

UK response to the EPC/SPC Questionnaire on Health and Long Term Care for the Elderly

1. Access

1.1 Health Care

1.1.1 Mechanisms for guaranteeing access

State health care in the United Kingdom is provided through the National Health Service (NHS). The NHS was set up in 1948 to provide healthcare for all citizens, based on need, not the ability to pay. It is made up of a wide range of health professionals, support workers and organisations.

The NHS is a universal service provider for all based on clinical need. The NHS does not exclude people because of their health status or ability to pay. The NHS aims to bring about the highest level of physical and mental health for all citizens, within the resources available, by:

- promoting health and preventing ill-health
- diagnosing and treating injury and disease
- caring for those with a long-term illness and disability that require the services of the NHS.

The NHS provides access to a comprehensive range of services through primary and community healthcare, intermediate care and hospital based care. The NHS also provides information services and support to individuals in relation to health promotion, disease prevention, self-care, and rehabilitation and after care.

Health and social services are funded nationally and available to all citizens of the UK. However, health and social services outside of England are provided by the devolved administrations of Scotland, Wales, and Northern Ireland.

The Department of Health sets overall health policy in England, is the headquarters for the NHS and is responsible for putting policy into practice. It also sets targets for the NHS and monitors performance. Around one million people work for the NHS in England and it costs more than £50 billion a year to run. This will rise to £69 billion by 2005.

The Scottish Executive Health Department (SEHD) is responsible for health policy and the administration of the National Health Service in Scotland. The Department has responsibility for the Health Education Board for Scotland, which promotes positive attitudes to health and encourages healthy lifestyles, and the Department is also responsible for social work policy and in particular for community care and voluntary issues.

The NHS in Scotland has around 132,000 staff, including more than 63,000 nurses, midwives and health visitors and over 8,500 doctors. There are also more than 7,000 family practitioners, including doctors, dentists, opticians and community pharmacists, who are independent contractors providing a range of services within the NHS in return for various fees and allowances.

The National Assembly for Wales is responsible for policy direction and for allocating funds to the NHS in Wales. The Assembly allocates funds annually to each of the five regional health authorities. The health authorities buy health services from professionals in primary care, such as family doctors, dentists and opticians, and from the NHS Trusts who provide secondary, and community care. There are 15 NHS Trusts in Wales that manage 135 hospitals and some 15,000 beds. Half a million people – a sixth of the population – will have a hospital stay in any given year. The NHS in Wales spends some £2.6 billion, rising to £3.6 billion by 2003-04. It is Wales' largest employer, with 60,000 staff, representing more than 7% of the Welsh workforce.

The Department of Health, Social Services and Public Safety administers the business of health and personal social services in Northern Ireland. This includes policy and legislation for hospitals, family practitioner services, community health and personal social services. Public health covers responsibility for policy and legislation to promote and protect the health and wellbeing of the population of Northern Ireland.

Public safety encompasses responsibility for the policy and legislation for the Fire Authority, food safety and emergency planning.

The Department's mission is to improve the health and social wellbeing of the people of Northern Ireland. It does this by ensuring the provision of appropriate health and social care services, both in clinical settings, such as hospitals and general practitioner surgeries, and in the community, through nursing, social work and other professional services. It also supports programmes of health promotion and education to encourage the community to adopt activities, behaviours and attitudes that will lead to better health and wellbeing.

The Department currently employs some 850 staff. More than 41,000 staff are employed in the health and social services sector and the Department's overall allocation for the financial year 2000/2001 was around £2.1 billion.

Throughout the UK, there are no specific provisions for facilitating access to healthcare for older people – since healthcare provision is made on the basis that it is available to all ages, that is not necessary. Age discrimination of any kind is not tolerated within the system. Healthcare is based on clinical need alone.

The UK Government published *The NHS Plan* in July 2000 - this set out a major package of investment to improve standards of care. In addition, the *National Service Framework (NSF) for Older People* was published on 27 March 2001. This is an England-only document. The *NSF for Older People* sets national standards for the care of older people across both health and social services. These standards apply whether an older person is being cared for at home, in a residential setting, or in a hospital. The NSF adopts a whole-system approach where NHS and social services treat older people as individuals. This is achieved through measures such as co-ordinated planning, integrated commissioning arrangements, integrated provision of services, and the Single Assessment Process (SAP).

The SAP is currently being implemented. It focuses assessment and care planning on helping older people maximise their independence and remain at home if that is their wish. It requires health and social services to work together when assessing the needs of older people; in order to assess needs holistically, to minimise duplication of assessment and to share information effectively.

