery of social security benefits. The rationale behind this argument – that such systems encourage profit-taking and raise costs by fostering administrative duplication - still stands.

1. Promoting Private Saving. The state pension has never provided for full retirement. All UK governments have promoted private supplementation. Outside the public sector, supplementary pensions are changing from DB (index linked: based on previous salary) and towards DC (where retirement income depends on returns available on personal savings).

2. Private Pensions as a Public Service. The implications of this shift and its full impact lie in the future (current retirement incomes are derived from DB schemes that spread in the 1950s and 1960s). Publicly subsidised private insurance companies are now delivering a public service: namely the accumulation and dissemination of pension products that, following the introduction of the National Employment Savings Trust (NEST -2012), the working public is being strongly ‘nudged’ into purchasing. This raises several problems:

a. Financial Literacy. This is very low: the average consumer does not understand different types of savings vehicles and products in a sophisticated market founded on principles of caveat emptor. To control sub-optimal decision-making, wave after wave of regulation has been introduced, increasing costs and complexity while generating more uniform products that remove the advantages of market provision. ‘Cures’ such as financial advice or education are expensive, not necessarily understood and require further monitoring (to control opportunistic advice).

b. Costs. As noted in the Introduction, market-based arguments claim that competition drives down costs. There is no evidence of this in pension markets. Charges for funds under management are notoriously high (sometimes eating up to 50% of the savings pot). Fees increase if customers switch providers, contribute irregularly or revise an investment portfolio (for example). During the 1990s, when returns were high, charges were sustainable. Since 2000, governments have tried to cap them (Stakeholder and NEST) but this alienates providers (marketing costs are substantial). Low-cost alternatives cannot afford to advertise and such schemes remain unknown to the wider public.

c. Orphan Accounts. [n.b. Minister Steve Webb is working on this]. Over a working life, people move, change jobs and – if female – change names. Companies they worked for and insurance companies are taken over, move location. Records get mislaid and deposit accounts lost. The foundation stone of occupational DB schemes (a single career with a single employer) is disappearing. On retirement the unfortunate retiree has to piece together 40 years of contributions to multiple authorities who have little interest in verifying her claim. Unsurprisingly, £3 billion of pensions lie unclaimed:

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332 Social Insurance and Allied Services Cmd. 6404/1942
surpassed only by £15 billion of bank account deposits whose owners cannot be traced. The personal pension was introduced because it was supposed to be portable: in practice it has proved to be anything but.

d. Oligarchic governance. Governments have sought to promote saving by fiscal incentives, controls on fraud, regulation of product marketing and so on. To date, this has mostly focused on savings accumulation: less attention has been paid to income generation from savings. That said, regulation has created an oligarchy of experts in financial services, insurance law and so on who are consulted by the Treasury on policy and whose decisions are then passed down to the citizen, who is viewed less as a democratic voter to be consulted than as a consumer of pension products whose customer rights should be protected. The result is at best public indifference, at worst uncertainty and distrust of both government and the financial services industry, whipped up sporadically by a hostile press. Financial crisis, twelve years of lousy asset returns and a chronicle of banking scandals have added fuel to this fire: results are reflected in a search for sustainable savings assets, creating an over-priced housing market, and thus another set of social problems.

3. Towards comparative perspectives The UK is not the only country facing demographic ageing, public finance problems and the need to promote private saving for old age, although it is easily the most reliant on market mechanisms to achieve this end. Other European countries are trying to cut their much higher statutory pensions and are, in consequence, promoting private alternatives. Equally, old DB schemes are being restructured into DC-type arrangements – so parallel trajectories exist.

D) Potential steps forward

1. Management Costs. This issue has also hit CEE states, In Poland, competition also failed to keep management costs under check and mis-selling proliferated. In Sweden, where both a Notional Defined Contribution and a mandatory personal Premium Pension have been introduced, the Swedish Tax Authority collects contributions, records are maintained by the Swedish Insurance Agency and contributory income is allocated by the Swedish Premium Pension Authority (PPM) between 700-800 different approved funds. The resulting fees and charges are kept lower than NEST’s and much lower than U.K. commercial alternatives.

