Appendix A

HOUSE OF LORDS

Select Committee on Public Service and Demographic Change

Report of Session 2012–13

Ready for Ageing?

Report

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The Select Committee on Public Service and Demographic Change

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

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See Appendix 1.
A full list of Members' interests can be found in the Register of Lords' Interests:
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Ready for Ageing?

REPORT

Introduction

1. The UK population is ageing rapidly, but we have concluded that the Government and our society are woefully underprepared. Longer lives can be a great benefit, but there has been a collective failure to address the implications and without urgent action this great boon could turn into a series of miserable crises.

2. The Committee focused on the implications of an ageing population for individuals and public policy in the near future, the decade 2020–2030. Key projections about ageing include:

   - 51% more people aged 65 and over in England[1] in 2030 compared to 2010
   - 101% more people aged 85 and over in England in 2030 compared to 2010[2]
   - 10.7 million people in Great Britain can currently expect inadequate retirement incomes[3]
   - over 50% more people with three or more long-term conditions in England by 2018 compared to 2008[4]
   - over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.[5]

3. Longer lives represent progress, and the changes do not mean a great economic or general fiscal crisis.[6] Moreover the contribution to our society made by older people, which is already impressive, will be even greater as a result: 30% of people aged over 60 volunteer regularly through formal organisations.[7] However, as well as opportunities, the changes create major challenges for individuals, for employers, for our welfare services, and for the Government and all political parties. Others have looked at aspects of these changes, but the Committee's approach was holistic: surveying the landscape to highlight key issues for our society and encourage public debate.

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

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

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

4 The King's Fund, supplementary written evidence.

5 Professor Carol Jagger, Newcastle University.

6 See Annex 4.

7 See Annex 3.

4. To make a success of these demographic shifts, major changes are needed in our attitudes to ageing. Many people will want or need to work for longer, and employers should facilitate this. Many people are not saving enough to provide the income they will expect in later life, and the Government must work to improve defined contribution pensions, which are seriously inadequate for many. People need help to make better use of the wealth tied up in their own property to support their longer lives.[8]

5. The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall, the quality of healthcare for older people is not good enough now, and older people should be concerned about the quality of care that they may receive in the near future. England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population. Further fundamental reform to the NHS in the next few years would be undesirable, but radical changes to the way that health and social care is delivered are needed to provide appropriate care for the population overall and particularly for older people, and to address future demand.[9]

6. Social care and its funding are already in crisis, and this will become worse as demand markedly increases. The split between healthcare and social care is unsustainable and will remain so unless the two are integrated. Sufficient provision of suitable housing, often with linked support, will be essential to sustain independent living by older people.[10]

7. An ageing society affects everyone: these issues require open debate and leadership by the Government and all political parties. The challenges are by no means insuperable, but no Government so far has had a vision and coherent strategy; the current Government are no exception and are not doing enough to ensure our country is ready for ageing.[11]

How will we support ourselves through later life?

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

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8 See Annexes 3, 5, 8, 7 for each point.

9 See Annexes 9 and 10, 12 to 14, 13, 12 to 14 for each point.

10 See Annexes 9 and 10, 12, 16 for each point.

11 See Annexes 7 and 18.

Later working

9. By 2030, men aged 65 in the UK will expect to live another 23 years, to 88, and women another 26 years, to 91.[12] As people live longer they will need enough income to support a good quality of life; it would be naive to think that this can simply come from taxpayer-funded sources. But many are not saving enough to pay for a decent standard of living over a much longer retirement. People should therefore be enabled to extend their working lives if they wish to do so, as a vital part of the response to increased longevity.[13]

10. Working for longer would increase income from work, potentially increase savings, and reduce the time of dependence on those savings. Working for longer can often improve health and brings social and intellectual benefits. More people working for longer also help sustain economic growth and improve the country's fiscal position. Employing older workers can benefit employers by using the experience and knowledge of people who still have much to contribute.

11. Making working for longer possible will require changes to attitudes, as well as policy and practice (more fully explored in Annex 5):

- The Government and employers need to work to end 'cliff-edge' retirement, by enabling more people to work part-time and to wind down work and take up pensions flexibly. It should be beneficial to defer taking state and private pensions. Employers need to be much more positive about employing older people. The Government should publicly reject the 'lump of labour fallacy' that wrongly argues this will disadvantage the young.
- We must abandon the idea of a fixed retirement age implicit in many pension structures, employment practices, and tax and benefit thresholds: people should decide for themselves how and when they retire. Incentives in the tax, benefit and pensions systems to retire early should be reviewed.
- Employers should help older people adapt, re-skill, and move to more suitable roles and hours when they want to do so, and should support those with caring responsibilities for older people to work part-time or flexibly.
- The Government should, with employers, help support those in manual or low-skilled jobs, who might need to work longer but have most difficulty in doing so. Welfare to work policies should also address the needs of older people.
- Age is no longer a good indicator of people's needs or income, so the Government should review whether age alone is a sensible determinant for tax liability, access to services or benefits.

Reforming pensions and savings

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

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

[13] See Annexes 4 and 5.

[14] Department for Work and Pensions, *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

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

13. But despite this, the current system of state and private pension provision is not adequate as many people, young and old, expect far more pension than they will get. While the poorest will be protected at a basic level by state provision, and the richest can afford to save enough in private schemes, there is a substantial gap for much of the rest of the population.

14. Under the current defined contribution pensions system, the individual does not know what income the pension will provide and therefore what he or she is saving for. Defined contribution pensions now dominate private pension provision, with risks and uncertainties, and are inadequate for many, especially women.

15. The Committee has concluded:

- The Government were right to raise the state pension age, but they are now adopting a timetable of increases slower than that recommended by the Turner Commission and will have to revisit this with rising healthy life expectancy. Those who work beyond state pension age should clearly benefit if they defer taking their pension.
- Auto-enrolment is a big step forward for people who would otherwise not be saving for a pension. However, while helpful, auto-enrolment alone will not solve the problem of under-saving. The scale of pension saving encouraged by this scheme, eventually 8% of an individual's earnings, will still result in a pension significantly below many people's expectations unless people save considerably more in addition.
- But saving more is made less likely as the current defined contribution pensions system is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.
- **The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contribution pensions and address their serious defects to make it clearer what people can expect to get from their pension as a result of the savings they make.**

Using the value in our homes

16. Many older people have seen the value of their homes increase considerably but have not viewed this as a partial solution to some of the challenges of living longer. The Committee considers that it is reasonable to expect those who have benefited in this way to support their own longer lives. People need to be able to use their assets to help pay for the cost of their social care, and to release money to adapt their homes and to support their incomes. Some schemes exist, but are little used.

17. **People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with the financial services industry to ensure such mechanisms are**

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

Living independently and well

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

Increasing pressures on health and social care

19. **The NHS is facing a major increase in demand and cost consequent on ageing and will have to transform to deal with this. Because of this rising demand, without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably.**

20. A rapidly ageing society means many more older people living for more years, often with one or more chronic long-term health conditions; a consequence of this and other pressures is a large increase in health and social care costs. Predicted increases in demand for health and social care from 2010 to 2030 for people aged 65 and over in England and Wales include:

- people with diabetes: up by over 45%
- people with arthritis, coronary heart disease, stroke: each up by over 50%
- people with dementia (moderate or severe cognitive impairment): up by over 80% to 1.96 million
- people with moderate or severe need for social care: up by 90%.[16]

21. The treatment and care of people with long-term conditions accounted for 70% of the total health and social care spend in England in 2010, so the large increases in the number of older people with long-term conditions will create significant extra costs.[17]

22. The Nuffield Trust has recently estimated that under the current healthcare system, the NHS in England will see a funding shortfall of £54 billion by 2021/22 if NHS funding remains constant in real terms, if no productivity gains are made, and if trends continue in current hospital utilisation by people with chronic conditions and in healthcare costs.[18] If the English NHS achieves unprecedented productivity gains of 4% a year in every year from 2010/11 to 2014/15, they predicted that this funding gap would be reduced to a potential shortfall of £34 billion. For comparison, the total budget for

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

16 Professor Carol Jagger, Newcastle University.

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

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

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

23. At the same time, public expenditure on social care and continuing healthcare for older people may have to rise to £12.7 billion in real terms by 2022 (an increase of 37% from £9.3 billion in 2010), just to keep pace with expected demographic and unit cost pressures (see Annex 10).[21]

24. Social care funding is already in crisis, and this will become worse as demand markedly increases. Many people needing social care now are not getting it as eligibility thresholds are tightened because of reduced local authority funding (see Annex 10). The Government's response to the proposals made by the Commission on Funding of Care and Support (the Dilnot Commission) is welcome and necessary but in our view will not be sufficient because it will largely benefit higher income groups by protecting them from depleting their housing assets rather than address the current funding crisis (see Annex 11). It does not bring extra funding into the system to tackle the current funding crisis or address the problem of expanding need in the coming decades—although we acknowledge that this was not the task given to the Commission.

25. There should be a sharing of responsibility for social care between individuals and the state. The implementation of the Dilnot Commission proposals makes this sharing explicit and puts a limit on individual risk. But many people do not have families who can provide care, nor the money to buy it, and cannot cope without care—and this situation will worsen as demand rises (see Annex 10). If the neglect of social care continues and these people are not properly supported in the community, they will end up with more severe needs, or will suffer crises and go into hospital, driving up healthcare costs.

Care at home—whenever possible

26. The Committee received expert evidence that a new system of health and social care is needed to:

- be more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration, with much less use of acute hospitals (see Annex 12)

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

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

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

- be centred on the individual person, with patients engaged in decisions about their care and supported to manage their own conditions in their own homes so that they can be prevented from deteriorating
- have the home as the hub of care and support, including emotional, psychological and practical support for patients and caregivers
- ensure older people only go into hospitals or care homes if essential, although they must have access to good specialist and diagnostic facilities to ensure early interventions for reversible conditions and prevent decline into chronic ill health.

27. A remarkable shift in NHS services will be needed to deliver this. Older people with long-term conditions need good, joined-up primary care, community care and social care, with effective out-of-hours services. Such services make it possible to minimise hospital stays. Time in hospital is often not what older people want or need, and is expensive.

28. This shift in NHS services would help move demand, and funding, from acute and emergency services (which consume nearly half of the NHS's budget[22]). This should allow more investment in services which prevent older people from going into hospital. Some of this released funding should flow into improving social care. It is obvious that if more older people could be treated in the community rather than admitted to hospital, expenditure on hospitals could be reduced. Improving the quality of hospital-based treatments through specialisation and rationalisation would also raise standards.

29. **To meet the needs of the population, and to achieve this shift in services, the health and social care system needs to work well 24 hours a day, seven days a week.** The Committee was heartened by the Secretary of State for Health's commitment to a 24/7 NHS, and calls on him within 12 months to set out how this will be made real. For this to have value, there will also have to be 24/7 community-based healthcare and social care.

30. **The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently. The Government and all political parties will need to rethink this issue.** We note the Government's commitment to introduce a national minimum eligibility threshold for social care from 2015: we consider that the consequence of this must be that the Government will address the public funding needed to make it possible, but we consider that health and social care integration is the longer-term solution for social care funding. **The health and social care systems also have to plan more systematically for changing long-term needs, so the Government should consider introducing a 10-year spending envelope for the NHS and publicly-funded social care.**

31. **The Government need to develop a new basis for health and social care for our ageing population and create a vision so that other decision-makers can work to bring it about.** Ministers told us the Government do not believe in top-down command and control, and that the

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

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

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

Personalised care

33. The local delivery of health and social care does not serve older people well: services operate independently of each other and are peppered with negative incentives. The Committee congratulates heroic professionals such as those in Torbay and the North West London Integrated Care Pilots who are striving to make this poor system function.

34. The Government must act now to challenge the barriers that make it difficult for professionals to deliver the kind of personal, integrated care that our older population wants, such as by doing away with restrictions on sharing data between care professionals, and encouraging less risk-averse attitudes. This will require support for a transparent, good quality market in privately provided social care (see Annex 14). The Committee heard exciting examples of how person-centred commissioning, a single point of contact for care, pooled budgets, new payment systems and new technology can bring improvement. A culture that facilitates experimentation is needed, so that local authorities and clinical commissioning groups are pushed to innovate to find the best local solutions.

35. Publicly funded care alone has never met all the needs of older people who are frail, vulnerable, ill or isolated. As our society ages, more informal care from family and friends will be required, and more volunteers. The number of disabled older people in households receiving informal care in England will need approximately to double over the next 20 years so the Committee calls for employers to make it easier for employees to provide informal care (see Annex 5), and for the Government to promote how crucial this is.[23]

36. Older people contribute greatly to society, including through volunteering and informal care. Increasing lifespans offer a great opportunity for older people to play an even greater role in public life (see Annex 15). We recognise the very valuable work already done by a number of charities to support older people. **Central and local government should work together with the third sector to increase volunteering especially by older people to support older people.**

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[23] Central Government (DoH, DWP and DCLG), written evidence.

Housing and wider public services

37. A better health and social care system to support people to stay living independently needs adequate housing and support in the home. The work done by housing adaptation and repair charities is commendable, but needs to become universal. The housing market is delivering much less specialist housing for older people than is needed. **Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people** (see Annex 16).

38. Other services such as urban planning, banking and product design will need to adjust to an older population and an older consumer base, and will have an important role in preventing the social isolation of older citizens. Older people must be involved in their design (see Annex 17).

Fairness

39. There are likely to be considerable increases in public and private spending over the next two decades on services that are particularly important to older people: healthcare, pensions and social care. This is not a bad thing; over time, an increasingly affluent society (as, on the whole, we expect to become) is likely to want to spend more on improving the lives of its citizens, and an older society is likely to want to spend more on the priorities of older people. This increased spending can only be financed by individuals directly, or through taxes, social insurance, or cuts elsewhere: it must be financed fairly.

40. The welfare state has largely meant people paying in when they are young and drawing out when they are older; this should continue. But we have to be wary of shunting too many costs onto younger and future generations. In particular, the property boom has led to a very large transfer of wealth to older, better-off homeowners, which has increased housing costs substantially for younger generations. Younger generations will benefit from being part of a richer society in many ways in the future, but they will also have to service large public and personal debts and may often have poorer pensions (see Annex 7).

41. It does not seem fair to expect today's younger taxpayers—especially those not born to better-off parents—to pay more for the increased costs of an older society while asset-rich older people (and their children) are protected. For this reason too, an effective equity release market to unlock the housing assets held by older people is important.

42. Fairness within generations is also important: people's later lives are affected by their socio-economic background, and men's and women's experiences of older age are markedly different. Older women are the primary users of health and social care and particularly lose out when it comes to pensions (see Annex 7). These divergences must be taken into account.

43. There is a potential for inequalities in our society to increase considerably as the population ages because of inequalities in health, savings and pensions, with a growing divergence between those for whom longer life is comfortable and those for whom living longer involves greater exposure to risks while they have few assets to draw upon.

Are the Government ready for ageing?

44. The Cabinet has not assessed the implications of an ageing society holistically, and has left it to Departments who have looked, in varying degrees, at the implications for their own policies and costs. The Government have not looked at ageing from the point of view of the public nor considered how policies may need to change to equip people better to address longer lives.

45. The ageing of the population is inevitable, and affects us all. The major changes this Report proposes may take a decade to bring about, and should inform the priorities for the next spending review. The Government must make the case to the public as to why changes are needed. If a government tries to move some age-related benefits onto different eligibility criteria without setting out a vision for our old age and committing to make major improvements in some areas, significant opposition would be inevitable. Our society is intelligent and pragmatic and is capable of understanding the arguments for change.

46. **The Government should set out their analysis of the issues and challenges, and their vision for public services in an ageing society, in a White Paper to be published well before the next general election.** There needs to be cross-party understanding of the importance of these choices, and an effort to seek as much consensus as possible. Progress will not be made if the solutions chosen by the Government change with each administration. So **the Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations: one to work with employers and financial services providers to examine how to improve pensions, savings and equity release, and one to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing population. Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation. We also conclude that when political parties are working on their manifestos, they ought to consider the wider implications of the ageing society for the balance of responsibilities between individuals and the Government.**

Principal conclusions and recommendations

47. **The Government and employers need to work to end 'cliff-edge' retirement, by enabling more people to work part-time and to wind down work and take up pensions flexibly. It should be beneficial to defer taking state and private pensions. Employers need to be much more positive about employing older people. The Government should publicly reject the 'lump of labour fallacy' that wrongly argues this will disadvantage the young** (paragraph 11)**.**

48. **The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contribution pensions and address their serious defects to make it clearer what people can expect to get from their pension as a result of the savings they make** (paragraph 15)**.**

49. **People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with**

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

50. **The NHS is facing a major increase in demand and cost consequent on ageing and will have to transform to deal with this. Because of this rising demand, without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably** (paragraph 19).

51. **To meet the needs of the population, and to achieve this shift in services, the health and social care system needs to work well 24 hours a day, seven days a week** (paragraph 29).

52. **The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently. The Government and all political parties will need to rethink this issue** (paragraph 30).

53. **The Government must set out the framework for radically transformed healthcare to care for our ageing population before the general election in 2015. All political parties should be expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 election** (paragraph 31).

54. **Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people** (paragraph 37).

55. **The Government should set out their analysis of the issues and challenges, and their vision for public services in an ageing society, in a White Paper to be published well before the next general election** (paragraph 46).

56. **The Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations: one to work with employers and financial services providers to examine how to improve pensions, savings and equity release, and one to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing population. Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation. We also conclude that when political parties are working on their manifestos, they ought to consider the wider implications of the ageing society for the balance of responsibilities between individuals and the Government** (paragraph 46).

ANNEX 1: OVERVIEW OF OUR WORK

57. The Committee on Public Service and Demographic Change was appointed by the House on 29 May 2012 "to consider public service provision in the light of demographic change, and to make recommendations".

58. We decided to focus our work on ageing because it is the most substantial demographic change underway, will affect the whole population, and will have wide-reaching implications for individuals, public policy and public services.

59. The United Kingdom population is ageing rapidly. The Office for National Statistics (ONS) has projected that in England in 2030, compared to 2010, there will be 51% more people aged 65 and over, and 101% more people aged 85 and over.[24] This shift will have major implications for society's attitudes and expectations and for the demands placed on many important services for the public, as well as for their affordability and the way they are delivered.

60. Our focus has been on the impact of ageing on public services in the medium term, looking ahead to 2020 and to 2030. Looking ahead by seven to 17 years gives enough distance to make the changes that are happening clear, yet this period is within the scope of realistic planning and allows for shifts in public policy and services to be made soon.

61. Many aspects of health services, social work and housing policy, along with other relevant public services, are devolved to the legislatures of Scotland and Wales, and transferred in the case of Northern Ireland. For this reason, the main focus of this Report is on England. However, many of the issues that we have highlighted apply throughout the United Kingdom.

62. The annexes that follow lay out in more detail the evidence that underpins the findings in our Report. They are designed to show how we came to our conclusions; highlighted in bold text are key findings relating to the proposals that we make in the Report. In the course of our inquiry, we heard oral evidence from 67 witnesses, and received a large quantity of valuable written evidence.

63. We are grateful to the many individuals and organisations that assisted in our work, and to the academics who undertook specific analyses for us.

64. We are particularly grateful to our Clerk, Susannah Street; our Policy Analysts, Tristan Stubbs and Tansy Hutchinson; our Specialist Advisers, Professor Howard Glennerster and Mr Jonathan Portes, for their expertise and guidance throughout this inquiry; and our Committee Assistant, Bina Sudra.

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24 Central Government (DoH, DWP and DCLG), written evidence.

ANNEX 2: DEMOGRAPHIC CHANGES (RELEVANT THROUGHOUT THE REPORT)

65. The Office for National Statistics (ONS) has updated its projections up to 2021 based on the recent release of data from the 2011 Census. In England[25] in 2021, compared to 2011:

- There will be 24% more people aged 65 and over
- There will be 39% more people aged 85 and over.[26]

66. The ONS has projected that in England in 2030, compared to 2010:

- There will be 51% more people aged 65 and over
- There will be 101% more people aged 85 and over.[27]

67. Looking further into the future, Guy Goodwin, Director of Population and Demography Statistics, ONS, told us that over a 50-year period we can expect a doubling of the population in the UK aged over 65, and a very substantial—four times or more—increase in the main projection of those aged 85 and over.[28]

68. These demographic shifts are occurring for two different reasons. First, people are living longer; secondly, we are now reaping the consequences of significant changes in the UK's birth rates in the period following the Second World War—the 'baby boom'. The first is a long-run phenomenon. The second is beginning to hit now, and will last for around the next 30 years (see figure 1 below).

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

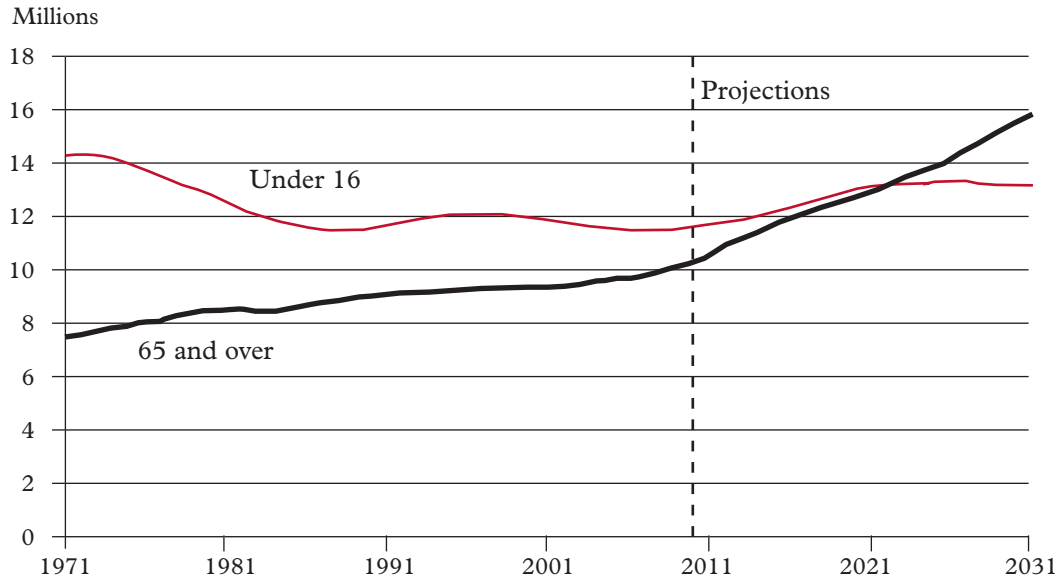
26 ONS, *Interim 2011-based subnational population projections: local authorities, counties, regions and England: single years of age, persons*.

27 Central Government (DoH, DWP and DCLG), written evidence.

28 Q 19

FIGURE 1

Population aged under 16 and 65 and over, United Kingdom[29]



Living longer

69. The same dynamics that have led to a higher proportion of older people in the population have also yielded a steady rise in our expectation of life at birth and at later ages. There are two principal methods to predict future life extensions: period life expectancy and cohort life expectancy. Period life expectancy assumes that a person will experience the age-specific mortality rates that hold at that time. The cohort method takes the predicted changes in those rates and builds them into the prediction. We have used the cohort method below, as it provides a more useful description of the length of life that individuals might expect.[30]

70. Babies that were born in 2011 can expect a median lifespan of 93.75 years for males and 96.7 years for females. Males born in 1991 can expect to live, after 2011, for another 71.0 years and females for another 74.3 years.[31] Professor Sarah Harper, Professor of Gerontology and Director, Oxford Institute of Population Ageing, University of Oxford, told us that if we use cohort life expectancy for the 2007-birth cohort, "you can say that 50% of that cohort will still be alive by the time they are 103".[32]

Confidence in projections

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

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

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

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

32 Q 101

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

Healthy life expectancy and disability-free life expectancy

Healthy life expectancy

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

33 Q 100 (Simon Ross, Population Matters).

34 Professor Philip Rees, University of Leeds.

35 Professor Philip Rees, University of Leeds.

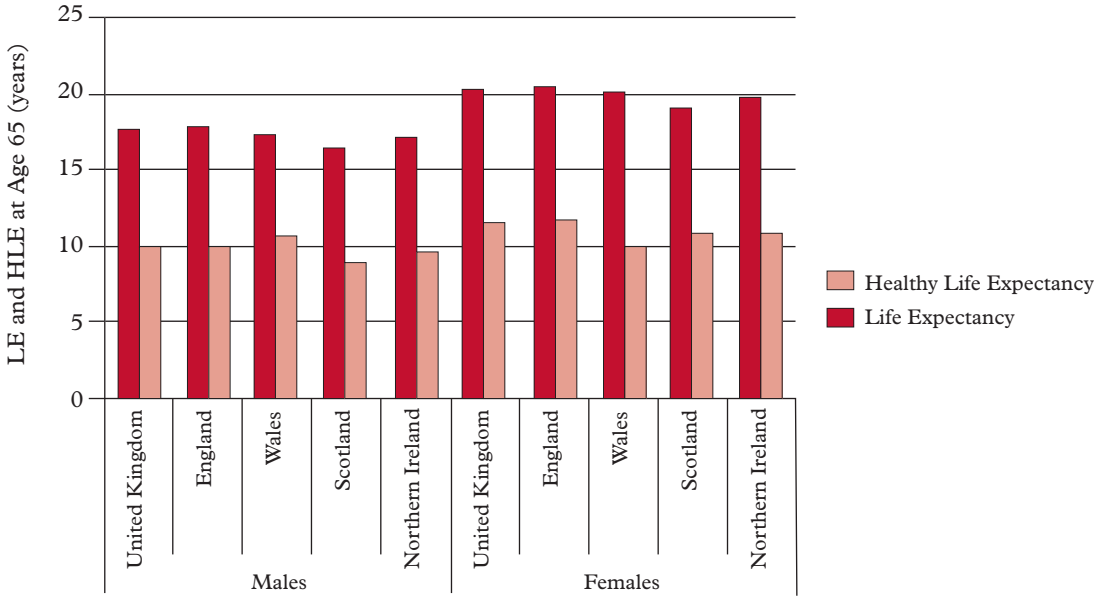
36 ONS, *Pension Trends*, Chapter 3: Life expectancy and healthy ageing (2012 edition), 16 February 2012, 3-4. It should be noted that due to European Union requirements, the definition of healthy life expectancy has changed recently: the definition formerly was based on expected years of 'fairly good'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

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

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

FIGURE 2

Life expectancy and healthy life expectancy at age 65 for males and females (for the period 2007–09) with the UK's constituent countries[39]



Source: Government Actuary's Department

Disability-free life expectancy

73. Disability-free life expectancy is defined as expected years of remaining life free from a limiting long-standing illness or disability.[40] Professor Harper suggested that international data supported the notion that people were "delaying the onset of disability". This meant that while life expectancy had increased, the number of years that people spend with disability had also increased. Thus, although people are seeing an increase in the number of years that they will spend with disability, this is decreasing as a percentage of their life.[41]

74. Drawing on a range of projections, Professor Rees found that population ageing will increase the population suffering from limiting long-standing illness by 39% between 2010 and 2050, but that if the decreasing trends of the last decade are reproduced in the next four decades, the increase will be clawed back to 6%.[42] Professor Rees also stressed that taking into account the specific disability suffered is very important. A significant challenge will arise from the projected growth in numbers of people with dementia. An 83% increase in the number of people with dementia by 2036 will place substantial extra demands on formal and informal care networks.[43] The Trades Union Congress (TUC) reported that the difference between the local authority areas with the highest and lowest levels of disability-free life

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

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

41 Q 95

42 Professor Philip Rees, University of Leeds, supplementary written evidence.

43 Professor Philip Rees University of Leeds.

expectancy at 65 is 12.1 years for men, and 12.3 years for women (see Annex 7).[44]

Effect on length of working life and active ageing

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

Past changes in fertility

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

Effect on the old age support ratio (OSR)

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

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44 Trades Union Congress (TUC).

45 Professor Peter Taylor-Gooby, University of Kent.

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

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

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

49 Central Government (DoH, DWP and DCLG), written evidence.

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

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

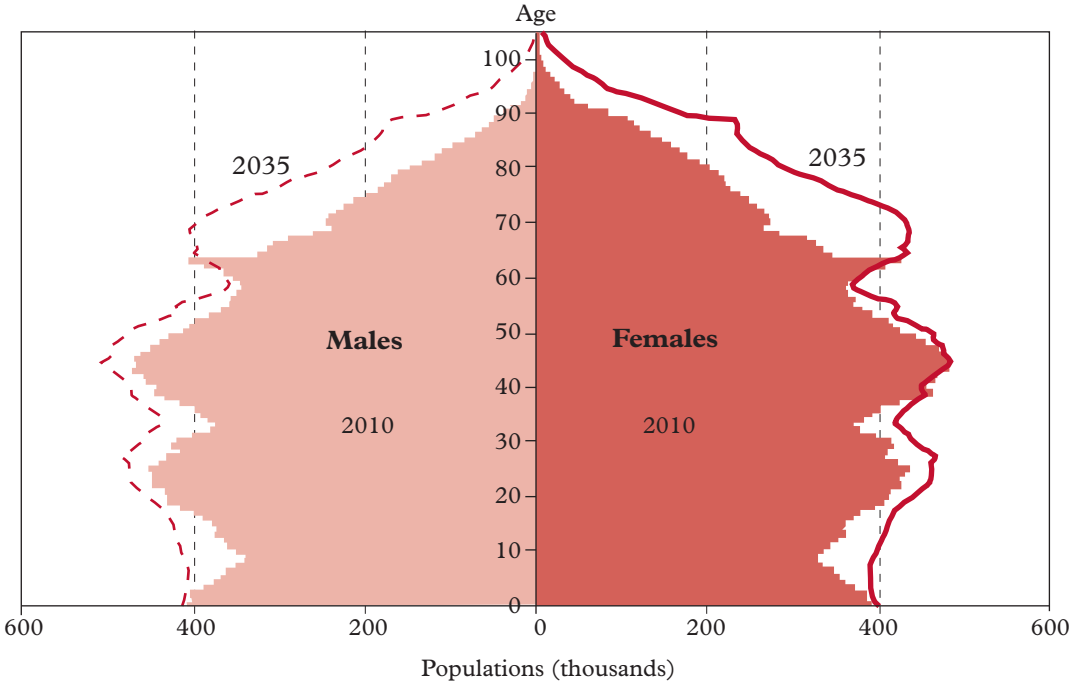
52 ONS, *National Population Projections, 2010 - Based Statistical Bulletin*, 26 October 2011, http://www.ons.gov.uk/ons/dcp171778_235886.pdf; Professor Philip Rees, supplementary written evidence. These figures take into account projected changes to the state pension age, and as such are very sensitive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

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

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

FIGURE 3

Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035[55]



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

Policy implications of demographic shifts

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

53 Central Government (DoH, DWP and DCLG), written evidence.

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

55 ONS, National Population Projections, 2010-Based Statistical Bulletin, 26 October 2011.

56 Professor Philip Rees, supplementary written evidence; Q 96.

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

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

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

82. For most people, living longer is to be celebrated. Many people now enjoy fuller retirements than ever before, or continue to work well into their later life. Older people make a considerable contribution to society, bringing maturity and varied life experiences to bear.[57]

83. People's definitions of what it means to be 'old' have changed, along with ideas about how dependent older people are. For a lot of people, being 'old' is a state of mind related to health and the ability to remain independent. The public does not necessarily associate being 'old' with retirement or the earlier 60s. Yet this is the age at which many public services, such as the free bus pass and winter fuel payments, are automatically handed out. Britons do not see themselves as elderly until they are approaching 70, and many in their 70s and beyond continue to be active and engaged in society.[58]

84. If being 'old' does not begin at an arbitrary age, perhaps it should not be associated with birthdays at all.[59] Society should move away from thinking about chronological age. Baroness Greengross, Chief Executive, International Longevity Centre-UK (ILC-UK), told us that society should "stop thinking about age itself as some sort of disease or handicap".[60]

85. Employers often equate older age with retirement, and policy-makers tend to assume that when people reach traditional retirement age, they will need to be supported by younger taxpayers (see Annex 4). Age UK considered that there is "a tendency for people, including politicians and policy makers, to frame the debate on ageing within a dependency narrative which sees older people as a 'burden' and a 'drain on the public purse'".[61] Yet there is no reason why retirement and dependency should relate to a specific age. Much employment is physically less demanding than it traditionally was for many, and fewer people are incapacitated by diseases in later life. Society, the media, and policy-makers should continue to rethink what they mean when they refer to 'old age'. Older age should be viewed as a spectrum, involving a smooth transition through different stages of life.

86. The Government have acted to legislate against age discrimination, through the Equality Act 2010 and the public sector equality duty which require equal treatment in access to employment and public and private services regardless of age. They have also abolished the default retirement age, so that retirement ages can only be set where they can be justified objectively.[62] We welcome these positive steps, but we also heard that negative attitudes and discrimination towards older age still abound.[63] Baroness Greengross told us that the "stigma" associated with older age results in age discrimination.