The SAP will ensure that older people's needs are assessed more promptly, more thoroughly, and with less duplication from different agencies. It will lead to more appropriate services and outcomes. Properly targeted assessment should improve access and may reduce demand for services through assessing need more accurately and by ensuring that services remain appropriate to needs.

1.1.2 Assessment

Waiting lists are an indicator of access to healthcare. We have now virtually eliminated waits of over 15 months and have reduced the number of patients waiting over 12 months. Long waiting times are starting to become a thing of the past; most patients receive their first outpatient appointment within 26 weeks (6 months). We have reduced the maximum waiting time for inpatient treatment from 18 to 15 months and have established a maximum waiting time for a first outpatient consultation of 6 months. Older people, as the biggest users of the health service, will be among the principal beneficiaries.

In relation to a number of acute sector interventions, we have looked to see how waiting times vary for different age groups. In the majority of cases, older people have experienced shorter

waits - in some respects this may be explained by the more severe case-mix associated with increasing age. We are also looking at intervention rates for different age groups for conditions such as hip replacements and cataracts, to see how intervention rate ratios vary around the country. This will help local health organisations to consider whether there is any inappropriate denial of access to services for older people. It is difficult to set an appropriate benchmark for intervention rate ratios, because there are often very varied and valid reasons for considerable differences.

Access to newly emerging treatments is regulated by the National Institute for Clinical Excellence (NICE). NICE is a Special Health Authority that appraises new and existing treatments to produce clinical guidelines and disseminate guidance to the NHS. NICE guidance may cover all aspects of the management of a condition - from self-care through to care by a family doctor, hospital and most specialist services, and they carry out appraisals of the most significant new and existing treatments each year. NICE guidance would differentiate between different age groups only if there was a clinical reason to do so.

For older people's services, performance indicators have also been established to measure areas such as delayed transfers of care, emergency admission to hospital and emergency re-admission to hospital – these act as proxies for the quality of service provided and for how well whole-system working is operating.

1.1.3 Challenges

Older people are the biggest single users of the National Health Service in the UK. With the increasing size of the population over 65, there is an increasing demand for health services. The next generation of older people is also more consumer-oriented, and keener to ensure that services meet their needs. The challenge is to ensure the provision of good quality person-centred care, delivered at the right time, delivered seamlessly, and in a range of services that are convenient and as close to home as possible.

The UK Government is committed to ensuring that the NHS is reformed to meet the needs of the patient. The Government has recognised the case for a radically different relationship between health and social services to improve care for older people. The NHS Plan recognises the challenges that need to be overcome to tailor healthcare to the needs of older people, such as:

- targeted initiatives
- workforce development
- reducing delayed transfers of care between health and social care
- improving access to services
- integration of health and social care.

The Government is committed to this reform and the implementation of the NHS Plan through increased funding of an extra £1.4 billion, to be invested every year by 2004 in better health and social care services for older people.

In April 2002 *Delivering the NHS Plan* announced the next steps on investment and reform for the health service. For the NHS there is an annual average increase of 7.5 per cent above inflation over the five years 2003-04 to 2007-08. This is now the largest ever, sustained increase in NHS funding; and older people, the biggest users of the NHS, will be among the principal beneficiaries.

The Government has recognised the need to increase public spending on healthcare as part of the challenge to improve public services. Through general taxation, the UK Government will fund a 'catch-up' period to increase spending on healthcare to 9.4% of GDP by 2008. This would place the United Kingdom on a par with European levels of health spending.

In delivering on the Government's plans for good quality health care for older people, one of the key challenges is having enough appropriately trained staff. This is one of the issues being tackled in implementing the Older People's NSF – see below.

1.1.4 Planned policy changes

The UK Government has produced a ten-year programme of investment and reform to push through changes to the healthcare system. As explained above, in July 2000 *The NHS Plan* was published, and this set out a major package of investment to improve standards of care across the healthcare system. Following on from this, the *National Service Framework for Older People (NSF)* was published on 27 March 2001.

The *NSF for Older People* sets national standards specifically for the care of older people across health and social services. These standards apply whether an older person is being cared for at home, in a residential setting, or in a hospital. The four underpinning principles of the NSF are:

- person-centred care
- timely access to specialist care
- promoting an active, healthy life
- effective whole systems working.

The UK has some of the best specialist services for older people in the world with a solid evidence-base for their effectiveness. But these services are not uniformly available and access to them can be haphazard. By implementation of the requirements of the NSF, and meeting the milestones laid down, the Government will ensure that access to all health and social care services are consistent, timely, and appropriate to need.

