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TOWARDS A HOLISTIC VIEW OF THE OLD AGE SUPPORT SYSTEMS IN ENGLAND

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Abstract

This paper takes a bird's-eye view of the existing old-age support systems in England involving pensions, health care, and long-term care. The paper clarifies the key elements of each system, reviews policy changes over the years, and describes current scheduled policy changes targeting these systems. Drawing on a scoping review of policy and peer-reviewed literature, we suggest that the three old-age support systems in England are interconnected. We also highlight that both the scheduled changes to the three systems and the future policy options should be subjected to a sustainability check.

Keywords: Ageing; England; Healthcare; Long-Term Care; Pensions; State Pension; Sustainability; Welfare; Wellbeing.

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Introduction

As the old-age population (i.e., individuals aged 65 and over) in England continues to grow, supporting this group to live well in old age is becoming increasingly challenging. Living well depends not only on the choices of individuals in this group but also on the coordinated functioning of the multiple public systems that support health, independence, and financial security (Ahmed et al., 2021; Srang, 2023; Xia et al., 2025). In this paper, we refer to these systems as old-age support systems, including health care, long-term care, and pensions. The health care system provides access to diagnostics and treatment to help older people maintain good health and/or slow their decline. The long-term care system supports daily living to maintain independence, minimise suffering, and preserve dignity (Ostaszkiewicz et al., 2020; Kisvetrová et al., 2022; Ahmed et al., 2021; Srang, 2023). The pension system focuses on financial security in the post-retirement period (Department for Work and Pensions, 2006; Xia et al., 2025).

In practice, these three systems are interconnected in supporting the well-being of the old-age population. However, policy decisions often fail to account for these interconnections, instead focusing narrowly on individual systems. For example, changes in the state pension age (SPA) may be framed as a pension-specific measure aimed at improving the fiscal sustainability of the pension system (Department for Work and Pensions, 2013; Cribb, Emmerson, Johnson, et al., 2023a). Yet such changes can have significant effects on the health and long-term care systems, effects rarely addressed in the formulation of pension policy.

Regarding the effects on the health care system from extended working years resulting from changes to the SPA, the evidence remains inconclusive. Some studies suggest that working longer may lead to a higher burden of complex health needs during retirement (Saporta-Eksten et al., 2021) and reduced opportunities for leisure and social engagement (Saporta-Eksten et al., 2021; Inukai, 2025). Other studies, however, find that longer working lives can improve health outcomes (e.g., Fitzpatrick & Moore, 2018; Banks et al., 2025), while some argue that the effects depend

largely on the type and conditions of work (Giesecke, 2019). There is also evidence highlighting no adverse health risks for the older population who work longer (Farrow & Reynolds, 2012), and in some cases, the effects are muted or even positive - particularly for men or in relation to specific job contracts and occupational settings (Baxter et al., 2021).

In the long-term care system, evidence indicates that changes in SPA often affect patterns of informal care provision. Policy simulations suggest that some individuals may stop providing informal care due to increased work demands resulting from delayed retirement (Fischer & Korfhage, 2021), while others may reduce the intensity of care (Carrino et al., 2021). These changes in the pattern of informal care provision can lead to increased demand for formal long-term care services and means-tested support for older people (Bancalari & Zaranko, 2024). While some of these demands may be met through privately purchased services, which place additional financial pressure on individuals, others may rely on publicly funded care, thereby raising adult social care expenditure (Roland et al., 2022). Alternatively, if this growing need for care is unmet, it may result in poorer health outcomes over time and, consequently, increased demand for health care (Fernandez et al., 2020).

Noting these interconnections across the three systems, public policy responses in England that address specific issues within each of the old-age support systems have often developed in silos. In essence, the systems themselves are not entirely fragmented; rather, it is the policy responses to challenges within each system that often fail to account for other cross-system effects. This siloed approach to policymaking is seen as a persistent challenge to the system (Richards et al., 2023), particularly in efforts to support the well-being of the older population. Supporting this population requires designing system features and implementing policy changes that consider the unintended effects on other systems, while keeping in mind the higher-level goal of enabling people to live well in old age.

In this paper, we provide a comprehensive overview of three old-age support systems (health

care, long-term care, and pensions) in England, describing their structure and functioning, and reviewing their historical development and current planned changes. We also assess the sustainability potential of the scheduled changes using our sustainability checklist. This paper makes three contributions. First, we highlight that the three old-age support systems are interconnected, both institutionally, through shared actors involved in policy formulation, funding allocation, among others. Traditionally, these systems have been viewed as independent structures that support older people to live well. Our study, however, demonstrates their diverse interconnections, while emphasising that any changes to one system can have a significant impact on others.

Second, we demonstrate that the pattern of policy evolution across the three systems has been siloed and has mostly occurred following global shocks. Specifically, our review of historic policy changes across the three systems between 1908 and 2023 indicates that for every five policy changes, four distinctly targeted a specific system. About 16% of the policy changes have addressed issues related across more than one system. In addition, about 84% of the policy changes during this period occurred in clusters during or shortly after major global events, a pattern that closely mimics reactionary, short-term responses to policy formulation. This pattern is also reflected in the parliamentary debates, which mostly focused on immediate service delivery and benefit provision, both of which are short-term in focus (Page et al., 2024).

Finally, our review of the scheduled changes to the three systems shows potential for unexpected effects on the specific system and other interconnected systems. For example, the inheritance tax on unused pensions and death benefits, together with the pension investment review, which are the two scheduled changes to the pension system, are designed to expand government revenue and reduce risks to savings and investment, but they may also create disincentives to save. Similarly, with respect to the scheduled changes targeting the healthcare system, although they align with all the sustainability dimensions described in this paper, they lack clarity regarding the guaranteed package of services and the scope of publicly provided services. Overall, while

these scheduled changes represent important steps toward sustainability, the limitations highlighted in this study underscore the need for a more comprehensive framework to assess the sustainability potential of policies targeting the three old-age support systems.

Background: Relevant Population Trends

There has been a steady increase in life expectancy over the past few decades. In 2000, around one in six people in England were aged 65 years and over (15.8%), increasing to around one in five people in 2023 - 18.7% (Office for National Statistics, 2023b). This trend is further projected to continue, reaching 23.9% (one in four people) by 2039 (Office for National Statistics, 2024b). One factor that is driving this trend is the declining fertility rate over the years (Office for National Statistics, 2024b). Between 2000 and 2023, the total fertility rate for England and Wales decreased from an average of 1.65 children per woman over their lifetime to 1.44 (Office for National Statistics, 2023a), which is the lowest ever recorded rate.

Supporting this growing population of older people has remained a policy concern For example, the total pensioner benefits (total expenditure on state pension, pension credit, pensioner housing benefit and winter fuel payment) rose from £48.8 billion in 2000/01 fiscal year to £138.2 billion in 2023/24 period (Office for Budget Responsibility, 2025), almost three fold increase in over two decades. This expenditure is further projected to reach about £172.15 billion in the 2028/29 fiscal year (Office for Budget Responsibility, 2025), equivalent to 5.34% of total GDP.

Adult social care, a type of support for people 65 years and older, is primarily provided by local authorities and accounts for around 60% of total social care grants[1] (Foster, 2025). This expenditure has also increased over the years. Between 2010/11 and 2023/24 fiscal years, the

[1] 40% of social care grants are spent on children's social care.

average percentage of adult social care spending as a proportion of total net current expenditure for local authorities in England increased from 12% to 17% (Foster, 2025). Furthermore, 81% of local authorities planned to overspend on their adult social care budgets in 2024/25, up from 72% in 2023/24 (Association of Directors of Adult Social Services, 2024). This increase in spending suggests that local authorities would be under significant financial strain due to their limited sources of revenue generation (Sandford & Brien, 2024).