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57 National Housing Federation.

58 Ipsos MORI.

59 Q 72

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

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

62 Central Government (DoH, DWP and DCLG), written evidence.

63 Q 72, Q 75

Though the law has changed, attitudes will take time to catch up, as happened with previous anti-discrimination legislation.[64]

87. Rather than viewing ageing with horror, society should pay more attention to the large social and economic contributions that older people make, in areas such as volunteering, childcare, care of other adults, charitable giving, and support for younger generations (see Annex 15).[65] We heard that:

- 30% of people over 60 volunteer regularly through formal organisations
- 65% of volunteers are aged 50 or over
- 65% of those over 65 regularly help older neighbours, and
- one in three working mothers rely on grandparents for childcare.[66]

88. Age UK have estimated that people aged 50 and over make an unpaid contribution to the economy of £15.2 billion per year as carers, £3.9 billion in childcare as grandparents and £5 billion as volunteers.[67] These unpaid inputs reduce public expenditure, enable other people to work, and help to make our society more cohesive. They remind us that many older people are anything but dependent (see Annexes 4 and 5).[68]

89. Many of our growing older population are in good health, will retire with a decent income and a strong social network, have much to offer society, and will want to combine work with new activities, volunteering and caring.[69] One way to promote public understanding that ageing will be a positive experience for most might be for the Government to produce a clear guide to the key facts and trends about living longer. There also needs to be a stronger recognition that older age, which can be conceived as including everyone from 60 to 120, covers a huge diversity of ages, levels of health and wealth, and economic and social activity.[70] **The Government should help people be better informed about how long they are likely to live in good health, the size of the pension that they are likely to receive, the likelihood of needing social care and its cost, and how best to use their own assets. By helping individuals and families analyse their own situation and make informed choices, the Government can give people some of the tools they will need to plan ahead.**

90. Providers of both public and private services need to meet the challenge of the ageing population. But acknowledging the changing role and diversity of older people puts new responsibilities on older people themselves: "We could start looking at older people as the same as everybody else. If they are wealthy, tax them; if they are frail, they should be able to access services that support them just like anybody else at any age", John Kennedy, Director of Care Services, Joseph Rowntree Housing Trust, told us.[71]

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64 Q 78; at Q78 see also Professor Thane.

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

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

67 Age UK.

68 Age UK.

69 Age UK.

70 Fabian Society; Q 72 (Professor Thane); Age UK.

71 Q 73

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

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

Economic impacts of the ageing population

92. Economic output (GDP) is broadly the product of the number of people working in an economy multiplied by their average productivity.[72]

93. Although GDP does not give the full picture of older people's contributions to the economy and society (as explored in Annex 3), an increased 'dependency' ratio will reduce GDP growth.[73] All other things being equal, GDP (and GDP per capita) will be higher if there are more people in work. Conversely, if the proportion of the population not working increases, this reduces growth output. So for economic reasons it is desirable to encourage older people to consider working longer, albeit perhaps part-time; this will boost per-capita GDP.[74] While there are additional health and social benefits to working longer (explored in Annex 5), we stress that the decision to continue working must represent an informed, independent choice, freely taken by individuals.

94. The result of an ageing population therefore does not necessarily mean that the country will be poorer: average productivity per worker will, barring economic disaster, grow very substantially over the next few decades.[75] But if ageing leads to a substantially higher 'dependency' ratio, this could mean that individuals will be significantly poorer in the future than they would have been if the 'dependency' ratio had stayed constant.

95. Improving pension provision, public and private, will not by itself get around this problem: current consumption has, by and large, to be paid for out of current production.[76] Fiscal policy and the way that we think about public and private savings will both need to respond.

96. While older people contribute much to society that measurements of GDP do not take into account, the Government need to take the potential impact of ageing on GDP growth seriously. Without Government action to mitigate the potential effects that an increased number of economically inactive older people would have on GDP growth, economic principles mean that the ageing of the country's population would stand theoretically to have a substantial negative impact on the health of our economy. This is not what we expect to happen: we explore the action that should be taken in Annex 5.

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

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

74 Q 597 (Paul Johnson, Director, Institute for Fiscal Studies (IFS)).

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

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

Fiscal impacts of the ageing population

97. The Office for Budget Responsibility (OBR) suggests that the direct fiscal impact of the ageing population will be significant, but manageable.[77] Tom Josephs, Head of Staff, OBR, told us that "In purely fiscal terms ... the adjustment that we think you might need to make over the course of the next 50 years is not a huge one, particularly if you were to do it gradually over time. The adjustment that has been made in the short term ... is much greater than the one that we are talking about for the future."[78] Andrew Harrop, General Secretary, Fabian Society, did not believe that the long-term prognosis for UK public finances would be undermined by demographic change. In his view, although "the consequences of taking no action would not be benign ... the scale and urgency of the change required is modest".[79]

98. However, other witnesses were more concerned. Michael Johnson, Research Fellow, Centre for Policy Studies, has contended that once the "deleterious impact of our ageing population ... is factored in, national debt is expected to fall back to 60% of GDP in the mid-2020s, and then climb inexorably through 100% of GDP (107% of GDP in 2060–61)".[80] Patrick Nolan and others at Reform claimed that the country is in political denial of the problems that demographic change will bring.[81]

99. Others thought that the risk was not so much of an overall fiscal crisis driven by ageing, but that pressures for increased social spending (especially on pensions, health and social care), primarily resulting from demographic change, would squeeze out other important priorities (for example capital investment, which the OBR projections assume remains at a historically very low level), or leave us vulnerable to future crises. The Institute for Public Policy Research (IPPR) outlined how over the last 50 years, the Government have been able to fund rises in social spending through falls in spending on non-social areas such as defence, nationalised industries and debt interest payments, and by cutting capital spending. But healthcare, social security and education took up 60% of the public budget in 2008. The IPPR argued that "There is a risk that the impact of ageing on the public finances is overstated while other, equally important trends are given less attention in public policy".[82] Similarly, the Social Market Foundation and the Royal Society of Arts have painted a bleak picture for most other Government Departments if health spending is protected on demographic or political grounds.[83] Dr Martin Weale, Professor at Queen Mary, University of London, pointed out that policy has to plan for possible future periods of substantial economic disruption.[84]

100. The Committee believes that the Government need properly to consider the potential long-term fiscal implications of the ageing population. Government

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

78 Q 150

79 Fabian Society.

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

81 Patrick Nolan et al., *Entitlement reform*, Reform, November 2012.

82 IPPR.

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

84 Q 122

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

101. The Government have a number of urgent decisions to make. Pressure on spending resulting from the ageing population will come primarily from increases in spending on health, social care and pensions (see Annexes 8 to 14).[85] How to manage the relative impacts of each of these spending pressures represents a choice. Improvements in technology in healthcare, and better public sector productivity in social care, potentially could improve the welfare of people using these services, but it will be a challenge to reduce spending pressures through productivity gains alone.[86] Further fiscal pressure would also result from any increase in the 'dependency' ratio, because a lower proportion of people in work means lower tax revenues, and, probably, higher public expenditure.

102. This still leaves the risk of additional pressures resulting from the 'political economy' of an ageing population: older people are more likely to vote, and they are growing in number.[87] This implies a growing pressure on the Government to provide improved state-funded services and benefits for older people. Such provision might be financed through higher taxes on the young and working population, through less spending on investment, or through both approaches, thereby increasing the size of intergenerational transfers (see Annex 7).

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85 Confederation of British Industry (CBI).

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

87 Patrick Nolan et al., *Entitlement reform*, Reform, November 2012.

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

103. As described in Annex 4, an increase in the number of retired people would affect the 'dependency' ratio, as well as having an impact on the economy and the fiscal choices that are available to the Government. But if the average retirement age rises as longevity increases, the 'dependency' ratio could be stabilised or reduced. This would result in a likely increase in GDP per capita (see Annex 4) and a boost in tax receipts.

104. More importantly, however, individuals choosing to work for longer would themselves benefit from additional income, the potential for more saving, a reduction in the length of time the individual is dependent on those savings and often an improvement in physical health, mental health, and in well-being.[88]

105. By employing older workers, employers would benefit from the fruits of older workers' experience, knowledge and wisdom and a substantial implicit wage subsidy from employing people over state pension age, because they may undertake part-time work for a relatively low wage due to enjoying supplementary pension income.[89]

106. Wider social benefits related to people staying in work for longer include reduced levels of isolation and loneliness among older people, with accompanying healthcare savings.[90]

107. By 2030, men aged 65 in the UK will expect to live until they are over 88 (23.4 years past the age of 65), and women to the age of 91 (26 years past the age of 65).[91] **If our society and economy are to maximise the benefits of longer lives, older people must be enabled to stay in employment for longer.**[92] **Expectations of early retirement must change.**[93] **Employers and the Government should remove disincentives for older people to work for longer—although the choice to continue in work must remain entirely with the individual.** Possible incentives are discussed below.

108. The Committee considered that the following measures would do much to change attitudes to people working later in life:

- **The incentives in the tax, benefit and pensions systems for both early and fixed-date retirement should be actively reviewed. It should be beneficial to defer taking state and private pensions.** ILC-UK conducted a survey on the prospects for extended working lives that demonstrated a strong willingness across all age groups to work for longer in various circumstances. For example, 41% of men and 39% of women said they would consider delaying their retirement if they could

88 Q 330 (Ben Jupp, Director, Social Finance); B&Q.

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

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

91 ONS, *Pension Trends*, Chapter 2: Population change, February 2012.

92 Central Government (DoH, DWP and DCLG), written evidence.

93 The Saga Group.

defer their state pension entitlement in return for higher payments later—which in fact they can already do.[94]

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

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94 ILC-UK; Age UK; Q 135.

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

96 Q 465; TUC.

97 Central Government (DoH, DWP and DCLG), written evidence.

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

99 TUC.

100 Q 155

101 Q 277

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

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

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102 Carers UK.

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

104 CBI.

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

106 Central Government (Department for Work and Pensions) further, further supplementary evidence.

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

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

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

110 TUC.

- The Government should communicate the benefits of people staying longer in the workforce. In particular, **the Government should publicly reject the 'lump of labour fallacy' that wrongly argues that more older people in work will disadvantage the young**. More older people in work will not mean fewer jobs for young people. A larger workforce, with more people in work and earning, creates its own demand; and we know that in practice the fallacy does not hold—previous attempts, both in the UK and abroad, to create jobs for young people by encouraging early labour market withdrawal have failed miserably. A 2008 report by the Institute for Fiscal Studies on early retirement and youth unemployment concluded "we find no evidence of long-term crowding-out of younger individuals from the labor market by older workers. The evidence, according to a variety of methods, points always in the direction of an absence of such a relationship".[111] Permanent Secretary, Department for Communities and Local Government and Head of the Civil Service, Sir Bob Kerslake, confirmed to us that "It is absolutely clear that we will have to work longer", but that while "the Government have faced up to that issue", he was "not yet sure the country has faced up to that issue".[112]

109. Extending working lives will be a vital part of the response to living longer. In addition, the country will still need to make important choices about public service delivery in order to ensure that the growing older population gets the public services that it will require. The following annexes outline these choices.

[111] Institute for Fiscal Studies, *Releasing Jobs for the Young? Early Retirement and Youth Unemployment in the United Kingdom*, July 2008,.

[112] Q 639

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

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

Individuals' lack of preparedness for ageing

111. Nevertheless, our population is far from perfectly informed about ageing. The Pensions Commission led by Lord Turner of Ecchinswell (the Turner Commission) found that people, on average, are unaware of or do not believe the projected increases in life expectancy, or even the best estimates of current life expectancy. In 2005, 30 to 39 year olds underestimated their own life expectancy by at least six years.[113] Ipsos MORI told us that "assumptions (based on little knowledge), a fear of the unknown, denial, and negative connotations of being a 'pensioner' mean that we put off our financial planning until we are forced to".[114]

112. People tend to deny the likelihood that adverse life events or disability will affect them, and men are more likely to misjudge the risks associated with old age.115 In particular, people are very unwilling to contemplate and provide for future disability or mental illness, even to the limited extent of adapting their houses to be suitable for older life.

113. Ipsos MORI found that generally, there is low awareness of, and there are common misconceptions about, who is responsible for looking after older people in need. The public often struggle to distinguish between social care services and health services provided by the NHS. Many assume that the state will provide for them in later life, meaning that people, particularly in younger age groups, generally give little thought to planning for their old age.[116] Furthermore, individuals often have a residual faith that their family will look after them in old age.[117] A presumption of substantial and growing levels of informal family care may not be realistic in a world in which the next generation of carers might need to remain in work, particularly in order to finance their own retirement (see Annex 5).[118]

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

[114] Ipsos MORI.

[115] Dr Joan Costa-Font, LSE.

[116] Ipsos MORI.

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

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

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

Market failures

115. Markets are failing to provide what is needed in the fields of long-term care insurance, pensions, and specialist housing for older people. The reasons for this market failure are related to the weaknesses in consumer knowledge and behaviour explored above. Although an insurer may know the likelihood that a person entering care today will stay for a certain length of time, such probabilities might change substantially over the period of an insurance contract, especially if the contract is entered into prudently early.[120] Medical progress might reduce the likelihood of people developing dementia, for example, but separate medical advances might increase the likelihood of an individual surviving disease but in a disabled state, with their care costs rising sharply as a result.[121] These factors make insurers very reluctant to offer long-term care products, with the result that markets for elderly people's healthcare insurance tend to be unaffordable. As of July 2011, no major financial services providers offered pre-funded insurance against social care costs.[122]

116. People suffer from a similar dearth of information when trying to decide which pension products they should take up. Pensions are associated with longevity risks (individuals do not know how many years they will need a pension for) as well as investment risks (individuals do not know how large their pension will grow). Many employers used to take on both of these types of risk when they promised a specified pension linked to an employee's final salary. But these risks eventually overwhelmed firms' capacity or willingness to provide such pensions (see Annex 8). Paul Johnson, Director, Institute for Fiscal Studies (IFS), explained: "We have moved from a world where the state, which is pretty good at bearing these kinds of risks ... was bearing most of the risk, through a period when employers were bearing most of the risk, to a situation for the current working generation where individuals are bearing most of the risk, and they are probably least well set up for bearing that risk".[123] As individuals become aware of the increased risk that is falling on their shoulders, this situation may not be politically or practically sustainable. The incomplete capacity of individuals to make good decisions for the long term, and of markets to cope with the uncertainties and risks of old age, is the fundamental reason why the Government have to take a

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

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

120 Professor Nicholas Barr, LSE.

121 Professor Nicholas Barr, LSE.

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

123 Q 585

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

Government progress

117. Successive governments have attempted to respond to the challenges posed by people living longer lives. Both the Turner Commission and the Commission on Funding of Care and Support (the Dilnot Commission) analysed some of the issues and presented ways forward.[124] Their proposals involved shifting more responsibility onto individuals and nudging or incentivising individuals to prepare financially for a longer life. Both reports showed what can be achieved by good analysis, impartially conducted, which engages public attention.[125] The Government have begun also to analyse problems related to the sustainability of services for older people at the local level.[126] However, neither the Turner Commission nor the Dilnot Commission recommendations have yet come to full fruition. Legislation based on the Turner Commission's pension plans was passed by Parliament in 2008, but is only just beginning to be implemented.

118. United Kingdom pension policy has adopted an unusual path.[127] Some countries, such as Australia or the Netherlands, either require employers to make pension contributions or make membership of occupational pensions virtually compulsory through collective bargaining.[128] The UK has never had a universal wage-related national pension scheme and the Government are currently proposing to incorporate the modest existing earnings-related state pension into a new single-tier flat rate pension (see Annex 8). The Government are not seeking to make membership of private schemes compulsory. Instead, they are working to incentivise individuals to join a regulated pattern of private schemes. In this regard, the UK's system is perhaps nearest to the one that has evolved in New Zealand.[129] With regard to social care, while other countries have introduced compulsory social insurance for long-term care, England's attempt to kick-start a private market in long-term care insurance, by the Government taking on the catastrophic risks associated with care (as recommended by the Dilnot Commission), will be highly innovative.[130] The UK with pensions, and England with long-term care, are following their own untried and as yet uncompleted paths to support an ageing population. While this does not mean that these paths are

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

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

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

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

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

129 Q 486 (Professor Noel Whiteside); Professor Noel Whiteside, supplementary written evidence; Reform.

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

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

Government failure

119. In other ways, however, successive governments have failed to meet the challenges posed by an ageing population. The Committee heard how democratic governments are ill-equipped for long-term, joined-up thinking on this issue (see Annex 18). In particular, successive UK governments have struggled to deliver the necessary adaptations to long-standing public service delivery structures. As we explore in Annexes 12 and 13, long-embedded structural designs and divisions, such as the split between healthcare and social care, can become extremely difficult to change.

120. The incapacity of individuals and markets to be able to respond efficiently to an ageing future has been exacerbated by a coterminous failure by the state to adapt its institutions. The Government have begun to respond with the help of independent reviews like those conducted by the Turner and Dilnot Commissions, as well as through their own internal analyses and local experiments. But the Turner and Dilnot Commissions' recommendations are not yet fully implemented, and much wider public policy changes are also required (see Annexes 8 to 17). The whole mechanism through which the Government manage the process of adaptation to ageing needs to go much further and faster (see Annex 18).

[131] OBR, *Fiscal sustainability report*, July 2012, p73.

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

What do people want?

121. Older people expect a decent minimum income in later life, humane services that work together to meet their needs and to be enabled to live independently for as long as possible.[132] This happy position may best be achieved by a combination of state support and individuals making provision for their own future. For state support to be affordable, people must manage their own future—and the uncertainties and risks in that future—as far as possible, but some risks are best managed by the state. The balance struck between personalised provision and risk, and collectivised provision and risk, is a matter of political choice. It is a deal, or social contract, made between the state and the individual, and within and between generations.

122. The social contract in the UK—the welfare state—has depended on people in earlier adult life on average paying in, and people in later life on average drawing out.[133] The younger support the older, and expect to be supported in their turn when they become old. But with an ageing population, there are likely to be large increases in spending on services which are particularly important to older people, especially pensions, healthcare and social care.[134] The 'deal' between generations will change.

123. This change is not bad or something to be resisted; over time, a increasingly affluent society (as on the whole the UK is, in terms of long-term GDP growth) is likely to want to continue spending some of that wealth on improving the lives of its citizens, and an older society is likely to want to spend more on the priorities of older people. Welfare and wellbeing will be enhanced as a result.

124. However, these increases will have to be financed. This could be achieved through higher taxes or social insurance contributions, through cuts in services for younger people, or through more direct payment by individuals. What matters more than the balance between these sources of funding is a) the efficiency of the payment mechanism, and b) who pays when. If some generations paid more in to the system throughout life than they got out, while other generations drew more out of the system throughout the different phases of life than they paid in, this would be fundamentally unfair and therefore unstable.[135]

125. **As society ages and demands more spending on the elderly, our society must avoid unfairly shunting the costs on to future generations. So it is important to ensure that those who are benefitting from longer lives pick up at least part of the tab.**[136]

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132 Q 170; WISE, supplementary written evidence; Care & Repair Cymru.

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

134 Q 547

135 Q 135 (Dr Martin Weale).

136 Q 135 (Dr Weale).

The need for a new deal

126. The deal laid out by the Beveridge Report in 1942 of "an insurance benefit adequate to all normal needs" in return for a lifetime of contributions, was never fully delivered.[137] The Government abandoned any attempt to provide a universal subsistence pension in the 1950s as too expensive a goal.[138] Pensions policy has been a major political battleground ever since: the resulting extremely complex system was described by the Turner Commission as "not fit for purpose".[139] Nor was Beveridge's proposed social contract ever complete: it did not include any right to state-provided long-term care, for example, while it did include state-provided healthcare. The deal proposed by Beveridge had wide appeal and was widely understood, but is now outdated.

127. The Turner Commission pointed out that the proportion of adult male life spent in retirement had grown steadily since the Second World War, from 18.0% in 1950 to an estimated 30.7% in 2005, with the proportion of adult female life spent in retirement rising from 26.1% in 1950 to an estimated 36.9% in 2000 and 36.4% in 2005.[140] The Commission argued that it would not be possible continuously to extend the proportion of adult life spent in retirement without either increasing taxes and savings or reducing the scale of pensions.[141] It proposed that the proportions of an average adult life spent in work and in receipt of state pensions should be stabilised. In return, the state would develop a more secure basis for retirement and nudge individuals to join pension schemes, while requiring more of their employers. But the implementation of this revised deal is not yet complete, and it covers only a portion of the needs of an ageing society. The implementation of the recommendations of the Dilnot Commission will clarify what help individuals can expect from the state in social care, but there is clearly further to go before it is clear what the social contract will look like for our older society.

The need for a clear deal

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

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137 *Social Insurance and Allied Services*, Cmd 6404, paragraph 29, 1942.

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

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

140 *Op.cit.* figure 1.44.

141 *Op.cit.* p.12.

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

143 Ipsos MORI.

144 Ipsos MORI.

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

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

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

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

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

A fair deal between generations

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

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

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145 The Saga Group.

146 Q 464, Q 474, Q 489

147 Q 545 (Professor John Hills)

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

134. The cost of fiscal retrenchment has often affected the young disproportionately.[150] Professor John Hills, London School of Economics and Political Science (LSE), cited the protection of the health service, state pensions, council tax benefit for pensioners, winter fuel payments, and free TV licences, and contrasted these with changes to working-age benefits, the education maintenance allowance, youth provision and child benefit.[151] We heard that the resulting spending balance may be less than efficient: Kayte Lawton told us that Nordic countries invest more in education, training, labour market programmes and childcare and that their spending is much more focused on long-term strategic priorities. She considered that "They have a sense that public spending should be there to drive jobs and growth, not just to respond to, 'We're getting older and richer, so we want better pensions and healthcare'."[152] Andrew Harrop asked whether it was sensible that "we have privileged welfare and public service receipt in old age and have not safeguarded some very sensible examples of public spending on younger age groups".[153]

135. Better informed public debate about intergenerational distribution and transfers is needed. Dr Weale wanted fewer Budget-day tallies of winners and losers, supplanted by the question "'How does it affect different people over their likely remaining lifetime?'"[154] Kayte Lawton was concerned that poor public debate led to bad choices, pointing out that it was easy to cut back on long-term investments for which there was not constant political pressure.[155] We believe that the Government and political parties need to make it clearer to the public what impact their policies will have on the balance of fairness between generations and over time (see Annex 18).

136. Professor Sefton singled out increasing property prices as a "huge transfer" from younger generations towards older generations.[156] The property boom has led to wealth being transferred to older, better-off homeowners. Many older property owners have seen large, tax-free capital gains over the past few decades due to the rising value of property. The house price boom has "masked what might have been expected to be the life cycle pattern of wealth accumulation followed by decumulation". The median value of household

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148 Q 135

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

150 Q 547 (Professor Hills)

151 Q 547 (Professor Hills)

152 Q 137 (Kayte Lawton)

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

154 Q 137

155 Q 137

156 Q 135 (Professor Sefton). Q 135 (Dr Weale).

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

137. This increase in wealth has benefited a large section of the population but not the poorest. It came about partly because of prudence and foresight exercised by many households, but also because of the tax-subsidised nature of owner-occupation, and good fortune (today's older people reaching property-buying age at an economically propitious time).[158] It therefore would be unfair to expect younger generations who have not enjoyed such gains (and who are obliged to pay higher rents and mortgages as a consequence) to pay more for the increased costs of an older society if asset-rich older people were entirely protected from those costs. (The case for protecting people from catastrophic costs arising from need for social care, as recommended by the Dilnot Commission, is discussed in paragraphs 25 and 25 of the Report.)

138. While understanding people's emotional attachments to their homes, these properties are part of their economic framework and represent investments as well as homes. **It is reasonable to expect those who have benefited from the property boom to support their own longer lives. We suggest that one way to address the current imbalance would be for more older people to consider unlocking housing wealth. Equity release could enable more people to use their assets to help pay for the cost of their social care** (see Annex 11)**, to adapt their homes** (see Annex 16)**, and to support their incomes. While equity release might impact on the inheritance of the children of wealthier parents and on people in areas where house values have increased most, older age still needs to be paid for. The Committee considers that it is right for those who have benefited from windfall gains to contribute to the costs of their longer lives through equity release, rather than for the full costs to be pushed to future generations.**

139. Some equity release schemes exist, but they are little used.[159] There are schemes that enable people to live in their own homes (many older, frail people do not want to move) but release money to pay for their needs in later life rather than passing the whole value on to their children (who will still benefit from any increase in house prices). People over state pension age in 2009 owned roughly £250 billion in home equity that was available to be released, and this figure could rise by 40% by 2030, in 2009 values and earnings levels, as the number of owner-occupiers in this age group rises.[160]

140. As James Richardson, Director, Fiscal and Deputy Chief Economic Adviser, Fiscal Group, HM Treasury told us, the equity release market suffers from

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

158 *Op.cit.*

159 Care & Repair England; Q 60.

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

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

141. We heard about ways in which these market failures could be addressed. Care & Repair England proposed that state support for social lending, possibly coupled with some grant help, could represent an important measure to ensure that equity release options become viable. This would need to be coupled with the strengthening of independent financial information and advice, they argued.[163] Gary Day, Executive Director for Land and Planning, McCarthy & Stone, told us that more communication is required: "We need to start talking about the positive beneficial implications of using equity in retirement planning" because "we are going to have to find something other than conventional pensions".[164]

142. Paul Broadhead, Head of Mortgage Policy, the Building Societies Association, recommended the work of the Equity Release Council, which aims to lay down standards for equity release providers. He told us that subscribers to the Equity Release Council need to give a "no negative equity guarantee" to borrowers. This means that if people decide to release equity, they will not owe more than the amount that they have released even if their property value falls.[165]

143. **Because there is an urgent need for greater consumer confidence in the equity release industry, we propose that the Government should work with the financial services industry to encourage the growth of a safe and easy-to-understand equity release market.** The Government could put more emphasis on communicating the importance of equity release for paying for later life; they could promote reliable equity release products that offer 'no negative equity guarantees' and companies that have signed up to the Equity Release Council's Code of Conduct.[166] The Government are taking action to improve access to Deferred Payment Agreements offered by local authorities to enable people to fund their social care needs.[167]

144. **It does not seem fair to expect younger taxpayers to pay more for the ageing society while asset-rich older people are protected**.[168] It could be argued that older people are undertaxed relative to their ability to pay and incomes, and they have often benefited from the boom in property prices.[169]

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161 Q 60

162 Q 493; Care & Repair England; Q 497.

163 Care & Repair England.

164 Q 212

165 Q 500

166 McCarthy & Stone; Equity Release Council.

167 Sir Bob Kerslake, supplementary written evidence.

168 Q 547 (Andrew Harrop).

169 Q 547 (Andrew Harrop).

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

A fair deal between genders

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

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

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

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

A fair deal within generations

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

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170 And grandchildren – Q 545.

171 Professor Noel Whiteside, University of Warwick.

172 Q 538 (Andrew Harrop); Q 538 (Professor Goldblatt)

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

174 Q 538 (Professor Arber).

175 Q 540 (Professor Hills).

149. More important, though, is the relationship between wealth and health.[176] Professor Hills told us that "a single predictor of mortality rates for people aged over 50 is their wealth level. Obviously, that is capturing a lot of things that have happened earlier in people's lives, which are linked to both health and wealth, but if you want to know one thing, wealth in itself tells you a lot about where people are heading, unfortunately. There are very considerable differences in mortality rates."[177]

150. Poorer people arrive in older age "lacking wealth, in particular, but also with poorer pensions and having accumulated health disadvantage throughout their lives", and "poorer people live shorter lives and spend more of those short lives with an illness or disability", with those who arrive at pensionable age more likely already to have an illness or disability.[178] In addition, the process of developing ill health in older age can lead to both social impoverishment in terms of isolation and resource impoverishment due to care costs. The grim message is that "overall, it is the accumulation of health and social disadvantage during the life course that will make a premature death and the earlier development of illnesses more likely".[179]

151. If you are working class, you are more likely to suffer from ill health but less likely to have the resources to support you through that ill health.[180] You are also more likely to need social care as "the requirement for social care is socially graded", and the means test applied to determine receipt of free social care "is then inequitable because it always excludes some groups who are disadvantaged" but who are not quite as disadvantaged as those who meet the means test and receive the free care.[181] Meanwhile, richer individuals can pay for good care and live-in carers.[182]

152. Income differences at older ages are much affected by pension rights, but also by "the extent to which the state has assisted through usually generous tax reliefs in the accumulation of those pension rights".[183] Professor Hills suggested that there was a contrast between professionals who were likely to have taken financial advice and built up tax-privileged pension rights, invested in an effectively tax-free house and so on, and to have passed money to their children tax-free, and people on lower incomes, who may not have been members of pension schemes, who may have saved in accounts with a very low return, and who are "hit by capital limits on the housing benefit and pension credit they are entitled to and spending on the contribution they are expected to make towards care". He concluded, "by and large, the better off you are in your working life, the more the state is likely to have done."[184]

153. Wealth in later life is also affected by other factors, such as the care costs of close relatives and inheritance.[185] Professor Arber emphasised the role of transfers from older to younger generations: richer parents could help their

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176 Q 544

177 Q 544

178 Q 540 (Professor Goldblatt).

179 Q 540 (Professor Goldblatt).

180 Q 541 (Professor Arber).

181 Q 548 (Professor Goldblatt).

182 Q 550 (Professor Arber).

183 Q 544

184 Q 546, Q 544

185 Q 544

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

154. Geographical differences also have a significant impact on the health and wealth of older people. Professor Peter Goldblatt, UCL, told us that, according to neighbourhood affluence, there was "a seven-year difference in life expectancy and a 17-year difference in healthy life expectancy, meaning that people in poorer neighbourhoods are living much shorter lives, in poorer health".[187] Rurality can also have an impact, especially on social isolation.[188] We also heard that while in Wales, life expectancy and proportion of life spent in good health is increasing, of the UK nations Wales has the lowest healthy life expectancy, the highest levels of deprivation, and the highest incidence rate of chronic disease.[189]

155. Professor Goldblatt highlighted that in poorer neighbourhoods, demand on public services is greater than in middle or high-income areas.[190] The migration of healthy older people to the south coast distorted demands for services, because "the middle-class, healthier old people on the south coast are very demanding", resulting in resources being shifted there from poorer areas through the latest changes in resource allocation, creating a new or widening inequity.[191] Professor Hills also highlighted the geographical distribution of the reduction in local authority support: "The areas that appear to be losing most are the ones where the older population probably has the least resources to cope."[192] The Government should ensure they pay sufficient attention to this issue and that the grant distribution formula sufficiently reflects levels of need.

156. Affluent areas tend to have the greatest proportion of people who volunteer.[193] Professor Arber suggested this might be because volunteers needed health capital, resources and energy. She was concerned that "the increasing emphasis on volunteers stepping in for everything may actually exacerbate the inequalities between areas, unless we use other mechanisms to foster volunteering in areas which, hitherto, have not had high levels of volunteering".[194]

157. Whether people benefited from the property boom has created substantial differences, varying across the country but also within age groups.[195] Andrew Harrop saw the cost of housing as crucial to intergenerational inequalities:

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186 Q 547

187 Q 540 and Q 551

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

189 Derek Jones, Welsh Government.

190 Q 551

191 Q 551

192 Q 552

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

194 Q 543

195 Q 544; Q 540 (Professor Goldblatt).

"That drives all the inequalities between different generations, different classes, north and south, homeowners and landlords."[196]

158. Other factors were also important in separating the experiences of different older people, including ethnicity,[197] mental health,[198] and social networks[199] such as employment networks.[200]

159. As policies towards older people are adjusted, it will be crucial that the diversity of older people is considered and inequalities are reduced. However, inequalities between older people may actually be widening. While we were told that income inequalities in older age are not increasing,[201] wealth disparities are increasing, due to higher saving rates for richer groups, house prices and other equity bubbles.[202] **We urge the Government to consider issues of inequality fully and directly as they develop public policy for our welfare state and services for the future.**

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196 Q 547

197 Q 538 (Professor Arber).

198 Q 540 (Professor Goldblatt).

199 Q 542 (Professor Goldblatt); Q 63; Q 79; Q 538; Q 541 (Andrew Harrop).

200 Q 542

201 Q 546

202 Q 546 and Q 541 (Andrew Harrop).

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

Reforming pensions and savings

160. The resources that older people use to sustain themselves after they cease earning come from the state (about half)[203], individuals' savings (largely in private pensions), and other income. As the average lifespan has grown, the proportion of life spent in retirement has grown with it.[204] But in future it will not be realistic or desirable to expect the state—and younger taxpayers in particular—to pay for this (see Annex 7). We agree with the Turner Commission) that people will need to choose whether to work for longer, save more, or have a lower income in retirement.[205] They will need to make informed decisions to do so.