The standards of the NSF cover: rooting out age discrimination, person-centred care, intermediate care services, general hospital care, stroke, falls, mental health and health promotion. More detailed information about the NSF is available if required.

1.2 Long-term care

1.2.1 Access to long-term care

State funding of long-term care in England is provided on a means-tested basis – following local authority social services departments' assessment of the individual's long-term care needs. This shares the responsibility for and the cost of care between the state and the individual. Nursing care is now free in nursing homes as in all other settings. This change benefits around 40,000 older people in England.

The support offered in Wales differs only in some minor respects from that available in England; for example the NHS nursing care contribution is a flat rate of £100 per week, and not a tiered system as it is in England.

Following devolution, the Scottish Executive has made a separate decision on the response to the Royal Commission on Long Term Care. Scotland introduced free personal as well as nursing care from 1 July 2002.

In Scotland, from 1 July 2002, those aged 65 or over in care homes and who meet their care home fees in full, will receive a contribution of £145, or £210, if they also need nursing care, towards these costs. Residents who contribute significantly towards their care home costs will also receive a contribution if the local authority is currently contributing less than the £145/£210. There will be no more personal care charges for people aged 65 or over being cared for in their own home. Regulations to implement this policy were made under the Community Care and Health (Scotland) Act 2002.

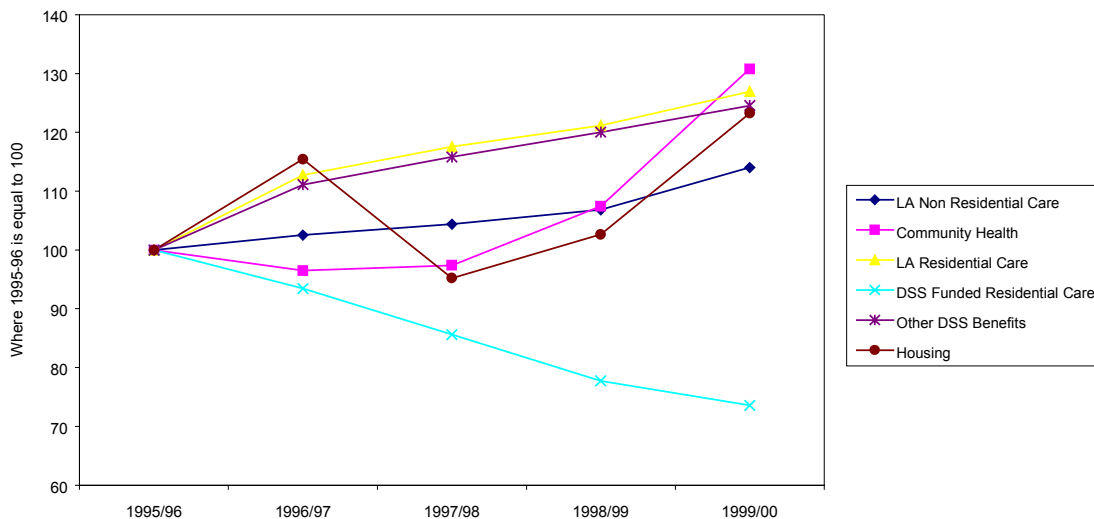
The Department of Health in England believes that rather than making personal care free, alternatives that are focused on improving the quality and delivery of care represent a better targeting of resources. Three quarters of those in residential or nursing home care already get some or all of their personal care costs met from public funds.

The Government is taking action on a number of fronts to reduce the costs of long term care for individuals, particularly by making nursing care free in all settings. They are also disregarding the value of people's homes from the means test for the first twelve weeks after permanent admission to a care home. This will benefit around 30,000 people each year. Extra resources are being provided to enable councils to offer deferred payments to residents in permanent residential care, benefiting around 5,000 people at any one time.

The latest Personal Social Services Research Unit estimate for long-term care expenditure for the UK for 2000 is around £13 billion. This comprises £8 billion public expenditure (NHS + PSS net) and £5 billion private expenditure (user charges + private purchase). The breakdown is roughly £9 billion for institutional services and £4 billion for non-residential services. The estimate relates to health and social services only. It is worth noting, however, that since 1995 Government policy has been to emphasise the alternatives to residential care and this has seen an increase in intensive home care packages. (See table below: details the changes to expenditure relative to 1995/96.)

Changes to expenditure relative to 1995/96

Figure 2.3.1
Expenditure on Community Care



1.2.2 Assessment

The Government is aware that significant numbers of older people stay longer in acute hospital care than is necessary or desirable, thereby risking premature loss of independence. Delayed transfer also reduces the capacity of the acute sector to respond to emergency pressures and increase elective activity.

