PRIME MINISTER

DEVELOPMENT OF DHSS POLICIES

You might find it helpful to have a note of the progress we have made so far on the long-term issues we discussed with you on 16 September.

As far as the health service is concerned, the most important development has been the publication of the Griffiths Report. This has confirmed our thesis that much can be done to improve the management of the health service and that we can expect significant cost improvements to follow. We are pressing ahead with the implementation of the report's main conclusions. Changes are already under way in the Department - I have chaired the first meeting of the Health Services Supervisory Board this week - and, following the completion of consultation at the beginning of January, I will be issuing instructions to health authorities about the steps they should take.

I will be looking to health authorities to achieve sufficient cost improvement to deal with backlogs in treatment and the additional costs of advances in medical technology where these occur. But we have accepted, in the decisions we reached during the last public expenditure round, that additional resources should be provided to meet the demographic pressures which are at their peak over the next few years. The next public expenditure White Paper will demonstrate this and show that we are living up to our commitment to the NHS.

In the Family Practitioner Services, we will be publishing the Binder Hamlyn report shortly after the Christmas Recess. This will provide the basis of legislation which I wish to introduce in the 1984/85 session to give us better control over the costs of these services. Those changes will not begin to bite for some time but we have already concluded negotiations with the pharmaceutical industry which will produce savings of £65 million next year rising

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to £100 million by 1985/86.

We have also moved to end the opticians' monopoly on the supply of glasses. The Health and Social Security Bill will not only improve competition in this field but will also pave the way for the NHS involvement in the direct supply of glasses to be ended.

In social security, I have launched my Inquiry into Provision for Retirement which held its first meeting last week. The Inquiry has many important issues to look at but we are going to give particular priority to the question of portable pensions. I will be chairing a sub-group which will prepare the ground for a separate report on portable pensions well in advance of the main report of the Inquiry.

Your meeting identified the question of benefit levels for teenagers as a key issue in the field of supplementary benefit and unemployment benefit. We are pursuing this issue in several ways.

- In the context of discussions about the YTS currently underway in E(A) Committee.

- Through a separate review of the entitlement of sixteen year olds to supplementary benefit which is scheduled for next summer in the light of the first year's experience of YTS.

- Through savings agreed during the last public expenditure round which were directed specifically toward the 16 - 20 age group - particularly the withdrawal of the non-householder housing addition and changes in non-dependent deductions from housing benefit.

Housing benefit needs further & deeper consideration. We shall need the forecasts from the time of unification and the record of what has happened now. MT

23 December 1983 N F

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POLICIES FOR HEALTH, SOCIAL SERVICES AND SOCIAL SECURITY

DISCUSSION PAPER FOR PRIME MINISTER'S SEMINAR ON 16 SEPTEMBER 1983.

KEY DATA REVISED JANUARY 1984

CONTENTS

		Page
SECTION I	Policies for health, social services and social security	2
SECTION II	Working people and their families	6
SECTION III	The elderly	14
SECTION IV	Other dependent groups (the sick, handicapped and disabled)	24
SECTION V	The unemployed	28
SECTION VI	General financial issues	32
Annex A	Government statements and commitments for the present Parliament	38
Annex B	The pattern of social needs	40

SECTION I: INTRODUCTION

POLICIES FOR HEALTH, SOCIAL SERVICES AND SOCIAL SECURITY

1.1 This paper provides an annotated agenda for reviewing medium and longer term policy issues in DHSS programmes at the outset of this Parliament. The time horizon is, in general, ten years: but for the retirement pension the discussion looks ahead into the next century. The aim is to settle a framework of policy objectives for DHSS for the longer term, and to set guidelines for the impending discussions on shorter-term public expenditure issues.

1.2 On many of the points discussed Ministers have made public commitments for this Parliament. These are referred to as necessary and set out in Annex A. But the timescale of the paper goes beyond this Parliament.

Demographic change and social need

1.3 The key data sheet opposite sets out the main demographic changes over the last ten years and those expected over the next ten years. A brief analysis of changes in the pattern of need is included in Annex B.

1.4 The main demographic change has been in the growth in the number of retired people in proportion to the working population. The next ten years will see some further growth - but at a progressively slower rate - together with a sharp increase in people aged over 85*. (The projected increase in the birth rate is important but uncertain). A further important change has been in the increase in the numbers of children in one parent families.

1.5 The analysis in Annex B shows that, looking back to surveys which influenced the Beveridge report, there have been significant changes in absolute standards of living but broadly the same groups are most likely to be poor - old people dependent on flat-rate retirement pensions, and families with young children, particularly one parent families.

1.6 While absolute standards of health and social services care have also been raised progressively, the demand if not the need appears to be virtually unlimited in all groups of the population. The fastest growth is for services for the elderly and very elderly. Other pressures arise from the continuing need to raise standards of care for neglected groups such as those suffering from mental and physical handicap and mental illness, and the demand for equal access to medical advances and new technology. In all parts of the health service there are striking examples of antiquated, shabby and inefficient buildings.

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*Based on OPCS latest projections which are under discussion as they assume more elderly people than hitherto.

POLICIES FOR HEALTH, SOCIAL SERVICES AND SOCIAL SECURITY

KEY DATA

OPCS Population figures

SOCIAL SECURITY (Great Britain)*

		1973 m	1978 m	1983 m	1988 m	1993 m	Average annual percentage growth 1973-83	1983-93
	0 - 15	13.7	12.8	11.6	11.1	11.8	- 1.7	+ 0.2
Men	16 - 64	16.5	16.8	17.4	17.6	17.5	+ 0.5	+ 0.1
Women	16 - 59	15.1	15.3	15.8	16.1	16.1	+ 0.5	+ 0.2
Men	65+	2.9	3.1	3.2	3.4	3.5	+ 1.0	+ 0.9
Women	60+	6.2	6.3	6.7	6.8	6.7	+ 0.8	0

HEALTH AND PERSONAL SOCIAL SERVICES (England)*

	1973 m	1978 m	1983 m	1988 m	1993 m	Average annual percentage growth 1973-83	1983-93
0 - 4	3.5	2.8	2.9	3.2	3.5	- 1.9	+ 1.9
5 - 15	8.1	8.0	6.9	6.3	6.6	- 1.6	- 0.4
16 - 64	28.4	28.7	29.8	30.2	30.1	+ 0.5	+ 0.1
65 - 74	4.1	4.3	4.2	4.3	4.3	+ 0.2	+ 0.2
75 - 84	1.8	2.1	2.4	2.6	2.5	+ 2.9	+ 0.4
85 +	0.4	0.5	0.5	0.7	0.8	+ 2.3	+ 4.8

Costs

1.7 Expenditure on these programmes is at present 41.8% of total public expenditure (health 10.5% personal social services 1.9% social security 29.5%. Total UK health spending (ie including Scotland, Wales, Northern Ireland and the private sector) is about 6% of GDP, and social security 11.8%. These percentages of GDP are in each case about two thirds of what are thought to be the comparable figures in France and Germany.