161. Our society will have to make difficult decisions about pensions and savings. There is already a major problem with individuals not saving enough for retirement, which demographic change will exacerbate.[206] Indeed, recent research suggests that UK residents are the "worst in the world" at saving for retirement.[207] Longer lives mean that many people are at risk of having insufficient income to pay for older age. Many people underestimate how long they will live and misunderstand what they will have to pay for, and so do not feel motivated to save (see Annex 6).[208] Where people do appreciate the need to save for later life, they are often bewildered by the complexity of the products available.[209]

162. The Government might consider developing a resource that will help people understand how much they need to save for older age, and the risks and benefits associated with investing in pensions and other savings vehicles. We were informed that in Finland a central Pensions Institute provides government and individuals with regular comprehensive information about pension trends and likely pension benefits; the US Department of Labor provides a 'Top 10 Ways to Prepare for Retirement' webpage.[210]

163. The Government are moving to incorporate the existing earnings-related state pension scheme into the new single-tier pension and are not seeking to make membership of private schemes compulsory. Instead, they plan to incentivise individuals to join a regulated pattern of private schemes. **We welcome the progress in pension reform that the Government have made, but consider that without urgent additional action to encourage saving more for retirement, demographic change will**

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[203] *Pensions: Challenges and Choices – The First Report of the Pensions Commission*, 2004, figure 4.1.

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

[205] *A New Pension Settlement for the Twenty-First Century: The Second Report of the Pensions Commission*, November 2005.

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

[207] HSBC, *The Future of Retirement: A new reality*, 2013.

[208] Ipsos MORI. See also Dr Joan Costa-Font, LSE; Q 592; Home Instead Senior Care.

[209] Dr Joan Costa-Font, LSE.

[210] www.dol.gov/ebsa/publications/10_ways_to_prepare.html.

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

Pension problems

164. Our pensions system is beset by major problems, many of which were identified by the Turner Commission[213]:

- Defined contribution (DC) pensions now dominate private pension provision. Since the Commission reported, the proportion of people with defined benefit (DB) pension schemes has continued to fall, and "by and large the private sector has become a DB desert".[214] Recent figures from the National Association of Pension Funds (NAPF) announced that 13% of final salary pensions were open to new joiners in 2012, a drop of a third from 2011, and the steepest fall since comparable data began in 2005, when 43% were open.[215] **While the defined benefit pensions system has proved to be unsustainable, we consider that for many savers defined contribution pensions are seriously inadequate.** They shift longevity and investment risks from employers to employees, who are the least able to bear those risks (see Annex 6).[216] The link between the sacrifices that a person makes in order to put money into a pension scheme, and the rewards from their saving that they can look forward to receiving when they retire, effectively has been broken.[217] Savers cannot know the scale of pension that they might end up with in a DC plan, and many employees are ill-equipped to understand or bear the risks that accompany this uncertainty.[218] When even a sizeable pension pot might buy only a small pension, it is less likely that people will feel that it is worth the sacrifice to pay into it. The big shift to DC pensions therefore carries risks and uncertainties largely unappreciated by the public, and sharply differentiates those who are able to look forward to the outputs of DB schemes from those who are not.

- Although our society has done better than some other countries at providing a safety net to keep older people out of poverty, the uncertainty over future pension income from DC schemes means that many of those on middle and lower incomes have uncertain or inadequate incentives to save.[219] For these and other reasons, the Government have estimated that

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211 Central Government (DoH, DWP and DCLG), written evidence.

212 CBI.

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

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

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

216 Age UK.

217 Q 585

218 Q 465; Q 466 (Dr Ros Altmann).

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

10.7 million people in Great Britain (excluding Northern Ireland) can expect inadequate retirement incomes.[220]

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

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

Policy responses

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

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

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

222 Q 602 (Paul Johnson).

223 Q 545

224 Professor Noel Whiteside, University of Warwick.

225 Department for Work and Pensions, *Older people and employment.*

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

227 Department for Work and Pensions, *Older people and employment*.

228 Central Government (DoH, DWP and DCLG), written evidence.

167. With auto-enrolment, the Government are attempting to incentivise people to take out DC pensions by requiring employers to offer and automatically enrol employees in a scheme, to which the Government then contributes. NEST provides a default for employees if they decide not to save with one of the other schemes on offer. The flat-rate state pension seeks to replace means-testing for certain state pension entitlements with a single state pension for all recipients.[229] Joanne Segars, Chief Executive of the National Association of Pension Funds (NAPF), told us that this reform would give people "a very clear indication of how much they will get and how much they need to save on top of that. Importantly, it means their private savings will not be means tested away, which currently does act as a disincentive".[230]

168. The Government also intend to introduce cost-stabilisers for public sector DB pensions[231], and have begun to reform rules on the requirement to annuitise pensions.[232] This means that the state will now have more understanding of the risk to which taxpayers are exposed in paying for public sector pensions, and DC pension investors will have a better understanding of their final settlement.

169. But further action will be required. The most recent pensions White Paper departed from the Turner Commission recommendations in laying out how the new full state pension age would not be linked automatically to increases in life expectancy: the Government told us that this is because the rate at which life expectancy is increasing has accelerated.[233] **We consider that, due to rising healthy life expectancy, it will only be a matter of time before the Government will have to revisit this decision.**

170. Moreover, it is not yet clear whether auto-enrolment will ensure pension coverage for employees who currently do not have pensions. The likely take-up and drop-out rates under this scheme are uncertain.[234] Even if take-up is high, it does not follow that the resulting pension income will be sufficient for all participants.[235] We consider that although it would be a major advance if those paying into pension schemes (employers, employees and tax relief) eventually contribute 8% of earnings into auto-enrolment schemes, as the Government have proposed, this will not represent enough for a decent pension income, even on top of the Government's newly suggested flat-rate pension.[236] Since the Turner Commission recommended a combined default contribution rate of 8%, life expectancy has risen and is very likely to rise further (see Annex 2). Moreover, returns on savings and annuities have

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

230 Q 468

231 Public Service Pensions Bill, introduced 13 September 2012.

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

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

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

235 Q 464 (Joanne Segars); Q465 (Dr Altmann).

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

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

171. The capacity of individuals to access additional sources of income is restricted if they are "old, disabled and poor".[240] In general, people have varying opportunities to build on the platform that the Turner Commission proposed by working in later life. Those with caring responsibilities (often women), as well as people with interrupted job histories, may find it very difficult either to retire later or to supplement their retirement by doing extra work (see Annex 5).[241] Public policy responses to encourage older people to save should therefore focus more strongly on these groups. Furthermore, pensions should not be considered in a vacuum. Wider policy choices include the provision of more employment opportunities, support for independent living, and flexible retirement. At present, the Government do not seem to be paying sufficient attention to these important policy areas (see Annex 5).

172. **The Committee concludes that despite significant progress, the current system of state and private pension provision is still not adequate for a large proportion of the future elderly population.** Many people, young and old, expect far more than they will get: society is behind where it needs to be.[242] The savings crisis for older age is exacerbated by a lack of clarity about what DC pensions will deliver, and concerningly weak pensions for many women and for many on middle and lower incomes. While the poorest will be protected at a basic level by state provision, and the richest can afford to save enough in private schemes, there is a substantial gap for much of the rest of the population. **While progress is being made on state pensions, we conclude that the current DC pensions system is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.**

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

238 Q 466

239 Q 545

240 Q 472

241 Professor Noel Whiteside; Q 538.

242 Central Government (DoH, DWP and DCLG), written evidence.

Policy proposals

173. **The Government should review how to strengthen incentives for saving.**

174. The Government should persist with the implementation of reforms set out by the Turner Commission. State pension reform must continue, ensuring the provision of a decent basic pension, although there will need to be further work on finding cross-party agreement on the basis for determining what a decent minimum level should be. The Government should continue to support auto-enrolment. But implementing the Turner Commission proposals alone will not be enough—as the Turner Commission report made clear. Many of the assumptions made in the report, for example those on expected longevity, have already changed (see Annex 2).[243]

175. Because of the cost to future taxpayers of public sector DB schemes, the Government must keep the Independent Public Service Pensions Commission reforms under review. This would enable the Government to track longevity changes, and assess if over time public sector pensions are fair and sustainable.

176. **We urge the pensions industry, employers and the Government to tackle the lack of certainty in DC pensions and address their serious defects, and to work together to re-design DC schemes to create better options so that people are clearer about how much they can expect to get from their pension as a result of the savings that they make.** The pensions industry needs quickly to find ways of improving the outcomes from DC schemes. The industry should more effectively align retirement income expectations with actual outcomes from DC plans, and seek better to manage the risk that these income goals are not realised. The industry needs to think more creatively about the basic architecture of DC schemes to avoid the risk that auto-enrolment fails to produce a greater take-up of retirement income planning. This is the whole point of auto-enrolment; we suggest that the inadequate performance of DC schemes to date poses the greatest risk to our savings culture and the move towards re-invigorating pensions saving.

177. The Committee welcomes the Government's recent proposal to consider a 'defined ambition' pensions regime which would "seek to give greater certainty for members than a DC pension about the final value of their pension pot and less cost volatility for employers than a DB pension".[244] Through such proposals, the Government are moving away from a focus on reforming DB pensions towards a more pressing issue for many taxpayers—how to make the DC market work. We consider that the 'defined ambition' proposal represents a positive step forward. More active Government intervention in this market is likely to be necessary to secure better outcomes for savers. Unless such an innovation comes about, there is a risk of fundamental and permanent damage to NEST and the settlement laid out by the Turner Commission. We urge the Government to make their plans concrete as soon as possible.

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243 Central Government (DoH, DWP and DCLG), written evidence.

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

178. Unless these actions are taken, incentives for saving will continue to be inadequate. People cannot adapt their life plans unless the Government help to make pensions and savings choices and their implications much clearer.

179. Given present longevity trends, the Government need to do much more to communicate to the public the importance of planning for an adequate income in older age.

180. People need to consider using a variety of sources of funds and ways of saving for later life.[245] More people working for longer will be part of the solution (see Annex 5), as will be unlocking the value in our homes. Many older people have seen the value of their homes increase considerably, but have not seen this rise as offering even a partial solution to the challenges of paying for longer life, or have been unable to gain easy access to the increased value (see Annex 7). **The Government should make it easier for people to use a variety of routes to save for their retirement, including equity build-up and release.**

[245] Q 464 (Dr Altmann); Q 210-211, Q 212; Q 478 (Richard Humphries); Equity Release Council; McCarthy & Stone.

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

181. Extended life expectancy is one of the greatest triumphs of the twentieth century. The NHS has had great successes in extending life: so much so that it is a victim of its own success.[246] People are now living for more years with multiple long-term conditions and need for long-term care.[247] This results in increases in the demand for, and the costs of, health and social care.

182. Eventually almost all of us will need healthcare, and two thirds of men and 84% of women currently aged 65 will need some social care before they die.[248] The box below gives some illustrations of the impact that the ageing society will have on demands for health and social care and informal care.

BOX 1

Increasing pressures on health and social care

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

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

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

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

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246 Q 217

247 QQ 216-217; Q 562

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

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

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

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

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

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

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

Rates of disabled people requiring care:

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

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

253 The King's Fund, supplementary written evidence.

254 Professor Carol Jagger, Newcastle University. See also Alzheimer's Society.

255 Professor Philip Rees, supplementary written evidence.

256 Professor Philip Rees, supplementary written evidence.

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

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

double in real terms by 2030 to sustain standards. Public spending would need to double, and private spending to rise by nearly 150%.[259]

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

Demand for unpaid care provided by families and friends:

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

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

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

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

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

261 Carers UK.

262 Personal Social Services Research Unit (PSSRU).

263 Carers UK.

264 Professor Nicholas Barr, LSE.

265 Q 129; Q 150 (Tom Josephs).

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

185. Demographic projections suggest that a substantial increase in demand is about to hit the healthcare system, adding to other long-term cost pressures (see Annex 9). This great increase in demand will naturally create a great increase in cost.

186. The Nuffield Trust has recently estimated that under the current healthcare system, if the real-terms funding freeze for the NHS is extended to 2021/22, if no productivity gains are made and if rates of hospital utilisation by people with chronic conditions and the rising cost of providing healthcare continues, then by 2021/22 the NHS in England will see a funding shortfall of £54 billion for the NHS as a whole.[266] If the English NHS achieves unprecedented productivity gains of 4% a year in every year from 2010/11 to 2014/15 but no further, they predicted that this funding gap would be reduced to a potential shortfall of £34 billion. For comparison, the total budget for the English NHS in 2010/11 was £107 billion. Yet continuing this rate of unprecedented productivity growth for a whole decade would be very difficult. Many of the 'savings' so far achieved are the result of a wage and salary cap that would be difficult to sustain for a decade. Even a constant real terms budget would be difficult to sustain into the next spending round, as it would result in heavy cuts to other departmental budgets.[267]

187. **If the current healthcare system did not change and the large NHS funding gaps for 2021/22 estimated by the Nuffield Trust materialised, this would have particularly serious consequences for older people, as the biggest consumers of NHS spending.[268] The NHS will have to be transformed, in service delivery terms, in order to deal with changing needs more efficiently; this transformation should help with the predicted funding shortfall.**

188. There is already a crisis in social care funding. The Dilnot Commission concluded in July 2011 that the current English social care system is inadequately funded and that "People are not receiving the care and support that they need and the quality of services is likely to suffer as a result". The Dilnot Commission calculated that demand had outstripped expenditure by around 9% over the previous four years in England.[269] The Nuffield Trust cited estimates which suggested that even without reform, spending on social care would have to rise from £14.6 billion in 2010/11 to £23 billion by 2025/26.[270] The Trust has calculated that with the number of people in England with moderate or severe disabilities projected to increase by 32% by 2022, public expenditure on social care and continuing healthcare for older people will have to rise to £12.7 billion in real terms (an increase of 37%

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

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

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

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

270 Nuffield Trust, *Reforming social care: options for funding*, May 2012.

from £9.3 billion in 2010), to keep pace with expected demographic and unit cost pressures.[271]

189. Recent cuts to social care budgets have intensified an underlying mismatch between funding and demand, so that a growing number of people on low incomes are no longer eligible for state support.[272] The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Society of Local Authority Chief Executives (SOLACE) told us that, following the capping of council tax, councils have managed demand by tightening eligibility thresholds and raising income via increasing fees and charges. Eighty-five per cent of English councils are now implementing a threshold at 'substantial' or 'critical' needs, resulting in a growing level of unmet need, with people unable to access support until their needs reach crisis point.[273] Many older people with moderate needs are therefore already suffering, and the situation is likely to continue to worsen without significant real terms increases in funding.[274] The result is further strains on public spending, as well as personal suffering: we heard from Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) that the NHS and social care are now in a very clear symbiotic relationship: "if you tighten the screws on the funding of social care, you put an extra load and burden on the NHS".[275]

190. Cuts to social care budgets are also driving down what local authorities pay private providers. Evidence suggests that the level of local authority funding is in many cases already below what residence in a care home costs. This means that "within a home, you often have private patients subsidising local authority-paid people".[276] This is a hidden tax on those who are funding their own care.

191. **There should be a sharing of responsibility for social care between individuals and the state, although on a basis that is less worrying for older people, as the Dilnot Commission proposed** (see Annex 11)**. But there are many people who do not have families who can provide care, or the money to buy it, but who cannot cope without care—and this situation is likely to worsen considerably with greatly increasing numbers needing such care in the coming years. If the neglect of social care continues and these people are not properly supported in the community, they will end up with more severe needs or will suffer crises and go into hospital, which is likely to be contrary to their wishes, not in their best interests, and more expensive.**[277]

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

272 Nuffield Trust, *Reforming social care: options for funding*, May 2012.

273 LGA/ADASS/SOLACE; Alzheimer's Society; Age Cymru.

274 LGA/ADASS/SOLACE.

275 Q 588

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

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

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

192. There is a serious public funding gap in social care in England, despite the fact that under current systems, massive costs for social care can also fall on the individual.[278] In response to the Dilnot Commission's report, the Government are proposing to raise the asset limit at which people must pay for all their care to around £123,000 in 2017/18 prices.[279] The Government are also proposing that individuals should not be called upon to pay more than £75,000 in 2017/18 prices in reasonable care costs over their total time receiving care.

193. We consider that the Dilnot Commission's proposals are far from a panacea for social care funding. The Government have estimated that the costs of their proposals in response to the Dilnot Commission will be £1 billion a year by the end of the next Parliament (i.e. 2020).[280] The major gainers will be the relatively better-off, who will be protected from depleting their housing assets;[281] and those who immediately gain will be the generation who have benefited from increases in housing wealth on an unprecedented scale over the past half-century (see Annex 7).

194. **The main advantages of the Dilnot Commission proposals were that they made clear to individuals the need to plan for the likely costs of long-term care, put a limit on the risks that individuals face, and would encourage the private insurance and pensions sectors to enter this market. The Committee considers that the Government's response to the Dilnot Commission proposals is a welcome step in the right direction, and necessary, but it will not be sufficient. The proposals are primarily concerned with redistributing the costs of care. They do not bring extra funding into the system to tackle the current funding crisis, avert the tightening of eligibility criteria for care access, or address the problem of expanding need in the coming decades—although we acknowledge that this was not the task given to the Commission.**

195. We have already argued (in Annex 7) that those who have benefited most from the housing boom should make a fair contribution to the rising costs of their own care. We consider that enabling people to access the value locked up in their homes through equity release will be crucial to helping older people to fund the care costs they may face.

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

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

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

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

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

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

196. **Older people are not well served by the current health and social care systems, and we have grave concerns for the future efficacy of these services as demands increase.**[282] Older people experience health and social care services as fragmented, underfunded, and not centred on their needs. The systems are peppered with perverse incentives, fractured by different funding streams, and feature a baffling array of different access levels, assessments and accountabilities.

197. The Health Service Ombudsman for England told us that "the NHS is failing to treat older people with care, compassion, dignity and respect".[283] According to Professor Chris Ham, Chief Executive, The King's Fund, "there is a long way to go before we can be confident that we are providing the right standards to all older people, wherever they come into contact with the health and social care system", as "public services for older people have not had the same priority in many parts of the country as other services in the NHS".[284] Professor David Oliver, the Royal Berkshire Trust, Department of Health and City University London, considered that "we are palpably failing" to deliver the evidence-based interventions required to achieve the desired outcomes for older people's care.[285] He explained that "There is endemic evidence of discriminatory attitudes from staff; of older people getting a worse deal than younger people when they have the same condition; of common conditions of ageing being neglected—dementia is now an exception, because there is a big policy push around dementia—and also of, historically, far less investment and fewer policy levers around the care for older people."[286] He also referred us to problems with patient safety amongst older people and with a lack of respect and dignity in the treatment of older people and their carers.[287]

198. We heard that a new model of care is needed, more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration.[288] Older people need care that is joined-up around the needs of the individual.[289] It must be person-centred, with patients engaged in decisions about their care and supported to manage their own conditions.[290] The home must become the hub of care and support, including emotional, psychological and practical support for patients and caregivers.[291] Older

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282 Q 216

283 Parliamentary Ombudsman and Health Service Ombudsman for England.

284 Q 216

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

286 Q 239

287 QQ 238-239

288 The King's Fund; Q 277 (Caroline Abrahams, Age UK).

289 Q 671 (Rt Hon Jeremy Hunt MP); Q 216.

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

291 Q 270; Q 277 (Caroline Abrahams).

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

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

The fundamental problem: the split between healthcare and social care

200. Older people in need of healthcare and social care often experience a complex combination of differing frailties, conditions and illnesses. Their care requires a mix of closely intertwined services from the NHS, their local authority and private providers, all centred on meeting the best interests of the individual (and, where relevant, their family and carers).[294] However, administrative structures, professional divisions and financial incentives in the current systems are making co-operation very difficult.

201. There is huge variability in the current performance of health and social care services for older people, with examples of excellent practice, average services, and services that are unacceptable. Many witnesses argued that one of the reasons for this variation and for poor quality care is fragmentation, including organisational separation between local authorities and the NHS, as well as separation between mental health providers, acute hospital providers and primary care, a historical division between GPs in the community and specialists in hospitals, and split funding streams.[295] Professor Ham argued that the key to unlocking better quality and more consistent care for older people was "tackling the fundamental problem of fragmentation".[296] Norman Lamb MP, Minister of State for Care and Support, acknowledged that there was "institutionalised fragmentation" and that there were divisions between mental health and physical health, primary care and secondary care, healthcare and social care. The divides were "not very rational from the patient's point of view".[297] According to Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent, having two inter-dependent systems that are not organised or run in partnership or collaboration results in "the potential for

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

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

[294] Q 216, Q 290, Q 613

[295] Q 216, Q 219

[296] Q 216, Q 219

[297] Q 680

inefficiencies, inappropriate services, and inappropriate balance between the services".[298]

202. The separations between NHS money, local authority money and private money are partly behind this fragmentation, and there is a strong argument for bringing the social care and healthcare funding streams together, at least on the ground.[299] Phil Pegler, Chief Executive, Carewatch Care Services, argued for a joined-up budget, and Geoff Alltimes, NHS Future Forum Joint Lead and former Chief Executive, Hammersmith and Fulham Council, argued for "the integration of the totality of the money, the main programme money".[300] Mike Farrar, Chief Executive, NHS Confederation, wanted the integration of not just community social care funding and community healthcare funding, but also primary care funding, through GP practices.[301] Professor Forder told us that pooling resources was only part of a gamut of solutions to integrated care, but advocated personal budgets which "facilitate [a] care manager pulling resources from different parts of the system", and might thereby result in integrated provider services.[302] However, others were sceptical about whether elderly people concerned about their own wellbeing would want to be worrying about personal budgets.[303]

203. Governance and accountability rules also currently limit the capacity for integrated care. Professor Elisabeth Paice, Chair, North West London Integrated Care Management Board, told us that "accountability is not shared but is allocated to different departments, people and organisations".[304] Dr Shane Gordon, CEO, North East Essex Clinical Commissioning Group, considered that unless differences of priorities were resolved between the different people he accounted to, it would be hard to continue with joined-up commissioning, especially when funding is under pressure.[305] For Professor Forder, mechanisms to bring the money together were less important than the values and lines of accountability of the separate parts of health and social care meaning that "those parts of the system charged with a certain set of activities are going to focus on those activities and not necessarily take into account what is going on elsewhere".[306]

204. Divisions embedded deeply into professional cultures can also be a barrier to integrated working.[307] Professor Forder told us that you can facilitate joint working by integrating structures and budgets, "but until people want to use those budgets in an integrated way around the patient and the service user, we are still going to get problems."[308] Professor Paice emphasised the importance of training to cultural change: "We do not train healthcare professionals necessarily to be collaborative but to be independent,

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298 Q 290; Andrew Harrop, Fabian Society.

299 Q 555, Q 557, Q 578 (Professor Elisabeth Paice); Q 81.

300 Q 296; Q 312

301 Q 313

302 Q 306, Q321

303 Q 316

304 Q 555

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

306 Q 314

307 Q 608; Q 303 (Mike Farrar).

308 Q 314, Q 299; Q 614

autonomous beings. Instead of the lonely hero, we need to develop a culture of collaboration."[309]

205. Joint working had to be approached from the bottom up rather than at the strategic level, according to Professor Forder. The solution had to be focused "around the individual person", rather than on the distinction between health services and social care services.[310] Professor Forder argued that person-centred care is facilitated by mechanisms like personal budgets, and an outcomes framework that recognises the whole care needs of the person rather than separate performance mechanisms for the health service and for the social care service.[311] Incentives had to be changed to bring health and social care workers together. For Geoff Alltimes, it would only work on a local basis, with the coming together of GPs and local councillors.[312] They will also have to overcome some defensiveness within professionals: Dennis Holmes, Deputy Director of Adult Services at Leeds City Council, feared that "there is a risk from the NHS perspective that any pooling will help in some way to cross-subsidise council services."[313]

206. We heard from Geoff Alltimes that Health and Wellbeing Boards, bringing together local government and Clinical Commissioning Groups, may help with integration, as he believed that the signs showed that people were beginning to recognise that in order to solve their financial problems and achieve improvements in care they would need to work together and commission joined-up services.[314] Professor Les Mayhew, Cass Business School and Andrew Bonser, Director of Public Policy, Alliance Boots, were hopeful that Health and Wellbeing Boards might help in spotting and taking opportunities for improving services.[315] However, Dennis Holmes raised concerns about working with multiple Clinical Commissioning Groups and a community healthcare trust rather than a single Primary Care Trust.[316] Mike Farrar told us that with the recent NHS reforms, "we stepped backwards from integrated commissioning, because effectively in these reforms we have taken primary care spend and moved it to a National Commissioning Board; we have moved specialist care spend into a different bit of the National Commissioning Board; community hospital and community services' health spend has gone into the CCGs; and local government has health improvement spend in one bit of it, and social care for adults and social care for children in different bits."[317] However, he was hopeful that commissioning support units, by uniting the technical support to these various commissioning bodies, might be able to secure integrated care.[318]

207. **The barriers to integrated health and social care explored above, and the inter-dependent nature of health and social care, have driven the Committee to conclude that the structural and budgetary split**

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309 Q 555

310 Q 291

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

312 Q 312, Q 319; Q 617 (Dr Jennifer Dixon, Director, Nuffield Trust).

313 Q 558; Q 557

314 Q 303

315 Q 358; Q 358

316 Q 558

317 Q 303

318 Q 318

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

Encouraging innovation in the meantime

208. There are some excellent examples of innovation despite the structural barriers that currently exist.[320] Professor Paice, who chairs two integrated care pilots in north-west London, told us how on dementia and the care of those aged 75 and over, they brought together acute and primary care, mental health, social care, patients' organisations and community trusts in a voluntary "club" with shared governance.[321] The Torbay and Southern Devon Health and Care Trust has co-located multidisciplinary teams of occupational therapists, physiotherapists, social workers and social care professionals, community nursing teams and community matrons, all working with clusters of GP practices, and enabling both GPs and the public to reach the whole team through a single point of contact.[322] Local decision-making allows access to both health and social care funding streams, although the Trust has to account for the money to its different sources separately.[323] Leeds City Council is also encouraging collaboration through co-locating adult social care workers with community NHS staff, coalesced around GP practices, and through collective spending aimed at outcomes shared with the NHS.[324] The council is fostering "social capital" through the use of volunteers and voluntary groups providing friendly visits to older people, and using a "whole-council approach" which includes engaging with housing provision and planning.[325] We also heard about a pilot for community budgeting in north-east Essex.[326]

209. Such examples of integrated service provision demonstrate ways of achieving better experiences and outcomes for older patients. We concur with Dr Jennifer Dixon, Director, Nuffield Trust, that "we have to put more effort into trying new and radical experiments", and with Mike Farrar that "in the financial circumstances ... and given the demographic pressures, we need to be achieving this at scale".[327] Sir Bob Kerslake agreed that there was not "some single dealbreaker barrier" obstructing co-operation, and that progress could be made within the existing framework.[328]

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

320 Q 680

321 Q 554, Q 555

322 Q 554, Q 560

323 Q 560, Q 561

324 Q 554, Q 558, Q 578, Q 579

325 Q 558

326 Q 554, Q 562

327 Q 608; Q 292

328 Q 650

210. The Nuffield Trust has found a common experience of initiatives with a high level of goodwill which fizzle out after a short while.[329] Dr Dixon argued for central assistance to keep momentum alive and to "help the most promising sites accelerate".[330] Central support might consist of leadership, information, thinking about the financial physiology across providers, or more community-based services. She also recommended centralised help with evaluating integrated projects.[331] Sir Bob Kerslake has suggested the creation of a 'what works institute' to facilitate learning from innovation.[332]

211. Norman Lamb MP told us that he wished to see "a culture that facilitates ... experimentation" within a vision of what the system needs to achieve.[333] **In the absence of counter-productive systemic change in the near future, and because full integration cannot be achieved immediately, there needs to be significant experimental work at the local level over the next five years. Local authorities and clinical commissioning groups must be allowed licence to experiment, and they must be pushed to innovate, especially with new forms of cross-service outcome-based commissioning, despite the local variations that would emerge. Innovation will be crucial to solving the problems of service integration, but innovation will not happen without an encouraging climate.[334] The Government must act now to challenge the barriers to effective and efficient collaboration, some of which we explore in Annexes 13 and 14, in order to free up the good people working in health and social care to innovate, deliver the kind of personal, integrated care that our older population wants, and reduce waste and inefficiency.**

329 Q 625

330 Q 608, Q 625

331 Q 608

332 Q 641

333 Q 677

334 Q 650

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

The current NHS model is outdated

212. The current form of NHS provision is not fit for managing the needs of the older population we have now, let alone coping with the greatly increased demand coming soon.