Delayed transfer is not a new problem, but the proportion of older people who have to wait while their transfer is arranged has fallen steadily over the past four years. In October 2001 the Government announced an additional £300m for local authorities to tackle the causes of delay. This will provide for 2,300 fewer people prevented from leaving hospital when they need to during 2002/3.

The Government is proposing to introduce a Swedish style model of cross charging, whereby local authorities would be charged for the cost of an individual occupying a hospital bed if that individual had been assessed as being ready for transfer, and if the delay was the fault of social services.

The Service and Financial Framework Return (SaFFR) is used to monitor progress against targets included in the *NHS Plan* and *National Service Frameworks*. Delayed transfer is an interface indicator towards this, and is included in both NHS and PSS Performance Assessment Framework indicator sets. The target is to reduce absolute numbers of delayed transfers by a further 20% reduction in the rate of all delayed transfers from acute beds. This is equivalent to a reduction of approximately 1,000 blocked acute beds between March 2002-03.

In England, over 5,000 people each day are occupying acute hospital beds that could be better cared for elsewhere. The Department continues to monitor the numbers of people who are unable to leave hospital when they are ready to do so. As a result of extra investment, we expect to see many more people helped to leave hospital through the provision of extra care home places, extra intermediate care beds, and support for more people to return to their own homes.

The number of care home beds in England fell by 11,300 between March 2000 and March 2001 (a 2% drop) and the number of local authority supported residents decreased (for the first time since 1994) by 3,400 to 261,800. The Department's own figure show that since 1996/97 the total number of residential and nursing places/beds has fallen by 6,400. There was a fall of 9,500 nursing beds during the same period, but an increase of around 3,100 residential care beds.

The policy of the Department is to allow people to remain independent in their own homes wherever possible. Between September 1999 and September 2000, there was an increase of around 3,400 in the number of households receiving intensive home care (i.e., more than 10 contact hours and 6 or more visits during the week). There are now around 1.5 million people receiving care packages of all types in their own homes. Local authorities purchased or provided 2.8 million contact hours of home help or home care during a survey week in September 2000, an increase of 4% on 1999. Home help/home care contact hours have increased by 65% since 1992.

In England, there have recently been targets introduced for the speed at which individuals should receive social services assessments of their needs, in order to monitor this element of access to long-term care services.

1.2.2 Challenges

Providers of long-term care have consistently highlighted the low level of fees paid to them by local authorities. The Government is increasing the resources available for social services to enable local authorities to deliver the improvements to social services to which the Government is committed. This means that local authorities have the resources they need to purchase services from providers at realistic prices.

With this new funding, the challenge is to ensure that it is used by social services to provide the long-term care needed for the future, for the growing numbers of older people, including growing numbers of very frail elderly people who need intensive long-term care.

Within this general challenge, our main concern is to identify where there are hidden needs, making sure that sections of society such as informal carers, ethnic minorities and people suffering from mental illness are fully included in the development of policy.

1.2.3 Planned policy changes

We are taking steps to improve the way that local authorities currently commission care services. Through the publication last year of the *Building Capacity and Partnership in Care* Agreement, the Department of Health has spelt out how we expect commissioners and providers to work together with the mutual objective of providing excellent services that promote independence, self-esteem and social inclusion. The Agreement also spells out how central government can assist in this.

2. Quality

2.1 Health Care

2.1.1 Standards

Quality is at the heart of the UK Government's agenda for modernising the NHS. A set of new policies, programmes and structures have been introduced since 1997 which have created in the NHS, for the first time in its history, the conditions for a comprehensive approach to assuring and improving the quality of care and patient safety.

The basic elements of the NHS quality programme specify clear national standards to help raise standards of care and reduce unacceptable variations for specific treatments, conditions and for patient safety, through routes including the National Institute for Clinical Excellence (NICE), National Service Frameworks (NSF) and a National Cancer Plan. This involves modern organisational delivery mechanisms to implement national standards effectively, dependably and safely, co-ordinated through comprehensive clinical governance arrangements, and strong monitoring mechanisms, including the Commission for Health Improvement (CHI), the NHS Performance Assessment Framework, and national and local patient surveys.

There will be a new mandatory reporting scheme for adverse healthcare events, to help minimise patient risk and improve the quality and safety of care and measures to improve patients' experiences of NHS services, including greater patient and public representation and improved customer focus. This agenda is underpinned by the Health Act 1999, which places a statutory duty of quality on all NHS organisations that provide direct patient care.

The Government is also committed to strengthening patient choice. By 2005 all patients and their GPs will be able to book hospital appointments at both a time and a place that is convenient to the patient.