2. Pension Guarantees. In Britain, the DC contributor takes all the risk. In Germany, the Riester pension provider has to guarantee the return at minimum of the total sum of contributions.

3. Savings Records. In Australia, DC pensions have been mandatory since 1985, yet a workforce of just over 8 million has generated 10 million ‘lost’ pension accounts. To combat this, the Australian government has agreed to centralise contribution records, using the unique personal tax code number to create a central database of contributors’ property rights.

4. Advice, Information and Regulatory Surveillance. In the UK, savings advice and information is provided by commercial organisations and surveillance is divided among several authorities. In Finland, a central Pensions Institute is responsible for full-time monitoring of fund development, demographic trends, employment trajectories and so on, to provide published information to be used by individuals, governments, Parliament and the insurance industry. This is similar to the permanent Pensions Commission advocated by Turner. An Office of Pensions Review (mirroring the Office of Budget Review) could absorb the regulatory duties of the FSA, the
Pensions Regulator and overview of the Pension Protection Fund. It could offer impartial advice and information and promote trust in saving for the future. The amalgamation of existing agencies would secure funding to meet part of the running costs and the industry could meet the rest.

In the light of recent financial crises and the escalation of public debt, no return to public pension provision is possible. However, pension and other savings have to be secure if habits are to change and these minor recommendations take a small step in that direction.

1 September 2012
Professor Noel Whiteside, University of Warwick, The King’s Fund, National Association of Pension Funds and The Saga Group—Oral evidence (QQ 463–495)

Transcript to be found under The King’s Fund
Structural features undermining the efficiency of pension provision

Some points in this note involve partial repetition of written Evidence submitted on 31 August 2012.

Structural features of occupational / private pension provision in the UK

In 2009, the OPCS estimated 61,830 pension funds existed in the UK (down from 77,703 in 2008): an estimate necessarily based on a sample of the whole. This number excludes Stakeholder and group/ individual personal pension plans, but covers plans that were frozen or in the throes of being wound up. These funds covered c. 40 per cent of the working population (public and private sectors) and about 75 per cent had fewer than a dozen members. While small funds dominate, however, they only cover a minority of contributors (below 15 per cent). Such small funds, however, tend to slip below the radar of The Pensions Regulator. Yet, as employers and funds merge / are taken over and as contributors move jobs, the likelihood of any one person accumulating pension rights in more than one fund remains high (particularly for women) and, in the absence of any central record, the likelihood of contributors losing pension rights by the end of their working lives remains strong.

Multiple funds, subject to different regulations, create administrative complexity that raises costs. The industry has repeatedly been criticised for high charges, yet charges reflect not merely high salaries and profits, but marketing costs (due to the competitive basis on which the industry operates), regulatory compliance costs (including taxation changes), duplication of administrative staffs and office accommodation. The Annual Management Charge (AMC), quoted as a percentage of assets under management, covers investments and company administration: the sum rises with the size of the pension pot and thus bears most heavily on Defined Contribution schemes (which are growing) in years just prior to retirement. The Total Expense Ratio (TER) is an additional charge exacted to pay the seller’s premium or for changes in investment portfolio. In general, the larger the fund the lower the charges as economies of scale kick in (the state pension is the cheapest pension to administer). Attempts by Stakeholder (in the past) and NEST (in the future) to contain charges tend to alienate providers: even under NEST (which is capped) only 89 pence out of every £1 finds its way into the personal pension pot. As marketing (bar the efforts by HMG) is non-existent, awareness of the advantages of low-cost provision is poor. The employer running a DC group scheme has little incentive to shop around to secure value for money as contributors pay the costs, not the employer. Like Self Invested Pension Plans and Approved Pension Plans, Stakeholder and NEST receive taxpayer subsidies. While all these schemes vary, this structure probably siphons money from the taxpayer and contributor to an industry whose first duty is the promotion of shareholder value. Choice may be considered desirable, but we should recognise it is expensive. It is possible to sustain choice at lower cost by centralising contributions and contribution records (as in Sweden, Denmark, Finland). The administrative structure of UK pensions has lost all sight of economies of scale.
**Structural features of pensions: the wider economy**