213. The current NHS model is simply outdated. We heard from Professor Oliver that "when the NHS was founded, 48% of the population died before they got to 65" but that this figure had now been "constant at 18% for the past two decades".[335] Professor Oliver quoted the Chairman of the House of Commons Health Select Committee, the Rt Hon Stephen Dorrell MP: "'Systems designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long-term conditions'".[336] Professor Mayhew and Professor Ham concurred.[337] Our health system, and the funding that flows through it, is dominated by the acute hospital sector.[338] Dr Gordon told us that "if we carry on funding and preserving a sickness service, we will very soon not be able to afford it" because the knock-on effect will be a lack of funding for social care with the consequence that more people will "become sick and add to the burden".[339]

214. The emphasis of the NHS, and its funding, needs to shift to take better account of the needs of older people. The core business of health and social care is now older people with complex needs.[340] Enhancing the quality of life for people with long-term conditions is "the biggest challenge of the 21st century", according to Dr Martin McShane, Director, Domain 2, NHS Commissioning Board.[341] Mike Farrar told us that in the community, "what we really need to do is have a care service with a medical adjunct rather than a medical service with a care adjunct", while Professor Ham urged "a reinvestment in primary care services and community-based services".[342]

215. The two most recent Governments saw record year-on-year investments in the NHS, but nearly all the extra spend went into acute care.[343] However, research suggests that more than a quarter of people in acute hospitals do not need to be there.[344] Unnecessary inpatient stays bring the risk of hospital-acquired infections and the institutionalisation of older patients who then lose the ability to look after themselves.[345] Sir Bob Kerslake acknowledged the need to "prevent emergency admissions to hospital ... [and] that pattern,

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335 Q 237

336 Q 239

337 Q 340, Q 217

338 Q 588

339 Q 562

340 Q 239

341 Q 248

342 Q 291, Q 217

343 Q 243

344 Q 618 (Professor Ham), Q 598.

345 Q 581 (Tony Watts), Q 618 (Dr Patel), Q 294.

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

216. **General, acute and accident and emergency hospital services absorb nearly half of the NHS's budget.**[348] **We consider that some of that money could be better invested in supporting older people to live well and independently in the community.** The key is to consider how to shift resources and staff into the community. Professor Martin Knapp, London of Economics (LSE) and PSSRU, told us that we need to "incentivise ... the system to get money out of acute wards or out of acute hospitals" because "It is the acute sector that is stopping things happening".[349] Professor Ham agreed.[350] This shift will have to involve reducing capacity in acute hospitals: we heard from Professor Mayhew that when a care co-ordination service in Brent achieved substantial reductions in days in hospital, the rate of hospital admissions stayed level because "the Health Service was just admitting people into the beds that were vacated". His conclusion was that "You have to take capacity out of one system to realise savings in another part of the system."[351]

217. Reducing capacity in acute hospitals may be necessary, but it is never popular. The Secretary of State for Health, the Rt Hon Jeremy Hunt MP, acknowledged that "every time a politician of any party has tried to paint a picture about why it is necessary to close hospitals, the public have not believed them".[352] Professor Knapp summed up the problem: "Politicians do not like using the word 'ration' and they do not like using the words 'close and hospital', but I think that is what you are going to have to do."[353] For Dennis Holmes, closing some acute hospital facilities is "a real political challenge for locally elected members and non-executive directors in local NHS organisations which we will need to confront."[354]

218. **NHS professionals must be supported by politicians publicly to make the argument that rationalisation and specialisation of hospitals will improve the quality of hospital-based treatment, as well as allowing a shift in funding to improve community-based care.**[355] Professor Oliver told us that there is a need for an honest discussion about reconfiguration of services rather than "hanging on to small units that are not providing high quality care."[356] Lord Warner believed the medical specialists would support

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346 Q 649

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

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

349 Q 359

350 Q 618

351 Q 332, Q 601

352 Q 676

353 Q 361, Q 77, Q 558

354 Q 558

355 Q 591

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

change but needed to be given political permission to drive such an agenda.[357] The Committee asked the Government for examples of Ministers publicly making the argument as to why the structure of our health and social care system needs to change, and they did not supply a single example of a Minister making the case for the closure of a hospital on clinical grounds.[358] **Politicians must take the lead, clearly explaining why changes in the way that NHS services are delivered will be in the public interest, and publish a clear vision of the care services we should aim for and a description of the framework that will achieve them.**

219. One option which might be more politically palatable would be to move the conversation from 'closing' hospital facilities to transforming them into units better suited to the needs of our ageing society. Professor Mayhew argued for "small community hospitals that look after older people for short periods until their condition is stabilised".[359] Baroness Greengross argued that we should "cut out 20% of our acute hospitals and transform them into primary-care-led hospitals."[360]

220. A public case needs to be made for helping people manage their long-term conditions at home. This will also require local strategic planning. Some double-running costs will be involved initially as there is a limit to how much it is possible to reduce the capacity of acute hospitals while replacement services are built up so planners will need to keep their focus on longer-term savings.[361]

Using financial incentives intelligently

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

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

357 Q 595, Q 601, Q 592

358 Central Government (DoH and DWP), further supplementary written evidence.

359 Q 333, Q 364

360 Q 72, Q 83

361 Q 574, Q 595

362 Q 579

363 Q 574, Q 456, Q 77

364 Q 601, Q 362

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

Preventing unnecessary hospital admissions of older people

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

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

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

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365 Q 692

366 Q 671

367 Q 456, Q 580

368 Q 692

369 Q 608, Q 75, Q 574

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

371 Q 618 (Dr Patel), Q 239, Q 553.

372 Q 242

373 Q 560

374 Q 560

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

226. **A crucial aspect of the shift to a new system of health and social care, more focused on managing long-term conditions and with much less use of acute hospitals, is adequate access to primary and community-based care. To meet the needs of our ageing population, and to achieve this shift, the health and social care system needs to work well 24 hours a day, seven days a week.** Currently, the health and social care system fails outside working hours on working days. People go by default to a hospital because it is the only part of the system that is open 24/7.[378] This results in unnecessary inconvenience and suffering, and means that "We have people in hospital that could be more appropriately looked after elsewhere."[379] Lord Warner told us that correcting this would require "a much more robust approach to the GP contract in terms of what they are expected to do".[380] We need "a model that can be as responsive in the community as those emergency services in hospitals."[381]

227. We agree with the Royal College of Physicians that the healthcare system must "ensure the availability of primary care services whenever they are needed, including at the weekend and at night".[382] One way of achieving something close to this was outlined by Professor Ham, who told us about areas that have pooled their budgets, and used what is nominally NHS funding to increase investment in social care and create rapid response teams available for extended hours who can be called in when there is a crisis in the care of an older person to avoid hospital admission.[383] **We were pleased that the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, agreed that "we have to have a 24/7 NHS". We are heartened by his commitment to 24/7 health services, and we call on him within 12 months to set out how this will be made real.[384] For this to have value, there will also have to be 24/7 community-based healthcare and social care.**

228. **We consider that the shift in the health and social care system away from acute and emergency services and towards preventing older people from going into hospital should also help with the funding pressures facing social care. Some of the funding released from acute**

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375 Q 343, Q 426, Q 81

376 Q 650

377 Q 650; Q 331 (Professor Les Mayhew).

378 Q 618 (Professor Ham); Q 77.

379 Q 618

380 Q 598

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

382 Royal College of Physicians.

383 Q 618

384 Q 679

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

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

The need for leadership

230. This fundamental shift in the focus of the health and social care system will require great leadership. When we pushed the Secretary of State for Health on how to bring about the re-configuration of services to cope with the needs of older people the response was, in essence, that the Government do not believe in top-down command and control, and that the decentralisation of budgets and responsibilities to over 200 clinical commissioning groups and new Health and Wellbeing Boards would drive the necessary changes.[389]

231. **In the light of the many local initiatives we have heard about, we have concluded that organic, bottom-up change has benefits and should be encouraged, but it will not by itself bring about the major changes to health and social care services that an ageing population will need.** Innovation must be combined with strategic management of the whole health and social care system, managing the complex balances and interrelations between the two halves of the whole so that hospitals provide care for people who are acutely ill while primary and social care keep people out of hospitals.[390] **Bottom-up change cannot by itself bring about the major shifts that we rapidly need if we are to cope with the considerable increases in demand. The Government need to develop a new basis for health and social care for our ageing population and create a clear vision so that other decision-makers can work to bring it about. The Government must set out the framework for radically transformed healthcare to care for our ageing population as a matter of urgency,**

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385 Q 581 (Tony Watts), Q 239, Q 264.

386 Q 560

387 Q 415

388 Q 74

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

390 Q 77

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

232. **This vision for the long term must not be undermined by short-term budgetary cycles. The health and social care systems need to be enabled to plan more strategically and systematically for changing long-term needs. We conclude that the Government should consider introducing a 10-year spending envelope for the NHS and publicly-funded social care.**

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

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

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

Reducing duplication and improving service

235. We have already discussed the need for health and social care to be better integrated. Older people do not want to have to repeat the same information to different professionals, or have their needs fall down the gaps between different systems.[391] We heard the case for care managers, who know the systems, can help people navigate through them, pull together funding streams, and advise people with personal budgets or help those who are paying for services privately.[392] Julie Foster, Associate Director for Adult Social Care, Torbay and Southern Devon Health and Care Trust, told us that Torbay's care co-ordinators are "the single biggest factor in making us more successful at integration", and Dennis Holmes did not think that integrated systems could work without a single point of contact.[393] Better co-ordination of care is crucial, and nominated lead care workers could help to bridge gaps between systems and make things happen, as well as ensure that older people feel informed and in control of their care.[394] We also encourage the health and social care services to consider how to ensure that professionals feel responsible for the whole care of the individual for whom they provide care.

236. Making sure that those delivering care can help to support that older person in a holistic way could save money and enhance wellbeing. Professor Mayhew told us that, in one study on intermediate care, he found there were, potentially, 22 different health services alone, excluding social care, which could be aimed at a person needing care at home. He questioned whether this was suitable, and suggested that a more multi-skilled care worker, who could undertake care tasks but also basic health tasks like taking blood pressure and blood samples, would improve the efficiency of home care.[395] Professor Paice agreed.[396]

Sharing data

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

391 Q 239, Q 560, Q 658

392 Q 312, Q 321; Q 565 (Professor Elisabeth Paice).

393 Q 582 (see Julie Foster and Dennis Holmes).

394 Q 624 (Dr Patel).

395 Q 346

396 Q 574

397 Q 622

398 Q 333

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

238. Some practitioners have made heroic efforts to join up the dots. Professor Paice told us that when the North West London Integrated Care Pilots brought together data across organisational boundaries, it had to ask 24,000 people for their consent, and only 300 objected.[402] In Torbay, the same computer system is being used across health and social care.[403] An electronic palliative care co-ordination system in London has resulted in the number of people in the system who die in hospital falling to half what it is across the rest of London.[404]

239. **Enabling more data to be shared is crucial. Constraints must be removed, risk-averse attitudes must be reduced, and myths which result in people feeling unnecessarily restricted must be challenged.[405] If necessary, legislation must be introduced. The Secretary of State for Health told us that he was going to dictate from the centre on this issue, requiring hospitals to update GP records so that they contain full acute, tertiary and social care trails.[406] We welcome this approach.**

Using technology

240. Technologies, including telecare and telehealth, also have the potential to save money and improve the quality of care that older people experience, as well as prevent accidents and crises. We heard about fire alarms, movement sensors, alarm pendants, temperature alerts and programmes to manage complex medication regimes.[407] Professor Oliver warned us that a recent survey of European experts had found that of every country in Europe, "the UK was the least confident about its ability to use telecare, telehealth, new technologies."[408]

241. New technologies are not a panacea—they have to be used carefully to work well and be cost-effective. Telecare and assistive technologies have to be well-designed from the user perspective.[409] Caution is needed to ensure that older people do not feel increasingly marginalised by digitalisation and automation, and to ensure that an expanding reliance on telecare does not increase loneliness.[410] The use of technologies must also keep up with the high pace of change in this sphere.[411]

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399 Q 555, Q 558, Q 562, Q 620

400 Q 277 (Caroline Abrahams).

401 Q 623

402 Q 555

403 Q 560

404 Q 251

405 Q 279

406 Q 694

407 Q 308; Independent Living.

408 Q 280

409 Q 509

410 Age UK; Older People's Commissioner for Wales; Low Incomes Tax Reform Group and Tax Help for Older People.

411 Q 69

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

Improving standards in social care

243. Scandals in the recent past have highlighted that standards can fall below acceptable levels in care homes and hospitals, but standards of care delivered within the individual's home are equally important and are difficult to monitor. The state has a fundamental duty to ensure that the vulnerable are protected, including when care is privately provided.

244. William Laing, Chief Executive, Laing and Buisson (Consultancy) Ltd, told us that a large survey of recipients of social care funded by local authorities, run by the Information Centre for Health and Social Care in early 2012, had found that 71% of respondents using residential care had been very or extremely satisfied with their care; this figure fell to about 55% for users of home care.[414] This survey also found that while 30% of residential care or community-based care users felt they had as much control over their daily life as they wanted, 25% felt they had not enough or no control over their daily life. 6% felt less than adequately clean or presentable or not at all clean or presentable. 5% reported that they did not always get adequate or timely food and drink, including 1% who felt that this posed a risk to their health. 7% felt less than adequately safe or not at all safe with regard to abuse, falling or other physical harm. 25% said that care and support services did not help them feel safe. Regarding dignity, 8% reported that the way they were helped and treated sometimes undermined the way they thought and felt about themselves, and 1% reported that it completely undermined this.[415]

245. Low rates of pay for care workers who look after some of our most vulnerable citizens are part of the problem. Sue Redmond said that an important change would be to value what care workers do more highly: "They are doing the most intimate and the most amazing work for people and their status and their pay is very low."[416] Tony Watts, Independent Chair, South West Forum on Ageing, argued that because local authorities do not pay sufficient money to the care homes for each resident, staff are not paid properly, with the result that "You do not get proper training, you do not get the right staff and people go into it as a low-skilled, low-fulfilment job".[417] Lord Warner agreed that "the pay of this work force is being squeezed to really quite potentially dangerous levels".[418] Higher pay rates might encourage more workers into the sector, and could encourage a focus on care as an important growth sector for the UK economy, as in France.[419]

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412 QQ 678–Q 679

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

414 Q 386

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

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

417 Q 573

418 Q 594

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

246. The way in which some care workers are expected to deliver care is also inefficient and an obstacle to good care. Care workers commissioned to deliver care during a 15-minute visit (travel time permitting), or to deliver a process such as getting a person up, are likely to become de-motivated and disengaged.[420] Wiltshire Council is now paying care workers according to "outcomes" for the people they care for, such as "'I want to get on with my life' or 'I want to be able to go and see my daughter'". Another aspect of Wiltshire's commissioned outcomes is reducing social isolation: introducing the older person to their local voluntary organisations or groups, or taking them to the library, so that the provider is incentivised to meet the outcomes that will directly improve the older person's quality of life.[421]

247. The Government should be careful that their actions do not work to suppress a healthy market in high-standard privately-provided social care. Phil Pegler told us that he wanted to stop providing care funded by local authorities, because the funding is too low to allow him a profit as the national minimum wage increases. He wanted to provide "a different type of offering that ... will suit the local community and provide a better provision and be more cost effective", but the market is too inhospitable.[422] The Government therefore need to be aware of the impact of local authorities' funding settlements on the private care market.

Opening up the social care sector

248. Ensuring high standards of social care has to go wider than pay, commissioning or funding restrictions. Social care—whether delivered by the public sector or privately—has to be opened wide to public scrutiny and state inspection if the care market is to work well in the interests of its customers.

249. Older people and their carers need better information on privately-run care homes. When people buy care it is often a "distress purchase", and buyers are not well-informed because the data do not exist or because they do not know where to find the data.[423] Steve McIntosh, Policy and Public Affairs Manager, Carers UK and Martin Green, Chief Executive, English Community Care Association, both regretted that the Care Quality Commission (CQC) does not provide star ratings for care services. Martin Green told us that "what we have now is you are either a pass or a fail service and there is no way to identify whether or not a service is of a much higher quality", although David Behan, Chief Executive, CQC defended the quality of the CQC's reports.[424] The Secretary of State for Health confirmed that he would "like to introduce Ofsted-style ratings across the care home sector, across hospitals, across GP surgeries, the works", as long as it was done in a way that was academically and clinically rigorous.[425]

250. Regulation alone is not enough to create transparency and fully monitor or drive up quality, as David Behan, Sue Redmond and Norman Lamb MP acknowledged.[426] We heard that there is also a role for local authorities, in

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[420] Q 375, Q 559, Q 377

[421] Q 377, Q 399

[422] Q 315

[423] Q 628

[424] Q 223, Q 375, Q 384, Q 629; Q 266 (Philip King, Director of Regulatory Development, CQC).

[425] Q 696

[426] Q 627, Q 377, Q 695

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

251. While local authorities can influence the social care market, they are limited as to how much information they can provide self-funders. Sue Redmond told us that social services could not advise people paying for their own care on whom they should use, due to competition law.[433] But users of these services are free to share information with each other. David Behan considered that "the voice of people that use services" is one of the most important influences on the quality of care.[434] When we discussed the idea of an informal system of care home monitoring by older people, Sue Redmond confirmed it was established practice in a number of local authorities, and that Wiltshire already had older people assessing all of its care agencies, with training and support.[435] Dennis Holmes described "dignity champions" who help to monitor care homes in Leeds, and Martin Green told us that something similar was also happening through the Experts by Experience programme which the CQC has developed, but that it "needs to get more traction and needs to be part of, perhaps, every inspection."[436] Tony Watts confirmed that it was already working in parts of the country, often led by older people's groups, but that many of these groups were closing down because of a withdrawal of funding.[437]

252. As well as welcoming visitors in, care homes should engage more with their local communities. This would have a triple benefit: these homes would be more open to scrutiny, would be able to spread knowledge about effective practice to local informal carers, and would improve their own profile.[438] Dennis Holmes and Norman Lamb MP also highlighted the role of local Healthwatch organisations in supporting the CQC with monitoring care.[439]

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427 Q 266

428 Q 379, Q 381

429 Q 383

430 Q 564

431 Q 564

432 Q 398

433 Q 394, Q 402, Q 403

434 Q 627

435 QQ 395-396

436 Q 572, Q 385

437 Q 567

438 Q 419

439 Q 572; Q 695

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

254. **We are encouraged that the Government are looking at how to improve the private social care sector, and urge them to provide support for a transparent, good quality private social care market.**

Spreading good practice

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

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[440] Q 397

[441] Q 397, Q 403

[442] Q 572, Q 403, Q 404

[443] Q 696

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

256. Publicly funded care has never been able to meet all the needs of the minority of older people who are frail, vulnerable, ill or isolated. The bulk of care is and has always been provided within families, with twice as many unpaid carers in the UK—nearly 6.4 million—as there are paid staff in the health and social care systems combined.[444] As our society ages and these needs increase, yet more informal care from family and friends will be required. The number of disabled older people receiving informal care in England will need approximately to double over the next 20 years if supply is to keep pace with demand.[445] Carers UK told us that it has been estimated that nearly 3.5 million additional carers will be needed in the UK by 2037.[446]

257. Demands on carers are already high. Steve McIntosh told us that the number of carers is rising rapidly, coupled with an increase in the intensity of the caring that they are providing: in the last decade the proportion of carers caring for over 50 hours a week has doubled.[447] Elderly parents may only have one child to care for them, and that child may no longer live nearby.[448] Currently one in seven employees combine work with caring responsibilities, and one in four carers has given up work to care, at an annual cost to the economy of £5.3 billion.[449] Pressure is also increasing on older carers. More men in their 70s and 80s are now looking after disabled wives, and Professor Rees told us that the age group of 55–69 year-olds, "the kind of age group that is going to be looking after their parents aged 80, 90 or 95", is projected to see very low growth, "while that of the people who need the care will grow very substantially."[450]

258. The support provided to older people by informal carers is massively valuable to UK society, as well as to the economy. One valuation, from Carers UK, is that their contribution across the UK is worth £119 billion a year, more than the cost of the NHS.[451] Informal carers deserve our society's support for the work that they do, and such support will improve older people's wellbeing and carers' wellbeing, as well as result in savings in health and social care spending. Mike Farrar told us that "the most strategic use of the resources available to help care for older people" would involve "spending not a lot of money but spending it very effectively supporting partners and carers to have a higher level of skill". He concluded that "some of that money should be spent by the state in helping them to be able to care for their loved ones maybe six months longer than otherwise", allowing the older person to stay in their own home for longer, and saving six months of hospital or care home costs.[452] Professor Knapp highlighted carer support and looking after the health and wellbeing of carers as one of the areas of intervention for which

444 Carers UK.

445 Central Government (DoH, DWP, DCLG), written evidence.

446 Carers UK.

447 Q 277

448 Q 96 (Professor Harper).

449 Carers UK; Age UK.

450 Q 96 (Professor Rees).

451 Carers UK, *Valuing Carers 2011,* L. Buckner and S. Yeandle.

452 Q 307

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

259. As we have explored above and in Annex 3, the contribution being made to our society by older people is already vast, but our increasing lifespan offers a fantastic opportunity for older people to play an even greater role in public life, and we must not miss it.[454]

260. We recognise the very valuable work already done by a number of charities such as Age UK, WRVS, Alzheimer's Society and Carers UK, to support older people. Voluntary and community engagement can support people to stay connected to their communities, reducing social isolation and loneliness.[455] Professor Goldblatt argued for the benefits of the "young elderly" supporting the "older elderly", forming a mutually beneficial network that reduces isolation as people move through older age.[456] Loneliness and isolation have an important impact on quality of life, and a very harmful effect on physical and mental wellbeing—we heard from Shaun Gallagher, Acting DG for Social Care, Local Government and Care Partnerships, Department of Health, that together they were "one of the biggest risk factors for people needing care and support".[457] Norman Lamb MP agreed that "Just a bit of companionship keeping the mind active can do an enormous amount to maintain independence and happiness, which is quite an important concept and can reduce the cost to the system".[458]

261. Mr Lamb stressed the need to recognise that "People in retirement so often want to give, want to help, want to give back, but often do not know how to". It is also important to ensure that risk-aversion does not get in the way of volunteering, as Martin Green argued.[459] Mr Lamb was enthusiastic that "We can unleash the power of people in their communities", especially to combat isolation.[460] **The Committee recommends that central and local government should work together with the third sector to increase volunteering especially by older people to support other older people.** The Government promoted the taking up of over a million youth volunteering opportunities through the 'v' programme.[461]

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453 Q 328

454 National Housing Federation; Age UK; Q 100 (Professor Harper).

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

456 Q 543

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

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

459 Q 414

460 Q 682

461 vInspired.

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

Preserving independence

262. If preserving independence is to be a central goal, appropriate and safe housing will become increasingly important.[462] Well-designed housing can also be cost-effective. For example, by providing a warm environment or making adaptations to prevent falls, investment in housing can reduce hospital admissions.[463]

263. Services that help older people adapt their own homes to allow them to live there for longer will become more important in the coming decades as the population ages. We heard impressive claims from Care & Repair Cymru about the cost-effectiveness of their Rapid Response Adaptations scheme, which makes small adaptations to housing to keep people out of hospital, or get them discharged more quickly, following referrals from professionals. Chris Jones, Managing Director, Care & Repair Cymru, told us that they had calculated that in Wales over the past 10 years, "the scheme has saved the NHS around £100 million through the reduced cost of hospital stays and hospital beds, and stopping accidents, which equates to £7.50 saved for every £1 spent".[464] **The work done by housing adaptation and repair services such as Care & Repair Cymru is commendable and must be supported.**[465] **Similar schemes should also be made accessible across England: currently only around 85% of residents in England have access to a home improvement agency.**[466] **Government, including local government, also have a role to play in providing advice on how to access housing adaptation services.**[467]

264. The Government can incentivise older people to adapt their homes by simplifying funding options such as the Disabled Facilities Grant process. There is currently some concern that the process for accessing Disabled Facilities Grants is too long and bureaucratic.[468] **The Government should support the development of housing adaptation services across England and Wales, both by ensuring adequate public funding and by encouraging the growth of a secure and easy-to-understand equity release market that can unlock funds to pay for housing adaptations** (see Annex 7)**.**

265. The Government could also support research into initiatives such as life-long homes and the use of technology in the home to support older residents.[469] New assistive technologies can, for instance, monitor older people remotely

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462 Q 170

463 Home Instead Senior Care; Policy Fen; Anchor.

464 Q 202

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

466 The website of Foundations, the (English) national body for home improvement agency and handy person services (www.foundations.uk.com).

467 Central Government (DoH, DWP and DCLG), written evidence; Central Government (DoH and DWP), supplementary written evidence.

468 Q 170

469 In their written evidence, Carers UK urged the establishment of a 'Health and Care Technology Taskforce'.

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

Ensuring adequate housing provision

266. According to Care & Repair England, while the majority of older people's homes are in a reasonable state, poor housing conditions remain. This is especially true for the 'older old'; low-income, long-term resident homeowners; and private tenants. Falling property values (outside London, parts of the South East and a few high-demand areas), combined with a stagnant market due to lack of mortgage availability and rising unemployment, will impact on 'moving on' or 'downsizing' options.[474]

267. Some local authorities and private housing developers provide staffed 'extra care housing', which offers more assistance than traditional 'sheltered housing'.[475] While cost-effective, this type of housing usually requires support or funding from other agencies. Encouraging stronger links between social care authorities and health providers such as home nurses could help to ensure that there is enough funding and service provision to meet care needs. In addition, private developers might ask users to 'buy in' using capital freed from selling their old home, or from other sources.[476] Housing associations potentially have a major role to play in providing access to extra care housing. Those associations that take on residents could likewise use the housing capital that has been released by the tenant moving from their own home. Or they could acquire the resident's property, manage it and collect rental income in order to pay for long-term care needs.[477]

268. At present there is little scope for housing associations to get involved. In countries that have direct, person-based long-term care and social health insurance (the Netherlands for example), not-for-profit housing agencies can

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[470] Independent Living.

[471] Age UK.

[472] Professor Anthea Tinker, KCL.

[473] Torbay Unitary Council, Q 558, Q 564, Q 415.

[474] Care & Repair England.

[475] Care Services Improvement Partnership, *The extra care housing toolkit*.

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

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

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

Stimulating the market in housing for older people through better planning

269. Many localities have a need for greater provision of more suitable housing for older people, with more support services.[480] The 2006 Wanless Social Care Review reported that 27% of older people would consider specialist housing if it were available.[481] In February 2012, a YouGov poll for Shelter concluded that 33% of people over 55 were interested in specialist housing, which equates to more than six million people.[482]

270. Despite growing demand for specialist housing and the substantial wealth held by some older people (see Annex 7), there is a gap in the market.[483] There are just 106,000 units of specialist housing for home ownership and 400,000 units for rent in the UK as a whole. Build rates are lower now than in the 1980s. In 2010, just 6,000 units for rent and 1,000 for ownership were built, whereas in 1989, 17,500 units for rent were built as well as 13,000 for ownership. These figures do not compare well with other countries. Just 1% of over-60s in the UK are estimated to live in retirement homes compared to 17% in the United States and 13% in Australia.[484] Shelter noted that if demand for retirement housing remained constant, supply would have to increase by more than 70% in the next 20 years.[485] McCarthy & Stone told us that "This is not going to happen without reform of the planning system".[486]

271. This is an issue not just for older residents but for the whole population. The Government have made efforts to improve access to housing for younger

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

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

480 Professor Anthea Tinker, KCL.

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

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

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

484 McCarthy & Stone.

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

486 McCarthy & Stone.

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

272. Major developers have not geared up for delivering developments of specialist housing for older people.[488] Gary Day explained that there are major barriers to entry into this market, and that "Public policy does not proactively encourage innovation and increasing supply in this sector".[489] Developers working in the market often lose out to businesses such as supermarkets and car park operators when applying for planning permission.[490] An efficient and trusted equity release market could provide some of the capital needed to stimulate the market in housing for older people, but many consumers do not have confidence in equity release schemes (see Annex 7).

273. **Local government should signal their intention to ensure better housing provision for older people by insisting that local planning agents both encourage the private market in housing provision for older people, and by making specific mention of older people's needs when drawing up their planning strategies.**[491] Developers of housing for older people would also benefit from a more favourable regulatory environment. Gary Day told us that the Community Infrastructure Levy (CIL) and Code for Sustainable Homes have serious cost implications. He argued that home builders were competing for sites against others who were not subject to the same obligations: for example, supermarket developers did not have enhanced building costs, because there was not an equivalent sustainability code for supermarkets, and did not have an obligation to provide affordable housing. He pointed out that in some instances supermarkets' CIL charges were lower, because the local authority wanted to encourage retail activity. This illustrated that housing developers were not operating on a level playing field for land acquisition, despite the growing need to ensure specialist housing supply.[492] Anchor, a care homes provider, told us that "new housing for older people should be exempt from the planning restrictions that apply to mainstream housing".[493]

274. Sites for older people's housing are best located either in urban centres, or at least in non-remote areas that have easy access to town or city centre amenities and activities.[494] The National Planning Policy Framework of March 2012 signalled that it is important to consider future demographic

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487 Q 190 (Ilona Haslewood).

488 Q 169

489 Q 169

490 Q169, Q176, Q180

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

492 Q 188

493 Anchor.

494 Q 172

change when making planning decisions.[495] The Framework said that it is also crucial to "address the needs of people over retirement age, including the active, newly-retired through to the very frail elderly, whose housing needs can encompass accessible, adaptable general needs housing for those looking to downsize from family housing and the full range of retirement and specialised housing for those with support or care needs".[496] However, the Committee heard that the Framework's mention of older people's housing needs was too vague to address the demand for suitable housing provision.[497] **Central and local government should jointly review how the National Planning Policy Framework's suggestions might be clarified and tightened to do more to ensure sufficient housing provision for older people.**

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

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

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

497 WISE, supplementary written evidence.

498 Care & Repair England.

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

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

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

276. As Annexes 7 and 16 suggested, the goal of developing services for older people should be to support the happy independence of older people.[501] Focusing directly on the needs of older people can be an effective route to service delivery. Nick Leon, Head of Service Design, Royal College of Art, told us that designing services should be about taking a user-, customer- or citizen-centric approach, and figuring out how to deliver a much richer and transformed user experience, "instead of looking at how one simply configures the service delivery resources in order to deliver what we have today with a modest, simple improvement". He suggested that: "If you design for the old, you can include the young. If you design for the young ... you will almost certainly exclude the old".[502]

277. A focus on older people's needs is particularly important when designing health services. Public service delivery mechanisms should have as a key aim how services might best contribute to preventive strategies in health and social care (see Annex 13), and, where possible, involve older people in their design.[503] A formal way to involve older people in the design and delivery of health and social care would be to encourage their representation on structures that have emerged from the recent reorganisation of the health system. Annex 16 proposed a potential role for local planners on Health and Wellbeing Boards. It is important that older people's representatives also have a standing position on Health and Wellbeing Boards, to ensure that the design of health and social care provision meets older people's needs.[504]

278. Urban planning is also important in ensuring that older people have access to the services that they need, and do not feel isolated. Housing developments suited to older people, with gardens, entertainment, and medical or fitness facilities are much needed.[505] Leeds City Council adopted a strategy that involved older people in local planning, which alerted planners to issues that will become even more pressing as the population ages.[506] **Urban planning and building design should respond to the needs of an older population.** The provision of disabled access and well-designed public toilets will be of growing importance.[507]

279. **Access to public transport, transport routes, types of transport provided and parking restrictions should all take the needs of older people into account, including considering their level of access to shopping and entertainment facilities.[508] This will be especially necessary for older people who live in rural communities.**

280. Older people can find themselves living at a distance from essential services and amenities, or living on large housing estates where they can feel

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501 Q 501 (Len Street).

502 Q 507

503 Alliance Boots.

504 Q 559, Q 558

505 The Saga Group.

506 Q 575 (Dennis Holmes), Q 558.

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

508 Q 501, Q 503, Q 506

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

281. Providers of vital private sector services accessed by older people should also consider how their services should adapt to the ageing population. There is evidence that lazy assumptions about older people's needs and desires mean that providers of goods and services are missing out on the expanding older consumer market, which is projected to grow by 81% on 2005 by 2030.[512] However, change is happening in some sectors. We were told by the Building Societies Association that some building societies are adapting. One in the north-west of England provides a drive-through branch, because the majority of their customers are elderly and cannot walk very far, but are drivers. Other branches have lower counters to enable frail customers to sit down while they are taking their money out or putting it in.[513] More fundamentally, however, there is a need to simplify financial products catering to people who are planning for older age. The products that provide for retirement, for example, are extremely complex, and few people are able to judge between them properly.[514]

282. The way that essential services are delivered will also have to adapt to the ageing population. **As more and more services are delivered online, service providers should take steps to ensure that older people, who might not be as computer-literate as people from other age cohorts, do not suffer from inadequate service provision.** Though the evidence that the Committee received is inconclusive about the extent to which current and future older people risk being 'digitally disenfranchised', public and commercial operators with a potential user or customer base among older people would be wise to avoid introducing services that are only available online, at least until the trends are clearer.[515] Government might consider supporting initiatives to provide education and skills training for older people, not just for those who wish to work in later life but also those seeking guidance on how to keep up with a changing technological world. We heard evidence that training and education have significant health and social benefits for older people, because they help to keep people stimulated and connected to wider society.[516]

283. **The continued growth of the country's older population means that action to combat isolation, loneliness and social deprivation among older people has acquired a new urgency. The Government have a responsibility to support older people to gain equal access to public and private services and to continue to engage closely with the rest of society.**

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509 Age Cymru;Q 558, Q 575 (Dennis Holmes).

510 Q 507 (Dr Mitchell).

511 Q 506 (Len Street)

512 ILC-UK, *The golden economy–the consumer market place in an ageing society*, David Sinclair, December 2010.

513 Q 502. Such counters may also be wheelchair-accessible.

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

515 Q 502, Independent Living, LITRG, Age UK.

516 Q 501 (Len Street).

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

284. Given the short-term nature of electoral and budgetary cycles, there are very weak political incentives for long-term thinking in the formulation of government policy.[517] Governments have been better at acting to limit their exposure to increasing costs as a result of ageing, such as in the field of pensions, than planning for improvements in the quality of the services that they deliver, commission or support. Although the Government have acted to reduce the amount that they will have to spend on state and public sector pensions (see Annex 8), they have been less successful at changing the quality of healthcare provision for older people (see Annex 12), ensuring the development of better private sector pensions (see Annex 8), or transforming the funding of high-quality social care (see Annex 11).[518]

285. Even where the Government have made progress in these areas, this progress has often been patchy, and the implementation of improvements dilatory. The problems for the future that the Turner Commission identified, such as a fall in the relative value of the state pension and the end of defined benefit pension schemes, were evident in the 1990s or earlier.[519]

286. **The Committee was disappointed to find how little the Government have done to initiate a long-term, coherent strategy to deal with the consequences of population ageing. We heard little evidence that the Government have the capacity, inclination or incentives to do the sort of planning that this issue requires.** The collapse of cross-party talks on social care before the last general election serves as confirmation that it is politically difficult for political parties to discuss the long-term implications of an ageing population, and the public spending choices that this demographic change might entail. In fact, electoral pressures tend to incentivise parties to avoid discussing long-term issues, which might involve confronting voters with unpalatable truths.[520] There are a few mechanisms in place to encourage the Government to think about the long term, such as the fiscal sustainability reports published by the OBR. While these reports are a welcome innovation, we are concerned that they have tended to have little impact on policy. The Government are not obliged to respond, there are no associated targets for the Government to meet, and the reports themselves receive far less attention in media and policy circles than the OBR's short-term economic and fiscal forecasts.

Important choices

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

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

518 Central Government (DoH and DWP), further supplementary written evidence.

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

520 Q 62

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

The current state of Government planning

289. The Cabinet has not initiated a process to assess the implications of an ageing society but has left the various relevant departments to lead. Caroline Abrahams, Director of External Affairs, Age UK, argued that "there is not an overall vision" and the response to ageing was "all fairly piecemeal".[521] While we acknowledge that the Government are doing some high-level thinking about the implications of an ageing society and some effective cross-departmental work, we feel that the Government have not looked at ageing from the point of view of the public nor considered how policies might need to change to ensure that people are better equipped to address their longer lives.[522]

290. **Without a collective understanding of the implications of ageing, and commitment to key Government actions, responses by individual departments will be insufficient—especially as responding to ageing requires services to work well together.** This Report has suggested a number of major changes that are needed. These new approaches—such as those that we have argued for in health and social care—may take a decade to bring about, and should inform the priorities for the next spending review, which will need to support the investment that some changes will require. Ministers must take the lead, and make clear to the civil service that inertia in planning for long-term issues such as demographic change is not acceptable.