While funding demands associated with supporting the older population continue to rise, the government's ability to generate the revenue required to meet these obligations is simultaneously undermined by demographic changes. Revenue raised through taxation of older people is lower than that from the working-age population (those below 65 years), primarily because older people tend to have lower earned income and reduced taxable consumption (OECD, 2020). Specifically, income tax, National Insurance contributions, and value-added tax, which are the three largest sources of government revenue in England, are predominantly generated by the working-age population (Warner, 2022). As the proportion of the working-age population is projected to decline by 370,000 people between 2023 and 2040 (CBRE, 2023). This tax base will further decline, resulting in fewer contributors to sustain the growing costs of supporting the older population.

These demographic changes and the resulting fiscal pressures are not the only factors that influence the government's spending on the ageing population. The degree to which they prioritise spending also depends on their ideological orientation and policy agenda. This ideological influence is further evident in policy reforms that targeted the 'sustainability' of the state pension system in England (Berry, 2016), in policy changes in the health and adult social care system (Birrel, 2007; Taylor-Gooby, 2013), and in general, the re-designing of the British welfare system (Adam & Güçeri, 2025). More broadly, these ideological orientations shape policymakers' shared, interrelated beliefs about how societies are organised (Corcoran et al., 2020) and which sectors of society should be prioritised for government spending.

The extent of support available to this growing population of older people from family members represents another challenge, particularly in light of changing family structures (Broese Van Groenou & De Boer, 2016; Evandrou et al., 2024; Pomeroy & Fiori, 2025) and changing job arrangements (Plaisier et al., 2015), both of which influence the supply and nature of informal care. Over the past decade, the proportion of married-couple families declined from 67% in 2012 to 65.2% in 2022 (Office for National Statistics, 2023b), while the share of families without children rose from 42.1% to 42.9%. In the same period, more older people are living alone: among men, the proportion rose from 15.25% to 19.65%, and among women, from 28.55% to 30.5% (Office for National Statistics, 2023b). These shifts in household composition may reduce the availability of informal caregivers for the older population (Evandrou et al., 2024), and even for households with children, the extent to which adult children perform informal care responsibilities depends on the nature and demands of their employment (Henz, 2006; Horrell et al., 2014 ; Plaisier et al., 2015).

Review Methodology

This review adopts a scoping methodology to explore three questions:

a) What are the elements of the three old-age support systems, in terms of actors and mechanisms of operation?
b) To what extent have there been policy changes within the systems over the years?
c) What are the scheduled changes and discussions that are aimed towards the sustainability of the systems?

Identification of Relevant Studies/Documents

We considered only those studies related to pension, health care, and long-term care systems in England. We reviewed policy documents, legislation, grey literature, and peer-reviewed

publications relevant to these three systems.[2] These materials were sourced from the websites of relevant national institutions, including the UK Parliament (specifically Hansard, the official report of all Parliamentary debates), the Department for Work and Pensions, the Department of Health and Social Care, HM Treasury, NHS England, and the Office for National Statistics (ONS).

We also sourced documents from other institutions whose work directly relates to one or more of the three systems, including the Pensions Policy Institute, The King's Fund, the Nuffield Trust, the Institute for Fiscal Studies, the Office for Health Improvement & Disparities, Care England, AgeUK, and the Care Quality Commission. In addition, we collected peer-reviewed literature from the Web of Science, PubMed, CINAHL, ECONLIT, MEDLINE, and SOCINDEX. These databases comprise diverse repositories of peer-reviewed literature in health care, long-term care, and pensions.

In this review, the term "system" refers to a broad institutional structure comprising interconnected operational elements and processes that function collectively towards a common goal. For "health care", we refer to the institution of healthcare service delivery in England – primarily the National Health Service. For "long-term care", we refer to adult social care services provided in various settings, including home-based care and residential or nursing home care. For "pension", our interest is the sources of income for the older population. These sources include state pensions, workplace pensions, or private pension schemes, as available in England.

Inclusion Criteria and Quality Check

We include peer-reviewed and grey literature with varying study designs or methodologies, published in English, and focusing on at least one of the three old-age support systems. Our review

[2] This initial search resulted in the production of three overview papers that describes these three systems in depth, including describing the historic evolution of policies that target these three systems, the implication of those policies on different demographic groups, and contemporary policies within these systems and their implication for sustainability. In this review, these discussions are now updated, but these papers form the foundation for this current review.

does not impose any date restriction on selecting studies, as it covers both historical and contemporary literature.

We followed a three-stage screening process to assess both the quality and relevance of the documents for this review. In the first stage, one researcher conducted a comprehensive review and documentation of the available evidence related to the three systems. In the second stage, this researcher, together with other members of the research team, reviewed the documented evidence. Decisions regarding inclusion or exclusion were made by consensus. In the third stage, the same researcher conducted a final review of the documented literature, while other team members further checked the documentation to ensure completeness in answering the research questions.

Data Extraction and Analysis

To review the different systems and policy changes, we collected information on the system being considered, the specific policy, the year of the change, and the objectives of those changes. The information collected was subsequently synthesised for this review.

We considered the full scope of old-age support systems, including both the public (i.e., services and benefits funded or provided by the government, including the NHS, state pension, and adult social care funded by local authorities) and private components (such as private pensions and self-funded care). Where relevant, references to specific components of the system are clearly indicated and justified throughout the discussion to minimise confusion for readers.

The Three Old-Age Support Systems

Description of the Three Systems

To streamline the discussion of the workings of the three old-age support systems, we begin by explicitly defining them and outlining our rationale for their selection. The pension, healthcare, and long-term care systems have been chosen because they collectively address essential dimensions of well-being and financial security in old age. They can be thought of as a “system of

systems" that supports people to live well in old age. In this section, we will describe them in no particular order.

The primary objective of the **pension system** is to ensure financial security for individuals as they age by providing income to support consumption and reduce the risk of poverty in old age (OECD, 2018). Within the pension system are the State Pension (SP), workplace pension schemes (WP), and private pensions (PP).

Unlike the WP and PP, which are primarily defined contribution schemes – where the final benefits received by individuals depend on the amount contributed and the investment returns generated, with the investment risk borne by the individual (Cribb & Karjalainen, 2023) - the SP is an income provided to individuals who have reached the State Pension age (66 years and above). The SP operates on a Pay-As-You-Go (PAYG) framework, such that today's workers finance today's retirees. It is a defined benefit scheme, with entitlement based on an individual's National Insurance contributions – a mandatory payment by workers and employers to the government, used primarily to fund various state benefits and services. It also accounts for an estimated 42% of total government expenditure on welfare (Office for Budget Responsibility, 2025) and constitutes 71% of income for the poorest fifth of individuals within the ages of 66 and 70 years, and 23% of income for the richest fifth (Cribb, Emmerson, Johnson, et al., 2023b).

The primary objective of the public health care system (i.e., the **National Health Service - NHS)** is to provide comprehensive, universal, high-quality healthcare that is free at the point of use, by ensuring equal access for everyone based on clinical need rather than the ability to pay. Although one section of the NHS relates to strategy, policy, and management, the provision of medical and clinical care section covers the delivery of primary care (Community Care, GPs, Dentists, Pharmacists, etc.), secondary care (hospital-based care accessed through GP referral), and tertiary care (specialist hospitals) (Grosios et al., 2010).

For the **long-term care (LTC) system,** the primary objective is to provide support and assistance to individuals - specifically, in this study, old people - who experience difficulties performing daily activities independently due to chronic illnesses, disability, cognitive impairment, or frailty associated with ageing. This system comprises a range of support services delivered in various settings by different caregivers, both formal (paid-for) and informal (unpaid), to enable service users to live as independently and safely as possible (National Institute of Aging, 2025). Broadly, support services within this system can take the form of institutional (facility-based) care or community-based care (NHS England, 2023).