The transfer of pensions from state to private provision was partly justified by the way it promised to limit future fiscal burdens on private enterprise. Under NEST, all employers will eventually become obliged to offer a company-based pension to all employees. This will involve administrative and compliance costs plus a 4 per cent employer contribution: whether this is less of a burden on industry than a tax hike is an open question. There were, of course, other reasons to privatise pensions that do not concern us here. The main point is that the structure of UK pension provision forms an unnecessary burden on private employers that may contribute to delayed economic recovery.

Finally there is the wider issue of who benefits from this type of pension structure and whether it exacerbates divisions between the wealthy, many working in financial services, and the rest of the population. The consequences of market risk (2008 crash and subsequent low asset returns) were to ask the population to save more, to make good shortfalls in original pension projections. The recent political response to growing deficits in company pensions was to redefine how such deficits are calculated – in order to protect shareholder value among companies running pension schemes, which also affects executive pay. While this may be helpful in the short term, it may prove disastrous in the long run – especially as numerous experts calculate that future costs of ageing (pensions and care) have been sadly under-estimated and as there are no guarantees that the heady returns that characterised the closing decades of the twentieth century will be restored. There are strong arguments for demanding that private pensions, as a public good, be provided by not-for-profit agencies under a more rationalised structure.

9 December 2012
**Professor Noel Whiteside, University of Warwick—Further supplementary evidence**

**Finland’s Pension System. Supplementary evidence by Noel Whiteside**

In response to a request from The House of Lords Select Committee on Public Service and Demographic Change, I append a brief outline of pensions in Finland.

A. **Structural features: similarities (and dissimilarities) with the UK pension system**

   a. A basic national (tax-funded, residence based) pension for all
   b. A ‘Guaranteed Pension’, means-tested, for those with insufficient resources
   c. An earnings-related, defined benefit, employment pension (mandatory, part PAYG, part-funded) run by pension companies, foundations & funds[^333] – dominates provision [Chart]
   d. Voluntary supplementary corporate / personal pensions (very small).

   ![Chart showing distribution of pension types](chart.png)

B. **Governance.**

   a. All pension systems in A (a-c) above are ruled by Parliament and are CPI indexed.
   b. Employment pension (funds run privately but form part of public finances under EU law)
      i. Coverage & returns specified in law to reflect pension accruals over working life.
      ii. Credits for full-time study and for child care.
      iii. No income ceiling (voluntary personal pensions crowded out).
      iv. The funded element designed to even out discrepancies in generation sizes.
   c. Finnish Centre for Pensions supervises viability, using long-term calculation models to advise on contribution rates, future costs (etc.) acting as adviser to

[^333]: 50 pension providers (companies, funds and foundations) manage contributions, payments and investments under the supervision of the Minister of Social Affairs & Health and the Financial Supervisory Authority.
government, social partners, commercial providers and publishing research results for general public.334

D. Facing the demographic challenge: recent reforms

a. Centre for Pensions created a life expectancy co-efficient to determine pension payments within age cohorts: this can decrease starting pension: stabilises expenditure

b. Delayed retirement can compensate for this reduction: exit age chosen by retiree (63-8)

c. Standardised pension accruals allow accurate information for individuals of likely future pension income, to enable informed choice.

A note on policy initiatives to shift attitudes towards older workers and working longer (as requested by the Chairman of the House of Lords Select Committee on Public Service and Demographic Change)

Professor Noel Whiteside, University of Warwick

Below I argue first, that opposition to a prolonged working life is not as severe as we might suppose: second, that policy should focus on employers to encourage them to widen pathway options for workers in their 60s and third that more flexible pension design in the private sector, as exemplified by the state pension, could encourage different approaches to retirement.