1.8 The economic cost of the services run by DHSS might be expected (on current policies and allowing for demographic trends) to increase by 0.9% a year over this Parliament and by 0.8% a year over the next decade. This follows an increase of 5.1% a year over the last decade. The table opposite shows that if GDP grows at 2½% a year, expenditure on DHSS programmes as a proportion of GDP will diminish over the next decade from 16.7% to 14.3% If GDP grows at 0.8% the share will be constant.

1.9 The chief imponderable in projecting social security costs is the future level of unemployment. Purely for illustrative purposes, the figures in this paper assume that the number of unemployed will remain constant for the next 10 years. A reduction to 6% unemployment would reduce social security costs by £2 to £3 billion a year. For health costs the chief uncertainties are the prospects for public service pay, and the financing of service increases apart from demography. These are discussed in Section 6.

Strategy

1.10 The theme for new strategies will be:

- to identify the priority needs of the next 10-20 years and adapt policies to meet them efficiently either by private or public provision
- to ensure that these needs are weighed against the need to contain and if possible reduce public expenditure and the tax burden, and encourage private provision
- to continue downward pressure on public sector manpower
- to simplify benefit systems where possible
- to direct expenditure where it is most cost-effective
- to increase personal rights and choice and encourage self-help.

1.11 These themes underly the discussion in the following sections, which approach the issues by looking at each of the main customer groups in turn:

- the working population and their families
- the elderly
- other dependent groups (the sick, handicapped)
- the unemployed.

A final section deals with some more general issues.

1.12 Key data are shown separately for each group. There is more information in the supporting documents:-

'Health Care and Its Costs'

Handbook of Key Facts on Social Security.

Cost of the programmes

£m. 1983/84 prices

	1973/4	1978/9	1983/4	1988/9	1993/4	Average annual percentage growth 1973-83	1983-93
Health (England)	9,250	10,860	12,540	13,220	13, 780	3.1	0.9
Social Services (England)	1,570	1,940	2,250	2,370	2, 500	3.7	1.0
Social Security Ø (Gt Britain)	19,600	27,300	35,300	36,800	37,800	6.1	0.7
Total	30,420	40,100	50,090	52,390	54,080	5.1	0.8
As a percentage of GDP (assuming 2½% future growth)	11.2	13.7	16.7	15.6	14.3		

* Throughout this document, social security data are for Gt Britain, whereas health and personal social services data are for England only (Scotland and Wales have separate programmes).

Ø The Social Security programme does not include rate rebates, which are classified as revenue forgone, not public expenditure. (Their value in 1983/4 is estimated at £1.23 bn).

SECTION II

WORKING PEOPLE AND THEIR FAMILIES

2.1 This group uses the family practitioner services, acute hospital services, some community health services, maternity services, and local authority child care services. It is not increasing in size, but expenditure rises because medical advance increases the range and costs of effective treatments (including drugs), and because births are forecast to rise.

2.2 Social security expenditure for this group is directed at help with the cost of children (child benefit, one-parent benefit and maternity benefits); and at means-tested help to low-income families (FIS and housing benefits).

2.3 Under this heading there are a number of separate problems.

Acute hospital services. How is the mounting cost of modern treatments to be tackled?

2.4 The estimated cost of keeping up with new treatment arising from medical advances will, on the present assumption of ½% growth per annum, require extra expenditure amounting to £90 m in 1988-89 and £170 m in 1993-94. Moreover there are still backlogs in major treatments and long waiting lists - eg for hip replacements, dialysis, by-pass grafts. It is estimated that it would cost about £50m a year to overcome these backlogs. How is this extra cost to be met?

2.5 Over the past five years, despite more complex treatments, costs per case have fallen - largely through reducing length of stay in hospital - so that resources have been released by greater efficiency to help meet mounting costs on new treatments. But to cover the full cost of medical advance larger and more sustained efficiency savings will be needed in future.

2.6 The drive towards greater efficiency has gone a long way since 1979, through such measures as:

- NHS reorganisation
- improved accountability and performance reviews
- manpower controls
- competitive tendering for support services
- Rayner scrutinies.

This drive will continue and the current Management Inquiry should give a renewed impetus. Provided efficiency savings can be kept to improve services, there is a fair chance of overhauling backlogs in major treatments, catching up on waiting lists, and keeping pace with future developments.

2.7 This must be the major strategy for advance on this front. Ministers have publicly rejected hospital charges for this Parliament. Expension of private health insurance mainly helps with non-urgent surgery - it has not so far had any measurable impact on waiting times for major NHS treatment. The role of private health insurance is discussed in Section 6.

WORKING PEOPLE AND THEIR FAMILIES

KEY DATA

Numbers in this Group (GB)

'000

	1973-74	1978-79	1983-84	1988-89	1993-94
People in the Workforce	24,500	24,700	23,000	23,400	23,400
Children of Working Families	11,050	12,890	11,500	10,920	11,680

Expenditure Trends

£m 1983-84 prices (gross for HPSS)

	1973-74	1978-79	1983-84	1988-89	1993-94
Health	5,920	6,420	6,710	7,060	7,520
Social Services	680	940	1,090	1,090	1,140
Social Security	1,410	3,260	4,590	4,530	4,780

Average Case Costs in Acute Hospitals (at 1983-84 prices)

1973-74	1978-79	1981-82 (latest available year)
£718	£776	£727

NHS In-Patient Waiting Lists (England)

1973	1978	1983 (March)
409,000	682,000	726,000

(Note: the March 1979 figure was 752,000, reflecting the 1978-79 strike. The March 1982 figure was 622,000 showing a declining trend. The higher 1983 figure is still affected by the 1982 strike.)