Elements of the Systems

Figure 1 provides an overview of the elements of the three old-age support systems in England. The leadership responsible for setting strategic priorities for these systems is represented at the top of the Figure. The respective government departments associated with the three systems are HM Treasury, the Department for Work and Pensions (DWP), and the Department of Health and Social Care (DHSC). HM Treasury is responsible for ensuring fiscal sustainability and allocating funds to both the DWP and the DHSC. The DWP (responsible for pensions) and DHSC (responsible for health and long-term care) are the two primary institutions overseeing the three systems. They are responsible for policy design, oversight of policy implementation, and funding allocation to the systems they oversee. Based on this institutional structure, the three systems are interconnected.

The second tier, as illustrated in Figure 1, comprises regulatory and advisory bodies that establish standards, monitor compliance, and provide technical guidance. The pension system includes occupational and private pensions, which are additional components alongside the state pension. The Pensions Regulator (TPR) oversees the governance, integrity, and security of the workplace (i.e., occupational) pension schemes (Clark, 2022). The Pension Protection Fund (PPF) provides a statutory safety net for members of eligible occupational defined benefit schemes that become insolvent (Pension protection Fund, 2024), and it offers compensation where employers are

unable to meet their pension obligations to scheme members (Pension Protection Fund, 2025). Meanwhile, the Financial Conduct Authority (FCA) is responsible for regulating financial service providers that offer private pensions.[3] It ensures consumer protection in case of insolvency (Financial Conduct Authority, 2025) and promotes healthy competition among financial service providers (Financial Conduct Authority, 2024).

In the healthcare and long-term care systems, the Care Quality Commission (CQC) regulates the quality of care across both systems (Rayner, 2022), while the National Institute for Health and Care Excellence (NICE) develops evidence-based guidelines that inform service delivery and resource allocation within the NHS (Garbi, 2021). Although these regulatory bodies operate under distinct mandates, they collectively ensure accountability in the delivery of health and adult social care services and help maintain standards and quality across the sector (Baguma & Obeta, 2020).

The third tier consists of commissioners and planners who operationalise policy objectives and coordinate service delivery at the local level. For example, the Integrated Care Systems (ICSs) are "local partnerships that bring health and care organisations together to develop shared plans and joined-up services"[4]. The ICS consist of two bodies – the Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). While ICBs are the statutory bodies responsible for planning and funding most NHS-localised services, ICPs are statutory committees that bring together a broad range of partners, including social care providers, the voluntary, community and social enterprise sector, among others, to develop a health and care strategy that is unique to the local needs of the population.[5] ICBs and ICPs are jointly responsible for planning and commissioning NHS services within defined geographic areas and for facilitating collaboration among system

[3] See https://committees.parliament.uk/writtenevidence/106296/pdf/
[4] see https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
[5] See https://www.england.nhs.uk/integratedcare/what-is-integrated-care/.

partners to address the broader healthcare, public health, and social care needs of the local population (Charles, 2022). Although these institutions have distinct roles and responsibilities, they are designed to work together within the broader Integrated Care Systems (ICSs).

Local authorities retain statutory responsibility for assessing an individual's long-term care needs, determining eligibility, and commissioning adult social care services. They also engage in broader market-shaping activities to ensure sufficient provider capacity (Davies et al., 2021, 2022). For this reason, local authorities are positioned between the third tier and service providers, reflecting the fact that planning and commissioning bodies collaborate with the local authorities to link the national policy goals set at Tier 1 and 2 with the care needs of local service users.

Service delivery is carried out by a diverse set of providers. In the pension system, there are two broad types of pension schemes: defined contribution schemes (including private and occupational pensions) and defined benefit schemes (primarily the State Pension). The DWP directly manages the State Pension through its Pensions Service unit. In the health care system, service providers include NHS Trusts, which deliver secondary and tertiary care, and General Practitioners (GPs), who provide primary health care. In the long-term care system, service providers include local authority-operated services and a range of private and voluntary providers. Overall, these providers deliver services that directly affect the well-being of the older population, although they often operate under different mechanisms and principles, as discussed in the next subsection.

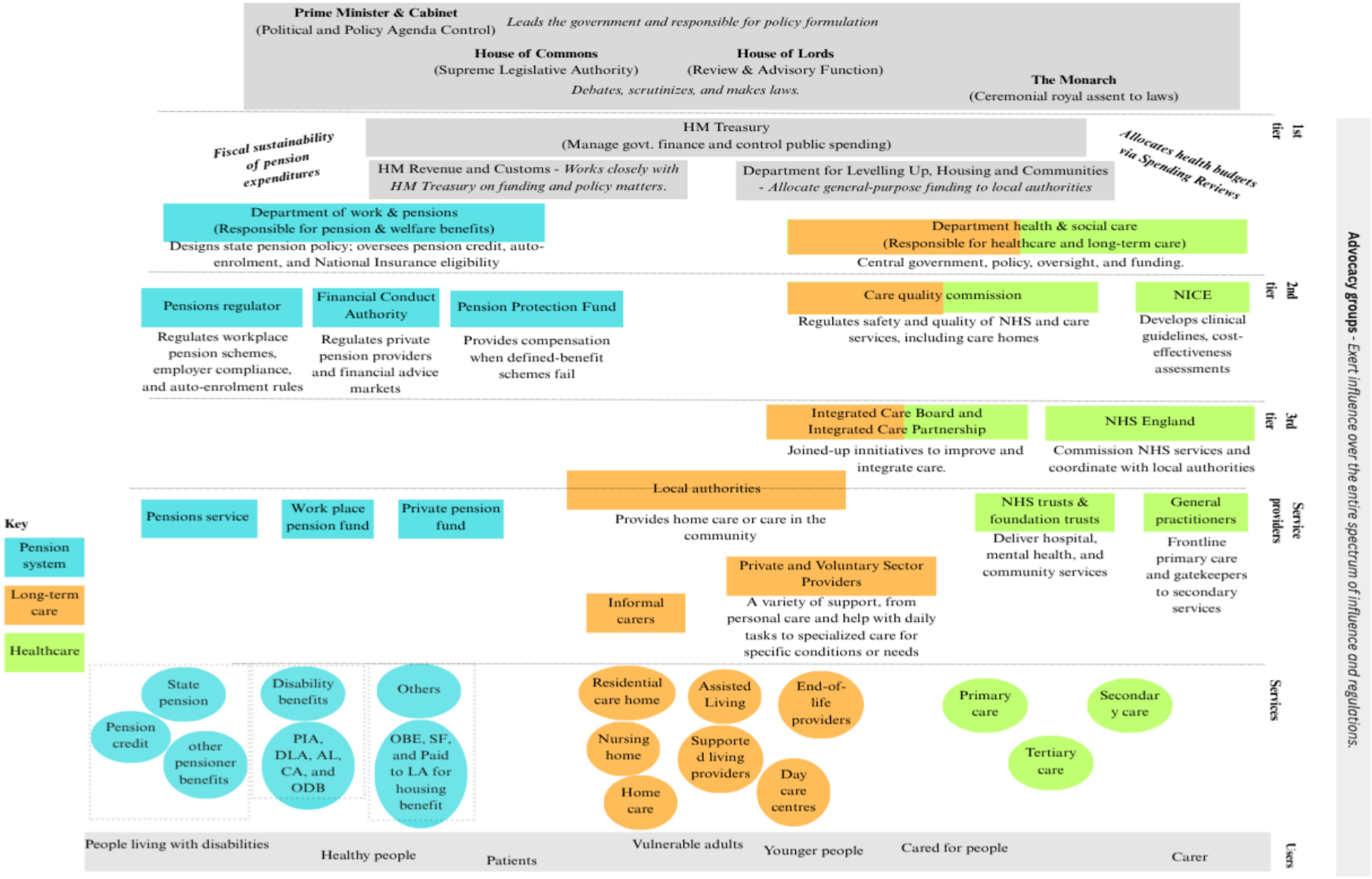

Figure 1: Overview of the Three Old Age Support Systems

Note: While not comprehensive, this figure illustrates the structure and governance of pension, long-term care, and healthcare systems in England. PIA- Personal Independence allowance; DLA- disability living allowance; AA – Attendance Allowance; CA- Carer's Allowance; ODB – other disability benefits; PLA-HB – Paid to local authorities for housing benefit; SF – Social Fund; OBE – Other Benefit Expenditure (see Hobson et al., 2022, Page 20).