1. Recent research by the DWP335 stresses the significance of contextual factors in shaping individual retirement decisions: when partial retirement or part-time alternatives are offered, most respondents were happy to consider alternatives. Policy can push at a slowly opening door. Other research has also revealed a rising awareness among the population at large that working into your 60s is not the worst of fates and represents a reasonable response to current demographic problems. In short, longer working lives are preferred to lower pensions. However, a large minority of working people in their 50s is not aware that official State Pension Ages are rising; governments are reluctant to advertise SPA changes, but this undermines the ability of working people to anticipate their futures.

2. From this perspective, policy should focus on employers and the options they offer to workers approaching what used to be retirement age; contextual options shape behavioural responses. Various possibilities involving reduced hours and partial access to pension income can facilitate such developments. Rising numbers of people in their later 60s are economically active: policy should seek to advertise and facilitate this change.

3. Higher pensions for those who choose to postpone full retirement could offer an incentive to stay at work. Delaying a claim to the UK state pension (at c. 10% p.a.) is, in the current financial climate, one of the best investments on offer, but only c. 50% of the UK adult population is aware of it. Even so, similar arrangements could offer a blueprint for occupational DB schemes to which many UK firms remain committed and many of which languish in deficit. Proportional pension rises could match partial retirement. Such changes would probably attract white collar / professional retirees

334 This was the type of agency that I was advocating in my evidence to the Select Committee (Q.479: 27 November 2012)

335 Extending Working Life: behavioural change interventions (Sept. 2012) DWP.
whose better health (and greater longevity) poses the biggest financial problem to both state and DB private pensions. As blue collar workers enter the labour market at an earlier age and die younger, fostering different retirement patterns represents a type of social justice (although the decision over when and how to withdraw from full time work should remain personal) while offering employers with DB schemes the opportunity to restore the financial viability of their pension funds.

The main problem with this solution remains informational: the consequence of the UK’s badly fractured and virtually incomprehensible pension system. DWP research demonstrates that c. 20% of the population has no idea at all of their pension prospects and many others have only a vague awareness (the necessary consequence of recent conversions to DC pensions where market risk joins political risk in undermining pension predictions). Some sort of pension guarantee (such as that found under the German Riester pension) is badly needed: as is a rationalisation of pension providers and funds as well as better, non-commercial information on comparative performance.

**Q56 Lord Mawhinney Q463** … Some years ago we changed the tax system in this country, and we separated husbands and wives or partners, or whatever their arrangement was, into two streams. Has any work been done on a similar separation in terms of public expenditure to families—benefits and pensions?

I have not found any direct work on the consequences of separate tax / NIC assessments of husbands and wives / partners for public expenditure on benefits and pensions. I append, for Lord Mawhinney’s information, tables I developed in 2010 from ONS data that offer some information on pensions. However, while public expenditure has risen, many other factors have influenced change.

First, the amounts being paid in state benefits to pensioners have, over time, risen (see Chart 1 below). The growing generosity of state benefits reflects multiple policy changes including the growing maturity of state second pensions (SERPS / S2P) and their wider coverage; the introduction of Pension Credit; rising longevity (and thus more disability / frailty payments) – among other factors

**Chart 1: Average weekly pensioner unit income 1997-2007**

[Graph showing average weekly pensioner unit income from 1997 to 2009 with different income categories labeled: Benefit income, Occupational pension, Personal pension income, Investment income, Earnings.]

Higher rates of female labour market activity have raised women’s pensions (see Chart 2) and legislation passed by the last Labour government – reducing the number of completed
NIC years for a full pension for both men and women to 30 – will raise them further. However, as the table demonstrates, these changes take time to work their way through: older women do not benefit.

Chart 2: Pensioner income by age and gender

Women’s rising access to state pension benefits may be attributable to the increasing numbers covered by a second tier pension (see Chart 3).