Numbers Privately Insured through Provident Associations

1978	1982 (latest available year)
2.4m	4.2m

WORKING PEOPLE AND THEIR FAMILIES

<u>Family practitioner services. How can cost control be improved?</u>

2.8 Expenditure on these services has depended on treatment costs; it has been demand-led and not cash limited.

2.9 <u>Family doctors</u> are most important - the point of entry to health service treatment, they deal with most problems without recourse to expensive hospital services and are an essential fall-back when those services cannot cope. Ministers are pledged for this Parliament against charges for GP visits. Management consultants have recently concluded that the cost of this part of the service could best be controlled by controlling the number of GPs. Some increase must be allowed to cope with growing numbers of elderly - and perhaps for some improvement in service to reduce pressure on hospitals. But subject to this the Government might aim to control tightly the growth in number of GPs.

2.10 <u>Dentistry, glasses and drugs</u>. There is scope for savings here without damaging crucial health care (but with considerable controversy) by:

- control on numbers of dentists
- reduction in drug industry profits
- privatisation of supply of glasses
- increasing charges

2.11 Decisions were taken during the 1983 public expenditure survey to achieve savings by:

- better controls on lines recommended by Binder Hamlyn.
- reduced drug company profits and promotional expenditure.
- ending of opticians monopoly and withdrawal of supply of NHS glasses to all but children and the poor.
- increase in prescription charges in 1984-85.
- introduction of cost-related dental charges in 1985-86.

In announcing the withdrawal of NHS glasses, Ministers made it clear that sight tests would remain free

2.12 Other possible savings rejected during the 1983 survey are cost-related prescription charges (£40m) and removing present exemptions from elderly and children (about £150m). But removing exemptions would be highly controversial both on health grounds (charging for treating children) and on social and administrative grounds (increased means-testing of the elderly). Ministers have previously stressed the importance of exemptions when defending increases in charges. Cost-related prescription charges would also be complex to administer, and pharmacists would have to be paid more.

2.13 The table opposite shows the latest forecasts for the family practitioner services, and past expenditure, in cost terms throughout. The forecasts take account of the savings agreed in the 1983 survey, and the higher estimates of future expenditure made since (there is a separate note on this). The forecasts, especially in the later years, are subject to a major review which is now in hand in DHSS, with Treasury participation.

WORKING PEOPLE AND THEIR FAMILIES

KEY DATA

FAMILY PRACTITIONER SERVICES' EXPENDITURE (PROJECTED ON PRESENT POLICIES)

£m, 1983-84 cost-terms

	1973-74*[1]	1978-79	1983-84	1988-89	1993-94
Pharmaceutical		1210	1430	1630	1800
Optical		130	160	120	140
Dental		480	590	650	720
Medical		650	870	930	1020
Total FPS Gross	2150	2470	3060	3330	3670
Charges	230	180	310	370	410
Total FPS Net	1920	2290 (3.6%)[2]	2740 (3.7%)	2960 (1.5%)	3270 (2.0%)

* 1. Split between services not available

2. Figures in brackets represent the annual average growth in preceding 5 years.

WORKING PEOPLE AND THEIR FAMILIES

Social security. Can work incentives be improved?

2.12 There are two separate - and often conflicting - issues here:

> the unemployment trap concerns the gap between income in and out of work, and the need to maintain an incentive to get off benefit and back into work. This can be tackled either by reducing out-of-work benefit levels, or by increasing the incomes of those in work through benefits or raising tax thresholds. Where the benefit approach is followed, the help given has to be withdrawn as income increases, and this gives rise to -
>
> the "poverty" trap, where the value of earnings is eroded by withdrawal of benefit. This is a problem of incentives rather than of poverty per se: the more rapid the withdrawal of benefit, the starker the disincentive to earn more. But slower erosion means allowing the help to spread further up the income scale, with more benefit expenditure going to relatively better-off families.

2.13 Support for children of working families. Help can be given through the tax or benefit systems. With the replacement of child tax allowances and family allowances, child benefit has become the means of helping families, both in and out of work, with the extra cost of children. But working families are of course still helped by tax changes, particularly raising tax thresholds. The comparative costs are:

Raising tax threshold	- Each weekly £1 increase per family costs £575m
Child benefit	- Each weekly £1 increase per child costs £500m (This would give each family on average an extra £1.80 a week).

2.14 Child benefit eases the unemployment trap, and on that ground there is a case for increasing it. But this is entirely at Government discretion. There is no significant demographic effect over the next ten years, and there is no statutory uprating requirement. The Government are committed to not changing the basis of the benefit.

2.15 Support for working parents. FIS increases income in work and so improves the incentive to resume work. Its 50% withdrawal rate is a major cause of the poverty trap, however. Originally introduced as a stop-gap measure, it has become a permanent benefit of some importance, and its operation is being reviewed. Its withdrawal would seriously worsen the unemployment trap: but it may be possible to restructure it to increase its cost-effectiveness and reduce its poverty trap effects.

WORKING PEOPLE AND THEIR FAMILIES

KEY DATA

Expenditure: Social Security

£m 1983-84 prices

1973-74	1978-79	1983-84	1988-89	1993-94
1,410	3,260	4,590	4,530	4,780

Numbers on Social Security Benefit

'000

	1973-74	1978-79	1983-84	1988-89	1993-94*
Child benefit+	7,060	13,480	12,660	12,070	12,830
One-parent benefit	-	290	540	630	630
Maternity benefits	70	100	130	155	155
Family income supplement	95	85	205	210	210
Standard housing benefit	-	-	400	300	300

+ Includes children in families where the head of the household is unemployed

* For illustrative purposes, it has been assumed that the numbers receiving benefit (other than child benefit) remain at the level assumed for 1985-86 until 1993-94.

WORKING PEOPLE AND THEIR FAMILIES

2.16 Housing benefits. These have the same effect as FIS - they ease the unemployment trap by adding to income of those in work as well as out of it. But they are withdrawn more slowly as income increases and extend the poverty trap a long way up the income scale, by comparison with other benefits: about one-third of all households are getting some help - mainly pensioners but including about 850,000 households where the head is in work, some with incomes above average earnings. **Some reductions have been made as part of the Autumn Statement changes and a review of the system is being put in hand.**

Should maternity benefits be rationalised?

2.17 This is a possible area for review. There are three separate benefits:

- a flat-rate non-contributory grant of £25 for all women
- a contributions related allowance for women who have been in work, worth £25.95 for 18 weeks
- maternity pay, under DE legislation, paid by employers as a proportion of previous pay, and reclaimed in part from NI contributions.