Mechanisms and Principles of the Old Age Support Systems

As described earlier, the old-age support system includes both private components, such as private pensions and self-funded health and care, and public components. Unlike the public support systems, which are guided by clear funding mechanisms and access principles, the private components are governed by individual responsibility and market-based principles that vary by providers (Antos, 2015; Bonizzi et al., 2023; Needham et al., 2017). Figure 2 summarises the distinct funding mechanisms and access principles that govern the public component of the three systems.

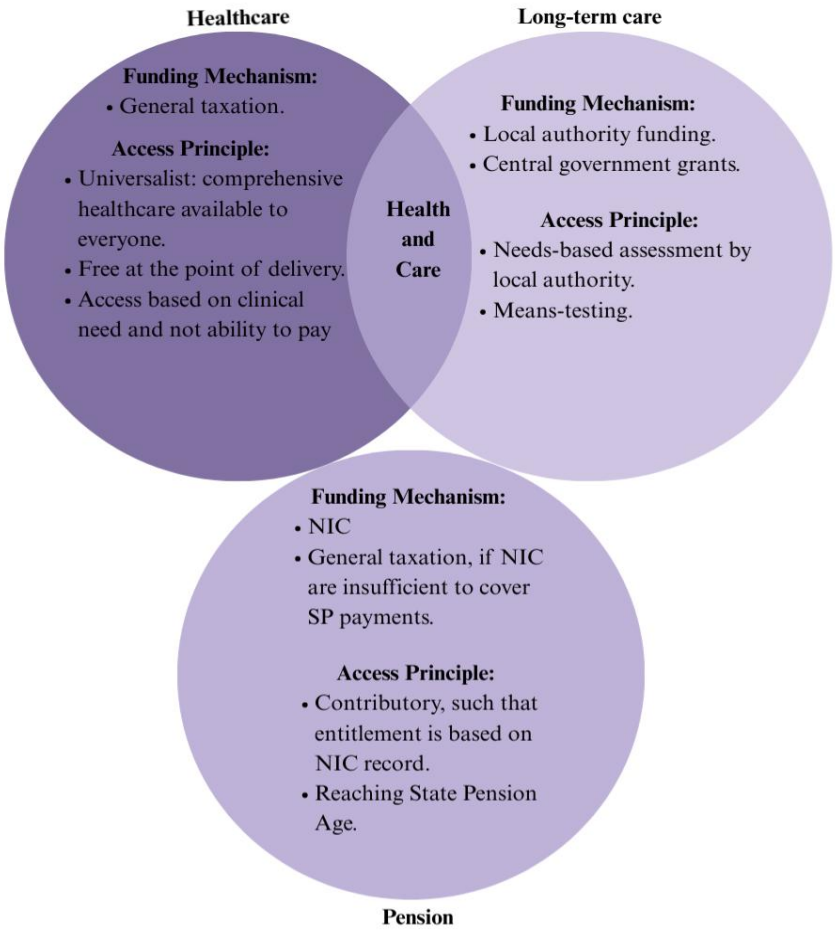

Figure 2: Summary of the Funding Mechanism and Access Principles of the Publicly Provided Components of the Three Old-age Support Systems

The publicly provided components of the pension system are based on the principles of contributory entitlements (e.g., the state pension) and welfare (e.g., the pension credit). The state pension system is primarily funded through National Insurance Contributions (NICs), collected

from both employees and employers, and is supplemented by general taxation to fund means-tested benefits, such as Pension Credit (Department for Work and Pensions, 2025a; O'Brien et al., 2024). The private pension is funded by the individual or their employer, and returns are not guaranteed; they depend on investment performance.

The public component of healthcare is predominantly funded through general taxation, with other sources including National Insurance Contributions and patient charges. They account for approximately 1% for services such as prescriptions and dental treatment (Arnold et al., 2025; Arnold & Jefferies, 2025). Private healthcare, by contrast, provides additional or supplementary services - and in some cases a wider range of services – at the individual's own expense.

The long-term care system operates under a mixed funding model, comprising local government revenues (e.g., council tax and business rates), central government grants, including ring-fenced social care grants from the DHSC, and means-tested contributions from service users (Foster, 2025). In the private component, individuals fund their care through savings, investments, or other assets.

The underlying principles for accessing these support systems vary by system. For state pensions, eligibility depends on reaching the state pension age (Department for Work and Pensions, 2023), currently 66 years in England, and on having a minimum number of qualifying years required for full or partial entitlement (O'Brien et al., 2024). Currently, an individual must have 35 qualifying years on their National Insurance record to receive the full new State Pension or at least 10 qualifying years to receive any State Pension (Low Income Tax Reform Group, 2025). Individuals who supplement their State Pension through workplace or private pension schemes can access their savings or investments at age 55 (Mirza-Davies, 2024) or earlier, depending on certain circumstances such as serious ill health (HM Revenue & Customs, 2021).

NHS services are universally available to all residents based on need and free at the point of use

(Wickens & Brown, 2023). However, these services are supplemented by private healthcare (Goodair & Reeves, 2022; Propper, 2000), which provides additional access to care based on the ability to pay and offers supplementary services at additional cost to the individual or their employer.

For adult social care, which constitutes the publicly provided component of the long-term care system, access is statutorily means-tested to determine eligibility for services. Local authorities are responsible for conducting such an assessment (Roland et al., 2022). Following this process, individuals with assets exceeding £23,250 are required to self-fund their care (Bancalari & Zaranko, 2024). Those who do not meet this criterion or who require additional care resort to self-funding (Whitehead et al., 2022).

Analysis of Historical Policy Changes in the Old-age Support Systems

Overlapping Timeline of Policy Changes

Table A1 in the appendix provides a detailed historical overview of some of the most prominent policy changes in England related to pension, health care, and long-term care systems. Between 1908 and 1929, these changes included the Pensions Act (PA) 1908, the National Insurance Act (NIA) 1911, the Ministry of Health Act (MHA) 1919, the National Insurance Act (NIA) 1925, and the Local Government Act (LGA) 1929. These were the earliest policies that laid the foundation for the welfare system, particularly through the emergence of state responsibility for supporting old-age people and reducing poverty (PA 1908), differentiating the models used to fund health insurance and pensions (NIA 1911, 1925), and structuring healthcare service delivery and responsibilities (MHA 1919 and LGA 1929).

The period from the 1940s onward saw the institutionalisation of the welfare system through the passage of the National Insurance Act 1946, the National Assistance Act (NAA) 1948, and the founding of the National Health Service (NHS) in 1948 (see Table A1 in the appendix). These foundational policy changes aimed to establish a comprehensive welfare state, comprising

pension and unemployment benefits, as well as a means-tested safety net to support individuals in need (Crafts, 2024; Gladstone et al., 1999; Timmins, 2024). The changes also brought about the institutionalisation of a universal, nationalised health care system that provided free health care at the point of use to reduce inequalities and improve access (Clement, 2023; Delamothe, 2008; Greengross et al., 1999; Smith & Tudor, 2018).