Chart 3: Numbers covered by second tier pensions (by gender) 1997-2007

The general rise in second tier coverage is explained by the wider remit of the state second pension (which took over from SERPS in 2002) to cover more part-time workers and the general growth in part-time female staff in social services, teaching, nursing and auxiliary professions – all contributing to second pensions paid for by the state in one way or another. (While rising individual coverage looks impressive, we must recall that this tells us nothing about persistence over time or amount paid: part-time contributions translate into a part-time pension on retirement).

It would be nice to think that public expenditure focused on helping the poorest elderly, but the data show that this is not necessarily the case. Incomplete NIC records (42 years for men and 39 years for women until 2010) and disinclination / inability to apply for the Pension Credit Guarantee help shape the disparities between pensioners when divided into income quintiles, as shown in Chart 4 below.

Chart 4: Income of single pensioners by income quintiles
The reasons for higher state expenditure on the richest pensioners are complex and reflect not only complete NIC records, but also class discrepancies in life expectancy that create a higher average age in the top quintile, who are therefore more likely to be in receipt of state disability benefits and associated allowances supplied to compensate for increasing frailty and incapacity (as well as higher winter fuel allowances for the very old).

Overall, these figures reflect how the growing gap in incomes between the very rich and the middle and lower income groups, much remarked on in the media, continues from working life into old age. Thanks to the propensity for the rich and professional to marry among themselves, income discrepancies between pensioner couples are even more marked, as Chart 5 shows.

**Chart 5: Income of pensioner couples by income quintiles**

Here at least the distribution of state benefits is not skewed in favour of the better off, but neither does it benefit the poorest. The top quintile contains households with one partner still in work (and thus unlikely to claim state pension) and the lowest quintile most probably...
contains immigrants with incomplete NIC records or those who, for one reason or another, are reluctant to claim means-tested supplementation. The data provided in these tables demonstrates the problems of evaluating the impact of the switch from couple to single person NIC / tax assessment on benefit rights and state expenditure. As far as state expenditure on pensioners is concerned, health-status, income status as well as personal NIC contributions to possibly two or three different state pension schemes – all have made their impact in terms of public expenditure. While individual assessment is evidently helping women establish a claim to a basic state pension in their own right, it does less for earnings-related public sector schemes. Overall, the record of improvement is very slow and is more likely to make an impact many years hence: until the older cohort dies out, women in later life will remain disadvantaged.

December 2012
WRVS, English Community Care Association, Laing & Buisson (Consultancy) Ltd and Wiltshire Council—Oral evidence (QQ 373–462)

Transcript to be found under English Community Care Association
University of the Third Age (U3A)—Supplementary written evidence

1 U3A in Operation

1.1 In the 30 years since foundation of the movement in 1982 we now have grown to 870 U3As distributed throughout the UK with a total membership of 300,000. The average U3A has about 320 members and the movement continues to expand with about 40 new U3As created every year. U3As are self-funded, low-cost, voluntary learning organisations run by third agers for third agers and, by drawing on the knowledge and experience of their members, they are able to offer their memberships many opportunities to learn from each other by sharing common interests. Clearly U3As are meeting a crucial need among older men and women by helping them socialise with their contemporaries, participate in mental and physical activities and continue to lead purposeful independent lives.

1.2 In addition to the monthly general meetings held by the 870 U3As, they organise a number of study and activity groups that also meet monthly or more frequently. In these groups a small numbers of members (commonly between ten and thirty) come together regularly to follow a particular interest. It is possible to get an idea of the scale of U3A operations in the UK from the fact that on average a U3A will have about thirty activity/study groups so that every month throughout the UK over 25,000 groups (ie 870x30=26,100) of U3A members meet to share a particular enthusiasm. When all the group time is aggregated over a year it amounts to the equivalent of a very large educational institution - all organised by volunteers.

2 U3As and Quality of Life of Older People

2.1 The continuing growth of the U3A movement, both in the number and distribution of the U3As as well as the number of individual members shows that the movement is adjusting to the demographic trends.