Previous attempts to find a consensus on rationalising this area have failed: but there is a commitment to review it again, and this could start with the objective of combining at least the allowance with maternity pay in a single benefit paid by employers. This could reduce public expenditure by up to £175m.

SECTION III

THE ELDERLY

3.1 Numbers over pension age will be stable, as a proportion of the working population, until 2010, but will increase thereafter as the post-war 'baby bulge' reaches retirement age. But within the total, the over 75s and over 85s will increase sharply in the 1980s (this increase tails off in the 1990s).

3.2 In health and social services the growing number of the very old present the biggest single challenge. Their demands increase sharply with age. They require geriatric hospital services, they are major users of acute hospitals, they take up most of the District Nursing Service, and they use local authority residential accommodation, day care, home helps and meals on wheels. They can benefit from more medical advance, provided it can be afforded through greater efficiency - for example, more joint replacements as surgical techniques develop (estimated cost: £110m in 1988/89, £200m in 1993/94)

3.3 Pensioners account for half of the social security budget through retirement pensions and supplementary pensions: benefit levels do not increase significantly after retirement age. Pensioners also account for two-thirds of expenditure on housing benefit. The Government is pledged to continue to price protect pensions and other linked long-term benefits.

3.4 About half of all workers are in occupational pensions schemes and contracted out of the State pensions scheme. The big issue here at present is that of early leavers and the possibility of introducing portable pensions. The Secretary of State has established a Pensions Inquiry which will consider these and other issues and which he is himself chairing. Significant legislation on private pension schemes is a possibility for this Parliament. A wider issue is what can be done to increase membership of occupational schemes.

THE ELDERLY

KEY DATA

Numbers in this group

	1973/74	1978/79	1983/84	1988/89	1993/94
ENGLAND	6.3m	6.9m	7.1m	7.6m	7.6m
GB	9.1m	9.4m	9.9m	10.2m	10.2m

Expenditure trends

£m. 1983/84 prices (gross for HPSS)

	1973/74	1978/79	1983/84	1988/89	1993/94
Hospital and Community Health Services	2,580	3,230	3,520	3,810	3,920
Social Services	810	1,040	1,160	1,310	1,400
Social Security	11,070	14,360	16,750	17,750	18,500

Numbers on Social Security benefits

'000

	1973/74	1978/79	1983/84	1988/89	1993/94
Retirement pension	7,750	8,530	9,180	9,670	9,790
Supp. pension	1,845	1,745	1,525	1,520	1,520
Non-contrib.RP	110	65	40	20	10
Christmas bonus	7,000	9,100	9,100	9,300	9,300
Standard housing benefit	-	-	1,300	1,000	1,000

Numbers in occupational pension schemes

Pension scheme membership has been at about the same level of about 11 millions since the early 1960's. The latest Government Actuary's survey in 1979 showed:

	Total	Public sector	Private sector
Employees in pension schemes	11.8m	6.2m	5.6m
Numbers contracted out	10.3m	4.8m	5.5m
Employees not in schemes	11.6m		

The Government Actuary thinks that the current position is not significantly different.

How can health and social services be provided for the growing number of very old people?

3.5 Ministers are pledged for this Parliament against hospital charges. Private health insurance does not contribute much to costs for the old:

- very few old people are covered by private insurance
- premiums for acute treatment rise sharply after 65
- long-term private care is uninsurable

New tax concessions to encourage insurance by old people could lead to extra private acute treatment. But this will not significantly reduce the burden on the NHS. Increased NHS expenditure on this age group, financed from taxation, is unavoidable, unless standards of care are to be reduced.

3.6 Much long-term care is at present unsuitable. Lack of community services leads to pressure on hospitals, which are inefficiently used and often give a poor standard of care. Longevity increases pressure on services for the elderly, and there is need for help to people looking after elderly relatives - who may often be elderly themselves - as well as for elderly people living on their own. Much of the necessary provision comes from local authority services, and pressure on their expenditure makes the prospect uncertain.

3.7 The present broad strategy is to improve services through:

- reduction in long-term care and shift of NHS resources into community health services (especially District Nursing) to support people at home
- development of role of family, neighbourhood resources and voluntary care
- continuing encouragement to local authorities to give priority to services for the elderly. 'Joint finance', provided for the NHS to share the cost of developing local authority provision, can help here (at present running at £ 96 m)
- some centrally-funded demonstration projects to encourage a better balance of services and more use of neighbourhood resources
- work through DOE and the private sector to encourage more provision of suitable housing to enable old people to live at home.

The aim will be to carry through this strategy without further resources - other than those required by demographic increase (£290m in 1988/9 and £400m in 1993/5 in health services alone).

3.8 Much voluntary and private provision is paid for through social security benefits (e.g attendance allowance and invalid care allowance). Is there a case for increasing this support?

THE ELDERLY

KEY DATA

<u>HPSS expenditure per head varies with age as follows</u>

	Birth	0-4	5-15	16-21	65-74	75-84	85+
HCHS	£950	£175	£70	£100	£345	£755	£1,290
FPS	£ 65	£ 50	£40	£ 50	£ 70	£130	
PSS	£ 20	£ 70	£ 70	£15	£ 60	£250	

<u>Numbers Living at Home</u>

35 per cent of old people live on their own, and 45 per cent with their spouses. The remaining 20 per cent live with relatives or others.

Paying for pensions

3.9 The assumptions on which the earnings-related scheme was based were that it was desirable:

- to improve pension provision (still low by comparison with other western industrial countries) to about one half of average earnings
- to transfer resources from the working population to elderly
- to reduce dependence on means-tested help
- to establish a partnership with the private pensions sector

Are these still the assumptions on which the Government wishes to act? If not, reversion to a flat-rate scheme - presumably with flat-rate contributions - is a possibility for examination. It would mean an end of the bi-partisan policy evolved over the last two decades; and since it would point to lower incomes in retirement for the less well-off without occupational pensions, it would need to be justified by overriding concern about the finances of the present scheme. It was stated before the election that there were no plans to change the earnings related component.

3.10 The scheme started in 1978, matures in 1998, and the costs of the scheme will have a major impact after 2010. There is no large demographic factor to drive up expenditure for the next 25 years, and benefits need not increase in real terms, since last Session's Act ties them firmly to the past movement of prices (no more uncovenanted "overshoots"). So long as we stick to no more than price protection, the emerging costs of the scheme will be lower than those so far assumed - see figures opposite - though benefits will also be lower. The Government Actuary's most recent forecasts, which are based on earnings indexation, have confirmed the original presumption that contributions (employer and employee together) would grow by 5 percentage points by 2025.