The 1970s saw structural adjustments to the welfare system with the passage of the NHS Reorganisation Act (NHSA) 1973 and the Social Security Pensions Act (SSPA) 1978. One significant reform under the NHSA involved restructuring the NHS by transitioning from a tripartite system – where hospital, primary care, and community health services were managed separately - to a more unified model. This included the establishment of Regional and Area Health Authorities and the integration of local authority health services (such as health visiting and community clinics) with hospital and primary care services under a single NHS management structure (Battistella & Chester, 1973; Begley & Sheard, 2019; Jonas & Banta, 1975; Maile et al., 2022; Price et al., 2019). Another major policy shift under the 1978 SSPA linked pension benefits to individuals' earnings and contributions (Hobson et al., 2024; Scottish Public Pensions Agency, 2025, 2025).

Margaret Thatcher's government led the privatisation agenda in the 1980s, which was central to reducing the state's role in the economy by promoting private ownership and reducing public sector borrowing.[6] The 1980 Health Services Act led to the reorganisation of NHS administration and the outsourcing of health services, while the 1980 Social Security Act played a significant role in the privatisation of the social security system in England, affecting long-term care. The 1986 Financial Services Act introduced personal pensions, allowing both individuals and employers to contribute by 1988.

[6] See Privatising the UK's nationalised industries in the1980s - Centre for Public Impact

The 1990s marked a significant shift in the health and long-term care systems, particularly with the passage of the National Health Service and Community Care Act 1990. This legislation introduced more market-oriented service delivery by creating NHS trusts and modifying social care delivery mechanisms managed by local authorities. According to policy documents, the aim of these changes was to improve health service delivery by allowing NHS trusts to borrow money, generate income, and raise revenue directly through service provision (The Health Foundation, 2025a).

Other policy and institutional changes since 2000 included the founding of the Pensions Commission (PC) in 2002, the introduction of the Payments by Results regime (PbR) in 2002, the NHS Act (NHSA) 2006, the Pensions Act (PA) 2008, and the Health and Social Care Act (HSCA) 2008. These reforms affected pension, health care, and long-term care systems in different ways. For pensions, the PC's recommendations focused on the sustainability and adequacy of the system. The PC proposed raising the State Pension Age (SPA), linking pensions to earnings for indexation, and introducing automatic enrolment. These measures aimed to ensure the long-term viability of the State Pension, both in terms of government fund capacity and in maintaining pension value in real terms despite inflation (Turner et al., 2004; Department for Work and Pensions, 2006). The recommendation for automatic enrolment led to the subsequent passage of the 2008 PA, which aimed to improve pension participation among individuals aged 22 up to the SPA who earn more than £10,000 annually (Department for Work and Pensions, 2023; Kennedy, 2023; Massala & Pearce, 2022).

In the health care system, reforms during this period established a market-oriented framework by tying hospital reimbursement to the number of patients treated at a fixed rate (Charlesworth et al., 2014; Maybin, 2007). The NHSA 2006 promoted patient involvement in care (NHS England, 2017), while the HSCA 2008 focused on improving the quality of care (Department of Health and Social Care, 2022b). Specifically, it led to the establishment of the Care Quality Commission to

strengthen oversight and accountability in health and adult social care delivery (Department of Health and Social Care, 2022a).

Reforms between 2010 and 2020 targeted changes across all three systems. In pensions, these included the introduction of the triple lock in 2010, the 2011 and 2014 Pensions Acts, and the launch of the single-tier State Pension in 2016. These policies aimed to ensure the long-term sustainability and adequacy of the pension system. The triple lock guaranteed real-term growth in the State Pension by linking increases to the highest of inflation, average earnings growth, or 2.5% annually (Department for Work and Pensions, 2025b; Hobson et al., 2023; Kirk-Wade, 2023). However, the policy later led to an increased fiscal burden (Cribb, Emmerson, & Karjalainen, 2023). In response, the government accelerated the increase of the SPA through the 2011 and 2014 Acts (Department for Work and Pensions, 2023; Hobson, 2023). The single-tier pension, introduced in 2016, aimed to simplify the system, reinforce the contributory principle based on National Insurance, and reduce inequality caused by earnings-based variation in benefits (Department for Work and Pensions, 2013).

In health care and long-term care, the 2012 HSCA extended the market-based principles and competition in service delivery (Department of Health, 2012; The Health Foundation, 2025b), while the 2014 Care Act clarified the roles and responsibilities of local authorities in managing and delivering long-term care (Care Quality Commission, 2022; CarersUK, 2020).

The two major policy changes since 2020 are the Health and Care Act (HCA) 2022 and the Pension Act (PA) 2023. The HCA aimed to deepen integration and reduce market competition in health care and long-term care, while also strengthening accountability and promoting proactive public health interventions. For example, the Act established Integrated Care Systems (ICSs), comprising Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), to improve coordination among health, LTC, and public health services at the local level, and ensure that interventions are tailored to local population needs (Department of Health and Social Care,

2025a; Murray, 2022). Additionally, the Act repealed the competition rules introduced under the 2012 Health and Social Care Act, marking a shift from market-based tendering and toward more collaborative service delivery (BMA, 2024). It also introduced a cap on personal care costs, strengthened NHS accountability (Holmes, 2022), and promoted public health through measures, such as restrictions on junk food advertising (Department of Health and Social Care, 2025b).

The 2023 PA focused on expanding access to the pension system by granting the Secretary of State the authority to lower the minimum age for automatic enrolment to 18 and to reduce the qualifying earnings threshold to £0.[7] As a result, automatic enrolment now includes younger individuals (aged 18 to 21) and low earners who would previously have been excluded (Mirza-Davies & Cunningham, 2025).

Of the thirty one policy changes featured in this review, fifteen were distinctly focused on the pension system, seven on the healthcare system, and four on the long-term care system. Only five of the policies involved changes in more than one system. This distribution of policy changes across the systems is summarised in Figure 3. Overall, the distribution suggests that most policies (about 84%) have focused on single systems, only 16% focused on more than one system.

[7] See legislation here https://www.legislation.gov.uk/ukpga/2023/44/section/1.

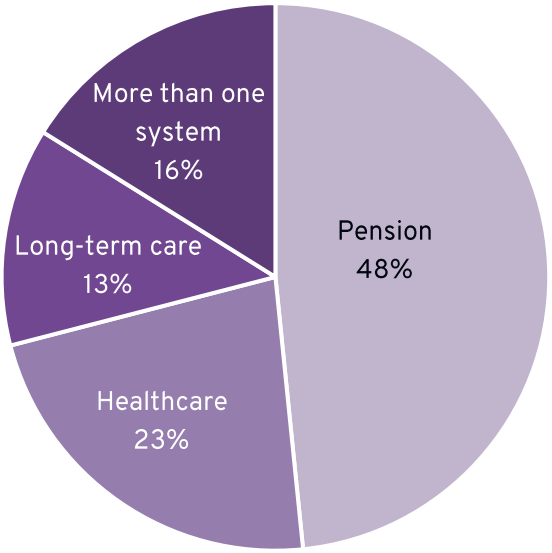

Figure 3: Distribution of Policy Changes across the Old-age Support Systems (1908-2023)
Note: "More than one system" describes instances where a policy targets at least two of the systems.

Clustering Policy Changes and Global Shocks

We further explored the clustering of these policy changes over periods marked by significant social, political, or economic shocks in England. We define large-scale shocks as events with substantial impacts that often compel governments to revise or reform existing policies in response (Hermann, 1990) and cluster policy changes only if they occur during or within five years following shocks. We purposively selected this five-year window to capture the period when governments are most likely to respond to the shocks. Although we do not draw causal conclusions from this exercise, we aim to identify whether any patterns emerge in the timing of policy changes.