291. **The Government also need to make the case to the public for why any changes are needed. If a government tries to move some age-related benefits onto different eligibility criteria without setting out a comprehensive vision for older age, explaining why changes are necessary, and committing to make major improvements to services in some areas such as healthcare, significant opposition would be inevitable.** Our society tends to be pragmatic—there was little opposition to raising the state pension age—but the Government do need to treat people as capable of understanding the issues and the arguments for change.

Central and local leadership

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

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521 Age UK.

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

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

Demonstrating political leadership

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

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

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

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

[523] The Saga Group.

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

The Members of the Committee which conducted this Inquiry were:

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

Declaration of Members' Interest

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

Baroness Blackstone
Chair, Orbit Group

Earl of Dundee
None relevant to the inquiry

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

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

Lord Griffiths of Fforestfach
None relevant to the inquiry

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

Lord Mawhinney
None relevant to the inquiry

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

Vice-Patron, Smile Children's Hospice

Baroness Shephard of Northwold
None relevant to the inquiry

Lord Tope
Councillor, London Borough of Sutton
Liberal Democrat Spokesperson on Culture, London Councils
Local Government Pension Fund Authority - Pensioner
Member, EU Committee of the Regions
Co-chair, Liberal Democrat CLG Parliamentary Committee

Lord Touhig
None relevant to the inquiry

Baroness Tyler of Enfield
Chair of CAFCASS (Children and Families Court Advisory Service)

Viscount Younger of Leckie
None relevant to the inquiry

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

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

Professor Howard Glennerster (Specialist Adviser)
None relevant to the inquiry

Jonathan Portes (Specialist Adviser)
Director, National Institute of Economic and Social Research (NIESR)

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at www.parliament.uk/public-services-committee

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

Oral evidence in chronological order

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

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

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

Alphabetical list of all witnesses

Action on Hearing Loss

Age Cymru

Alzheimer's Society

* Age UK

* Alliance Boots

** Geoff Alltimes, NHS Future Forum joint lead

Anchor

** Professor Sara Arber, University of Surrey

Audit Commission

B & Q

Barchester Healthcare

Professor Nicholas Barr, London School of Economics and Political Science(LSE)

Bedfordshire Fire and Rescue Service

* British Academy

British Society of Population Studies

** BT

** Building Societies Association

Cambridge Past, Present and Future

* Care & Repair Cymru

Care & Repair England

* Care Quality Commission

* Carers UK

CarewatchUK

** Chartered Institute for Personnel Development (CIPD)

Cheshire Fire and Rescue Service

Chief Fire Officers Association

Confederation of British Industry (CBI)

Dr Joan Costa Font, London School of Economics and Political Science (LSE)

Paul Durkin

English Community Care Association

Equity Release Council

* Fabian Society

* Professor Julien Forder, Personal Social Services Research Unit (PSSRU) at the University of Kent

** Professor Peter Goldblatt, University College London (UCL)

* Professor Sarah Harper, University of Oxford

** Professor John Hills, London School of Economics and Political Science (LSE)

Home Instead Senior Care

Housing21

Independent Living

* International Longevity Centre—UK

* Institute for Public Policy Research (IPPR)

Ipsos MORI, Social Research Institute

** Michael Johnson, Centre for Policy Studies

** Institute for Fiscal Studies

* Joseph Rowntree Foundation

* The King's Fund

** Laing & Buisson (Consultancy) Ltd

Howard Lewis, UK Older People's Advisory Group

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

Low Incomes Tax Reform Group and Tax Help for Older People

* Professor Les Mayhew, Cass Business School

* McCarthy & Stone

** NHS Commissioning Board

** National Association of Pension Funds

* National Housing Federation

** NHS Confederation

** Nuffield Trust

** Office for Budget Responsibility (OBR)

** Office for National Statistics (ONS)

Older People's Commissioner for Wales

** Professor David Oliver, The Royal Berkshire NHS Foundation Trust, Department of Health and City University London

* North West London Integrated Care Management Board

* Dr Chai Patel CBE FRCP, HC-One

UK Parliamentary Ombudsman and Health Service Ombudsman for England

Pensions Advisory Service

Personal Social Services Research Unit (PSSRU), London School of Economics and Political Science and Health Economics Group (LSE), University of East Anglia (UEA)

PolicyFen

* Population Matters

** Royal College of Art

Reform

* Professor Philip Rees FRGS FBA CBE, University of Leeds

** Professor John Philpott, Economist and Labour Market Analyst

Royal College of Physicians

* The Saga Group

** Professor James Sefton, Imperial College London

** Professor Ludi Simpson, University of Manchester

Social Institute for Excellence

* Len Street OBE, Former Chair, University of the Third Age (U3A)

Professor Taylor-Gooby, University of Kent

Ten Professional Support

* Professor Pat Thane, King's College London (KCL)

Third Sector Research Centre

Professor Anthea Tinker, King's College London (KCL)

* Torbay Unitary Council

* Trades Union Congress (TUC)

Vale Older People's Strategy Forum

** Rt Hon the Lord Warner, Commissioner, Commission on Funding of Care and Support (Dilnot Commission) 2010–11

Derek Jones, Permanent Secretary, Welsh Government

Welsh Local Government Authority

** Wiltshire Council

* Dr Lynne Mitchell, WISE (Wellbeing in Sustainable Environments), University of Warwick

* Professor Noel Whiteside, University of Warwick

** WRVS

APPENDIX 3: CALL FOR EVIDENCE

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

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

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

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

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

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

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

We invite you to contribute written evidence to this inquiry by 1st September 2012.

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

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

(1) Does our culture about age and its onset need to change, and if so, how?

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

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

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

(5) What should be done now and what practical actions are needed?

(6) How can we stimulate national debate about these issues?

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

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

Appendix

A. What challenges will an ageing population pose?

(1) The population projections from the Office for National Statistics show the very significant growth of the older population, and there will be many social benefits from this. But the OBR's recent Fiscal Sustainability Report, July 2012, forecasts a worsening fiscal deficit as a consequence. Do these forecasts capture the challenges or underestimate them?

(2) If life expectancy rises further but healthy or disability free life expectancy does not there will be costs for health and social care, for state pensions and for public sector pensions. Are these risks and costs adequately shared?

(3) Raising productivity in the NHS and in public services generally is fundamental to coping with the immediate fiscal challenge. Do you think it will happen? If not, what are the implications for the coming demographic challenges?

(4) What will an ageing society be like? What might this imply for individuals, families, and communities? What are the implications for individuals' capacity to work longer and live independent lives, and for productivity, competitiveness and inequality?

(5) Do the additional fiscal deficits caused by an ageing society, the increased demand for services and better outcomes require a radical re-think by central and local government and the NHS to prepare and change to address them? What should be done?

B. What strategic choices need to be addressed?

(6) There are many benefits from an ageing population, but growing public sector demands and a growing fiscal challenge are consequences too. If society will not accept substantial tax increases what are the big choices for what the state does and what individuals do? Who should pay for what?

(7) The increasing cost of an ageing population could put great pressure on expenditure on other priorities and investment. Will free health services, improved social care and decent state pensions all be affordable? What are the choices?

(8) We will be better off in the future but there will still be a need to re-shape our expectations and our welfare state for an ageing population. Which attitudes and expectations need to change about our welfare state, about retirement, the age of retirement and inheritance?

(9) Do we need greater clarity about what the state will and will not fund for the future, and a more explicit contract between the state and individuals? What should this be?

(10) Do the dates when the state pension age rises reflect these coming changes? Are the risks and costs of public sector pensions shared fairly between beneficiaries and taxpayers?

(11) How might inter-generational fairness be achieved? If we need to encourage younger people to save more for their own retirement, their social care and their higher education, can they also pay more taxes for an ageing population?

(12) How are countries with similar ageing populations adapting?

C. What reforms to public actions are needed?

General

(13) The additional demands and fiscal challenges caused by an ageing society, plus dissatisfaction with current services and outcome, require all public services to change for the better. Is this recognised, is it happening, if not what must be done?

(14) Fundamental service re-designs may be needed. What might be the principles behind such re-design and are there attitudinal, structural and cultural impediments to making them happen such as silo structures and budgets, lack of preventative actions?

(15) Where is it important for the state to reduce demand or transform its actions? Should we look at where expenditure is high yet outcomes are poor such as the management of long term conditions?

(16) Which preventive programmes are most needed? Could new funding mechanisms such as social impact bonds make this happen?

Older people

(17) How good are current services for older people? Services for older people are highly fragmented and subject to unhelpful financial incentives. What evidence is there of good practice in resolving these issues in the UK or abroad?

(18) How should labour markets, employment law and practices change to enable older people to work?

(19) How might government best stimulate and regulate markets to respond to the varied risks faced by vulnerable elderly people? What are the limits to such markets?

(20) How can public actions help extend individuals' health and independence in older age? How can voluntary and community actions contribute more? How should housing services change better to support independent older living?

(21) Funding constraints have already squeezed the resources available to private providers of long term care and NHS geriatric care. There have been concerns about standards in all sectors. What more should be done to improve standards and public confidence?

D. What should be done now?

(22) Addressing these challenges requires public debate about choices, attitudes, and expectations. How can this happen? How can the public be stimulated to address the likelihood that they will live longer?

(23) What should central government and local government and the NHS be doing now to address these challenges?

(24) Changes to state priorities and efficacy for the medium term should arguably be significant considerations in the next public spending round. Is this happening?

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

APPENDIX 4: ABBREVIATIONS AND ACRONYMS

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

Appendix B

"A new generation of retirement housing could set off a property chain reaction..."

THE TOP OF THE LADDER

Claudia Wood

DEMOS

Demos is Britain's leading cross-party think tank. We produce original research, publish innovative thinkers and host thought-provoking events. We have spent 20 years at the centre of the policy debate, with an overarching mission to bring politics closer to people.

Demos is now exploring some of the most persistent frictions within modern politics, especially in those areas where there is a significant gap between the intuitions of the ordinary voter and political leaders. Can a liberal politics also be a popular politics? How can policy address widespread anxieties over social issues such as welfare, diversity and family life? How can a dynamic and open economy also produce good jobs, empower consumers and connect companies to the communities in which they operate?

Our worldview is reflected in the methods we employ: we recognise that the public often have insights that the experts do not. We pride ourselves in working together with the people who are the focus of our research. Alongside quantitative research, Demos pioneers new forms of deliberative work, from citizens' juries and ethnography to social media analysis.

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THE TOP OF THE LADDER

Claudia Wood

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At Demos, huge thanks go to Jo Salter, for coordinating and carrying out the field work for this report; Rishab Mehan, who put in some long hours pulling together the data on ownership, housing size and equity; and Chris Tryhorn, whose literature review was helpful in shaping the final report. I would also like to thank several of our excellent interns for their help with this project – particularly Lindsay Pain, Callum Anderson, Laura Russell and Marco Bartholdy.

Credit for expertly guiding the report through the production and launch stages goes to Ralph Scott, Rob Macpherson, Sophie Duder and Sophie Hind.

All errors and omissions remain my own.

Claudia Wood
September 2013

Executive summary

This report brings together the evidence regarding the UK's 'next housing crisis' – the chronic undersupply of appropriate housing for older people. While all eyes are on those struggling to get on the bottom of the property ladder, those at the top are often trapped in homes that are too big and unmanageable. They struggle to compete with first time buyers (supported by Help to Buy and other initiatives) for small properties currently in the market – nor would they necessarily want to. A lack of choice of suitable homes to downsize into is having a negative effect not just on older people's health and wellbeing, but on the rest of the housing chain, as 85 per cent of larger family homes owned by older people only become available when someone dies.

Many policy reports have been written on this issue and a range of robust evidence already highlights the benefits of retirement housing. And yet little has been done so far to implement the proposals made in these reports. We lack a coherent strategy at national level and guidance at local level on retirement housing and this shows in everyday planning decisions and the attitudes of those dealing with developers. Retirement housing remains in an uneasy space between general needs housing and residential care, and suffers from association with both.

Demos sought to distil the evidence presented from a range of sources (academic, policy orientated and grey literature) on the scale of the problem, the impact this was having, the benefits or resolving it, and how to go about this. We supplemented these findings with new polling of our own and analysis of the English Longitudinal Study of Ageing (ELSA) to get a better picture of the housing chain effect that could be achieved if more of those older people interested in downsizing or moving to retirement properties were able to. We also spoke to a range of experts

(listed in appendix 1) for their suggestions on how to tackle supply and demand issues regarding older people's housing. We found that, while retirement properties make-up just 2 per cent of the UK housing stock, or 533,000 homes, with just over 100,000 to buy, that:

- One in four (25 per cent) over 60s would be interested in buying a retirement property – equating to 3.5 million people nationally.
- More than half (58 per cent) of people over 60 were interested in moving.
- More than half (57 per cent) of those interested in moving wanted to downsize by at least one bedroom, rising to 76 per cent among older people currently occupying three-, four- and five-bedroom homes.
- These figures show that 33 per cent of over 60s want to downsize, which equates to 4.6 million over 60s nationally.
- More than four in five (83 per cent) of the over 60s living in England (so not Scotland, Wales or Northern Ireland) own their own homes, and 64 per cent own their home without a mortgage.
- This equates to £1.28 trillion in housing wealth, of which £1.23 trillion is unmortgaged. This is far more than the amount of savings this group has (£769 billion).
- Therefore the over 60s interested in downsizing specifically are sitting on £400 billion of housing wealth.[1]
- If just half of the 58 per cent of over 60s interested in moving (downsizing and otherwise) as reported in our survey were able to move, this would release around £356 billion worth of (mainly family-sized) property[2] – with nearly half being three-bedroom and 20 per cent being four-bedroom homes.[3]
- If those wanting to buy a retirement property were able to do so, this would release £307 billion worth of housing.[4]
- Combining NewPolicy Institute (NPI) analysis of current market chain effects of older people dying and moving each year with our own analysis of ELSA, we can estimate that if all those interested in buying retirement property were able to do so, 3.5 million older people would be able to move,[5] freeing up 3.29 million properties, including nearly 2 million three-bedroom homes.[6]

- If just half of those interested in downsizing more generally were able to do so, 4 million older people would be able to move,[7] freeing up 3.5 million homes.

Apart from the obvious gains to the housing chain, there is robust evidence that retirement housing has a very beneficial effect on older people's health, wellbeing and social networks, and could save health and care services considerable resources. The equity released could help tackle pensioner poverty and have wider economic benefits.

With all of this in mind, it is somewhat surprising that the current government has not done more to work in partnership with the private sector to encourage greater supply of retirement property. There are a range of relatively low-cost steps which could stimulate the market, including:

- giving retirement housing special planning status akin to affordable housing, given its clear and demonstrable social value.
- tackling S106 and community infrastructure levy (CIL) planning charges, which make many developments untenable and affect them disproportionately compared with general needs housing developments.
- quotas and incentives for reserving land for retirement housing, and linking this to joint strategic needs assessment and health and wellbeing strategies for local areas.

Of course, we cannot assume that 'if we build it, they will come'. While poor supply does drive down demand, there are other factors at play, both practical and emotional. Methods of overcoming these include providing practical help to older people to move, giving financial incentives (such as stamp duty exemption) and – some have argued – bringing in financial penalties for under occupation.

We conclude by reflecting on the fact that the housing needs of our rapidly ageing population (the number of over 85s will double by 2030) is the next big challenge this government faces. And yet the costs associated with overcoming this are far lower than those related to the effects of the ageing population

on health or social care. The money is there already – locked up in over a trillion pounds' worth of assets across the country. Hundreds of millions of pounds could be released to stimulate the housing market if (low-cost) steps were taken to unlock the supply to meet the demand already there – let alone if demand were further stimulated. While there must always be a place for social housing and affordable tenancy for older people, the vast majority of older people can be helped into more appropriate owner-occupied housing without any direct delivery costs incurred by government or local authorities.

So the fact that no recent government has yet grasped this nettle is a surprise, given how substantial the benefits could be. The Coalition Government has focused significant attention and resources on the currently more visible plight of renters unable to afford their first home and others unable to move because they lack the necessary deposit. Somewhat inevitably this focus has largely ignored the specific needs of housing the elderly.

We argue that the government needs to have a 'whole chain' view of the housing market – recognising that assisting the private sector to help serve older people will have a trickle-down effect of unlocking supply and benefiting those on every other step of the ladder.

1 The UK housing crisis

We have not built enough homes to keep pace with demand for many years. Looking at long-term trends, the National Audit Office concluded that there has been no consistent growth in private house building since 1970.[8] Demand for extra homes in England is now estimated at around 210,000 properties a year to meet population growth, and yet the average output from house builders and social housing providers has been 154,000 extra homes a year since 2008. Moreover, building is slowing down – 146,000 dwellings were added to the housing stock in 2011, 43 per cent down on the figure for 2008, while in 2012 this had fallen to 112,500 – almost half the number required. The Joseph Rowntree Foundation (JRF) calculated that at the current rates of building, the gap between demand and supply would be a shortfall of 1.1 million homes in 20 years' time.[9]

The most obvious and direct result of this shortage is spiralling rental and house prices, with young, first time buyers bearing the brunt of this problem. Between 1997 and 2011 there was a 20 per cent increase in the number of 20–34-year-olds living with their parents, and now considerable attention is given to first time buyers and the shortage of housing for the under 30s (the so-called 'generation rent').[10] To try and help this group, the Government has recently extended its First Buy scheme with Help to Buy, as part of a package of measures to enable people buying new homes with small deposits to secure 95 per cent mortgages.[11]

However, it is important to recognise that the UK's housing crisis is not simply a case of a shortage at the bottom of the housing ladder – it is a shortage across the housing chain, which is preventing families from moving into bigger homes and making space at the bottom of the ladder for first time buyers.

To help 'generation rent' trying to get on the bottom of the housing ladder, as well as those families struggling to find bigger homes, one needs also to look at the top of the housing ladder – older people who may be in homes which are too big or otherwise no longer suited to their needs, who we might call 'generation stuck'. Enabling this group to move to smaller properties – essentially extending the housing ladder – will have a domino effect down the housing chain, freeing up family homes and in turn freeing up smaller properties for first and second time buyers.

2 Housing at the top of the ladder

Although an important solution to the shortage of housing in this country would be to enable older people to move out of large family homes into more suitable and smaller properties, there are currently very few specialist properties. Just 2 per cent of the UK housing stock – or 533,000 homes – meets the needs of older people, and most are in the social rented sector – just over 100,000 are for ownership.[12] This number is dwarfed by an over-65 population of 10 million and an over-60 population of 14 million.

Demographic change, supply and demand

The numbers of older people are increasing rapidly. As part of a parliamentary committee set up last year to explore the implications of demographic reform, the following projections about ageing were considered:

- There would be 51 per cent more people aged 65 and over in England in 2030 than there were in 2010.
- There would be 101 per cent more people aged 85 and over in England in 2030 than there were in 2010.
- 10.7 million people in Great Britain can currently expect inadequate retirement incomes.
- There would be over 50 per cent more people with three or more long-term conditions in England by 2018 than there were in 2008.
- There would be over 80 per cent more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 than there were in 2010.[13]

With these sobering statistics in mind, the committee produced a 100-page report detailing the various ways in which this change in our demographic make up would affect our lives – from health and pension spending to our welfare system and housing needs. Related to this latter point, the committee concluded:

The housing market is delivering much less specialist housing for older people than is needed. Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed and to give as much priority to promoting an adequate market and social housing for older people as is given to housing for younger people.[14]

The fact that of the older population, the 'very old' (those in their 80s) are increasing in number more rapidly than other segments of the population is particularly important: 69 per cent of over 85s currently have a long-term illness or disability, compared with 34 per cent of 65 to 74s.[15] This increasingly old population may well need housing that offers care and support services on site.

Yet the chronic undersupply of specialist retirement housing – built with the physical and social needs of older people in mind – is a long-standing problem exacerbated by rising demand associated with larger numbers of older people. McCarthy & Stone's submission to the aforementioned parliamentary committee provided some sense of the demand for this housing – it stated that a third of older people would consider living in retirement housing, and quoted statistics from the 2006 Wanless Review showing that 27 per cent of older people would consider this form of accommodation if it were available, and a YouGov poll for Shelter in February 2012, which found that 33 per cent of people over 55 were interested in it.[16]

Research produced by the University of Reading in 2011 provided detail on the level of supply supposedly meeting this potential demand: the author noted that there were around 105,000 units of owner-occupied private retirement accommodation in the UK, just 2 per cent of the total number of

homes for those aged 65 and over. If that share of the total were to grow to 5 per cent of the over-65 market over the next decade or so, 16,000 units would need to be built a year, up from just 4,400 delivered in 2007. The report argued that because of restrictive planning and housing policies, many older people were not being provided with the opportunity to purchase a unit.[17] This is discussed in more detail in the following sections.

Again, McCarthy & Stone's parliamentary submission illustrates this problem – they explained that planning constraints meant that provision of retirement housing lagged far behind other developed countries, while build rates for specialist housing in the UK were lower now than in the 1980s. In 2010, just 6,000 units for rent and 1,000 for ownership were built, down from 17,500 for rent and 13,000 for ownership in 1989 – yet the number of older people has increased rapidly within the same time frame. Unsurprisingly, only 2 per cent of the UK's housing stock is retirement property, housing 1 per cent of the 14 million over 60s (compared with 17 per cent in the US and 13 per cent in Australia).[18]

Box 1 **What do we mean by 'retirement housing'?**

In this report we use 'retirement housing' as a generic term for specialist housing for older people, which includes sheltered housing (also known as warden assisted), retirement villages and extra care schemes. Key features include individual dwellings with their own front door (whether for rent, sale or shared ownership), communal areas such as lounges and restaurants, scheme managers (or other types of support service) and varying levels of personal care and support.

Sheltered housing *is the most widely known form of retirement housing; schemes include a house manager, shared lounge and laundry and other facilities. The term has generally now been superseded by 'retirement housing', although it is still used in planning circles.*

The term enhanced sheltered housing *is used to describe sheltered housing that provides more in facilities and services than traditional sheltered housing but does not offer the*

full range of support that is found in an extra care housing scheme.

Extra care housing *is the term used for a complex of retirement housing that also provides care in a style that can respond flexibly to increasing need while helping individuals to retain their place within their community. There is usually a range of 'lifestyle' facilities for social, cultural, educational and recreational activities, including restaurants, gyms, libraries and other facilities.*

Retirement village *is a term generally used to describe large-scale extra care or continuing care retirement community developments, generally in the range of 90 to 350 units, with developments of around 250 units being common. They provide a range of accommodation and tenure options, potentially with a care home on site.*

The term very sheltered housing *has largely been superseded by extra care housing.*

Where specific types of scheme are referred to in the evidence we will identify it as such rather than use the general term 'retirement housing'.

3 Policy background

As there is such potential demand for retirement housing, and yet such poor supply of it, it would be interesting to know why nothing has been done at national or local policy level to remedy the situation and ease the wider housing crisis at the same time. In reality, much has been written, discussed and proposed on this issue, but very little action has been taken or policies implemented. In 2008, the Labour Government published its blueprint for the future of housing in an ageing society: *Delivering Lifetime Homes, Lifetime Neighbourhoods*.[19] It described 'two nations in old age… increasingly polarised by housing wealth'. Following a 2007 green paper on housing, it promised to build more mainstream and specialised homes for older people over the next three years, including increased investment in social housing and equity sharing. It also outlined a new approach to a national housing advice and information service, with strengthened local housing information services, to enable older people to find out about their housing options, whether to stay put or move home, or to consider equity release.

The strategy argued in favour of making it easier and safer for people to stay in their own homes, near their family and neighbours. It also outlined a 'new positive vision' for specialised housing for older people as somewhere they might aspire to live. The Labour Government said it would create 'more homes and more choice', through increased funding for public housing and by encouraging private sector provision through reform of the planning system.

However, relatively little was achieved following these policy pronouncements, and in June 2009, the Homes and Communities Agency set up Housing our Ageing Population: Panel for Innovation (HAPPI) to build on the work of *Delivering Lifetime Homes, Lifetime Neighbourhoods* and to examine what

further reform would be needed 'to ensure that new build specialised housing meets the needs and aspirations of the older people of the future'.[20]

The panel's focus included 'influencing the availability and choice of high quality, sustainable homes and neighbourhoods', 'challenging the perceptions of mainstream and specialised housing for older people', and raising aspirations to demand higher quality, more sustainable homes.

Among its many recommendations, it urged house builders and housing developers to recognise 'the extent of the commercial opportunity' and to develop new types of housing for older people that would respond to the aspirations of this burgeoning market.

However, as a consequence of the economic downturn and a new Coalition Government in 2010 much of the good work undertaken by HAPPI fell by the wayside and its recommendations were not followed through. HAPPI 2 – published in 2012 to review the progress of the original panel and make further recommendations, stated:

the publication of the HAPPI report coincided with a worsening economy and policy uncertainty following the 2010 General Election. It was also suggested that the austerity measures adopted by the incoming Coalition Government created nervousness in the housing market and reduced public and private sector appetite for innovation. Clearly this operating environment has limited the take-up of the recommendations in the HAPPI report.[21]

It urged the government to act, stating that improving housing options for older people could lead to reduced health and social care costs and create new housing options for younger people and families if older people could be moved from large, under-occupied family homes into retirement accommodation. It recommended that 100,000 retirement, supported housing and extra care homes should be built every year.

In spite of a lack of progress since 2008, the panel was encouraged by the new Coalition Government's report *Laying the Foundations*, published in November 2011, some 18 months after coming to power.[22] The document noted that 'for some older

people a move to a smaller, more accessible and manageable home can also free up much-needed local family housing'. The Government promised to work with planners and developers to produce guidance for local strategic planning and delivery of a wider range of housing for older people. However – crucially – it said it did not intend to introduce national regulation, and that decisions on the number of 'lifetime homes' within each development should be made at a local level, according to need. Moreover, the New Deal for Older People's Housing announced in the strategy focused mainly on keeping older people independent and living in their own homes (and out of residential care) for as long as possible. This included maintaining investment in repairs and adaptations, and even the investment in housing advice through the First Stop service was described as 'independent advice to older people looking to plan their future housing needs – whether in their own homes, or in care homes'.[23] The exclusion of a middle way – a move into specialist retirement housing – is telling.

In 2011 the Government also published *Lifetime Neighbourhoods* to pick up on the original themes in the 2008 report, but this addressed the question of housing in just one chapter, and focused on house design and housing-related support services rather than issues of housing supply or demand.[24] It noted: 'A range of choices – from standard housing through to sheltered or extra care housing would help to maximise the value of neighbourhoods, and the range of choices available to older people' but – like many of the previous strategies – gave little indication as to how this would be achieved.

4 Obstacles to supply

We have thus far presented information regarding the current housing shortage in the UK, the government focus on creating effective demand and getting people on to the housing ladder as a solution to this, and the potential for a longer term and more meaningful solution coming in the form of enabling older people at the 'top' of the housing ladder to downsize. We have also explored briefly the limited supply of older people's housing compared with the rapid and significant increase in the number of older people in the UK, despite several policy documents issued on this subject.

In this section, we consider why so few older people live in specialist retirement housing in this country, compared with, say the US or Australia.

There has been a significant amount of research exploring why the supply of older people's housing has been limited in the UK. Reviewing the assembled evidence, there seems to be three key obstacles.

Commitment at local level

First, the benefits of such housing have not been understood at a local level despite warm words from central government departments. The 2012 National Planning Policy Framework states that local authorities must address

the need for all types of housing, including affordable housing and the needs of different groups in the community (such as, but not limited to, families with children, older people, people with disabilities).[25]

But a report from Policy Exchange concluded:

Councils are not even able to put in place up-to-date broad [strategic housing market assessments], let alone plan specifically for ageing populations in their areas.. But even where they have such plans in place they do not address the housing needs of an ageing population. In fact they often make it worse.[26]

The Home Builders Federation (HBF) similarly cast doubt on the effectiveness of strategic housing market assessments (SHMAs). They concluded that they 'vary greatly; they are often deficient, looking mainly at the housing needs of younger people, first time buyers, and those in the social sector'.[27]

The experts we interviewed for this report made many similar observations about local authorities' approach to retirement housing. They commented that older people's housing assessments carried out by local authorities tend to focus on social sector stock and issues (eg extra care housing), with very few addressing the needs of owner occupiers or private renters. Where strategies for older people do exist (in local authorities and in the NHS), they are often light on detail about how strategies would be delivered.

The experiences of two of the housing providers we spoke to for this project is informative. One provider – Hanover – reported that it had particularly concentrated in the past on providing extra care housing, predominately for social rent, and had experienced few difficulties in gaining planning consent for this. This is because local authorities are generally positive about providing extra care in the public sector and can see a clear link between housing with care models and reductions in demand for care from those who qualify for care on their registers, who may otherwise need (for example) traditional residential home settings.

In contrast, another provider – McCarthy & Stone – had looked more to owner-occupied housing. As Gary Day, Land and Planning Director, put it: 'our focus has actually been on the other end, it has been on the private market'. As a consequence, McCarthy & Stone struggled more to convince local planners of the value of their offer. Around two-thirds (65 per cent) of the housing developments for older people it operates were permitted only on appeal after being rejected by local planners,

who have a poor understanding of the need for such housing in the private sector. Many schemes were opposed at the planning stage because local authorities were concerned about the impact of an increased older population on local services, such as GP practices and hospitals – which the company suggested indicated a 'lack of joined up thinking'.

Interestingly, Hanover now too wants to provide housing in the owner–occupier market. Gillian Conner, Head of External Affairs at Hanover, told us that public funding for extra care was harder to come by following care cuts, but a big driver in moving away from this provision was feeling 'increasingly not in control of our own development in this area' – local authorities were setting out terms and conditions for extra care, and making referrals, increasingly of people with higher needs. Hanover is keen to shift to more preventative models of housing (care-ready housing that helps people maintain their independence for longer), but a barrier to this was that 'local authorities focus strategy on older people with care needs, which only constitute 5 per cent of all older people'.

Jeremy Porteus, chief executive of Housing LIN, admitted there was a narrow focus when it came to local approaches to housing supply for older people:

It's been seen as a numbers game. About the number of units we need, not the prices and how we'd be able to market them. It's not really about understanding what the aspirations of the older people will be. As a result, we've tended to build to a lower common denominator and the benefit of that has been 'Yes, we've met housing targets', we can say we've done x, y and z in terms of good density ratios, we've developed x number of care homes for people etc, but it is not clear whether this is going to be desirable in 20–30 years' time.

This point was echoed by Bill Gair, CEO of Urban Renaissance Villages, who felt that local authorities and central government were displaying a lack of imagination over planning and delivery of housing, measured purely by number of units rather than any wider outcomes.

Planning rules

The second main obstacle to supply relates to planning rules. For example, Section 106 agreements of the Town and Country Planning Act 1990 are designed to offset the impact of new developments, with developers of private housing charged so that local authorities can invest in affordable housing. This treats private retirement housing the same as private general needs housing, even though the social value of the former, and the important role it plays in local communities, is greater than the latter.

The additional costs of S106 charges are often passed to the buyer in the form of higher prices, and a recent report by the University of Reading concluded that as a lot of affordable housing provides accommodation for younger people, elderly middle income households were subsidising younger buyers and the process was 'discriminatory' against older people.[28] Joe Oldman, housing policy adviser at Age UK, also told us that affordable housing quotas are an issue for private retirement developers (not for registered social landlords, as all their housing is affordable), which stifles innovative models, such as cooperative housing and cohousing, which could deliver the same sense of community as retirement housing, but in a way that allows residents to maintain more control.

Another extra cost burden borne by private retirement developers, which makes them less competitive compared to open market housing providers, is the CIL. A flat rate planning charge, CIL has been criticised as being 'one size fits all' and based on standard residential properties rather than specialist provision which may have services on site or communal areas. CIL is charged as a flat rate per square metre on new housing development, but a third of the floor space in normal sheltered housing developments is shared, so not sellable. Such developments are therefore hit disproportionately by CIL. Gary Day, Land and Planning Director from McCarthy & Stone, told us that CIL was 'causing us real concern, in fact that's one of our biggest business threats at the moment, because that could stifle supply for us'.

The disproportionate – some may say discriminatory – effect of S106 and CIL, driving up the cost of supply (or simply

making it not possible) is, many believe, a lack of appreciation of what role retirement housing plays at local and national level. As the HBF explains in a parliamentary briefing, retirement housing is

a complex form of accommodation. 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.[29]

Retirement housing occupies an uneasy space between residential care and general needs housing and seems to lose out as a result – penalised by general needs planning rules, and misunderstood by social services.

Some of the experts we spoke to suggested that this uneasy position – bringing with it a different and inappropriate set of planning rules, the complexity of coordinating service provision with housing, and a negative attitude among planners – was discouraging new entrants from entering this part of the house building market.