Paying for pensions: projections into next century

The following tables are based on assumptions used by the Government Actuary for the Quinquennial Review. They assume an unemployment level of 6 per cent over the whole period and are based on population projections which do not take account of the 1981 census.

The present rate of NI contribution is 17.65 per cent, but would be 15.3 per cemt if unemployment were currently 6 per cent.

	Numbers		
	1985	2005	2025
Number over pension age (Millions)	10.0	10.1	12.3
Ratio of working age to pension age population	3.33	3.37	2.74

1. If real earnings increase by 2 per cent per year

	1985/86	1995/96	2005/6	2015/16	2025/26
NI contribution rate if basic pension linked to earnings	15.3	15.5	16.1	18.0	20.3
Cost of Pensions as proportion of GDP	5.6	N/K	6.2	N/K	8.7
Average pensioner income as proportion of non-pensioner income	68	72	75	76	80

2. If real earnings increase by ½ per cent per year

	1985/86	1995/96	2005/6	2015/16	2025/26
NI contribution rate if basic pension linked to earnings	15.4	15.7	16.6	18.9	21.5
Cost of pensions as proportion of GDP	5.6	N/K	6.6	N/K	9.6
Average pensioner income as proportion of non-pensioner income	69	72	76	79	85

3. If basic pension linked to prices not earnings

	1985/86	1995/96	2005/6	2015/16	2025/26
NI contribution rate	15.3	13.6	12/6	12.9	13.5

THE ELDERLY

3.11 The factors causing growth in expenditure will be:

- maturing of the earnings-related additional component ("second tier")

- increases in numbers of pensioners.

This growth is to be funded largely from contributions with the Exchequer contributing 13% diminishing to 11% from April 1984.

3.12 But there is much uncertainty:

- demographic factors may change

- a continuing high level of unemployment would alter the pensioner/worker ratio over a period and reduce contribution income

- different rates of economic growth will affect the rate of contribution needed; low growth requires higher contribution rates

- it will be argued that price protection of pensions may not be enough indefinitely. The original scheme was designed on the basis of earnings relation in both contributions and benefits

- pressure could mount to give something extra to pensioners who retired before 1978 and are not getting any second tier benefit.

3.13 Options to be explored for reducing the public expenditure costs of the present scheme are:

Extending the role of the private sector. At present private schemes can contract their members out of the State scheme second tier and pay lower contributions in return for guaranteeing an equivalent to the second tier on retirement. There could be scope for further contracting out of:

- part of the basic pension

- part of the responsibility for inflation proofing the second tier after retirement.

This would reduce public expenditure over a period - perhaps mounting at a compound rate from 1988 onwards to £500m next century. It would not reduce resources going to pensioners, but switch the balance from public to private provision. It would need careful exploration with employers and pensions interests, and would entail some increase in contributions needed within the State scheme.

Reducing some of the benefits. Options for this have been prepared in consultation with the Treasury, following the Government Actuary's review of the first five years. They would be controversial, but could reduce expenditure on the second tier by up to 30% in the long run, and hold back the contributions needed to finance it by up to 2.8%.

THE ELDERLY

3.14 There is a substantial range of issues here which could be publicly debated, with a view to changes later in the 80s to reduce the burden of expenditure arising from 1990 onwards.

<u>What is to be done about pension age?</u>

3.15 It has become conventional wisdom, endorsed in a report by the Select Committee on Social Services last Session that it is desirable that pension ages for men and women (now 65 and 60) should be equalised at a common age, and that some flexibility should be allowed for people to retire earlier or later in return for reduced or enhanced pensions. The Select Committee has recommended 63: this would cost £500m a year. Given the public expenditure setting, it looks increasingly unrealistic to consider changes in pension age which cost money.

3.16 Equalising pension age at nil cost could only be achieved by bringing women's pension age up above 64 - a common age of 64 would still cost £50m a year. If the idea of flexibility to retire early were dropped, there would be savings for each year women's pension age was increased, mounting to £400m at age 65.

3.17 The Government **has replied to the Select Committee drawing attention to the costs of a common pension age at 63, and referring the issue to the Pensions Inquiry which the Secretary of State is chairing.**

SECTION IV

OTHER DEPENDENT GROUPS

4.1 Under this heading come the mentally handicapped or ill, and the "younger disabled", who have special health needs; and the sick and disabled for whom there is a wide range of provision in the social security schemes.

<u>How far can mental illness and handicap services be improved?</u>

4.2 The pressures on these services come not from growth in the caseload (except for severe mental illness associated with old age), but from widely acknowledged need to improve standards and get a better balance between hospital and community provision.

4.3 The NHS inheritance of old, remote long-stay hospitals used in the past as dumping grounds with scandalously low standards of care is taking a long time to remedy. Much progress has been made, but there are still poor hospitals and the cost of improvement (and particularly of increasing the number of nurses) is high.

4.4 The established policy is to restructure the services on a local basis, with more community care and more hospital provision near the community, and gradually close the old hospitals. There is a case for more finance than has been assumed in the projections opposite to assist this transition through:

- replacement of buildings

- retraining of staff

- development of local authority and voluntary services, through joint finance, grants to voluntary bodies and demonstration projects

and to avoid scandals while old hospitals continue to serve large numbers of patients.

OTHER DEPENDENT GROUPS

KEY DATA

Expenditure Trends

£m 1983-84 prices (gross for HPSS)

	1973-74	1978-79	1983-84	1988-89	1993-94
Hospital and Community Health Services*	1,270	1,350	1,420	1,460	1,470
Social Services	180	280	340	340	340
Social Security	4,980	6,230	6,600	6,970	6,970

* Projections allow only for increasing numbers of old people at risk of severe mental infrimity

OTHER DEPENDENT GROUPS

Should there be changes in cash help for the disabled?

4.5 Expenditure on cash benefits for this group has nearly doubled in real terms in a decade, through the introduction of new benefits, improvement in benefit levels, and a large growth in claims. There is no commitment to further benefit improvements, but much pressure for an extension of benefits.

4.6 These benefits now cost £3.8 billion. Their aim is:

- to help with extra living costs of the disabled

- to replace lost earning capacity

- to help people to live in the community.