Figure 4 presents the number of policy changes clustered with different shocks. It shows that most policy changes (84%) between 1908 and 2023 occurred during periods of significant events, typically linked to wartime government spending, privatisation, or efforts to stabilise the economy following a recession or financial crisis. Specifically, 23% of the policy changes occurred during or immediately after periods of war – namely, World War I (1), World War II (3), and the Global War on Terror (3). Thirty five percent coincided with periods of economic shock, including the Second Industrial Revolution (2), global recessions (2), and the Global Financial Crisis (7), while 19% were

in the period of privatisation. The remaining two policy changes occurred during the COVID-19 pandemic. Only five policies (approximately 16%) could not be linked to any identifiable shock.

In summary, the pattern that emerges from Figure 4 is that the timing and frequency of policy changes are consistent with reactive policymaking across the three old-age support systems in England. Approximately, four in every five policy changes between 1908 and 2023 occurred in clusters during or shortly after significant events. Whether these events directly caused the policy changes is beyond the scope of this review. However, the timing of these changes nonetheless suggests that policy responses across all three systems may have been influenced by pressures arising from these events.

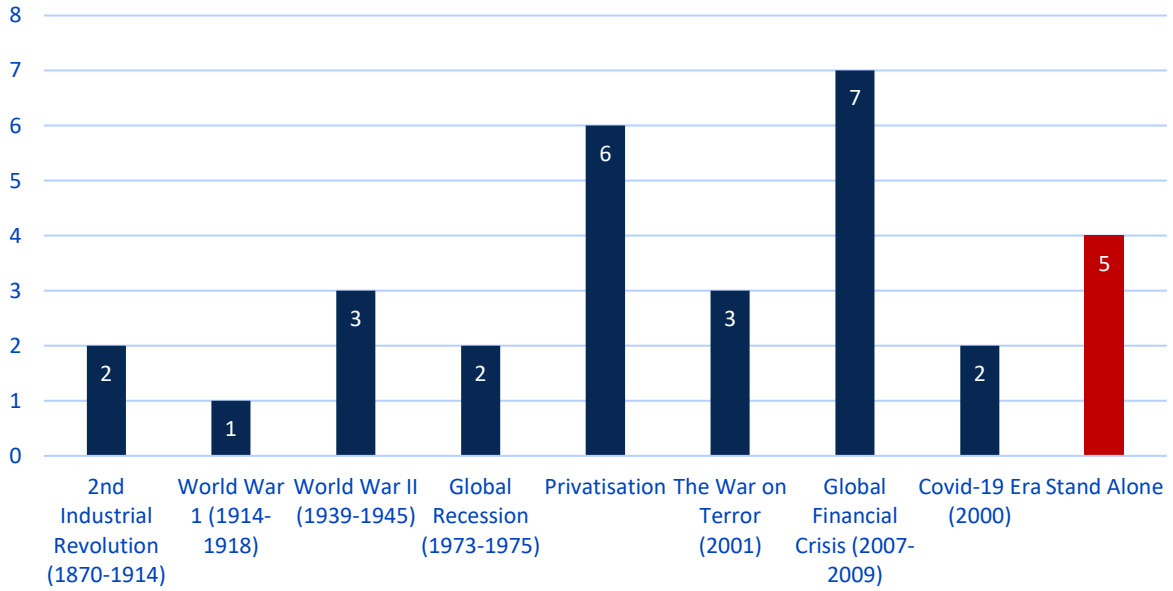

Figure 4: The Number of Policies Coinciding with the Identified Shocks

Note: This figure was generated by counting the number of policy changes corresponding to the identified shocks listed in Table A1. To identify relevant events, we examined each decade between 1908 and 2023 and identified major global events. We then recorded the dates of these events and clustered policy changes that occurred during or within five years following each event. The dates of these events are based on declarations made by global institutions. For example, although the COVID-19 outbreak began in December 2019, the World Health Organisation declared it a pandemic in March 2020. Stand-alone refers to policy changes that could not be clearly linked to any significant shock with an identifiable impact on England.

Scheduled Changes to the Three Systems

Part of the overview of the three systems is the scheduled changes. These are the changes published after July 9, 2024, on the websites of various government departments, including the Department of Health and Social Care, the Department for Work and Pensions, and HM Treasury.

This period corresponds with the change in government leadership in England.

The results of our search reveal the changes across three government initiatives. The first is the *"Fit for the Future: 10 Year Health Plan for England."* This change aims to improve the health system based on three major reforms: (a.) Localising healthcare; (b.) improving workforce and system productivity that leverages modern technology to deliver the best healthcare by enhancing training, leverages modern technology, harnessing data, and promoting health research and development; and (c.) focusing health and care on prevention by embedding health in all government policies, promoting healthy lifestyles, and addressing health inequalities (see Table 2 for a comprehensive description of the changes).

The second change is outlined in the Pensions Investment Review (PIR), which was launched in July 2024 by the Labour Government. This reform seeks to achieve scale and promote consolidation within the Defined Contribution (DC) scheme market. The rationale is that larger and better-managed schemes are more capable of delivering stronger returns for savers while also mobilising capital for domestic investment in the UK economy (Department for Work & Pensions, 2024; HM Treasury et al., 2025).

To achieve this scale in the DC scheme market, the proposed mechanisms include setting a minimum asset threshold for pension providers and master trusts (between £25 and £50 billion in assets under management) and reducing the number of standard investment options available in the marketplace (i.e., default arrangements). These measures are intended to ensure that savers benefit from larger, better-managed schemes (HM Treasury et al., 2025).

Another change concerning the pension system, as described in Table 2, is the consideration of an individual's pension as part of their estate for inheritance tax purposes. Under this policy option, which is set to take effect from April 2027, pension scheme administrators (PSAs) will be responsible for reporting and paying any Inheritance Tax (IHT) on unused pension funds and death benefits accrued to service users (HM Revenue & Customs, 2024).

Proponents of this change argue that, beyond meeting the government's fiscal needs, it contributes to reducing wealth inequality (Fize et al., 2022; Nekoei & Seim, 2023). Addressing wealth inequality is particularly relevant in England, where children of parents in the wealthiest fifth inherit an average of £830,000, compared to just £180,000 for children of parents in the least wealthy fifth (Advani & Sturrock, 2023). However, some other studies (e.g. Advani & Sturrock, 2023; Fize et al., 2022) contend that IHT alone is insufficient to mitigate the inequality of opportunity created by inherited wealth. While others note that this policy remains unpopular in England (Ansell, 2023).

Debated Policies in Parliament

Apart from the scheduled changes to the three systems, we also present the relevant debates in parliament. The main aim of this exercise is to highlight recurring patterns in the debates' focus. To achieve this aim, we collected information from the UK Parliament website, Hansard, the official record of all Parliamentary debates. We restricted our search to policies since July 9, 2024, with specific keywords that are unique to each of the systems, such as: "state pension", "pension" for the pension system; "NHS", "healthcare", "health" for the healthcare system; and "social care", "long-term care", "adult social care" for the long-term care system. Debates related to foreign policy, even when they reference one of the three systems - such as *"Gaza: Healthcare System Reform"*- were excluded from the review, as they concern systems outside England.

This review is disaggregated by the two chambers of parliament (the House of Commons and the House of Lords). The aim is to broadly explore whether there are differences in patterns, priorities, or perspectives in policy debates over the three old-age support systems. A detailed description of the policy actions is provided in Table A2 in the appendix, and a summary is presented in the Figures in this subsection. Specifically, Figure 5 shows that there were 134 debates across both chambers of parliament. Most of these debates focused on the healthcare system (51 % of all debates), followed by long-term care (27%) and the pension system (22%).