2.1.2 Assessment

The Department has made a commitment to provide both patients and the general public with more comprehensive, easily understandable information on the performance of their local health services. In September 2001 all non-specialist acute NHS Trusts were issued with performance ratings that reflect their performance during 2000/1.

For the first time hospitals are being ranked on their performance, with more freedom and rewards for the best and more help for the worst. NHS trusts have been rated according to their performance on the things that matter to patients such as waiting times and hospital cleanliness. This will help monitor and improve the quality of healthcare provided over time.

The Commission for Health Improvement (CHI) aims to improve the quality of patient care in the NHS. CHI is an independent body (an executive non-departmental public body) set up to provide advice and guidance to assist NHS organisations to improve the quality of care they provide. CHI conducts a rolling programme of local reviews that report on the adequacy of clinical governance arrangements, and they carry out investigations into serious service failures. The Commission also conducts national reviews into the implementation of National Service Frameworks (it will shortly be working with the Audit Commission and Social Services Inspectorate to look at the Older People's NSF) and the uptake of NICE guidance.

The National Care Standards Commission (NCSC) is responsible for regulating social care services and private and voluntary healthcare. To ensure consistency and quality of service provision, new national minimum standards have been developed for each of the services to be regulated. The Commission will ensure that all services meet these minimum requirements.

NCSC, in addition to the Audit Commission and the Commission for Health Improvement, plays an important and effective role in regulating and assessing healthcare performance. To improve the current fragmentation in the structure of NHS inspection the Government has announced its intention to establish a tough, new independent healthcare inspectorate, the Commission for Healthcare Audit and Inspection (CHAI).

CHAI will be fully independent from government and will focus its inspections on demonstrating accountability for the use of NHS and social care resources and to help identify how services can be improved for the benefit of patients and the public

2.1.3 Promoting quality enhancements

The *NSF for Older People* specifically addresses those conditions that are particularly significant for older people such as stroke, falls and mental health problems associated with older age. Implementation will also ensure that older people are supported by newly integrated services with a well co-ordinated, coherent approach to assessing individual's needs and circumstances and for commissioning and providing services for them.

Through the Single Assessment Process (SAP) older people can be assured that their needs are met in the round. It will focus assessment and care planning on helping older people maximise their independence and remain at home if that is their wish. It will make health and social services work together when assessing the needs of older people, in order to assess needs holistically, minimise duplication of assessment and share information effectively. In this way, older people can be assured that they will have access to suitable good quality practices.

Implementation of the Standards contained in the NSF will help to promote the value and quality of older people services. Monitoring of the milestones contained within the ten-year plan will ensure that the overall standard of care of older people will improve.

2.1.4 Challenges

The UK Government aims to re-shape the NHS around the needs of its users, the patients, to improve the delivery of quality health and social care. This is a major objective of the *NHS Plan* and involves reforms established to empower frontline staff and patients and change the culture and structure of the NHS.

On April 1 2002, England's 95 Health Authorities were abolished and the majority of their functions have been passed on to over 300 Primary Care Trusts (PCT).

The PCTs are thus now responsible for improving health, securing the provision of all health services and integrating health and social care. They are the 'cornerstone' of the NHS. The PCTs are 'local' organisations and are best placed to ensure that the local health service really reflects the needs of local communities.

There are also 28 'new' Strategic Health Authorities, each serving a population of approximately 1.5 million people, and their role is to create strategic frameworks and performance manage the local health service provided by the PCT. These changes are being introduced to shift responsibility for the provision of health care to a local level. In this way, decisions can be made closer to the patient. This follows very much the aims of the *NSF for Older People* to improve standards and for the needs of older people to be assessed in the round.

The current system of inspection and regulation for health and social services has evolved rapidly. But early experience is demonstrating that these arrangements are fragmented and involve several different organisations. This is burdensome on front-line staff and also creates a lack of clarity for the public. By creating the Commission for Healthcare Audit and Inspection (CHAI) the UK Government will rationalise the number of bodies inspecting and regulating health and social care and will reduce the burdens placed on front-line staff.

All these changes involve devolving decision making from the centre and empowering local staff best placed to identify local needs. This needs to be well managed to ensure that the quality and availability of services is not affected.

2.1.5 Planned policy changes

The NSF is a ten-year programme of improvement to raise the standard of health and social care of older people. Implementation of the NSF will improve the quality and range of services available to older people. The NSF is a living document and other conditions, such as arthritis and respiratory diseases, that are important to older people will be also be addressed. However there are other important health issues, around sight and hearing for example, and we are keeping these under review for the next priorities for action.