The requirements of retirement housing

A third obstacle to supply is related to the requirements of retirement housing itself. First, such developments are 'capital-hungry' because they needed to be entirely completed before sales are made rather than sold 'off plan' like other housing, as prospective buyers need to see the entire development, with communal spaces and services already in place, rather than just their own apartment, before purchasing. Therefore a considerable amount of up-front working capital is required, to complete the development entirely, before revenues from the sales of apartments come on stream.

A second issue is that such developments also need to be located near shops, services and transport links, where residents

wished to live. This makes good sites hard to find, in higher value areas and in demand for a variety of uses, both residential and non-residential. McCarthy & Stone reported that it had lost out on sites to drive-through restaurants, car parks, storage companies and care homes. Gary Day told us:

It does make it difficult to find good sites, and they are critical to the success of this type of housing. You've got to get the site right – even if you have a wonderfully designed apartment and all the facilities – the whole idea is to let people remain as independent as possible.

This impact of this shortage of supply was described by the JRF when interviewing groups of older people seeking to move home. They noted that for those wanting to move for a long time:

a key issue was the availability of a suitable property. Waiting lists for warden-controlled properties were seen as problematic. The perception of being overlooked and 'fobbed off' led to frustration at the lack of progress and ability to do anything about it… Obstacles for home-owners included the affordability of bungalows, limited supply of owned properties for older people and not being comfortable with the idea of renting.[30]

5 Build it and they will come? Obstacles to demand

Of course, the lack of older people's housing may be more than a supply-side issue. Perhaps, culturally, the UK's older population do not warm to the neatly laid out retirement villages so frequently seen in the US and prefer to stay in their (albeit difficult to maintain and too large) family homes. The attachment to our homes – as places we raise our children, fill our lofts with their belongings and then hand over to them when we die – makes us cautious about downsizing. Recent research by Demos for Hanover Housing also found an aversion to 'age segregated' housing and communities among the over 60s living in mainstream housing, and an association between this form of housing with 'ghettoisation'.[31]

As retirement housing can be associated in people's minds with either public sector sheltered housing or residential care, private developers (building owner-occupied properties) can lose out. Gary Day told us:

Historically the private sector has suffered – still suffers to an extent – with the reputation of historic public sector provision, because a lot of local authorities developed sheltered housing on sites that we certainly wouldn't have considered suitable. There is a lot of sub-standard accommodation.

Andrew Burgess, Managing Director of Planning at Churchill Retirement Living, suggested that all 'sheltered housing' should be renamed 'retirement housing' to avoid some of the historical stigma attached to the term 'sheltered housing'.

Nonetheless, our previous research suggests that if the 'right' sort of housing was available – as we describe in the next section – then attitudes are more positive and receptive to the prospect.[32] To gather a more precise picture of the demand for smaller and/or more suitable homes among older people, Demos

carried out a survey of 1,500 over 60s. We asked a variety of questions related to their current housing situation, their ideal situation, and what factors they considered when staying put or considering a move (see appendix 2).

The findings suggest that there is considerable appetite among the over 60s for moving to a new property at some point in the future, with 58 per cent of people saying they would consider this – this equates to over 8 million people nationally. People in semi-detached and detached houses and those who owned their property outright (with no mortgage left to pay) were more likely to consider moving in the future. Those in slightly larger and more expensive properties were also more likely than average to say that they would consider moving. The mean house size for 'movers' was between 3.47 bedrooms and the mean value of home was £270,000, compared with 3.4 bedrooms and £240,000 for 'non-movers'.

But does this interest in moving automatically involve downsizing, or moving to specialist retirement properties? One-quarter (25 per cent) of the over 60s in our survey (increasing to 41 per cent of the 76–81 age group and 34 per cent of the over 81s) said they were interested in buying a purpose-built retirement property, and 25 per cent also said they would be interested in renting one on an assured tenancy (which gives tenants the right to live in the property as long as they wish). This equates to over 2 million people.

Our findings seem in line with the information developers shared with us – for example, the average age of McCarthy & Stone's customers is 79, in the peak demand group in our survey. In their assisted living schemes, the average age is 83. Hanover has seen this age profile increase recently – formerly it was people in their 60s, now it is people in their 70s, and this is in part due to increasing numbers of referrals for the more frail elderly people with higher support needs.

Of course, many older people may be able to secure a more suitable house simply by reducing the size of their property and considering things like stairs and garden maintenance. By asking about the size of people's current homes, and the number of bedrooms they would like to have if they were to move, we were

able to ascertain how many of the 58 per cent of over 60s who were interested in moving specifically wanted to downsize. Unsurprisingly, more people were interested in downsizing to another home than purchasing a specialist property.

Excluding older people living in one-bedroom properties, only 4 per cent on average of those interested in moving wanted a larger home: 57 per cent of those interested in moving wanted to downsize – this represents 33 per cent of over 60s, or 4.6 million nationally. However, this figure rose to 76 per cent of those interested in moving who are currently occupying three-, four- or five-bedroom homes. Only 1 per cent of those with five bedrooms or more did not want to downsize. Of all those who wanted to downsize, 56 per cent opted for a reduction of one bedroom, and 44 per cent a reduction of two or more bedrooms. Only those currently in two-bedroom homes were more likely to say they wanted to stay in the same size home if they moved rather than downsize (73 per cent said this). Indeed, two-bedroom properties were the most popular choice across the board, with the majority of all groups stating that their preferred move would be into a two-bedroom property. This is in line with other previous research on this issue, such as JRF's 2012 review of evidence into downsizing, which found:

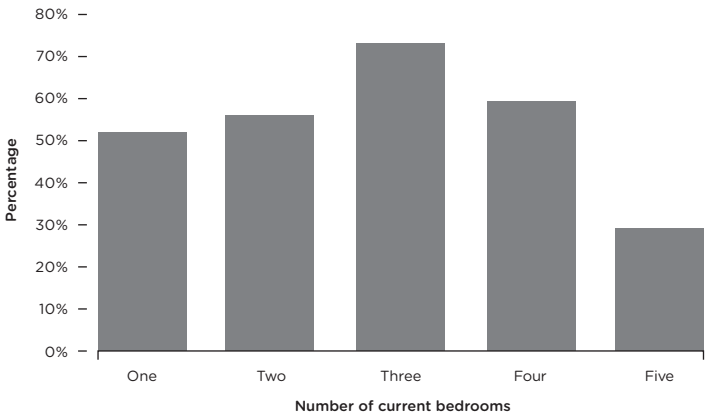
Two bedrooms is the minimum that most older people will consider, to have enough space for family visitors, a carer, storage, hobbies, or separate bedrooms for a couple. Analysis of moves by older households in the last five years within the private sector (rent or owner-occupier) shows that 87 per cent move into a dwelling with two or more bedrooms.[33]

The second most popular choice was three-bedroom properties, particularly among those in larger (four and five or more bedroom homes) with 57 per cent and 68 per cent opting for this respectively.

For those in one-bedroom properties, downsizing is not an option. Nonetheless, 41 per cent of those in one-bedroom properties said they would like to move to another one-bedroom property, while 52 per cent said they would like two bedrooms.

This appetite among older people to buy smaller, more manageable properties, of two or three bedrooms in size, is

Figure 1 **Percentage of over 60s wanting a two-bedroom property, by number of current bedrooms**



relevant for retirement housing developments. As explained below, much of the existing supply is one bedroom only, and for rent – two factors likely to put off the average 'downsizer'. We will return to this point in the next section.

Push factors

As they get older, people want to move for different reasons. Often these are practical considerations associated with physical limitations (opting for a bungalow, a smaller garden, or another a home which is generally more easy to maintain), social considerations as a result of becoming widowed and/or wanting to move nearer to family or friends, or financial – downsizing as a form of equity release to pay for care or a better quality of life in retirement.

Our polling explored the reasons most commonly cited by the over 60s reporting an interest in moving home: 43 per cent of this group said it was because they wanted a more suitable property – one that had a garden that was easier to maintain, or had fewer stairs, for example; 26 per cent said their property was

too big for them – rising to 44 per cent of people with four bedrooms and 60 per cent of those with five or more; while 19 per cent said maintenance was now a problem. Interestingly, while maintenance and size problems were less frequently given as reasons to move by over 60s in one-bedroom properties, the response 'I want to live somewhere different' was far more of a push factor for this group, as was the need for more support or care. Those in one-bedroom properties were more likely to be in social economic groups DE and also older (81+), and to be renting from the council or a housing association. This suggests these older people may be single and unsupported by health or care services, and perhaps also socially isolated.

Pull factors

While retirement housing is not for everyone, there are clear reasons why people are unnecessarily discouraged from even considering this as an option. There is a dual barrier at play here – many more older people would no doubt downsize, if they could, while a proportion of those might also look to retirement property as an option if there were not a series of barriers to this. In this section we consider what these might be.

First, and most obviously, there is a lack of understanding among older people about what 'retirement housing' is and the lifestyle it offers. As Gary Day commented:

A lot of our customers that walk into our showrooms walk in and say, 'I didn't realise it was going to be like this' – they had this image of it being more like a care home than simply different standards of living for later life.

This issue is exacerbated by some of the terminology used, with different people talking about the same thing using different names ('retirement', 'sheltered', 'warden assisted' are used interchangeably, while an 'extra care home' can be assumed to be a care home). This makes it very difficult for older people to know what their options are, and there is a general dearth of information, advice and help for older people to navigate the housing market.

Therefore few people are making a positive choice to move to retirement housing until something forces them to do so – a death of the partner, an accident or a fall within the house, burglary or major maintenance problem. A move to retirement housing is more akin to a last resort or 'distressed purchase', commonly seen in moves to residential care, rather than a preventative or – better yet – aspirational move for a more active retirement.

People's tendency not to think about the future or plan ahead for ageing or future care and support needs exacerbates this reluctance to move; they perhaps worry about energy bills and maintenance but do not consider a move, which requires them to accept that they may well need care and support in the future.

But older people's reluctance to move is not simply a lack of awareness, information or planning. We should not underestimate other pull factors – perhaps practical or emotional issues, which discourage older people from moving even if they recognise their current home is too large or unsuitable for them. JRF's research with older people considering a move illustrates this. The researchers found that moving home was a 'developmental process' – 'a series of steps or a combination of factors that contributed to participants' decision-making and the practicalities of moving'; many older people worked up to a move but were often deterred before taking the final step:

While many older people recognised the sense in moving to smaller, more manageable properties, they had concerns – for example, the daunting process, the emotional ties to their home, they would miss their garden, the new property's rooms would be too small, uncertainty about sleeping on the ground floor and not knowing where to go. Participants also mentioned psychological barriers to moving to a property that was designed specifically for older people… As with reasons for moving, barriers to moving were often multifaceted, with a range of practical and emotional factors in play.'[34]

In our survey we asked the 42 per cent of over 60s not interested in moving to tell us why this was the case. The most common responses were:

- My current house already suits my needs (88 per cent).
- I am close to family and friends here (32 per cent).
- It would be too stressful (23 per cent).
- My house/the local area has sentimental value to me (21 per cent).

We then asked the 43 per cent of over 60s reporting that it would be difficult to move (whether they wanted to or not) why this was the case. The most common answers were:

- The process of packing up all my belongings would be too stressful (50 per cent).
- It would be too expensive (45 per cent).
- I would find it physically difficult (29 per cent).
- There are no suitable properties available (26 per cent).

Only 5 per cent of the non-movers said that there were no suitable options available for them, rising to 16 per cent of people aged over 80, and 10 per cent of people currently living in one-bedroom properties. More than half (56 per cent) of people aged over 80 said it would be too stressful to move.

Overall, 52 per cent of people felt that it would be easy for them to move, if they wanted to, compared with 43 per cent who felt moving would be difficult or impossible. The importance given to ease of moving broadly increased with age – from 53 per cent in the youngest age group (60–65) to 26 per cent in the oldest (81+); 44 per cent of those considering moving in the future said they would find it difficult or impossible. This compares with 49 per cent of people who said that they would find it easy to move, but would not want to.

Physical difficulty and stress of moving were highlighted more by older people, while expense was highlighted more by younger older people. For people living in larger properties (with four or five bedrooms), the biggest obstacle was the stress of packing up personal belongings and the sentimental value of the house and local area. In contrast, for people in smaller properties (one or two bedrooms), expense and physical difficulty were highlighted as bigger problems.

The process of packing and moving seemed to put people off the idea the most, with 63 per cent of people who would not choose to move highlighting this as a barrier, compared with only 41 per cent of people who would consider moving.

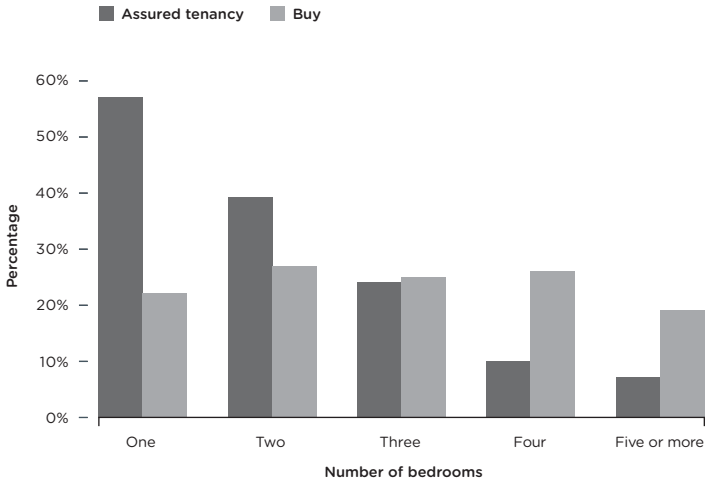
It is interesting to compare this list with the reasons given by those not wanting to move: 5 per cent of those not wanting to move said they didn't want to move because no properties were available, but for those reporting difficulty in moving (44 per cent of whom want to move), 26 per cent said there was a lack of suitable properties. Indeed, a lack of suitable properties (and to a lesser extent, not knowing how to go about looking for another property) were the only factors that was more of a problem for people who would like to move (30 per cent) than for people who would not like to move (20 per cent). This suggests that these are the key obstacles that stand in the way of people who would otherwise like to move.

Supply and demand

The evidence reviewed above suggests that both supply and some demand factors have prevented older people at the top of the housing ladder from downsizing, moving into retirement property or finding an otherwise more suitable home in later life. However, it is clear that supply and demand are linked, with issues of supply likely to be dampening demand. If the 'right' sort of housing – which meets the needs and preference of prospective buyers – is not available, then obviously people will not pursue the possibility of moving in the first place.

This could be a potential problem as relatively few developers operate in the marketplace for specialist retirement housing (mentioned above), so there may be a lack of choice and variants of the retirement housing model in areas where people want to live. The quality and location of much of the available housing can also be off-putting – Gillian Conner of Hanover Housing explained how much of the existing public provision is not ideally placed: 'If you were building units now, you would never build them where they are – tucked away behind an estate, not on a bus route, not near shops.'

Figure 2 **Percentage of people who would be interested in a retirement property, by number of bedrooms in their current property**



Our polling and the wider literature on this subject suggests that most older people would want a two- or perhaps three-bedroom home to move to. And yet, a considerable amount of specialist retirement property has only one bedroom.[35] It is also noted that while 76 per cent of older people are owner occupiers, only 23 per cent of retirement property is for sale, with the remainder for rent.[36] It is suggested that older people's desire to remain property owners for a greater sense of stability therefore deters them from moving to rented retirement homes,[37] although our survey suggests people would equally be interested in moving into retirement properties with an assured tenancy – giving them the sense of permanence and security they need. Older people with one-bedroom properties (57 per cent) and two-bedroom properties (39 per cent) were particularly attracted to this option.

Policy Exchange also reflected on how a poor supply of the 'right' housing would dampen downsizing to general needs housing more generally:

There is already a huge financial gain for those downsizing. The idea pure cash gain will make most people move from a large family-sized home, one that often contains precious memories, to a smaller one, is disproved by the evidence… what are needed are the homes that older people like and so would like to move into. But planning policy prevents these homes from being built.[38]

One developer we spoke to had recently experienced higher than expected demand for purpose-built accommodation designed for the 'active elderly downsizer', compared with another local development, which was targeting the same market but where properties were more 'formulaic', where low demand forced the developer to discount the properties by 30 per cent in order to liquidate the stock. The lesson he and his colleagues learnt from this is that not all retirement housing is the same, and it can be made more attractive through good design and knowing one's market.

Then there is the issue of affordability – as outlined above, problems of planning and associated charges and the demand for well placed land can drive up the price of retirement property. Many of the studies on this issue assume that all older people have significant housing equity to enable them easily to cover the costs of purchasing specialist housing, but this is not always the case, and less wealthy older home-owners can be priced out of the market. There is a risk that housing models like extra care – which are fairly expensive per resident – become unattainable for all but the very wealthy. This can lead to regional variations in provision, as retirement property is built near homes where adequate equity can be released from nearby housing to increase the chances of purchases by people from the local community. Therefore retirement housing may not be available in some poorer parts of the country. As Karen Croucher told us:

[Private developers have] not concentrated on nice retirement housing in places like Barnsley, Hartlepool or Blackpool, but on the nice market towns… so that's fine if you have a house you can sell in those places, but not so nice if you wanted to sell in not so nice an area.

In conclusion, there is likely to be a complex interplay of push and pull factors when people consider moving into retirement housing. As JRF's recent report regarding downsizing concluded:

The current discussion of downsizing is misleading because it presents the issue as a simple matter of older people holding onto housing. This ignores both the lack of housing choice, as well as older people's psychological and social reasons for staying put. If the government believes that more older people should move to smaller homes, it must make choice its watchword, finding ways to induce providers to offer a range of attractive alternatives.[39]

6 Helping those at the top of the ladder – a win-win-win

We now know why older people may (or may not) downsize or move to retirement housing, and the supply and demand problems at play. In this section, we explain why resolving these supply and demand problems is so critically important – for older people themselves, for the housing market and for the wider economy.

Benefits to older people

Evidence suggests older people who move to specialist retirement housing enjoy a higher quality of life than they did before they moved and improved social networks, reducing isolation and loneliness. Evaluations also show positive outcomes in health, and safety and wellbeing tends to improve, while moving to smaller, more energy efficient accommodation can help older people to stay warm and save money on energy bills. One survey carried out by the University of Reading among the owner occupiers of retirement properties found:

- More than eight in ten residents reported that they generally feel happier in their new home.
- Almost 45 per cent of residents reported having better or much better contact with family and friends; a further 48 per cent reported no change.
- Half of residents thought that their energy bills were lower.
- Residents reported spending less time in hospital and nearly a third felt that their health had improved since moving.[40]

A review of retirement villages on behalf of the JRF found that developments for older people that included communal areas help improve the social relationships of isolated older

people, and those with facilities such as leisure or learning activities can increase older people's wellbeing and help them to stay mentally and physically active. Other benefits on offer in larger scale sites included: finance and benefits advice services, healthcare, and on-site care homes, so residents did not have to move if their needs increased. The researchers also noted:

As homes are purpose built, decent and accessible, they are safer and warmer; particularly beneficial if people develop mobility problems or ill health… Residents tend to feel safer and have less fear of crime [and] there are self-reported improvements in health and well-being.[41]

Gary Day confirmed this:

There is a strong community benefit in that, previously [older people] would live in their family house and be more remote from the community, they didn't have that sense of wellbeing, companionship, security and everything else we offer. They didn't have the confidence to go out and involve themselves in the local community.

A review in 2011 of 19 extra care schemes by the Personal Social Services Research Unit (PSSRU) found that the occupants had considerably lower rates of mortality than a matched sample in care homes.[42] Over 40 per cent were also at an improved level of physical functioning after moving in, and had improved levels of social interaction. This supports the findings from three earlier evaluations cited by the Institute of Public Care (IPC). The first was a survey in 2004 of over 300 residents in sheltered housing, which found that over 50 per cent believed that their housing helped to promote good health, while 55 per cent considered their health to be good or very good. The average age of this group was 79; in the wider population only 41 per cent of 65–74-year-olds feel their health is good, falling to 32 per cent for those aged 75+.[43] The second was a study by Biggs et al, which suggested that on average the residents in a retirement scheme they reviewed improved by more than 35 per cent in mobility and 20 per cent in functions of daily living. They also found a 25 per cent reduction in the use of medication by

residents after admission.[44] Finally, research undertaken by the Extra Care Charitable Trust found that superficial physical assessment scores improved by an average of 50 per cent, mobility by 35 per cent, daily living functions by 20 per cent, and sensory ability by 10 per cent,[45] and (as the study by Biggs et al found) there was a 25 per cent reduction in the use of medication.[46]

Of course, all of the evaluations cited above relate to retirement housing or extra care housing, which unsurprisingly have health benefits thanks to the presence of support services, and include communal spaces to improve social networks, physical and mental activity. However, it is clear that simply downsizing into general needs housing that is more efficient to heat and maintain, or perhaps has adaptable bathrooms, or is on one floor, will have a range of health and financial benefits associated with staying warm, avoiding fuel poverty and reducing the risk of falls.

Downsizing and moving into retirement property can both release equity and boost the financial wellbeing of older people. Analysis of a group of retirement property owners found that their property was around 10 per cent cheaper than the median values of their previous homes, giving significant average equity release. Over 40 per cent of the group studied were able to withdraw £25,000 or more in housing equity as a result.[47] For downsizing into general needs housing the gains could be larger – analysis of housing markets by the NPI suggests £100,000 of equity would be released on average, across most areas of the UK, by moving from a detached home to a semi-detached or apartment.[48] Policy Exchange considered London and the South East specifically and found potentially greater gains:

An older couple moving from an average detached property in London to a semi-detached property in London would move from a £751,184 property to a £459,182 property, gaining nearly £300,000. In the South East, downsizing from a detached to semi-detached property would mean moving from a property worth £438,891 to a property worth £259,922, gaining around £180,000.[49]

The HAPPI2 report (2012) summed up the evidence on the benefits of retirement property thus:

Solutions to health and social care problems so often lie in provision of specially designed, high quality homes: these reduce risks of falls; provide safety and security; protect against the effects of cold homes and fuel poverty; enable earlier discharge from, and fewer re-admissions to, hospital; prevent the need (both temporary and permanent) for institutional residential care. And the companionship that comes with retirement housing can combat the depression and poor health that so often results from isolation and loneliness. These factors can save public (NHS and local authority) funds as well as conserving private resources.[50]

The housing market

As explained in the introduction to this report, the housing market in the UK is under considerable pressure. Supply is not matching demand and the result is unaffordable house prices and extortionate rents. At the time of writing, the Halifax house price index reported that house prices are rising at their fastest rate since August 2010, and in the three months to July 2013 were 4.6 per cent higher than the same period in 2012.[51]

The Government has responded by making borrowing easier for those with smaller deposits, in the hope that more first time buyers will be able to get on to the housing ladder and this increase in demand will stimulate an increase in supply. But increasing supply need not only involve building more property for first time buyers or family homes. An efficient chain reaction can be created by increasing the supply of a range of retirement properties to enable those at the top of the housing ladder to move to somewhere more suitable. This, in turn, frees up a range of properties for families of different sizes, which in turn frees up smaller properties for first and second time buyers to move into. The entire housing chain benefits as a result. When thinking about 'whole chain' improvements in this way, it is obvious that focusing on first time buyers will not solve the challenges of the housing market on its own. As Shelter's 2012 report explained:

The market is currently stagnant, but it operates on swaps, chains and cycles, with households trading up and so allowing others to enter at the bottom of the ladder. If more households were to downsize they would obviously need somewhere to move to. While there are potentially enough smaller homes in the market they are not necessarily the right kind, in the right tenures or the right areas. Building more homes that are suitable for older people could help to stimulate the market by increasing their propensity to downsize.[52]

Shelter calculated that if those in the 20 per cent of older households which are currently under-occupied were to downsize, around 840,000 family-sized homes would be released, including 760,000 in the owner-occupied sector:

This approach would potentially be at a lower cost than building the equivalent number of new family homes and would create family housing more quickly – it has taken eleven years for 828,000 new homes with three or more bedrooms to be built. This is a big 'if', as we have seen that developers are not currently catering for the older market or building sufficient levels of new specialist housing[53]

Analysis from the University of Reading found that two-thirds of residents currently living in retirement property had moved from homes with three or more bedrooms. The researchers calculated that for every 5,000 retirement units sold, property to the value of £1.1 billion would be released into local housing markets.[54] However, as JRF pointed out, 85 per cent of homes with three or more bedrooms are currently 'released' by older people as a result of death rather than a move to a smaller home.[55]

For this report, Demos carried out new analysis of the latest wave of the English Longitudinal Study of Ageing (ELSA)[56] to get an up-to-date picture of how those at the top of the ladder might affect the housing market if they were to move.

Our analysis shows that 83 per cent of the over 60s living in England (so not Scotland, Wales or Northern Ireland) own their own homes, 64 per cent without a mortgage. Rates of home ownership peak in the 76–80 age bracket (at 91 per cent), before

sharply dropping (this may be the point at which people generally enter residential care). This equates to £1.28 trillion in housing wealth, of which £1.23 trillion is unmortgaged. This is far more than the amount of savings this group has (£769 billion).

Therefore the 33 per cent of the over 60s looking to downsize (57 per cent of the 58 per cent over 60s interested in moving) are sitting on £400 billion of housing wealth.[57] If just half of the 58 per cent of over 60s interested in moving generally, as reported in our survey, were able to move, this would release around £356 billion[58] worth of (mainly family-sized) property – with nearly half being three-bedroom and 20 per cent being four-bedroom homes.[59] Whereas if those 25 per cent of over 60s interested in buying a retirement property were able to do so, this would release £307 billion worth of housing.

Analysis from the NPI suggests that 200,000 older people (defined as over 55) move each year, while 271,000 die. This releases 189,000 owner-occupied properties back on to the market for other (non-older-person) families: 43,000 two-bedroom properties, 101,000 three-bedroom and 21,000 four or more bedroom properties each year, once any moves by older people into the properties have been taken into account (table 1).

Combining this NPI analysis with our own analysis of ELSA, we can conclude that if all those interested in buying retirement property were able to do so:

- 3.5 million older people would be able to move.
- This would free up 3.29 million properties, including nearly 2 million three-bedroom homes.

If just half of those interested in downsizing more generally were able to do so:

- 4 million older people would be able to move.
- This would free up 3.5 million homes.

However, change on this scale would be impossible because of the inadequate supply of housing that is suitable and

Table 1 **Estimated annual change in use of housing stock by older households due to mortality only, and mortality and moves combined, 2008/09–2009/10 (thousands)**

	Owner-occupied		Private rented		Social rented	
Number of Bedrooms	Mortality	Mortality & moves	Mortality	Mortality & moves	Mortality	Mortality & moves
0 or 1	–5	0	–3	1	–24	3
2	–61	–43	–4	–2	–21	–28
3	–101	–117	–9	–13	–17	–38
4 or more	–21	–28	–2	–3	–3	–3
Total	–189	–189	–17	–17	–65	–65

desirable for older people to move into. It is a startling fact that it would take 20 years to see this level of change at the current rate of movement in the current market. By that time, the population of over 85s in the UK will have increased by 101 per cent.

Wider benefits of building more homes suitable for older people

House building – in whatever form it takes – is seen by many as highly beneficial to the economy in the current climate. It would stimulate growth and create jobs in a variety of construction-related industries, reduce spending on housing benefit and bring down the cost of living.[60] Developers calculate that a 40-unit scheme puts around £5 million into the economy, with 50 people directly employed during construction and 17 jobs created in a typical extra care development.[61]

Enabling older people to downsize would have additional benefits – the equity they release through downsizing would increase consumer spending and reduce costs to services such as the NHS associated with pensioner poverty.

The building of retirement properties would combine the benefits associated with both of these, but may then (as the University of Reading argues) also have benefits for the environment, as properties are far more energy efficient than the homes older people move out of.[62] McCarthy & Stone's submission to the Lords committee on demographic change also stated that retirement housing made efficient use of previously used land – brownfield sites.[63]

There are also cost savings to be had – by promoting better health outcomes cost savings are made to acute care services in social care and the NHS, fewer hospital admissions, and so on. The HAPPI2 report summed up the range of savings very well, ranging from reduced risk of falls to combating mental health problems.[64] Specialist housing for older people delays and often prevents the need for residential care. Since for each year a person postpones moving into residential care the state would save on average £28,080,[65] the cost savings can be substantial. Both the University of Reading and IPC calculated net cost savings to the NHS of hundreds of millions of pounds in building more retirement housing.[66]

7 The top of the ladder – recommendations for policy and practice

In the previous sections, we have gathered the available evidence and combined it with new analysis on the problem of the supply of older people's housing meeting demand; the barriers to further demand; and the potential benefits in overcoming these. In this section, we tackle the most important question – how can we improve both supply and demand?

As we explain above, this is a multifaceted problem. There is no 'magic bullet' here. Nonetheless there are a number of fairly obvious issues that, if tackled, would make a huge difference.

Unleashing supply

Guidance from above

Retirement housing currently makes up around 2 per cent of housing for the over 65s – making it a small, niche area and perhaps easy to overlook by the Government. It also presents no obvious problem: older people with their own homes who are unable to move are understandably less obvious a challenge to policy makers than younger people unable to get on the housing ladder in the first place. This is seen as a more obvious, direct and urgent issue, but the two are fundamentally linked. It is vital that the government connect the present housing crisis of unaffordable rents, spiralling housing benefit and young people living with their parents to the lack of options available to older people to downsize.

The government needs a 'whole chain' focus rather than simply looking to first time buyers, but it is clear from policies such as the spare room subsidy (or 'bedroom tax') – from which older social renters were exempt – that older renters and home

owners are simply seen as a static link in the chain, not to be moved while all other links take the strain.

Without fully appreciating the benefits of retirement housing to individuals, the housing market and the wider economy, encouraging policy statements are made without adequate follow-through. The Government's strategies and guidance on the need for more retirement housing remain unclear, and several bodies have made similar suggestions of ways to address this. The HAPPI2 report recommended setting up a Cabinet Office task force to bring together the Department of Health (DH) and the Department for Communities and Local Government (DCLG) to work towards building the homes needed by an ageing population.[67] This echoes the call by McCarthy & Stone for the formation of a ministerial working group on specialist housing for older people to bring together the key decision makers in the DH and DCLG to develop policies to support this kind of housing.[68] In a briefing note for MPs in July 2012 entitled 'Increasing build rates of specialist housing for older people', the HBF added its voice to this and called for a housing, health and planning working group to be set up to build greater understanding of the link between better housing and improved health, and to see how planning should play a role in this.[69]

All of these organisations recognise that some type of national cross-departmental coordination is required to push for a national strategy and a clearer position on this issue. The Lords committee report on demographic change, referred to in the introduction of this paper, presents an opportunity to do this.[70] The Government could review its position on older people's housing and take a coherent line on how to encourage both demand and supply as part of its response to the report. The Government's initial written response to the Lords report was muted, without any promise of new legislation to tackle the range of problems (including housing supply) identified. Nonetheless, the Government has yet to follow up the initial response with further policy statements – so the window of opportunity for action in this area has not yet closed.

Local direction

A clearer national strategy, underlining the importance of a greater housing offer for older people and the need to work in partnership with a range of providers, would no doubt trickle down to local level, where retirement housing schemes encounter most problems.

However, leadership at local level is also vital. Council chief executives need to consider the Lords committee report on demographic change very carefully and think what the implications might be for service provision and ensuring local markets are fit for purpose, across all departments. The priority need for having a local housing market which meets the needs of older people must be articulated not just across housing and adult services, but in all departments.

With this vision at the top, subsequent changes would then need to be made. For example, the local plans that each local authority must have in order to lay out the overall development plan for the local area must include a strategy for ensuring that local housing reflects demographic change. The National Planning Policy Framework stipulated that these plans needed to be up to date, and look ahead – preferably with a 15-year time frame – to the needs of the local population.[71] It seems unlikely that any 15-year plan would be able to avoid the issue of an exploding over-65 and over-85 population and what that means for planning policy.

The HBF has also advocated clear guidance for local SHMAs, which (as explained above) have been described as patchy and inadequate. The HBF said local authorities should be encouraged to review the need for specialist housing for older people across all tenures in their assessments.[72] It also suggested neighbourhood forums should be encouraged to consider the housing requirements of their ageing populations, while HAPPI2 recommended that local housing and social care departments should give strategic priority to assessing and investing in older people's housing. Jeremy Porteus told us that the

idea of local strategies is really important but it shouldn't be about the numbers, it should also be around the quality of outcomes, such as lifestyle and design outcomes, and have a greater recognition of the links between those.

Demos has also in the past argued that housing providers should be represented on health and wellbeing boards, given how important housing is to public health generally.[73] However, retirement housing's role as (in some cases) an alternative to residential provision and (in others) a way of preventing or delaying this makes this particular form of housing a key player in the local market of health and care services. The Care Bill currently being debated in parliament places considerable emphasis on the prevention of acute health and care needs and the promotion of wellbeing. Inclusion in joint strategic needs assessments and representation on health and wellbeing boards should be the very least retirement housing should expect at local level, and these in turn must engage with planners to address the disconnect that currently exists when applications for retirement housing are considered.