They have been aimed selectively at particular needs, regardless of the recipients' income: in some cases benefits are related to previous earnings (and are higher for those who had enjoyed better earning capacity); in others they are related to the degree of disability (and are higher for the more severely disabled). This is a very distinct basis of provision from that adopted for other groups, and it has never been thought right to contain the expenditure by means-testing.

4.7 The present much-criticised patchwork of benefits (invalidity pensions, contributory and non-contributory; war and industrial injury benefits; attendance allowance; mobility allowance; invalid care allowance) has the merit of concentrating help on target groups. Though it is administratively cumbersome, the cost of rationalisation (up to £2 billion) prohibits advance in the foreseeable future.

4.8 It may be possible to arrange more contracting out. Sickness benefit is now paid by employers for the first eight weeks, with a saving in public expenditure and administrative costs of about £385 million*. This process could be extended to longer periods of sickness - though with diminishing returns in terms of savings (going up to 28 weeks would only save another £30 million), and at the likely cost of much employer resistance to a mounting administrative burden. (Industrial injury is another area that might be looked at, though the obstacles here, and the likely employer resistance, are very great.)

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* Employers are reimbursed through deductions from National Insurance contributions, which reduce revenue. The net effect is a PSBR saving of £90 million.

OTHER DEPENDENT GROUPS

KEY DATA

Numbers on Social Security Benefits

'000

	1973-74	1978-79	1983-84	1988-89	1993-94
War Pensions	465	385	315	275	275
Industrial Disablement and Death Benefit	240	240	215	205	205
Attendance Allowance and Invalid Care Allowance	125	270	455	540	540
Mobility Allowance	-	95	315	390	390
Sickness Benefit	525	560	155	155	155
Invalidity Benefit	440	600	725	745	745
Widows Benefit	580	495	435	410	410
Supplementary Allowance (less unemployed)	585	670	-	-	-
Non-contributory invalidity pension	-	150	205	255	255
Christmas Bonus	1, 300	1,500	1,800	1,800	1,800

For illustrative purposes, it has been assumed that the numbers receiving benefit (other than child benefit) remain at the level assumed for 1985-86 until 1993-94.

SECTION V

THE UNEMPLOYED

5.1 The cost of benefits for the unemployed has been the main growth element in the social security budget over the past five years. As a result of the increase in numbers of unemployed, it has more than doubled in real terms from £2.25bn to £5.68bn, despite measures to reduce the value of benefit significantly; and it has shifted an increasing load on to supplementary benefit.

Is the benefit structure appropriate to present needs?

5.2 The benefit system is computerised, and has coped with threefold increase in caseload. But the benefit scheme is not well adapted to unemployment on its present scale:

- two Departments and two sets of offices are involved. (The DHSS Operational Strategy points a way towards integrating the offices later in this decade).
- 28,000 staff in DE offices deal with UB; about 16,000 in DHSS offices have to review many of the same cases to top them up with supplementary benefit
- unemployment benefit (UB) is available, regardless of other resources, as an insurance-based benefit, for up to 12 months. But only 40% of the unemployed qualify for it, and many of these have to have it topped up by supplementary benefit. 60% of the unemployed are entirely ineligible for UB and have to rely entirely on supplementary benefit. UB is no longer the main source of support for the unemployed.

5.3 **It is proposed to review the supplementary benefits scheme during 1984 to see whether greater simplicity and economy can be achieved.**

Should benefit expenditure be reduced?

5.4 In the last Parliament the value of unemployment benefit was reduced to its lowest level in relation to earnings for thirty years by:

- abolition of earnings related supplement
- 5% abatement of benefit in lieu of taxation (restored this November)
- introduction of taxation of income from benefit after return to work
- reduction of dependency additions for children.

These measures reduced expenditure on the unemployed by £800m: but this has been more than cancelled out by the rise in numbers on benefit.

5.5 A drop in the number of unemployed would reduce benefit expenditure

UNEMPLOYED

KEY DATA

Numbers in This Group

'000

1973-74	1978-79	1983-84	1988-89	1993-94
540	1,300	3,030	3,020	3,020

* for illustrative purposes the number unemployed is assumed to remain at the level assumed for PES 1983 until 1993-94.

Numbers on Social Security Benefits

'000

	1973-74	1978-79	1983-84	1988-89	1993-94
Unemployment Benefit only	155	402	790	) 2,660	2,660
Supplementary Allowance and UB	43	90	240	)	
Supplementary Allowance only	186	516	1,620	)	

Characteristics of Unemployed on Benefit

21% have children

70% are single without children

19% are under age 20

60% have been unemployed over 6 months: 35% over 1 year

Expenditure Trends

£m 1983-84 prices

1973-74	1978-79	1983-84	1988-89	1993-94
1,170	2,250	5,820	5,890	5,890

by £185m for each 100,000. Otherwise benefit expenditure can only be reduced by a direct cut in present levels; or by a new and simplified benefit system which is less generous.

5.6 Abatement of benefit for the unemployed during the last Parliament was confined to UB: the "safety net" level of supplementary benefit was not reduced. If abatement were to be pursued again, the saving at the November 1984 uprating for each 1% would be -

	1984/85	1985/86
on UB only	£ 4 m	£ 11 m
on UB and supplementary benefit	£ 15 m	£ 42 m

5.7 By confining cuts to the insurance benefits, and leaving supplementary benefit untouched, the Government has been able to assert that the poorest have been protected. One area where some reduction in supplementary benefit might nevertheless be considered is that of the teenage school leaver. Young people who do not find jobs on leaving school can receive benefit in their own right from 16, even if they are still living at home with comfortably-off parents. If parental resources were taken into account there would be overtones of the "family means-test" of the 1930s. But there is a case for reducing benefit levels at least for school leavers living **at home. Some reductions were made as part of the changes announced in the Autumn Statement and the benefits available to young people are being reviewed.** Should individual benefit payments be related to in work income?

5.8 With the abolition of the "wage stop" provision in supplementary benefit in 1975 and the earnings related supplement to the unemployment benefit in 1982, benefits for unemployed people are no longer related in any way to their previous or future earning capacity. Is there a case for reintroducing a limit to benefit payments which would serve a similar purpose to the wage stop? The effect of the wage stop was to limit benefit so that the unemployed person was not better off than he would have been in his usual occupation. When it was abolished, it only applied to 4-5,000 cases (or 1.6%) out of 300,000 unemployed people on supplementary benefit. The logic of such a provision is clear. The practical difficulty, which was evident in the wage stop, is to administer it in a way which is accepted as fair but is not burdensome and administratively costly.