The Commission for Healthcare Audit and Inspection (CHAI) will be formed by bringing together the functions of the Commission for Health Improvement with the private healthcare-related functions of the National Care Standards Commission, and the Audit Commission's national value for money studies. CHAI will focus its inspections on demonstrating accountability for the use of National Health Service (NHS) and social care resources and to help identify how services can be improved for the benefit of patients and the public.

CHAI will have the following principal roles in improving the quality of services available (including those for older people):

- inspecting all NHS hospitals
- licensing private health care provision
- conducting NHS value for money audits on a national basis

- validating published performance assessment statistics on the NHS, including waiting list information
- publishing star ratings for all NHS organisations - with the ability to recommend special measures where there are persistent problems
- independent scrutiny of patient complaints
- publishing an annual report to Parliament on national progress on healthcare and how resources have been used.

CHAI will help to improve the quality of services for patients and ensure value for money is achieved in the NHS and social care services. Legislation to create the Commission for Healthcare Audit and Inspection (CHAI) is to be introduced as soon as UK parliamentary time allows.

The new Commission for Social Care Inspection (CSCI) – see below – will also be relevant to quality in some elements of health care provision for older people, for example in the provision of intermediate care beds in social care settings.

2.2 Long-term Care

2.2.1 Standards

The UK Government made a commitment to establish an independent inspection and regulation system for social and independent health care services. They set out their proposals in the White Paper *Modernising Social Services* and this was followed by legislation - *The Care Standards Act 2000*. This provided for the establishment of an independent national body, the National Care Standards Commission (NCSC), to regulate social care and also independent healthcare services.

Since 1 April 2002 the NCSC has been responsible for the regulation, (registration and inspection), of social services and private healthcare in accordance with national standards.

The NCSC took over the regulation of social care services and private and voluntary healthcare from local authorities and health authorities, as well as the inspection of the welfare arrangements in boarding schools. Registration and inspection of nurses agencies, domiciliary care services, residential family centres and local authorities' own adoption and fostering services is planned to come on stream later.

National standards are designed to ensure care provision is fit for the purpose and meet the assessed needs of residents. It is for the Commission to decide in the particular circumstances of each individual home whether the home conforms to the standards necessary to meet the assessed needs of its residents.

National standards apply to all providers across the country. They mean that providers are clear about the standards they have to meet to gain and maintain registration and users and their carers know what they can expect as a minimum.

The aim of the new regulatory arrangements is to drive up the quality of services and improve the level of protection for vulnerable people while safeguarding and maintaining good quality care homes.

2.2.2 Monitoring and promotion of quality

Under the *Care Standards Act 2000* the NCSC is responsible for regulating care services and independent healthcare in accordance with national minimum standards, to ensure consistency and improve the quality of life and level of protection of some of the most vulnerable people in society. National standards will promote better quality care and help prevent abuse by grounding practice in the principles of dignity, choice privacy and respect. The standards will guarantee residents access to an effective complaint procedure. It will also ensure that trustworthy and reliable staff cares for residents, and that they will have been properly trained for this difficult and sensitive job.

There are a number of different indicators used by the Department of Health to analyse performance in relation to long-term care. Performance Assessment has been developed to incorporate the requirements placed on local councils to deliver Best Value (BV). They are expected to ensure that their services are responsive to the needs of citizens, are efficient and of high quality and provided with a clear policy framework. Over a 5-year period, they are required to review all their services to consider new approaches to service delivery, and set demanding performance targets that will deliver continuous improvement. They have to prepare annual local performance plans.

The Social Services Inspectorate (SSI) liaises with local auditors on the social care aspects of performance plans and inspects whether BV reviews have been undertaken appropriately. BV is the driver to deliver on national and local priorities. The SSI monitors the performance of local councils in respect of all social services.

The Department also uses Performance Assessment Framework indicators that comprise an all round view of a council's performance for social services based on in-year Position statements, inspections and performance indicators.

2.2.3 Challenges

The main challenges facing the UK Government at the moment as we try to ensure the provision of quality long-term care are mainly recruitment and retention problems in the sector such as:

- the relatively high turn over of care staff in both care homes and domiciliary care.
- ensuring that commissioning is done on the basis of need and quality and not of cost.
- that care services available are tailored to need of the individual.

2.2.4 Planned policy changes

Policy changes are under review to strengthen the systems that are designed to ensure that people receive a good assessment sufficient to accurately identifying their needs, which will in turn lead to the provision of appropriate types of care.