2.2 Stereotyping of older men and women is still widespread – the media are particularly prone to do this and the practice should be actively discouraged.

2.3 For informal learning groups like the U3As to flourish they need day-time access to meeting rooms of various sizes. Conference centre facilities and hotels are usually prohibitively expensive and it should be much easier to hire meeting rooms in public buildings i.e. schools, government premises, local council properties, public institution premises etc.

2.4 If older men and women are to be able to continue to enjoy their membership of U3A and reap the benefits, it is crucial that they are able to get to their meeting so good public transport availability should not be subject to a ‘Post Code Lottery’. In rural areas where numbers do not readily justify a full transport service, there will have to be much more widespread provision of the ‘Dial-a-Ride’ type of scheme.

2.5 The Third Age Trust realises (a) that it must address the problem of those mentally active members who gradually losing their mobility but wish to retain their association with U3A and (b) there is a need to provide facilities for limited numbers of members, mostly widely scattered throughout the UK, who are interested in studying a specialised subject at a greater depth than is possible in a monthly meeting. The Trust is exploring Internet based solutions to both of these problems.

2.6 On the general questions of both design and planning it is crucial that third agers are involved in any consultations at all stages – that means the clientele speaking for themselves.
and not having employed second agers speaking for them. It is always a source of great irritation to third agers when second agers, who by definition cannot have first-hand experience of being retired, tell third agers what is best for them.

4 December 2012
vInspired—Written evidence

Older people volunteering

1. About vInspired

1.1. vInspired is a national charity dedicated to providing opportunities for young people to do good things. Our innovative programmes and online services help young people to recognise and reach their true potential, whilst supporting great causes through volunteering and social action. Our projects develop skilled, caring, motivated young people, who feel they belong to their communities.

1.2. As youth unemployment levels remain at record highs, now more than ever we are dedicated to ensuring that we help young people build new skills, confidence and experience, whilst doing things they enjoy, care about, and can feel proud of.

1.3. Young people are at the very core of everything we do – they shape our objectives, our strategies and our delivery. The young people we work with, both in our programmes and on our Youth Advisory Board, make sure that everything we do is fresh, relevant and never, ever boring.

1.4. We are proud to say that no group in society is under-represented in our work – no matter what their personal circumstances, interests or qualifications, we have opportunities for all young people to do good things.

2. History

2.1. vInspired was launched as v, the National Young Volunteers Service in 2006 with an exciting challenge: to change the face of volunteering for 16-25 year olds.

2.2. The organisation was set up as the result of a 2004 inquiry led by Ian Russell (the Russell Commission) into how young people were involved with their communities, and what could be done to get them doing more. Following 6,000 of responses from charities, community leaders and young people, the Commission identified a need for a new organisation, which could create a 'step-change' in the quality, quantity and diversity of youth volunteering.

2.3. For the first 5 years of our existence (as v) we were funded by the Government, to make grants to help charities develop their youth volunteering activities and to change the way that young people viewed volunteering and social action.
2.4. When v reached the end of the five year funding arrangement our Government funding decreased significantly. v took its achievements, expertise and innovation to evolve into vInspired.

2.5. We now have more than 140,000 young people and more than 2,000 organisations registered on our online volunteering marketplace, vInspired.com. Our innovative programmes provide tailored support to thousands young people every year. We remain committed to our core purpose – providing opportunities for young people to do good things.

3. Impact

3.1. In our first 5 years v delivered a social return on investment of at least £6 for every £1 spent. We helped and inspired a new generation of young volunteers to some amazing achievements by:

- delivering over one million volunteering opportunities for 14 - 25 year olds across England
- enabling over 800 young people to create their very own projects to make their world a better place
- recruiting over 125,000 members and 1,600 charities to vinspired.com - our very own volunteering hub
- working with over 200 corporate partners and persuading the likes of Nike, Tesco and ITV to invest over £50 million in youth volunteering and social action
- match funding our corporate partners' investment, meaning well over £100 million raised for youth volunteering
- reaching marginalised and disadvantaged groups who are traditionally under-represented in volunteering. We helped a total of 25,500 homeless young people, 25,000 people who've been in the care system, 31,850 young people who are lone parents, 331,240 young people on low income and 44,950 young people who've offended to volunteer
- creating a national community of young volunteers through our full-time volunteering programme
- launching a suite of volunteering apps to bring volunteering closer to young people.