INCOME IN AND OUT OF WORK

The comparison below is between take home pay and supplementary benefit at November 1983.

	Take-home pay	Benefit
Single person:	£115.94	£26.80 + housing costs
Married couple + 2 children under 5	£134.76	£63.85 + housing costs

NOTE "Take home pay" is based on estimates of average weekly earnings of men aged over 21 and allows for the deduction of tax and NI contributions and the addition of child benefit. Housing costs would have to be met out of this figure.

"Benefit" is the supplementary benefit scale rates plus age related heating addition.

4% of men becoming unemployed receive higher income than when last in work.

25% of men becoming unemployed receive at least 80% of income when last in work (mainly family men and occupational pensioners - not young single men).

UNEMPLOYMENT BENEFIT AS % OF
AVERAGE MALE MANUAL EARNINGS

	Single rate	Married rate
July 1945	19.1	30.9
August 1951 (lowest) point)	15.9	25.7
March 1963	20.9	33.8
October 1973	35.5	46.8
November 1978	31.6	42.8
November 1982 (provisional)	17.8	28.7
November 1983 (estimated)	18.1	29.2

SECTION VI

GENERAL FINANCIAL ISSUES

Financing Social Security through taxation or contributions?

6.1 About three-fifths of social security expenditure is on contributory benefits. But after allowing for the Treasury contribution to the NI Fund, and for administration costs, slightly over half of the total social security budget comes from general taxation. The tax share has risen substantially over the last 10 years, with the introduction of new non-contributory benefits (disablement benefits, child benefit) and sharply increased spending on supplementary benefits. Is it worth retaining the contributory structure, with its extra administrative cost?

6.2 So far, the answer of successive Governments has been 'yes', for three main reasons:

- people prefer to build up their own title to benefits through contributions and are readier to pay for them in this way than through general taxation

- the earnings-related pension scheme needs some system of recording earnings, even if contributions as such are abandoned; and the arrangements for contracting out hinge on a differential contribution structure

- the contributory principle provides a test of entitlement; it is thus a rationing device to constrain benefit expenditure. If it were abandoned, some other test of entitlement would need to be substituted to prevent a substantial increase in benefit costs, particularly in paying full benefits to married women who have not contributed.

6.3 One possibility for making more use of the contributory system to finance social security would be to increase the range of earnings over which contributions are paid. In effect this entails raising the Upper Earnings Limit (ie the ceiling below which contributions are paid). But this amounts to increasing taxation of higher earners.

The tax credits approach

6.4 It has long been a proposition that tax and social security might be combined into a single system. But tax credits schemes involve extra expense, if they give cash payments to people below the tax threshold who fail to qualify for tax allowances. The cost of the 1972 scheme was estimated at £1.3 billion. The present cost would be considerably greater. The 1979 Manifesto declared this to be a long-term aim - this has not been repeated in the 1983 Manifesto. The child benefit scheme has implemented one element in this approach. Operationally it is necessary to await the completion of the current computerisation projects in Inland Revenue and DHSS, but there may be prospects for further progress towards tax credit objectives in the 1990s. If that were to be a Government objective, planning would need to be put in hand by the middle of this Parliament.

GENERAL FINANCIAL ISSUES

KEY DATA

Sources of finance for social security

£bn 1983-84 prices

	1973-74	1978-79	1983-84	
NI contributions	13.4	15.2	17.4	) Future trends) depend on the) development of) the earnings) related scheme
NI Fund investment income	0.2	0.8	0.4	
Taxation	6.0	11.3	17.0	

Treasury Supplement

	1973-74	1978-79	1983-84
(i) as % of contribution income	18	18	13
(ii) Amount at 1983-84 prices	£2.2bn	£3.3bn	£2.8bn

National insurance contribution rates

(excluding allocations to NHS, Maternity & Redundancy Fund and National Insurance Surcharge)

	1973-74	1978-79	1983-84	
Standard contracted in rate for employee	5.36	6.10	8.00	) Future trends) depend on the) development of) the earnings) related scheme
Standard contracted in rate for employer	5.99	9.15	9.65	
Total	11.35	15.25	17.65	

Health Expenditure - General Issues

6.5 The preceding sections show that there are pressures for increased provision of health care. Taking a ten-year view, the costs of the NHS on present policies would remain at roughly the same proportion of GDP provided that:

- all medical advance and improvement in hospital services, except for meeting demographic change, is paid for by savings from increased efficiency

- improvements in long-term care are achieved by more community care, including family, neighbours and voluntary care

- NHS costs do not rise faster than prices generally. (If NHS pay were to rise in line with the amount assumed in the 1982 public expenditure exercise, this would affect costs as shown in the table opposite.)

- GDP grows at about 1 per cent a year over the next decade.

6.6 This is an ambitious scenario. The strategic questions are:

(a) Will efficiency improve sufficiently to pay for the improvements which people demand?

Much of the increase in efficiency will come from reducing manning levels and increasing productivity in existing services, especially non-front-line staff. Public sector manpower and costs will also be reduced by increasing use of the private and voluntary sectors, including contracting out of support services. Some increase in manpower will, however, be unavoidable to cope with the growing number of very old and dependent people, who need above all nursing and other personal care, and to provide better services in the North and Midlands. The aim will be to keep manpower under strict control, and to ensure that existing services are made more efficient and any increases are justified in terms of the cost-effective provision of service to patients. Other measures to increase efficiency will also be pursued (see para 2.6).

(b) Can NHS costs, including pay, be held to the general level of inflation?

In the past two years and the present one services for more old people and medical advance have been financed without any cost to the taxpayer by a combination of increased efficiency and lower real incomes for health service staff. In the long term, however, if real incomes of the working population generally rise as GDP improves, there will be pressure to allow health service workers some rise as well, particularly if their productivity continues to increase. Health service pay will, of course, have to be considered in the context

GENERAL FINANCIAL ISSUES

KEY DATA

Future NHS expenditure (England) on alternative assumptions

	1983/4	1988/9	Annual average growth over 5 years	1993/4	Annual average growth over 10 years
If pay and prices rise with inflation after 1983/4:					
Economic cost (£'000)	12,540	13,220	1.1%	13,780	0.9%
GDP share*	4.2%	3.9%		3.6%	
If pay and prices rise faster than inflation:					
Economic cost (£'000)	12,540	13,860	2.0%	15,160	1.9%
GDP share	4.2%	4.1%		4.0%	

*Assuming GDP grows at 2½% a year.

of public service pay generally.