Table 2: Scheduled Changes that will Shape the Three Systems

Source	Description	Scheduled Changes
' *Fit for the Future: 10 Year Health Plan for England, available here Fit for the future: 10 Year Health Plan for England*	A Labour government policy that targets the healthcare system. The aim is to modernise the NHS based on three key policy objectives: a) Hospital to Community, b) Analogue to Digital, and c) Illness to Prevention.	Localising healthcare by: • From hospital to community, by localising healthcare services. • A devolved and diverse NHS operating model. • A new transparency of quality of care Improved workforce and system productivity that leverages modern technology to deliver the best healthcare by: • Moving from analogue to digital. • Upskilling workforce towards an NHS fit for the future. • Innovatively powering transformation to drive reform by leveraging data, AI, and other technology for better service delivery. • Drive productivity and establish a new financial foundation. Focus healthcare on sickness prevention by: • Public health measures to drive healthy living, prevent sickness, and address health inequalities.
Pensions Investment Review by the HM Treasury| DWP | Ministry of Housing, Communities, & Local Government here https://assets.publishing.service.gov.uk/media/	This policy aims to address fragmentation in the defined contribution (DC) workplace pensions market. It also aims to boost investment, increase saver returns by reducing administrative duplication, lowering fees, and streamlining the market from many small schemes into fewer, better-governed large funds.	Scale and consolidation in Defined Contribution Schemes • New scale requirement by requiring providers and master trusts of multi-employed schemes to hold at least £25 billion in assets under management (AUM) in a default arrangement by 2030, while single-employer trusts are not subject to this requirement. • A transition pathway for schemes that can demonstrate a credible plan to reach £25 billion by 2035, provided they have at least £10 billion by 2030. • A separate "new entrant" pathway will allow innovative new products to enter the market with plans to achieve scale over the long term. • To accelerate the consolidation of smaller, underperforming, and legacy schemes, a contractual override mechanism will be introduced through the Pension Schemes Bill, only permitted when certified by an independent expert as being in the savers' best interest.
Inheritance tax on Unused Pension and Death Benefits by the HMRC here https://www.gov.uk/government/publications/reforming-inheritance-tax-unused-	Scheduled to be implemented in April 2027. This policy aims to include most unused pension funds and death benefits in an individual's estate for inheritance tax purposes.	Pension scheme administrators will be responsible for reporting and paying any inheritance tax due on unused pension funds and death benefits. Previously, large, untouched DC pensions were a very tax-efficient way to pass on wealth. This change makes them significantly less so. Under this new policy, pension savings are now treated as an estate and so inheritance tax will not be based on the combined value of the estate, including pension savings and other estates (see HMRC, 2024). Under this regime, the responsibility for paying the inheritance tax is now split between the estate's representative, who pays the portion from the estate and the pension scheme manager, who pays the remaining. • Hence, the tax liability is now split between the pension scheme and the estate, which creates a new process for settling the deceased's affairs.

Note: The Table contains a description of the policy changes that target any of the three old-age support systems.

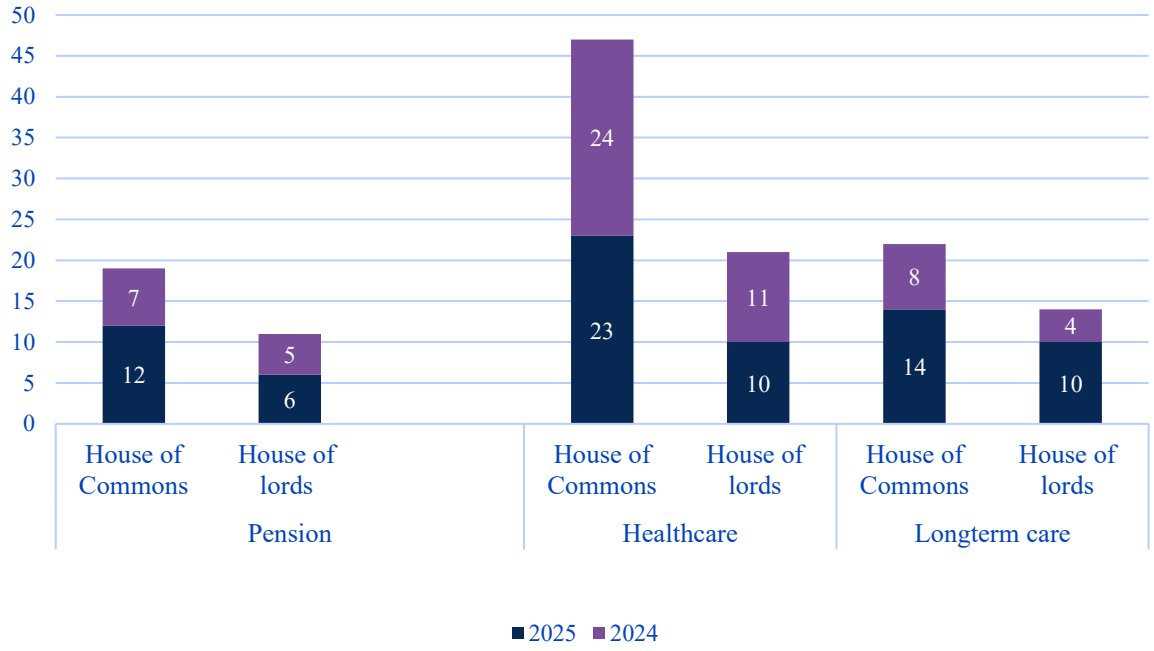

Figure 5: The Number of Policy Debates Targeting the Three Old-Age Systems (July 9, 2024 - June 20, 2025)

In the pension system, debates have primarily focused on government-provided benefits (the state pension age and benefits) and means-tested benefits – particularly Pension Credit (see Figure 6). This emphasis on pension benefits and means-tested benefits accounted for 60% of all pension-related debates during the period, compared to 27% focused on private pension schemes and savings returns, and 13% on regulations or policies aimed at improving efficiency in the private pension market.

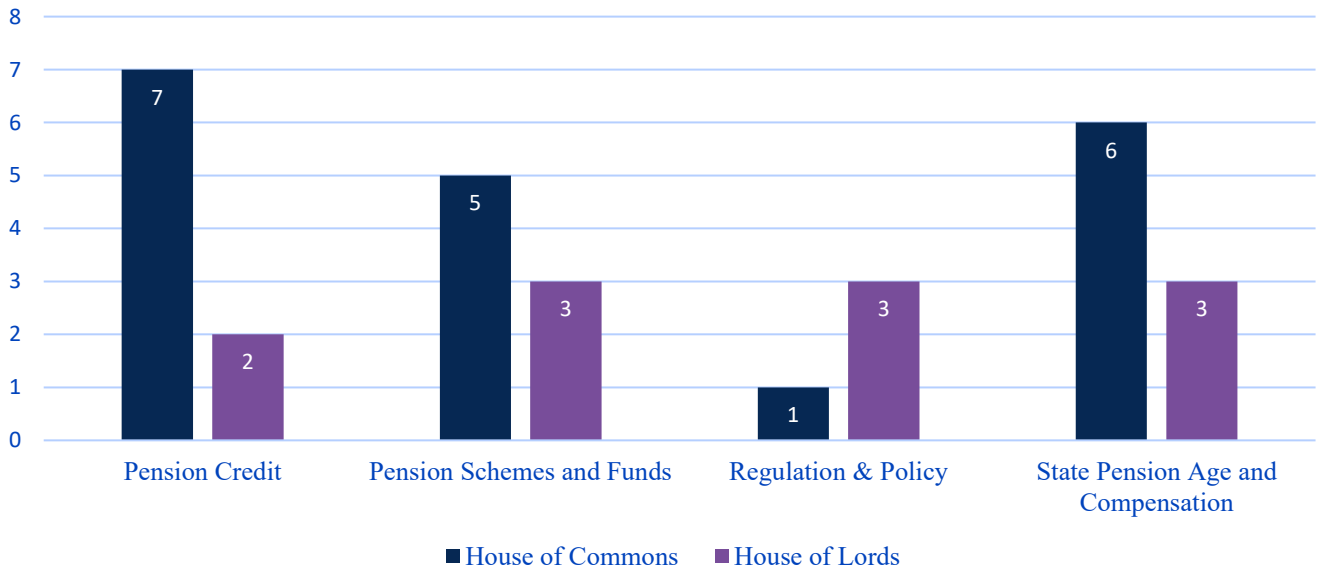

Figure 6: Different Categories of the Debate for the Pension System (July 9, 2024 - June 20, 2025)

Note: The researchers subjectively grouped the debate topics into the categories shown in Figure 5.