We also intend to legislate to introduce a system of cross charging similar to that used in Sweden and Denmark. Under this system local authorities will use extra resources to expand their care at home and to ensure that all older people are able to leave hospital once their treatment has been completed and it is safe for them to do so. If councils are able to reduce the number of delayed transfers of care, they will have the freedom to use these extra resources to invest in alternative social care services. If they cannot meet the agreed time limit they will be charged by the local hospital for the costs in incurring in keeping older people in hospital unnecessarily.

In April, the Government announced plans to introduce a new Commission for Social Care Inspection. This will create a single comprehensive Inspectorate for social care, bringing together the inspection functions of the Social Services Inspectorate and the National Care Standards Commission and including the regulation of social care providers.

The Inspectorate will:

- carry out local inspections of all social care organisations – public, private, and voluntary – against national standards and publish reports
- register services that meet national minimum standards
- carry out inspections of local social service authorities
- publish an annual report to Ministers and Parliament on national progress on social care and an analysis of where resources have been spent
- validate all published performance assessment statistics on social care
- publish the star ratings for social services authorities
- undertake independent scrutiny of complaints.

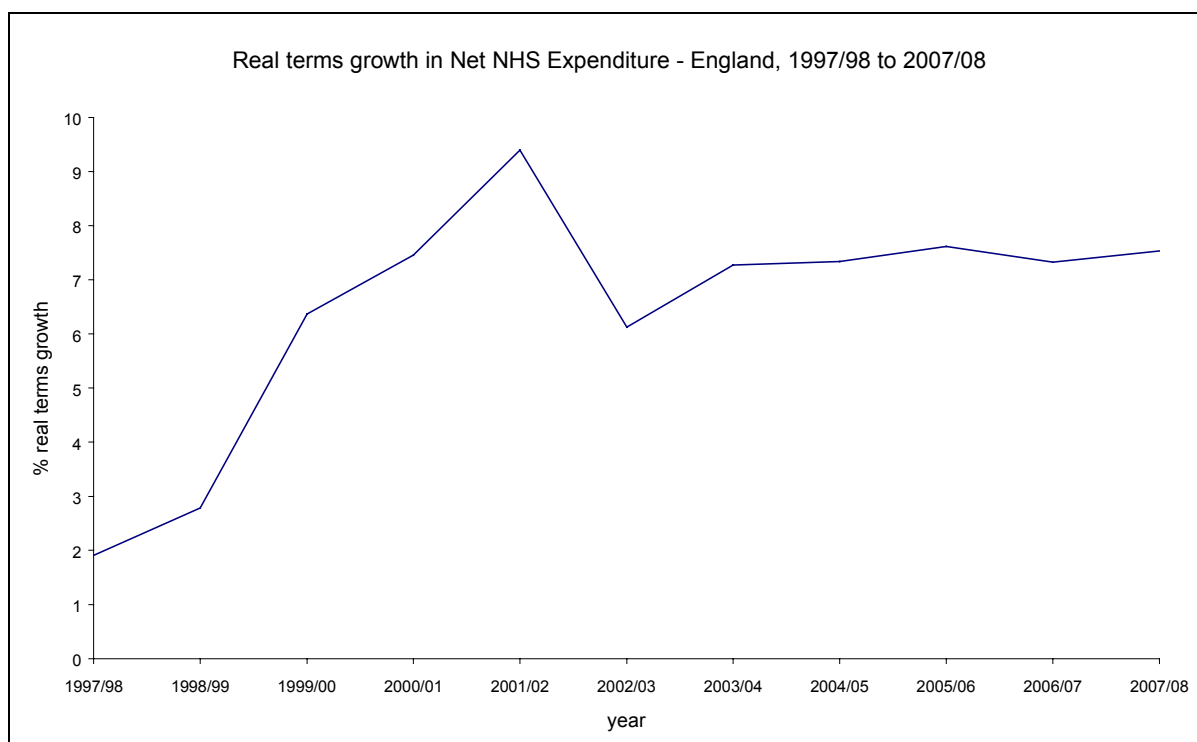
The new Inspectorate will have an important role in promoting good quality long-term care services for older people.

3. Sustainability

3.1 Health Care

3.1.1 Expenditure and financing

The 2002 UK Budget set out the largest sustained increase in funding of any five year period in the history of the NHS - an annual average real terms increase of 7.4% over the period. This fully meets the recommendations of the Wanless Review. This means that over the same five-year period, there will be an increase of £34 billion or 43% in real terms, from £56bn in 2002-03 to £90bn in 2007-08. The EU average share of GDP spent on health is about 7.7% in 2002-03. By 2007-08 we expect the UK share of GDP spent on health to be 9.4%.