The planning system

Perhaps the key problem stifling supply and driving up costs at local level is problems with planning, which at least in part stem from lack of coordination at local and national level between housing and health teams, and a lack of strategic direction and guidance on the role of retirement housing. The effect on the ground – as explained earlier in this report – is a housing and planning policy which is not fit for purpose when dealing with retirement housing.

Several measures have already been suggested to help remedy this by a range of organisations. The University of Reading and several others producing research in this field have come to the conclusion that owner-occupied retirement housing should be treated as a form of affordable housing, and given 'enhanced planning status' alongside low-cost home ownership for younger households. Developments of retirement properties should be exempt from paying Section 106 charges towards affordable housing, and a proportion of the charges levied from other private developments ought to be put towards helping develop older people's housing. This would in turn reduce the

costs of these properties, making them more affordable, and stimulate demand.

The argument for such a move is strong. Planning policy is currently used to encourage the provision of affordable homes for groups particularly disadvantaged in the current housing market, as this has clear social value. But building homes for older people which can improve their health and wellbeing also has obvious social value. It can also be argued that older people are disadvantaged in the housing market – they may not be struggling to afford the rent, but many are struggling to maintain their current homes and cannot remedy this by moving home. Being unable to buy a home should be seen as a crisis not just for renters, but for home-owners too, stuck in the wrong property. When older people are risking their health and wellbeing as a result, this obviously vulnerable group is clearly in need of special planning measures. Current housing policy seems to focus almost entirely on issues of finance, with affordability being the only measure of social good. A more joined up way of thinking would enable the DCLG at national level and planners at local level to recognise the close relationship between housing and wellbeing and that social value is derived from more than just its price.

Other steps planners could take if they were to prioritise older people's housing as part of the overall housing market include developing quotas for local provision (part of recognising that this housing has value in its own right), putting aside land specifically for retirement housing developments, and operating with a presumption that planning permission will be granted (currently around half of the sector's applications are refused, and two-thirds are then won on appeal[74] – adding costs and delays). CIL tariffs for retirement homes could be set at more viable levels by exempting communal space in designated retirement properties (perhaps up to a capped amount, set in consultation with planners and reviewed as new innovative models are developed). The IPC also suggests that incentives should be provided to local authorities to release land for the development of older people's housing schemes.

Specific measures – changing S106 and CIL rules – could be trialled in pathfinder areas of the country to establish what the impact might be on speed and cost of development and resulting demand (eg developers involved could pledge to use the money they save to reach out to the local community, improve awareness, ensure they understand local preferences and needs, and encourage take-up).

Working in partnership at national and local level

It is worth remembering that retirement housing need not be built by local authorities or housing associations. Indeed we have focused primarily in this report on the barriers of retirement housing being built by private developers, suggesting it is a nascent market currently being stifled by lack of understanding by national and local government and the public. The reasons for this focus are twofold. First, we know that many older people want to remain home owners, and yet there is a lack of retirement properties to buy, with more than three-quarters of the current properties for rent. Building more council-owned or social housing tenancies is less urgent than encouraging private providers to improve the supply of homes to buy.

Second, in the current economic climate councils are not in a position to embark on or subsidise large-scale home-building schemes. The strategic housing policy officer for West Dorset Council told us that while the council had previously relied on government grants for affordable housing, these were drying up. The council could therefore no longer afford to 'build their way out' of the problem, and those in the housing department are having to think more cleverly about their existing housing stock. They have tended to focus on funding services that help people to remain in their homes and live independently, such as floating support, home improvement agencies, loan schemes, and energy efficiency and retrofitting.

With these two factors in mind, it is clear that solutions to the issue of older people's housing must be sought in partnership with the private sector at national and local level. The focus of these partnerships are more likely to be about market facilitation

– making properties easier to build and therefore more affordable to buy – than about engaging in costly direct provision. While the IPC suggested that there should be 'support to developers in sharing financial risk through the development of interest-free loan schemes to be repaid as properties are sold', many of the ways the market can be encouraged are relatively low cost or cost neutral – related as they are to changing planning rules, refocusing strategies and (as outlined in the next section) ensuring there is adequate information and support given to older people to help them move.

At national level, the HAPPI2 report said the DCLG should encourage and incentivise the private sector and registered social landlords to meet the rising demand of people seeking to move to 'elegant, functional, sustainable and manageable homes' for later life.[75] While the University of Reading observed,

Though social providers are clearly important and costs of social care are high and of concern to both central and local government, particularly at a time when expenditure is being squeezed, the opportunities offered by the private sector are under-played.[76]

While developers would prefer regulatory reform (like the reforms outlined above) to state funding, the Care and Support Specialised Housing Fund announced by the DH in July 2012 is a step in the right direction. Although much of the focus of this fund is on affordable properties for older and disabled people, £160 million has been put aside to look at how 'to stimulate development in the wider private market'.[77] Jeremy Porteus told us that this scheme marked a promising new era where the Homes and Communities Agency is no longer just a grant giver, but also a place shaper by working in partnership with private providers. We would urge the Government to use the findings of this work to feed into a more robust response to the Lords committee on demographic change (mentioned above) aimed at age proofing our housing market in partnership with private developers and landlords, social housing organisations and local authorities.

At local level, the concept of market facilitation is not new. Local authorities have increasingly been shaping the care and support market for many years as these services have moved from direct in-house provision to being offered by a range of third sector and private providers. Local authorities now have to issue 'market position statements' as part of the national programme Developing Care Markets for Quality and Choice (DCMQC),[78] which sets out the outcomes they hope to achieve in care and support, a demand analysis, how they think this should be met, and so on.[79] The key assumption behind these statements is that local authorities are providing very few (if any) services themselves, but rather working to ensure other providers know the types of services in demand in the local area and the types of services the local authority is likely to commission. There is an opportunity for these statements to also cover housing needs – to give a clear steer to providers of the local demographics and care and support profile of the area, and to give the local authority a chance to consider the housing-related health outcomes the local authority is focused on (and indeed, what steps they might take to facilitate or encourage this in partnership with private and social housing developers and providers).

Encouraging demand

Back to supply

There is already healthy interest among older people in retirement housing, and many more express the wish to downsize in order to have a more manageable home. Nonetheless, what the sector can offer is generally poorly understood and there remain several reasons why any older person wanting to move would find it difficult to do so. Retirement housing certainly will not be for everyone but how can we ensure older people know of the benefits it can offer, and can be supported to move if they decide it is right for them?

Perhaps most obviously, the housing offer needs to be of the right quality, in the right location, have the right number of

bedrooms and look like the type of home an older person would want to live in. It also has to be available to buy – at a reasonable price – for those who want to maintain a sense of asset ownership and security. As Gillian Conner commented: 'You've got to get the housing right first, making it aspirational, somewhere people want to live.'

If supply is too scarce, in the wrong place, of the wrong type or too expensive, then we should not be surprised when no one wants to move in. Many older people have spent years making their own family homes comfortable and attractive places to live, so the pull factor has to be strong in order to tempt them to move.

This then comes back to the supply-side solutions outlined above – tackling planning problems may well lead to a larger number of and more affordable schemes. It may also encourage more developers to enter the market, bringing new models and ideas to meet different preferences. This would create greater variety for older people to choose from, and again potentially reduce costs.

We must remember that while 83 per cent of older people are home owners who would therefore be able to release equity, not everyone can afford retirement property or indeed afford to downsize. Karen Croucher from York University explained this latter problem using a local example. She explained that in Barnsley, a three-bedroomed ex-council house was worth £70,000. But a one- or two-bedroomed bungalow in the same town was worth £120,000. For older people in this housing market, downsizing could actually be more expensive. She felt that there should be more tenure choices, such as shared ownership and shared equity (as under HomeBuy), to help make retirement property more affordable, particularly for people who are selling in low house price areas. She felt the social rented sector had a role to play as many were now developing homes to buy, not just rent. She commented, 'The boundaries between social rented sector, private sector landlords and private sector developers are becoming quite blurred.'

Support and advice

Offering a good range of housing options will only do so much to encourage older people interested in moving. We also have to consider what is holding them back. Our polling, and the findings of the polling carried out for Shelter in 2012, suggests this is a combination of practical and emotional issues. While the latter may be harder to help with, the former is certainly easily remedied.

First and foremost there needs to be a far better local offer of practical help for older people looking to move. The physical strain of moving – packing up years of belongings from a large home, storing, giving away or disposing of items and moving into a smaller property – is a mammoth effort for all of us, so for someone in their 80s (as our polling suggests) this may seem an insurmountable problem. The experts we spoke to suggested that age-friendly removal services should be encouraged to develop (perhaps as part of local authorities' market position statements) in the same way as age-friendly handymen and gardeners are. Local 'housing options services' already exist, which can provide advice to people who are weighing up the pros and cons of moving and provide practical help, such as being there when the removal van comes, and helping to disconnect and reconnect utilities in a new property. These services were encouraged through Care & Repair England's initiative 'Should I Stay or Should I Go?', though this ceased several years ago. While many of these housing options schemes still exist, awareness of them is fairly low and many of those we reviewed for this project were focusing on more traditional local authority challenges – social housing waiting lists, affordable housing and homelessness. However, in Dorset a large population of older people has prompted a more comprehensive offer from the Dorset Housing Options Service.

Box 2 **Dorset Housing Options Service**[80]

We recognise that 'staying put' in their own home is no longer the best option for a proportion of older people. However, the idea of having to even consider the options that might be

available can be very daunting and often that alone puts people off at the start.

The Dorset Housing Options Service has been developed by the Dorset Home Service to provide older people with the information, specialist advice and practical support that they need to enable them to make informed choices about whether to move property or to stay put at home.

On occasions, a single visit may be all that is required to look at options. In other cases people may want more support to:

- *appraise the housing options available*
- *advise on repairs and grant assistance*
- *arrange property viewings*
- *help with packing belongings*
- *help with the sale of unwanted furniture*
- *help with the safe disposal of household records*
- *make contact with removal companies*

This sort of comprehensive service ought to be the standard fare in all local authorities. In the Care Bill currently being debated in parliament there is a duty on local authorities to provide information and advice services on people's care and support options and how to fund them. As retirement housing (and indeed downsizing to more suitable property) is an important means of promoting wellbeing and preventing or delaying care needs, and releasing equity can pay for care, we suggest that advice on downsizing and housing options is included as part of this duty and that housing options services are reinvigorated and brought within the remit of the duty presented in the Care Bill.

Financial incentives and penalties

In addition to support of this kind, others have also suggested financial incentives. The Intergenerational Foundation among many others has suggested that stamp duty should be scrapped

for downsizers, while the IPC and others have suggested there should be a reduction of stamp duty and/or a council tax abatement for those downsizing or for buyers of specialist retirement properties.[81] The IPC suggested these as well as providing financial support for legal and conveyance fees (older property owners of smaller homes reported in our survey that they were put off by the cost of moving), as well as extending the Help to Buy scheme for older buyers (who are downsizing or moving to retirement property).[82] The costs of such measures are likely to be recouped (in part at least) by a housing chain reaction, generating stamp duty as families are able to move into the properties vacated by older people (which is more than could be said for financial assistance given to first time buyers, whose ability to get on the bottom of the ladder has no effect on potential buyers above them on the housing ladder).

It is also worth noting that many local authorities offer financial incentives to working age council tenants to downsize and free up properties.[83] The reasoning behind this is that a voluntary move to a smaller property enables the family to avoid facing the bedroom tax and the costs that could follow as a result of arrears and eviction. A similar cost-saving calculation could be made regarding the health and care savings made if older people were financially encouraged (in the ways outlined above) to sell their homes and move into more appropriate housing.

Financial penalties have also been considered by some, alongside incentives. Currently there are no penalties for older under-occupiers in the social rented sector (as they are exempted from the bedroom tax), although extending this charge to older people has been mooted. So too has the idea of withdrawing some universal older people's benefits from owner occupiers living in houses worth over £500,000. The Intergenerational Foundation also proposed the abolition of council tax concessions for single occupation, to 'eliminate a perverse incentive which currently encourages single occupants to remain in large houses'.[84]

Such suggestions should be treated with extreme caution, if not dismissed out of hand. The spare room subsidy (or bedroom tax) has proven extremely controversial, leaving many families in

a dire financial situation. It is likely that such policies will more effectively exacerbate pensioner poverty than induce people to downsize. For those who do downsize, a forced move is unlikely to reap the benefits associated with voluntary and planned moves, such as improved wellbeing and sense of security. In short, penalty systems may deliver some benefits to the housing chain, but the negative impact on older people's health and wellbeing would far outweigh these.

8 Concluding thoughts

This report has drawn together existing evidence and supplemented it with new analysis to create a clear picture of the next big housing crisis we face – the fact that our housing supply is not fit for purpose in an ageing society where the population of over 85s will increase by 100 per cent in the next 20 years.

On review, it is clear that the evidence on the problem, how to overcome it and the benefits of doing so is thorough and robust: we know exactly what the problem is, how to fix it, and who stands to gain if we do.

We also know – crucially – that this does not involve massive investment in housing building by the government. Unlike costs related to health or social care, the costs associated with overcoming the challenges of housing an ageing society are relatively small, because the money to stimulate supply of new housing, built by the private sector, is there already – locked up in over a trillion pounds' worth of assets held by older people across the country. Hundreds of millions of pounds could be released to stimulate the housing market if (low-cost) steps were taken to unlock the supply to meet the demand already there – let alone if demand were further stimulated.

The lack of appropriate housing supply cannot be remedied by the government building housing itself – this is economically unfeasible. We also know that many older people want to remain home owners, and yet more than three-quarters of the current retirement properties on offer are for rent. Building more council-owned or social housing tenancies is less urgent than encouraging private providers to improve the supply of homes to buy.

While there must always be a place for social housing and affordable tenancy for older people, the vast majority of older

people can be helped into more appropriate housing without any direct delivery costs incurred by government or local authorities.

The retirement housing market is a nascent market currently being stifled by lack of understanding from national and local government, and the public. It would take a small number of relatively low-cost steps to unlock it. So the fact that the Government has yet to grasp this nettle remains one of the great mysteries of UK policy making, given how substantial the benefits could be. One can only assume that the more obvious, seemingly more urgent and visible plight of renters unable to afford their first home is clouding the issue. The Government needs to have a 'whole chain' view of the housing market – recognising that helping the private sector serve older people at the top of the ladder will have a trickle-down effect of unlocking supply, benefiting those at every other step of the ladder.

Summary of policy recommendations

Unleashing supply

Guidance from above

The Government needs a 'whole chain' focus rather than simply considering first time buyers. To achieve this, some vehicle for cross-departmental coordination is required. This may take the form of a Cabinet Office task force to bring together the DH and the DCLG, or a ministerial working group on specialist housing for older people across housing, health and planning to build greater understanding of the link between better housing and improved health, and to see how planning should play a role in this. The need to respond to the Lords committee for demographic change is a good opportunity for the Government to take such steps.

Local direction

Leadership at local level is also vital. Council chief executives need to consider the Lords committee report on demographic change very carefully and think what the implications might be for service provision and ensuring that local markets are fit for purpose across all departments. The priority need for having a

local housing market that meets the needs of older people must be asserted, not just across housing and adult services, but in all departments.

In particular, local plans, in which each local authority lays out the overall development plan for the local area, must include a strategy for ensuring local housing reflects demographic change. SHMAs also need to be improved to include a strategy for developing retirement housing.

Given the vital role housing plays in public health, and the way retirement housing can delay or prevent the need for residential care, there should be representatives from local retirement housing schemes on health and wellbeing boards and should feed into joint strategic needs assessments. These in turn must engage with planners to address the disconnect that currently exists when applications for retirement housing are considered.

The planning system

Developments of retirement properties should be exempt from paying Section 106 charges, which are put towards affordable housing, and a proportion of the charges levied from other private developments ought to be put towards helping develop older people's housing. This is based on a strong argument regarding its clear social value.

CIL tariffs for retirement homes should be set at more viable levels by exempting communal space in designated retirement properties (perhaps up to a capped amount, set in consultation with planners and reviewed as new innovative models are developed).

Other ideas to improve the planning regime for retirement property ought to be considered, including developing quotas for local provision (part of recognising that this housing has value in its own right), putting aside land specifically for retirement housing developments; and operating with a presumption that planning permission will be granted (currently around half of the sector's applications are refused, and two-thirds are then won on appeal[85] – adding costs and delays to housing supply).

Encouraging demand

Back to supply

There are many ways we might encourage supply, but perhaps most obviously, the housing offer needs to be of the right quality, in the right location, have the right number of bedrooms and look like the type of home an older person would want to live in. It also has to be available to buy – at a reasonable price – for those who want to maintain a sense of asset ownership and security. This then comes back to the supply-side solutions outlined above – tackling planning problems may well lead to a larger number of and more affordable schemes. It may also encourage more developers to enter the market, bringing new models and ideas to meet different preferences. This would create greater variety for older people to choose from, and potentially reduce costs, encouraging more people to purchase property.

Support and advice

Offering a good range of housing options will only do so much to encourage older people to move. We also have to consider what is holding them back. First and foremost, there needs to be a far better local offer of practical help for older people looking to move. The physical strain of moving – packing up years of belongings from a large home, storing, giving away or disposing of items and moving into a smaller property – is a mammoth effort for all of us, so for someone in their 80s (as our polling suggests) this may seem an insurmountable problem.

In the Care Bill, currently being debated in Parliament, there is a duty on local authorities to provide information and advice services regarding people's care and support options and how to fund these. As retirement housing (and indeed downsizing to more suitable property) is an important means of promoting wellbeing and preventing or delaying care needs, and releasing equity can pay for care, we suggest that advice on downsizing and housing options is included as part of this duty and that the housing options services are reinvigorated and brought within the remit of the duty presented in the Care Bill.

Financial incentives

In addition to support of this kind, others have also suggested financial incentives. The Government should consider a reduction or exemption of stamp duty and council tax for downsizers or for buyers of specialist retirement properties.[86] Financial support for legal and conveyance fees as well as extending the Help to Buy scheme for older buyers (who are downsizing or moving to retirement property) are also viable proposals.[87] The costs of such measures are likely to be recouped (in part at least) by a housing chain reaction, generating stamp duty as families are able to move into the properties vacated by older people.

Appendix 1

We interviewed the following experts during the course of this research:

Chris Branch, Strategic Housing Policy Officer, West Dorset Council
Andrew Burgess, Managing Director of Planning Issues, Churchill Retirement Living
Gillian Connor, Head of External Affairs, Hanover
Karen Croucher, Research Fellow, Centre for Housing Policy, University of York
Gary Day, Land & Planning Director, McCarthy & Stone
Bill Gair, Chief Executive, Urban Rennaisance Villages
Joe Oldman, Policy Adviser (Housing), Age UK
Jeremy Porteus, Director, Housing LIN
John Slaughter, Director of External Affairs, HBF
Amy Swan, Policy Officer, NHF

Appendix 2

Questions put to 1,510 over 60s on 17–18 July 2013

1 What type of property are you currently living in?
   a Semi-detached house
   b Detached house
   c Bungalow
   d Terraced house
   e Flat or apartment
   f End-of-terrace house
   g Static caravan
   h Other

2 Do you own or rent your property?
   a Own outright (mortgage paid off)
   b Own (with a mortgage)
   c Rent from a council or housing association
   d Rent from a private landlord
   e Other

3 How many bedrooms does your property have?
   a 1
   b 2
   c 3
   d 4
   e 5 or more

4 FOR OWNERS – Approximately what value band does your property fall into?
   a Less than £150,000
   b £150,001 – £200,000
   c £200,001 – £300,000
   d £300,001 – £400,000
   e £400,001 – £500,000
   f £500,001 – £750,000
   g £750,001 – £1 million
   h Over £1 million

5 How many people are living in your house in total (including you)?
   a 1
   b 2
   c 3
   d 4
   e 5 or more

6 If you were able to, and suitable properties were available, would you consider moving from your current property in the future?
   a Yes – definitely
   b Yes – maybe
   c No – unlikely
   d No – definitely not
   e Don't know

7 If YES – What would be your main reasons for wanting to move? Please tick all that apply.
   a I need a property that suits my needs better (eg no stairs, smaller garden that is easier to maintain)
   b I want to live somewhere different
   c The house is too big for me
   d Ongoing maintenance is becoming an increasing problem
   e I am too far from family and friends here
   f I need to reduce my fuel bills
   g I need to free up cash for other expenses

h I need more support and care
i I can no longer afford my current property
j Other (please state) [open]

8 IF YES – What number of bedrooms would you ideally be looking for?
a 1
b 2
c 3
d 4
e 5 or more

9 IF YES – How likely would you be to consider the following options when planning a future move?
a Buying a purpose-built retirement property
i Very likely
ii Quite likely
iii Neither likely nor unlikely
iv Not very likely
v Not at all likely
vi Don't know

10 Renting a purpose-built retirement property on an assured tenancy (which gives you the right to live in the property for as long as you wish)
a Very likely
b Quite likely
c Neither likely nor unlikely
d Not very likely
e Not at all likely
f Don't know

11 IF NO – What are your main reasons for not wanting to move?
a My current house already suits my needs
b I am close to family and friends here
c It would be too stressful
d My house/the local area has a sentimental value to me

e I have only recently moved to my current home
f There are no suitable options available to me
g I do not want to move until my children/grandchildren are independent
h Other (please state) [open]

12 How possible do you feel it would be for you to move if you wanted to?
a Very easy
b Quite easy
c Quite difficult
d Very difficult
e Not possible
f Don't know

13 IF DIFFICULT/NOT POSSIBLE – What are the main reasons why it would be difficult for you to move? Please tick all that apply.
a The process of packing up all of my belongings would be too stressful
b It would be too expensive to move
c I would find it physically difficult to move (due to illness or age)
d There are no suitable properties available to me
e My house/the local area has a sentimental value to me
f I would find it too difficult to leave behind memories
g I have no family or friends who could help me
h I would not know how to go about looking for a new house
i Other (please state) [open]

Notes

1 All those interested in moving is 58 per cent of over 60s – 58 per cent of the £1.23tn unmortgaged equity they own is £701 billion. Of this group, 57 per cent would want to downsize – or 33 per cent of over 60s. They own £400 billion in housing equity.

2 All those interested in moving is 58 per cent of over 60s – 58 per cent of the £1.23tn unmortgaged equity they own is £701 billion. Half of this is £356 billion.

3 The proportion of people owning homes of different bedroom size was taken from the responses to our survey – see Appendix 2.

4 This is calculated as 25 per cent of £1.23tn owned by over 60s. 25 per cent of over 60s in our survey reported to be interested in buying retirement property.

5 25 per cent of 14 million people – the number of over 60s in the UK.

6 Using proportions identified through NPI analysis.

7 33 per cent of over 60s.

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The chronic undersupply of appropriate housing for older people is the UK's next housing crisis. While all eyes are on those struggling to get on the bottom of the property ladder, those at the top are often trapped in homes that are too big and unmanageable. This is due to a lack of suitable homes to downsize into and in turn has a negative effect not just on older people's health and wellbeing, but on the rest of the housing chain.

The Top of the Ladder uses original quantitative research to investigate older people's housing preferences, and the likely impact of giving them greater choice. It estimates that if all those interested in buying retirement property were able to do so, 3.5 million older people would be able to move, freeing up 3.29 million properties. Apart from these gains, retirement housing has a very beneficial effect on older people's health, wellbeing and social networks, and could save health and care services considerable resources.

The report suggests that this would be a triple-win for government, improving older people's lives while stimulating the property and home-building market, at little cost to the public purse. It recommends changes to the planning code to encourage the development of retirement housing, while also providing practical help and giving financial incentives to encourage downsizing. It concludes by arguing that the Government should adopt a 'whole chain' view of the housing market, as helping those at the top of the ladder will unlock supply and benefit those on every other step.

Claudia Wood is Deputy Director of Demos.

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Appendix C

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Identifying the health gain from retirement housing

Executive summary

June 2012

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

Identifying the health gain from retirement housing

Executive summary

Introduction

The government in England is currently considering the future development of social care in a forthcoming White Paper. The intention is that it primarily responds to the Law Commission's report on Adult Social Care and the Dilnot report on the future funding of social care. It would also be hoped that the government recognises and responds to the evidence presented in this paper, that there is considerable health and care benefit to be gained from an expansion of retirement housing, particularly in the private sector.

The basis of the argument

As is widely recognised the older people's population will both numerically increase and increase as a proportion of the total population over the next thirty years. However, it is neither a uniform increase nor an explosion, as is often suggested.

Within that substantial population increase there is a distinction to be made between years of healthy life as compared to life with some form of incapacity. If old age policy is to be seen as successful it not only needs to extend the lifespan but also the number of years of healthy living. There is little indication that this is yet occurring.

On the other hand many more older people have access to greater financial resources than they did at the founding of the welfare state, both through their housing equity and through occupational pensions. However, where this wealth is tied up in property it is not necessarily easily accessible and many older people remain in accommodation that does not help their health.

The simplistic view of older people's housing preferences is that they want to remain in their long term family home. This may be a reflection of what is available and the difficulty of moving, as much as being about a genuine desire to stay put. However, the coming generation of older home owners are a group who have been more familiar with seeing 'home' not as a permanent, lifetime dwelling but a changing place purchased on the basis of family and personal circumstances.

Older old age can often be a time when people become much more physically frail and are more likely to be subject to conditions such as strokes, falls and dementia. The consequences of these conditions are then often exacerbated by poor health sector performance which has recently been detailed in a wide number of research reports. The consequences of increased prevalence and poor performance are of a rapidly increasing cost spiral for the NHS.

The overarching message is that, even if the NHS considerably improves its performance with regard to old age conditions, the health service will be under considerable and growing pressure over the next thirty years. Therefore, any interventions that can cost-effectively help to lessen either the impact of those conditions or the likelihood of them occurring is clearly well worth exploring.

If the health outcomes are potentially a cause for concern, it is equally clear that warm, well designed housing can play a significant part in changing that outcome and reducing costs. Some of this can be achieved by people making modifications to their own home, but for many a move into a wider range of age-suitable housing would offer benefits to government and older people alike.

Regardless of the type of retirement housing scheme, there is a considerable uniformity about the key features of such housing, eg, appropriate location with accessibility to transport and external services, warm accessible accommodation, companionship and security, access to care and support and an emphasis on offering a positive quality of life. The variables between different types of accommodation are more around the volume in which the above benefits are offered, the form of tenure and, for owner occupation or lease, the price to be paid.

What is clear is that there is an unequivocal health gain to be made through the provision of a range of types of retirement housing. None of the studies reviewed showed there was either a health deterioration or even a standstill in people's health and well-being when they moved into this form of accommodation. Instead for many people, retirement housing offers a substantial improvement in health, a diminution, at least for a time, in the volume of care and support required and a greater sense of security and well-being.

Over and above the health gain, other reports have shown there is a general gain to public expenditure through the development of retirement housing and a diminution in expenditure on other forms of care[1].

[1] *Frontier Economics (2010)* Financial benefits of investment in specialist housing for vulnerable and older people

Summarising the gain

For government more retirement housing offers:

- A reduction in expenditure on health provision through people purchasing into retirement housing schemes using their existing equity.
- A release of family housing through older people moving.
- A stimulation to the economy through increased housing development.

For older people more retirement housing offers:

- An improved lifestyle and health gain.
- A lessening of anxiety about accommodation that people find increasingly hard to maintain.
- The potential to hold onto a substantial amount of their existing housing equity.
- Reduced heating and maintenance bills

Although further economic modelling is required, a growth in the volume of the supply of housing suitable for older people as recommended by Professor Michael Ball[2], together with the anticipated health and social care gain, could be producing a net benefit in excess of £300 million per annum in 2030.

Recommendations

What can government do to help bring about this advantageous set of circumstances? The Ball report has already made it clear that current developments are nowhere near even a modest increase in retirement housing. Most of the suggestions below are either no cost or low cost. Where there is a cost implication, government might wish to consider using the NHS budget as the evidence suggests it stands to gain the most, and the quickest, from improved housing for older people. If nothing else it is one area where the benefits of a preventative approach are demonstrable.

Therefore, it would be hoped that the forthcoming Social Care White Paper might provide a stimulus to development. There are a variety of relatively low cost measures that could help in this respect:

- To ensure that in any role local authorities play in offering older people better information, that buying and selling housing and moving into retirement housing, heavily features.
- To encourage the delivery of new retirement housing across all tenures through the planning system.
- To establish with the sector a national kite mark for housing that identifies it as offering accessibility and the capacity to have a range of

[2] *Ball M (2011).* Housing markets and independence in old age: expanding the opportunities, Henley Business School.

health and care services delivered into it. This does not have to be just for designated retirement housing but could be for any housing that applies and meets the standard.

- Older people are clear that the prospect of moving in older age is not easy, either in terms of selling their property or in terms of physically packing up and moving. There are already a number of schemes around the country to help with this but these need a considerable extension and much greater publicity. This could include financial assistance with pack and move schemes for older people aged over 75 where they are moving into purpose built retirement housing.
- A stamp duty holiday / reduction for older people moving into new accommodation and for those buying their property.
- A reduction in council tax for older people living in retirement housing, to encourage take-up.
- Financial support for legal and conveyance fees for older people moving into retirement housing.
- Support to developers in sharing financial risk either through the development of interest-free loan schemes to be repaid as properties are sold.
- Incentives to local authorities to release land for the development of older people's housing schemes.
- Many of the current public and indeed private schemes still convey a sense of 'less eligibility', of ageism and institutionalisation. An annual design competition which focuses on properties and schemes that can evidence; good design, reduced maintenance costs for owners and show reduced health care expenditure may help to challenge the sector to stop producing older people's housing and to produce housing suitable for older people. The aim should be to develop properties that people want to live in and want to buy rather than properties which they feel obliged to occupy.
- Commission a longitudinal study comparing heath performance of different forms of retirement housing.

Increasing the range and extent of retirement housing is potentially a "win-win" for government and older people alike, particularly in the case of housing for purchase. Older people using their equity to deliver a health and care gain to society, at little to no cost to the public purse, whilst at the same time freeing up family housing, can only be of considerable benefit.

Given the demographic data, the health implications of inaction and the time it takes to get schemes from concept to occupancy, the need is for government to stimulate this sector now. This is genuinely an approach where a little help may go a very long way.

IPC, June 2012

Appendix D

Policy: summary

A better fit?

Creating housing choices for an ageing population

England's population is ageing, and fast. By 2030 one in three people are projected to be aged 55 and over. Older people will be a diverse group, ranging from economically powerful 'baby boomers' to over-85s with high care and support needs. How will the housing market respond to this demographic change? Do we have the right kinds of accommodation for older people, in the right places?

Older people and housing today

There are approximately 14.7 million older people and 7.3 million 'older households' in England today. These are households where everyone is aged 55 or over. Most are couples or single people living alone; in particular there are many single women aged 75 or over.

Most older people are owner-occupiers and have already paid off their mortgages. Older people, in particular older owner-occupiers, tend to live in larger homes than other households. Sixty-eight per cent of older homeowners live in a home that has at least two spare bedrooms, technically known as 'under-occupation'. This measure is controversial, not least because most older people think that their home is about the right size for them. However, there is also a growing problem of intergenerational housing inequality with younger households unable to buy their first home without over-leveraging on debt.

Older people's attitudes to housing

Many older people want to stay in their current home for as long as possible and have strong emotional ties to their home, possessions, or neighbourhood. Moving house can be a very daunting and stressful experience for some older people, and they are often unaware of their housing options, or simply perceive that there are no suitable homes available for them.

While some older people plan a move, or move for lifestyle reasons, many only move later in life or at a time of crisis, for example when care needs or health problems become unmanageable. Tailored support and practical help can assist older people with their housing needs.

Although a minority, a significant number of older people we surveyed felt that their home was difficult to manage, or would become difficult in the next ten years. The need for social interaction, and for a safe, warm and accessible home often becomes more important with age. Older people want housing that is attractive, in a safe, well-connected neighbourhood. They typically value homes that are well insulated, have some outdoor space, and have a spare bedroom. Over a third of older people are interested in the idea of retirement housing either now or in the future, suggesting a latent demand for this market.

The current market for older people's housing

Specialist housing – that is available only to older people – makes up a small proportion of the market and the majority of older people live in general, mainstream housing. There are approximately 533,000 specialist homes in England, mainly in the social-rented sector with some support facilities to give residents practical day-to-day help.

There is very little specialist housing available to buy or rent privately, and very little mid-range specialist housing for older people who are not wealthy but do not rent socially. In the mainstream housing sector there is an under supply of bungalows relative to demand, and not all homes are easily accessible to those with limited mobility.