(c) What scope is there for increasing income from charges to patients?

Because of the pledge against hospital charges, the main possibilities in this Parliament are family practitioner service charges. Paragraph 2.11 and 2.12 set out which were accepted and rejected during the 1983 Survey.

(d) Can the amount of care provided by the private sector be increased?

There are two possibilities here. One is to drop functions now performed by the NHS (eg the supply and dispensing of glass already agreed - para 2.11). The other is to encourage greater growth in private health insurance. Ecnouragement through fiscal relief might be possible, but there is a large 'dead-weight' cost (£65 million a year) in giving tax relief to those already insured.

GOVERNMENT STATEMENTS AND COMMITMENTS FOR THE PRESENT PARLIAMENT

1983 MANIFESTO

"We have a duty to protect the most vulnerable members of our society, many of whom contributed to the heritage we now enjoy. We are proud of the way we have shielded the pensioner and the National Health Service from the recession.

"Only if we create wealth can we continue to do justice to the old and the sick and the disabled. It is economic success which will provide the surest guarantee of help for those who need it most."

WORKING PEOPLE AND THEIR FAMILIES

Hospital Charges and Charges for GP Visits

"I gave two undertakings. One was that I would not put, or not institute charges for stays in hospital nor for going to the doctor. I repeat those pledges."

(Prime Minister on 'Panorama', 31 May 1983).

Exemptions from Prescription Charges

"No responsible Government could ever promise not to increase prescription charges. I repeat that now. The important thing is that the exemptions remain."

(Prime Minister, Hansard, 10 May 1983).

The Unemployment and Poverty Traps

"Further improvements in allowances and lower rates of income tax remain a high priority, together with measures to reduce the poverty and unemployment traps".

(1983 Manifesto).

Child Benefit

"The importance the Government attaches to child benefits was made clear by the Chancellor of the Exchequer ... in March this year when he said:

> 'It is important for families and in particular for the low paid. Indeed it is the benefit which provides the greatest help to many of the poorest families in the country.'

There are no plans to make any changes to the basis on which the benefit is paid or calculated."

(Prime Minister's letter to Bynmor John, 20 May 1983).

"Nor is child benefit [a 'pledged benefit'] ... [but] we have managed to price protect ... and that would be our aim in the future."

(Mr Fowler, Press Conference, 7 June 1983).

THE ELDERLY

"In the next Parliament we shall continue to protect retirement

pensions and other linked long-term benefits against rising prices."
(1983 Manifesto).

"Nor are there any plans to change the earnings-related component of the state pension."

(Prime Minister's letter to Brynmor John, 20 May 1983).

"It remains our intention to continue raising the [earnings] limit and to abolish this earnings rule as soon as we can."

(1983 Manifesto).

"The Christmas Bonus ... will continue to be paid every year."

(1983 Manifesto).

"We will consider how the pension rights of 'early leavers' ... can be better protected."

(1983 Manifesto).

OTHER DEPENDENT GROUPS

"The benefits to which the pledge to compensate for price increases applies are:-

Widow's pension (including widowed mother's allowance and widow's allowance).

Industrial death benefit paid by way of a widow's or widower's pension.

War disablement pension and industrial injury disablement pension.

War widow's pension.

Attendance Allowance.

Non-contributory invalidity pension.

Invalidity benefit."

(Chancellor, Hansard, 11 July 1983. Other benefits not relevant omitted from list).

"We have given an unqualified commitment that the abatement of invalidity pension will be restored when the benefit comes into tax."

(Mr Newton, Hansard, 26 July 1983).

THE UNEMPLOYED

"We will maintain special help ... for the older unemployed through early retirement schemes."

(1983 Manifesto).

" ... the unemployment benefit from next November to the following November has already been announced. The question about the rate for the following November does not therefore arise until after the Budget next year, and probably until after the RPI figure is announced next June."

(Prime Minister, Hansard, 5 July 1983).

ANNEX B

THE PATTERN OF SOCIAL NEEDS

Levels of Poverty

1. Much of the survey material on needs in the Beveridge report was based on the work of Rowntree, in particular his study in York in 1936. The findings of his work and others were assessed in the ESRC report "Despite the Welfare State" (1982) which drew together the results of a programme of research studies undertaken over ten years. The authors of the 1982 report conclude that "there is ample evidence to assert that there have been marked improvements in living standards over recent generations for people on all rungs of the social ladder." Data from the New Earnings Survey show that by the middle 1970's the median earnings of a male manual worker were three times greater in purchasing power than that of his equivalent in 1914.

Groups most at Risk

2. Beveridge found that the old and children with young families were least well supported:

- in 1936 one third of the pensioners surveyed in York by Rowntree were living below his standard of human needs.
- in 1937 one family out of every nine in Bristol was in sheer physical want.

His recommendations were aimed at "better distribution of purchasing power ....., as between times of earning and not earning, and between times of heavy family responsibilities and of light or no family responsibilities."

3. The figures quoted in "Despite the Welfare State" suggest that much the same groups continue to have the lowest incomes. The 1975 General Household Survey showed that of those recorded as living on annual incomes at or below the level of supplementary benefit, 50 per cent were elderly and 25 per cent were children (nearly half of them in one parent families).

4. The Black Report on inequalities in health (1980) reinforces this view of the persistence of differences in the incidence of sickness, disability and death according to socio-economic class.

The form of social provision

5. Beveridge thought that the essential elements in a satisfactory system of social provision were -

- children's allowances
- the avoidance of mass unemployment
- a comprehensive health and rehabilitation service.

6. The policy recommendations in "Despite the Welfare State" focus on development of a more effective family income maintenance service. There is concern that the level of supplementary benefit is inadequate, particularly for long term recipients; but recognition that it cannot be raised within the existing structure without increasing undue reliance on means-tested benefits (with all its difficulties for incentives).

<u>Growth in demand</u>

7. Despite the real growth in health spending (34% over a decade) there is no diminution of demand. Activity and expenditure has grown much more quickly for some groups, as a result of policy priorities (eg for the mentally ill and mentally handicapped) and demographic pressures (eg the elderly). Examples:

- in-patient cases treated in hospitals increased by 25% between 1971 and 1981, and regular day attendances went up by over 90%.

- home nurse visits increased in the same period by nearly 90%.

- operations on people between 65 and 74 increased by about 30% over the decade, and on people aged 75 and over by about 50%.