Over the ten-year period from 1997/98 to 2007-08 (see above graph), the average annual real terms increase will be 6.9%.

The NHS is financed mainly through general taxation with an element of National Insurance contributions. It is estimated that around 92 % of gross NHS spending in England is met from these two sources, about 80 % from the Consolidated Fund, that is, from general taxation, and 12 % from the NHS element of National Insurance Contributions. The remainder of the NHS Expenditure comes from charges and receipts, including land sales and the proceeds from income generation schemes.

3.1.2 Expenditure trends

The Chancellor of the Exchequer commissioned an independent review of the cost of delivering a high quality health service. The review was led by Derek Wanless, the former Chief Executive of a major bank, and considered factors such as cost pressures from an ageing population. The Government's decision on the amount of funding to allocate to health services in the UK was informed by the recommendations of the Review, but this was done in the context staying within the Government's fiscal rules.

3.1.3 Cost control mechanisms

The majority of National Health Service spending is limited by a fixed budget constraint. The Government has announced a range of reforms to improve the performance and value for money of the NHS. This includes stronger incentives for good performance, greater diversity in supply of services, devolution of control for the appropriate decisions, and stronger audit and accountability arrangements.

3.1.4 Challenges

The NHS is in a process of growth and reform. Expenditure is growing at record levels, but the Government expects to see radical improvements in the quality of services. The key challenges are to improve access (e.g. reduce the maximum waiting time for inpatient care to six months by 2005), to increase choice (e.g. allow patients the choice of time and place of treatment), and improve quality (e.g. reduce deaths from cancer and heart disease).

3.2 Long-term Care

3.1.1 Expenditure and financing

The Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) has estimated total expenditure on long-term care services for older people in 2000 at around £13 billion for the UK. This comprises:

- around £3.6 billion NHS expenditure on long stay hospital care, nursing home care, day hospital care and community health services;
- around £4.4 billion net social services expenditure on residential care, nursing home care, home care, day care and other non-residential services;
- around £2.7 billion client contributions in charges for residential and non-residential social services
- around £2.3 billion private expenditure on purchase of residential care and home care services (estimate subject to some uncertainty).

This estimate does not include social security disability benefits, funding of special housing facilities or the opportunity costs of informal care.

There are in general no special funding arrangements for long-term care for older people. Health services – acute and long-term – are funded mainly from general taxation. Social services are funded from a combination of user charges, local taxation and grants from

central government. The main grant from central government is not hypothecated: local authorities are free to determine their own breakdown of expenditure between social services and education etc. There are also some specific grants and special grants, such as the Promoting Independence Grant and Carers Grant, which are hypothecated for specified long-term care purposes.

3.1.2 Cost control mechanisms

There are user charges for social services but not for health services for older people (other than for dentistry). The user charges for social services take account of the person's income and assets. They are not intended to deter people assessed as requiring care from receiving the care they need.

The Department of Health has commissioned research on the relative costs and cost-effectiveness of different types of long-term care. The PSSRU at the University of Kent has conducted a range of studies, including a substantial recent evaluation of community care for elderly people.

Arrangements for managing social services budgets vary between local authorities. In some areas budgets are devolved to local care managers. This can give care managers an incentive to give careful consideration to the relative costs and cost-effectiveness of different forms of care.

It is important that cost-effectiveness studies should consider the full costs of the different types of care under investigation. Studies, such as the PSSRU evaluating community care study, have collected data on the costs of a range of services used by their samples of service recipients

3.1.3 Challenges

The Department of Health has commissioned the PSSRU at the London School of Economics to conduct a study of long-term care funding. The study has involved the development of a model to make projections of future demand long-term care for older people and associate public and private expenditure. This work contributed to the UK projections for the EPC.

Projections produced by the PSSRU show that there is a wide range of uncertainty around projected future expenditure on long-term care for older people in the UK. Different scenarios investigated by PSSRU show projected long-term care expenditure rising slightly as a proportion of GDP, falling slightly or rising significantly, depending on key assumptions. Projections of future demand are particularly sensitive to assumptions about future mortality and dependency rates but less sensitive to assumptions about the future pattern of household composition. Projections of expenditure are highly sensitive to assumptions about future rises in the real unit costs of care.

3.1.4 Planned policy changes

The four constituent countries of the UK have all made recent changes to their means test for social services. These changes are in response to the recommendations of the Royal Commission on Long Term Care. The Commission recommended that nursing care and personal care should be free of user charges.

Scotland instituted free personal care and nursing care in all settings from July 2002. England instituted free nursing care in all settings from October 2001 but not free personal care. Wales and Northern Ireland have also instituted free nursing care.