This summary is based on the full report that is available from Shelter's Policy library at shelter.org.uk/policylibrary

Shelter

Few developers are active in building for the older people's market and they are constrained by complex planning regulations, financial viability and a lack of strategic vision at local authority level. We need a much greater supply of specialist housing for older people. If demand for specialist housing remained constant, the supply would need to grow by 70 per cent just to accommodate the growth in the number of older households over the next twenty years, some of which may be met through turnover in the existing stock but some of which must come from new builds.

The benefits of expanding options for older people

Evaluations of retirement housing schemes have largely shown positive outcomes for older people. Residents' health, safety and well-being tends to improve and there are increased opportunities for social interaction. Moving to smaller, more energy efficient accommodation can help older people to stay warm and save money on energy bills. Economic benefits can include employment opportunities for the local community and cost savings to the NHS through improved health and the reduced likelihood of accidents and falls. However, service charges and reductions in on-site care facilities are contentious issues for some older people living in specialist accommodation.

When older people downsize to smaller accommodation, there is a market chain effect and larger properties become available to other households. This is a complex picture however, as new buyers may themselves 'under-occupy'.

How to increase housing options for older people

England has a rapidly growing population of older people, but few strategies exist to ensure that they will all be able to live somewhere decent and affordable that meets their changing needs. There is also very little recognition among policy makers of the wider socio-economic benefits of such provision. For older people themselves, the fear of the unknown and the lack of suitable and attractive options present further barriers to more widespread downsizing.

Recommendations

- We need a significant increase in the supply and range of suitable housing for older people, including private-rented and owner-occupied specialist housing.
- Developers should build attractive and well-designed homes for older people and specialist providers must be upfront about their services and charges.
- The planning system must support the development of housing for older people. The introduction of the National Planning Policy Framework provides an opportunity to give housing for older people a higher priority and to clarify the guidance on how housing for older people should be classified.
- Older people need to be better informed about their housing options at an early stage and to plan ahead accordingly. Many need practical help and support with their housing and with planning their later life.
- Local government can do more to facilitate schemes that help older people move to accommodation that's more suited to their needs.
- Local planning authorities must factor older people's housing into local plans, strategies and housing market assessments, while integrating these with health and social care strategies.

A copy of the full report can be downloaded at **shelter.org.uk/policylibrary**

Methodology

The report was informed by:

- A market assessment of housing options for older people carried out by the New Policy Institute (NPI) on behalf of Shelter and the Joseph Rowntree Foundation. The full analysis can be downloaded from NPI's website at www.npi.org.uk
- A survey of respondents aged 55 and over carried out by YouGov Plc on behalf of Shelter in February 2012. This survey has been weighted and is representative of GB adults aged 55 and over.
- Secondary analysis of existing literature and data sources, as well as informal consultation with sector stakeholders.

Until there's a home for everyone
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Shelter

Appendix E

REAL ESTATE
& PLANNING

HENLEY
UNIVERSITY OF READING

Housing markets and independence in old age: expanding the opportunities

Executive Summary | May 2011 | Professor Michael Ball

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About the research

This piece of research has made me realise that, while housing supply affects us all, its impact varies across the ages.

Housing needs in older years are somewhat different. They are obviously as important as those of any other group, though often overlooked in policy debate. I hope the research outlined in this report casts further light on this important issue.

I should like to thank McCarthy & Stone Retirement Lifestyles Ltd for sponsoring this research at the University of Reading. They made it possible for the research team to conduct a survey of residents; provided other data; and granted free access to managers and staff at the company, who were always kind, helpful and open to enquiries. However, I should like to emphasise that this report is based on independent research and that the arguments, analysis and recommendations are based on my ideas and understanding of the issues at hand.

I should like to thank the rest of the research team at the University; the many others who helped with enquiries and requests for information; the house managers and wardens of the places contacted; and, most of all, the owners of the retirement properties - the residents - who with great kindness talked to me and my colleagues. I always left the discussions I had with them with a smile, which is something I shall always remember.

Michael Ball

This independent report was sponsored by retirement property developers McCarthy & Stone Retirement Lifestyles Limited.

Housing markets and independence in old age: expanding the opportunities

Executive Summary | May 2011 | Professor Michael Ball

This report highlights the benefits of specialised private retirement accommodation and recommends a number of simple policy changes at no cost to the public purse to help increase its supply and address the challenges of housing an ageing population.

Introduction – why OORH matters

This report outlines the findings of a major piece of research on housing for older people who live in specialist private retirement accommodation, called owner occupied retirement housing (OORH). This type of housing is purchased, on a leasehold basis, and found in specially designed blocks of apartments which have communal facilities, house managers and other networks of support integrated within them. There are currently around 105,000 OORH dwellings in the UK, about 2% of the total number of homes for those aged 65 and over.

Why should policy makers be concerned about OORH? The reason is that it delivers a series of benefits for residents, their families, communities, the public sector and society in general. The key benefits of OORH are:

Personal

- A higher quality of life for residents and their families. The report notes that 92% of OORH residents are very happy or contented and the great majority would recommend the accommodation to others.
- Greater security and convenience, and reduced feelings of isolation and vulnerability.
- Improved independence, well-being and health.

Environment and neighbourhood

- Environmentally better than traditional housing, with reduced energy use, including less travel. The report states that 51% of OORH residents said that their energy bills were noticeably less.
- Sustains local shopping and other services, helping to sustain local communities. 80% use the shops almost daily or often; over 40% used the library or post office almost daily or often.

Government/social

- Private rather than public – its provision entails no cost to the public purse.
- Reduced demand on public sector resources and health services. Residents manage better and spend fewer nights in hospital.
- The release of home equity in retirement; though not all release home equity.

Communities

- Most OORH residents have family and friends in the locality. Older people form an important part of the core of most communities.
- Increases availability of much-needed family housing in areas of shortage. On moving, most OORH residents free up substantial family homes, with two thirds moving from homes with three or more bedrooms. This boosts supply in local housing markets.

This report highlights that far more elderly people could benefit from this type of accommodation than live in it now. However, due to supply side constraints created by restrictive planning and housing policies, many older people are not being provided with the opportunity to purchase OORH. **Relatively simple policy changes could address this without any cost to the public purse.**

Why the supply of OORH needs to increase

The population is ageing but older people have not featured much in recent policy discussions about localism, housing or planning. As the UK's population grows and ages over the next 20 years, **the number of households over 65 years old will increase at a particularly fast rate. There are expected to be an extra 3.5 million older households by 2033 in England alone, a 60% increase on today.** By then, a third of all households will consist of those aged over 65, up from 28% in 2008.

The ageing of the UK population is going to have a substantial housing impact. Many older households will face growing health and housing difficulties as they continue to age. Although people are living longer, unfortunately the incidence of age-related ailments is not being delayed at the same rate to progressively older ages.

Home owners aged 65 and older collectively own £1 trillion of housing equity and most want to stay where they currently live for as long as possible. However, as many as 130,000 older people moved in 2008. Many move to be in preferred accommodation or to enjoy living at a different location and few are motivated by releasing housing equity. But, for others, the drivers are primarily push factors associated with being unable to manage in their current home: due to declining health, increasing isolation or financial problems. Even amongst non-movers, there will be many potential reluctant stayers. This is coupled with the fact that most home owners wish to maintain ownership of their home. OORH offers the opportunity for an improved lifestyle while remaining an owner occupier.

However, the report notes that due to policy restrictions surrounding housing and planning, the supply of OORH has not matched growing demand. Build rates are low and need to grow four times from that achieved even before the 2007/8 downturn to cope with just a moderate increase in demand. Forecasts in the research show a potential increase in the use of this accommodation from 2% currently to 5% of housing for those aged 65 and over the next decade or so. This would generate a build rate of 16,000 OORH units a year, compared to just 4,400 delivered in 2007.

In a society which is increasingly searching for ways of growing private provision, housing for the elderly seems an obvious candidate for a greater emphasis on the private sector, especially as so many older households are now owner occupiers. Also, within private provision, the benefits of direct property ownership can be maintained.

The benefits of OORH

The report notes the substantial benefits of OORH for many older people. OORH dwellings are around 10% cheaper than the median values of the previous homes sold, giving significant average equity release, while maintaining continued housing equity. Over 40% are able to withdraw £25,000 or more housing equity but, at the same time, many others have none. An overall increase in the supply of OORH would lower the price of this type of housing, enabling millions more of the elderly to contemplate this as a lifestyle.

The report outlines the following benefits of OORH:

- **A higher quality of life for its residents.** The report notes that 92% of OORH residents are very happy or contented and most would recommend their accommodation to others. 83% said they were happier in OORH and 51% also said that their energy bills were noticeably less.
- **Improved health for residents and reduced impact on the NHS.** The overall balance of residents' perceptions of being able to manage their health was that it was better since their moves. As OORH accommodation is designed for impaired mobility, residents can manage better and spend fewer nights in hospital. This finding is important because of the high costs of in-patient care for older people.
- **OORH is good for the environment.** 51% of OORH residents said that their energy bills were noticeably less than they had been in their previous homes. This is backed up by comparative analysis of the energy costs of larger, older homes and new purpose-built energy-efficient flats. What is more, people tended to travel less once living in OORH, because they are often closer to friends and relatives and to shops and other facilities. Moving into OORH also allows the new owner of the previous home to undertake renovations to improve the energy efficiency of that house, increasing the energy savings potential.
- **OORH boosts local neighbourhoods.** Older people regularly use shops and local facilities during weekdays, when they are often underutilised, and at weekends. 80% use the shops almost daily or often; over 40% used the library or post office almost daily or often. The elderly are integral to any local area and because most have lived there for a long time have built deep roots in their neighbourhoods. This is reflected in extensive family and friendship networks. So, providing OORH means a much wider group of people benefit than simply the person or couple buying the property. Many local market-based services are under threat with the growth of out-of-town shopping and the Internet, but the elderly are more likely to use local amenities than many other residents.
- **OORH has a positive impact on local housing markets.** On moving, most residents free up a substantial family home, with two thirds moving from homes with three or more bedrooms. This boosts local housing markets – for every 5,000 OORH sold, property to the value of £1.1 billion is released into local housing markets. The turnover of this type of housing is essential for a healthy housing market.

How public policy constrains the delivery of OORH

The research found that the building industry provided this type of accommodation in a competitive environment, so that its price and availability is driven by the costs and availability of construction inputs, including land.

Therefore, a number of policy-related factors have inadvertently contributed to restraining the supply of OORH to date and therefore limited its potential benefits. These include:

- **A lack of understanding of the benefits of OORH at a local and national level.** Evidence of a less than positive attitude to OORH is found in the extent to which McCarthy & Stone have had to go to appeal in relation to its sites. A large portion of its developments are only permitted on appeal, because agreement could not be struck with the local planners (65% of cases). Even on the minority of schemes where the appeal is refused, a clear blueprint is provided by the Inspector that then allows most sites to then receive consent at local authority level in a form of development that the authority had originally indicated to be objectionable. This process of being forced to appeal seems a particularly inefficient, wasteful and time-consuming way of planning for the provision of OORH and raises the prices of the homes built.
- **An inappropriate use of S106/s75(Scotland) charges.** Local planning authorities negotiate with developers of OORH for s106/s75 and Community Infrastructure Levy contributions. The analysis in this research shows that in the case of OORH some or all of the development charges are borne by the user: in this case, elderly middle income households, who do not seem a sensible group to target for this taxation. Under s106, development contributions are made towards providing affordable housing, much of which is used for providing accommodation for younger people. This policy is discriminatory against older people.
- **The role of inflexible building regulations.** The current government has committed itself to reducing the regulatory burden but many issues remain and raise the costs of providing homes for the elderly, especially as there are specific factors that add costs and compliance problems for OORH building. A fundamental problem is that regulations are 'one-size-fits-all'.

How can public policy help increase the supply of OORH in the future?

The report makes the following four recommendations for amending planning and housing policy to boost the delivery of more OORH and meet demand. All entail little, if any, cost to the public purse.

1. **Better national strategic guidance on housing for the elderly.** The forthcoming National Planning Policy Framework offers an avenue to provide a set of ground rules for the delivery of more suitable accommodation and can help cut through local bureaucracy. It should include recognition in principle that demographic change and an ageing society are central issues for planning. It should also recognise that the elderly should be able to operate effectively in the private market and that the planning process should facilitate that.
2. **Better local strategic guidance on housing for the elderly.** This includes the allocation of sites for OORH in local plans and references to the benefits of this type of accommodation in local housing strategies. The greatest emphasis regarding housing for the elderly and planning is obviously at the local level. It will be highly useful in the context of a more positive, socially responsible attitude towards OORH, if the sector was integrated into planning strategies, local development frameworks and strategic housing market assessments rather than treated on a generally negative and individual site-by-site basis as currently occurs.
3. **Treat OORH as a form of affordable housing.** To improve the supply and lower the price of OORH, this type of housing should be redefined as the equivalent of affordable housing in terms of negotiations with builders over development charges. Treating all OORH as a form of affordable housing in planning terms, because of its significant personal and community benefits, would help reduce prices and increase availability. However, to impose price or quality caps on part or all of it would damage supply. Rather this proposal suggests that all OORH new build should be given enhanced planning status alongside low-cost home ownership for younger households, which is already treated as a form of affordable housing.
4. **Rethinking building regulations.** The government's principle of less all-round is a good one. The analysis here suggests that it would be useful if regulations and other requirements were more sensitive to differences in types of residential building and recognised the distinct roles that they play within housing markets. Regulations have differential costs and outcome impacts depending on the housing types and sub-markets in question. There is also a regulatory bias towards the most common types of built structure. Greater flexibility in allowable solutions, including recognition of the dynamics of household moves, would avoid imposing unnecessary burdens that limit the supply of OORH.

Conclusion

OORH encapsulates many of the ideas that the current coalition government is promoting. This type of housing is about self-help: using resources built up over a lifetime to fund an appropriate lifestyle in older age, when the frailties of life begin to mount.

It is about private endeavour: utilising personal resources and social networks rather than relying on the state. It is about being able to enjoy life in older age, even when health matters may impose constraints.

It is about maintaining a sense of independence in old age, within an improved framework of emotional and physical security. Also, it is about building up communities: with people living in situations where friendships can be made and mutual support offered and where they can engage with the wider community, especially through links to families and friends.

It is about bringing families together, with grandparents being better linked with their children and their grandchildren living in the local area. It is about recognising the intergenerational linkages in any local community, the cycle of life, and the relation of local resources to these.

It is about ways of living that keep down public costs and save energy, without compromising preferred lifestyles.

The changes recommended in this report are in line with current government policy intentions. If enacted, the benefits would be substantial and the costs limited.

Housing markets and
independence in old age:
expanding the opportunities

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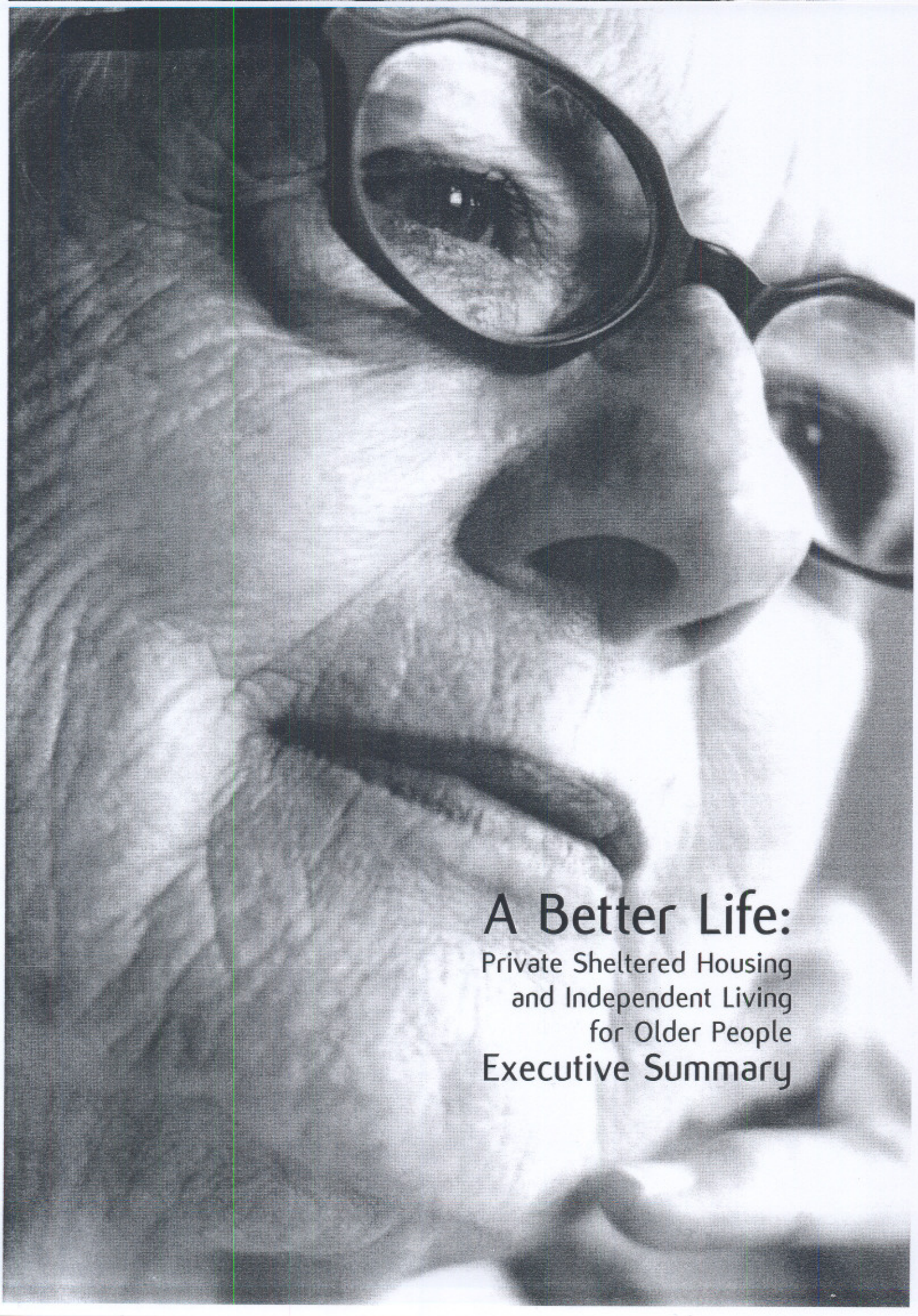
Appendix F



A Better Life:

Private Sheltered Housing and Independent Living for Older People

Executive Summary

Executive Summary

The Reality of Private Sheltered Housing

This report sets out the findings of one of the largest studies into sheltered housing in the United Kingdom. It represents and examines the opinions of over 1,500 current and prospective residents of private sheltered housing – their priorities, levels of independence, health, happiness and contribution to their local community and the wider economy.

It aims to contribute to the wider debate on the needs and wellbeing of older people, ensuring appropriate housing choice and, in particular, the importance of housing in delivering a good quality of life.

Additionally, the report dispels many myths about private sheltered housing that seem to have been allowed to grow in the past.

To summarise the key findings that emerge from this report:

01 THERE IS A SHORTAGE OF PRIVATE SHELTERED HOUSING IN THE UK

- 39% of prospective residents have had to look further afield to find suitable accommodation as there was not enough in their area;
- 81% of prospective residents believe there should be more private sheltered housing in their area;
- If the rate of demand and provision remain at their current levels, there is likely to be a shortage of around 62,500 private sheltered housing units by 2020.

02 PRIVATE SHELTERED HOUSING HELPS OLDER PEOPLE ENGAGE WITH THE LOCAL COMMUNITY

- 39% of current residents live a more active life in private sheltered housing than they did before they moved there;
- 76% of current residents feel that they are a member of the local community;
- 92% of current residents have contact with friends/family on a regular basis.

03 PRIVATE SHELTERED HOUSING PROMOTES INDEPENDENT LIVING

- Since moving into private sheltered housing, 58% of residents have become less dependent on their children;
- 59% of residents have a more independent lifestyle in private sheltered housing than they did in their previous homes;
- 61% of prospective residents strongly believe that moving to private sheltered housing will help them maintain their independence;
- 83% of current residents believe that living in private sheltered housing helps maintain independence.

04 PRIVATE SHELTERED HOUSING IS A HOME FOR LIFE

- 66% of prospective residents strongly believe that moving into private sheltered housing will enable them to avoid the need to move into assisted living accommodation;
- 66% of current residents believe they will live longer in private sheltered housing;
- 86% of current residents believe that their home is a home for life.

05 "STAY PUT AND ADAPT" IS NOT THE BEST SOLUTION FOR MANY OLDER PEOPLE

- 29% of prospective residents spend more time on their own than they would like to;
- 32% of current residents highlight companionship as the greatest advantage of private sheltered housing;
- 66% of current residents enjoy their lifestyle more living in private sheltered housing than they did in their previous home;
- 78% of prospective residents strongly believe moving into private sheltered housing will increase their security;
- 84% of current residents moved into private sheltered housing to have better access to local shops and facilities. 81% did so to have supervision by a house manager. 60% did so in order to rid themselves of unwanted responsibilities.

06 LOCAL ECONOMIES BENEFIT SIGNIFICANTLY FROM PRIVATE SHELTERED HOUSING SCHEMES

- One in three current residents walk to the local shops each day;
- 45% of current residents buy the bulk of their shopping within one mile of their private sheltered housing scheme, with 65% travelling no further than two miles;
- 62% of private sheltered housing residents prefer to shop in local centres rather than major town centres;
- Each week, a typical private sheltered housing scheme generates £11,735 in resident spending (£610,000 per year), generating an additional £1,750 per week (£92,000 per year) in local spending compared to what would have been generated in a conventional high density housing scheme (deadweight). Over the lifetime of a scheme, this equates to around £2.3 million more in local spending than would have been generated by a conventional scheme.

07 PRIVATE SHELTERED HOUSING SCHEMES ALLEVIATE PRESSURES ON THE NHS

- Only 21% of current residents have received inpatient medical care in the last 12 months. Amongst this group, the average number of nights of inpatient care is 7.4, under half the average for the national population aged 75+. This saves the NHS £2,598 per resident recieving inpatient care per year;
- The average number of visits per annum to a GP by current residents is 4.2 compared to 6 visits amongst the national population aged 75+;
- 41% of residents confirm that their health has improved since moving into private sheltered housing;
- 55% of current residents class their health as very good/ good.

08 PRIVATE SHELTERED HOUSING SCHEMES INCREASE THE AVAILABILITY OF ORDINARY LOCAL HOUSING STOCK

- 23% of those moving into private sheltered housing sell their previous homes to families;
- 43% of those moving into private sheltered housing sell to couples;
- 45% of current residents moved within five miles of their previous homes;
- 85% of those who purchase private sheltered housing flats will downsize from houses to do so.

09 PRIVATE SHELTERED HOUSING OFFERS SUFFICIENT SPACE AND HIGH STANDARD SPECIFICATIONS FOR OLDER PEOPLE

- 71% of prospective residents believe that they do not need to live in a house as big as the one they currently live in;
- 71% of current residents moved to private sheltered housing to meet their specific design and mobility needs.

10 PRIVATE SHELTERED HOUSING TRANSFORMS THE QUALITY OF LIFE OF ITS RESIDENTS

- 64% of current residents feel their sense of wellbeing has improved since they moved into private sheltered housing;
- 78% of current residents believe that private sheltered housing helps to alleviate their worries and anxieties;
- 88% of current residents believe that private sheltered housing helps to improve their personal security. 53% of current residents cite personal security as the biggest advantage of private sheltered housing;
- 92% of current residents would recommend private sheltered housing and their way of life to their friends.

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Appendix G

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McCarthy and Stone

Local area economic impact assessment

Executive Summary

March 2014

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McCarthy and Stone

Local area economic impact assessment

Executive Summary

1 Summary table

Area of economic impact	Average MCS Retirement Living development	Average MCS Assisted Living development
Capital investment	£3.6 million	£4.5 million
Community & employment benefits / yr	£2.23 million one-off £18,900 pa	£2.44 million one-off £180,000pa
Housing stock released	£7.53 million 66% under-occupied	£9.20 million 66% under-occupied
Average Council Tax (based on survey results)	£69,000	£69,000
Average New Homes Bonus (based on survey results)	£343,000	£343,000
Resident spend in local economy / yr	£670,000	£1,234,000
Resident spend in local economy above general needs development / yr	£125,200	£261,300
Health & Social care savings / yr	£1,419 directly attributed £30,000 / person / year when entry to residential care is	£1.04 million

	prevented or delayed	
Social capital / yr	£5,000	£5,000

2 Introduction

This summary presents the results of a study by the Institute of Public Care at Oxford Brookes University of a sample of McCarthy and Stone Retirement Living and Assisted Living Extra Care schemes and interviews with 100 owners across that sample in England, Wales and Scotland. The study aimed to assess the local area economic impact of Retirement Living and Assisted Living Extra Care schemes. It took into account the health and well-being benefits to individual owners and the wider contribution to local communities in terms of investment, employment and other factors.

To summarise, the key findings from the report are:

Health and social care

Total estimated saving in health and social care costs per development (Retirement Living): £1,419 per year directly attributed. £30,000 / person / year when entry to residential care is prevented or delayed

Total estimated saving in health and social care costs per development (Assisted Living): £1.04 million per year

Both Retirement Living and Assisted Living Extra Care schemes facilitate the health and well-being of owners in a variety of ways:

- 80% of owners of Retirement Living and Assisted Living apartments felt more secure in their current home compared with their previous one.
- 71% felt warmer.
- 65% said that they have a better quality of life and felt less socially isolated.
- Visits to the GP and hospital in-patient admissions were lower for owners in the last 12 months compared with the previous 12 months in their old homes, with a slight increase in district nurse visits.
- For a typical Retirement Living scheme of 50 residents, it is estimated that the lower number of GP visits results in a reduction in costs to the NHS of £1,419 per annum.
- Assuming 63% of residents of a typical 55 apartment Assisted Living Extra Care scheme would otherwise have needed residential or nursing care, this would cost just over £1 million per annum in residential care costs, assuming annual cost of residential care are £30,000 per annum.
- Design-related benefits of Retirement Living and Assisted Living Extra Care schemes enabled people to live without additional help in their

own homes, even when they require a mobility aid for moving around outside the scheme.

Capital investment

Total capital investment per development (Retirement Living): £3.6 million

Total capital investment per development (Assisted Living): £4.5 million

For the wider community, Retirement Living and Assisted Living Extra Care schemes make significant contributions to the local economy both during the construction stage and the operational stage, providing capital investment and employment in local communities.

- An average Retirement Living scheme generates £3.60 million of expenditure (including labour, materials, fixtures and fittings) through its development and construction stage.
- An average Assisted Living Extra Care schemes generates £4.55 million of expenditure through its development and construction stage.
- The overall impact of the construction stage of Retirement Living developments is estimated to be £8.64 million.
- The overall impact of the construction stage of Assisted Living Extra Care developments is estimated to be £10.92 million.
- Many schemes brought a significant contribution through Section 106 payments to the local area.
- Five schemes brought an average of £343,000 per development in New Homes Bonus monies.
- Schemes frequently involved a degree of site clearance and preparation, often constructed on former retail or industrial sites which help to revive and improve empty sites.
- Assuming homes are valued at current average house prices[1], residents moving into a typical Retirement Living scheme of 45 apartments will release £7.53 million from the sale of their homes; and residents moving into a typical Assisted Living Extra Care scheme of 55 apartments will release £9.20 million from the sale of their homes.
- Two-thirds (66%) of the owners freed up an under-occupied home. Most owners freed up a family home, with 60% moving from homes with three or more bedrooms. Where the buyer was known, 65 per cent of their homes had been sold to a couple or a family.
- Where known, 42% of previous homes had been repaired or improved since the owners moved to a McCarthy and Stone apartment.

[1] Land Registry House Price Index, December 2013.

Community benefits

Total value of community benefits per development (Retirement Living): £2.23 million one-off, £87,900 per year including Council Tax

Total value of community benefits per development (Assisted Living): £2.44 million one-off, £249,000 per year including Council Tax

- Much of this investment is spent locally. Construction and other staff contributed to the local economy through their use of local cafes, bakers, other retail outlets, petrol stations, bed and breakfasts, etc.
- Wages of construction workers (including sub-contractors) are on average: £2.23 million for Retirement Living schemes and £2.44 million for Assisted Living schemes.
- Retirement Living schemes typically employ a dedicated house manager, while Assisted Living Extra Care schemes employ an average of 17 staff including a qualified estates manager, care, catering, cleaning and gardening staff, providing a wide range of local employment opportunities.
- Average annual staffing expenditure in Retirement Living schemes was £18,900; and just under £180,000 in Assisted Living Extra Care schemes, much of which will be spent by staff locally.
- Schemes contributed to the aim of retaining older owner occupiers in their local area by providing them with a wider choice of appropriate accommodation.
- Many owners felt warmer in their McCarthy and Stone apartment, while also finding it cheaper to run – indicating the dual benefits of improved energy efficiency.
- Lower rates of car ownership contributed positively to the environment.
- Living at high densities, owners contributed sizeable sums to local authorities through their council tax payments. The total sum of council tax payments received per scheme averaged nearly £69,000 per annum.

Additional expenditure in the local economy

Total expenditure in the local economy per development (Retirement Living): £670,000 per year, £125,000 more than a general needs housing scheme

Total expenditure in the local economy per development (Assisted Living): £1,234,000 per year, £261,000 more than a general needs housing scheme

In terms of the local economic impact of Retirement Living and Assisted Living Extra Care schemes, the study found strong evidence of significant additional expenditure, compared to a hypothetical conventional housing

development on a similar site. This contributes to the viability and sustainability of local shops and services.

- More than three-quarters (78%) of owners used local shops at least once a week; and around 90 percent used local shops and/or supermarkets more than once a month.
- Other local services were also used regularly by owners, with around a quarter using services such as local taxis, hairdressers, pubs, cafes and restaurants more than once a week.
- In a typical Retirement Living scheme, residents generate annual local spending of over £670k.
- The additionality of residents' spending in a Retirement Living scheme compared with a conventional housing development after allowing for leakage, multiplier effects and (deadweight) is estimated to add over £125,200 a year to the local economy.
- Over the 60 year lifetime of a Retirement Living scheme, the additional local spending is calculated to amount to over £8.598 million which is £3.155 million more than a conventional housing development on a similar sized site.
- In a typical Assisted Living Extra Care scheme, residents generate annual spending of over £1.234 million.
- The additionality of residents' spending in an Assisted Living Extra Care scheme compared with a conventional housing development after allowing for leakage, multiplier effects and deadweight is estimated to add over £261,300 a year to the local economy.
- Over the 60 year lifetime of an Assisted Living Extra Care scheme, the additional local spending is calculated to amount to over £15.294 million which is £6.585 million more than a conventional housing development on a similar sized site.
- In conventional housing developments, a substantial flow of housing expenditure will leave a community through mortgage payments. In comparison, much of the housing spending in a McCarthy and Stone scheme will be on service charges which include salaries of staff, many of whom live locally.

Social capital

Total estimated social capital value per development (Retirement Living): £5,000 per year

Total estimated social capital value per development (Assisted Living): £5,000 per year

Retirement Living and Assisted Living Extra Care schemes provided additional social capital in local communities:

- Over one-third of residents (37%) in the McCarthy and Stone schemes contributed to their local area through their involvement in community activities. Based on hours contributed and valued at minimum wage rates, per scheme this would be equivalent to an annual contribution of just over £5,000.
- 6% of those interviewed provided significant amounts of informal care to their spouses. It is likely that by moving to more age-suitable housing, some informal carers were able to provide care for longer to their partners, thereby delaying or preventing a move into residential care.
- By providing greater housing choice to owners, specialist housing for older people meets important societal needs as indicated by people's reasons for moving: nearly two-thirds (65%) sought more appropriate housing; 44% wished to feel more secure and 31% to be closer to family members.
- Around two-thirds of owners felt less socially isolated in their McCarthy and Stone apartment compared with their previous home. It is likely that the proportions who feel socially isolated will decrease, as a number of those interviewed were relatively recent arrivals.

Overall, this analysis indicates that both Retirement Living and Assisted Living Extra Care schemes bring substantial benefits to local economies where they are established, while increasing the range of housing choices for older people. For individual owners, there are health and social benefits – some of which are related to the design of housing tailored to the needs of older people. For the wider community, schemes can attract investment, provide employment and social capital, environmental improvements, and free up family housing which can contribute to the health of local housing markets, while generating substantial Council Tax revenues. They provide a valuable means to increase the available housing stock, using sites effectively through their high densities.

The additional expenditure in the local economy generated by both Retirement Living and Assisted Living Extra Care schemes is significant. The figures presented here are conservative estimates, actual spending in local economic areas is likely to be even higher, given the level of use of local shops by owners in the two types of scheme.