3.2. An independent evaluation of our work, published in 2011, showed that 99% of young people felt more confident as a result of the volunteering opportunities we provided. Ninety per cent felt they had a better chance of getting into work, and almost half have gone on to employment or further education.

4. A personal view from vInspired’s founding Chair, Sir Rod Aldridge

In my view, unlike some Government initiatives or calls for action, vInspired delivered because of the following key reasons:-
a) We started with a clear mandate from the very top of Government, i.e. the Chancellor of the Exchequer/PM, who adopted the findings of the independent report by Ian Russell.

b) The independent report took substantial first hand evidence not only from the established organisations that set out to serve young people, but more importantly the young people themselves. The Russell Commission Report also looked at the wider market and thus set out the case for the radical rethink that was needed in the landscape for the development of a new youth volunteering service.

c) This therefore challenged the third sector organisations that purported to represent these young people. As you can well imagine there was a strong call that the monies being made available for this initiative should all go directly to them rather than to setting up a new organisation. However, there was clear evidence from the Report that this would merely continue to deliver the status quo rather than the ‘step change’ that the report set out to achieve. Although there was very strong lobbying to Ministers and senior civil servants by many prominent organisations, the Government stood firm about needing a new approach.

d) This led the way in March 2006 for the structuring of a new, innovative organisation - v, with the appointment of a CEO/ team, a new Board of Trustees representing a mix of industry, business and young people charged with the responsibilities of implementing the findings of the Russell Commission.

e) The Government supported the initiative with a significant investment over 5 years, both to fund a small core team at v, but mostly for stimulating the development of programmes to encourage young people to volunteer for opportunities - the latter being delivered through existing third sector organisations but with v’s guidance and in many cases matched private sector funding. The Match Fund, as it was called, massively enabled money to be raised - from a standing start more than £50m was raised from the private sector. These private sector organisations then became the supporters of the programmes developed, delivering them in conjunction with a number of existing third sector organisations. v was able to invest in building the capacity of these organisations to work with young people and ensure improved and consistent standards of performance.

f) The Cabinet Office and the Treasury brought together Ministers from a range of departments, including Education and Communities and Local Government, to harness cross Government support to deliver the Russell Commission recommendations.

g) To ensure that v remained in touch with young people a Youth Advisory Board of 20 diverse young people around England was established, who came together for a year
at a time to guide the work of the charity. Four of these young people each year joined the main Board of the charity and were trained in finance, legal and business so that they could take a full part in discussions. In many cases they fronted pitches to private sector organisations for funding. Over the 6 years it gave us access to 120 incredible young people many of whom will go onto achieve great things in their careers but will always put volunteering high on their personal agenda.

h) v worked hard to ensure that the positive impact that our work had on youth volunteering in England was not lost in the event of a change of Government following the 2010 election. As a result the incoming Government recognised our successes and continued to fund vInspired, albeit at a reduced level whilst the Charity developed a range of income streams. It has since secured funding from a more diverse range of sources and has successfully bid as part of a consortium to deliver the current Government’s headline youth initiative, the National Citizen Service.

The independent evaluation of vInspired published in July 2011 covering v’s first five years of funding was key. This showed that v exceeded our first five year target for creating new volunteering opportunities for the young by 265% with no group under-represented among the volunteers. v had achieved a minimum Social Return of Investment of £6 for every £1 spent even if v only took credit for 10% of the outcomes achieved. This ability to deliver has both been proof of concept and proved very useful in vInspired securing future funding.

February 2013