For the healthcare system, Figure 7 shows that the primary focus of parliamentary debates has been the operation of service delivery in England. Across both the House of Commons and the House of Lords, 30 debates between July 9, 2024, and June 20, 2025, addressed this topic, accounting for 44% of all health system debates. 22% of the debates in both chambers were focused on the governance and regulation of health service delivery, while debates on access and funding accounted for 13% and 10%, respectively.

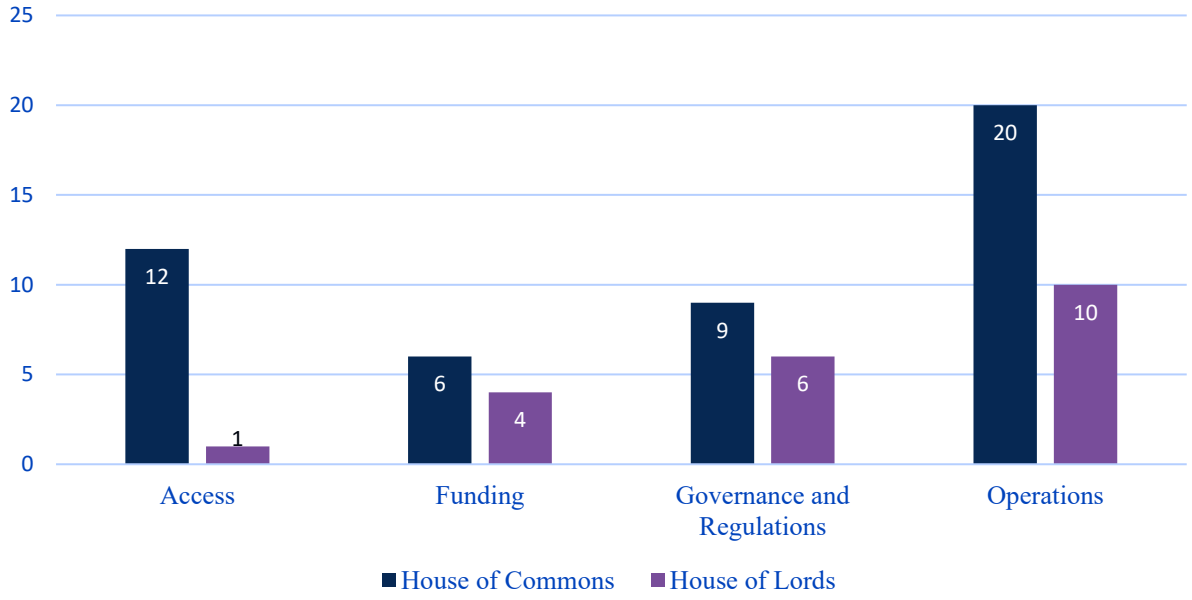

Figure 7: Different Categories of the Debate for the Healthcare System (July 9, 2024 - June 20, 2025)

Note: The categorisation of Parliamentary discussions draws on themes identified in earlier sections, specifically: access (the ability and ease with which individuals can obtain healthcare services when needed), funding, governance and regulation (the frameworks, rules, and oversight structures that guide the healthcare system), and operations (the actual delivery and management of services within the existing regulatory framework). While the researchers subjectively grouped the debate topics into the categories shown in the figure, these categories provide a structured and representative overview of the issues most frequently debated.

Finally, for the long-term care (LTC) system, the review of debates in both chambers indicates that the primary focus has been on the delivery of long-term care services - particularly the scope and provision of care - which accounted for 47% of all debates. Policy, reform, and legislation constituted an additional 39% of the debates during the review period. In contrast, funding of LTC received limited attention (approximately 8%), and only 6% of the debates addressed governance and administration of the LTC system in England.

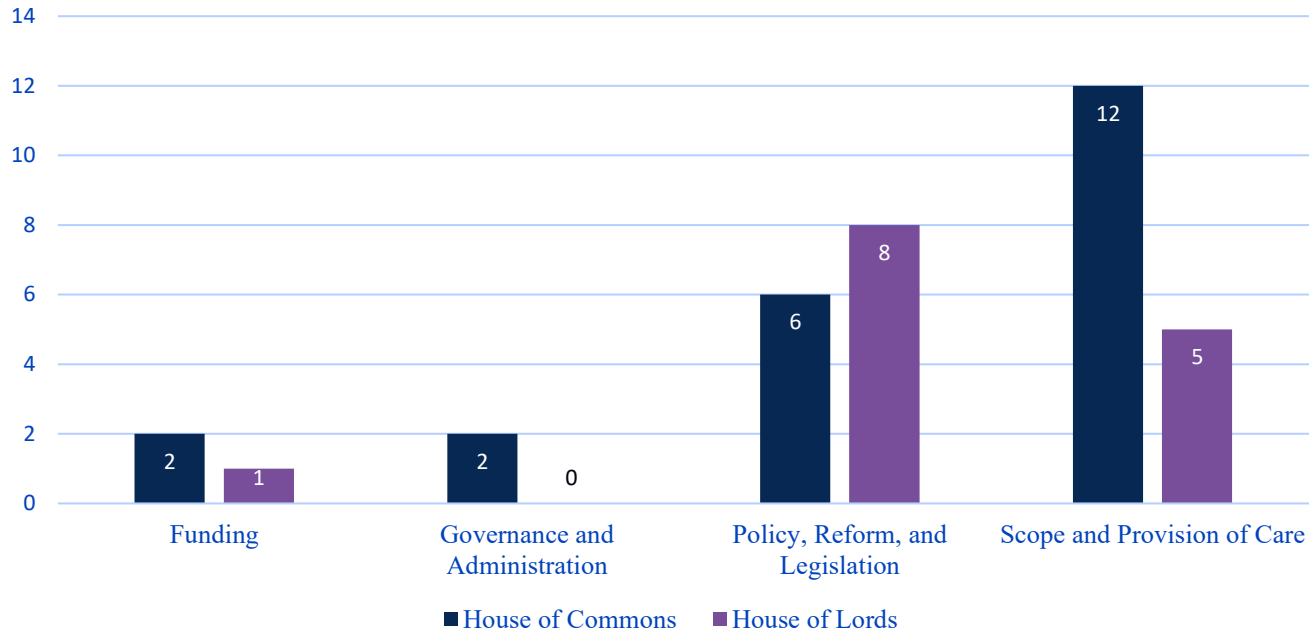

Figure 8: Different Categories of the Debate for the Longterm Care System (July 9, 2024 - June 20, 2025)

Note: The categorisation of long-term care policy debates is based on four themes: (1) Funding. (2). Governance, and administration – focusing on the structures, processes, and oversight or accountability mechanisms that shape the long-term care system; (3) Policy, reform, and legislation – addressing the foundational frameworks, strategic direction, and legal mandates that define how long-term care is conceived, structured, and delivered; and (4) Scope and provision of care – concerning the practical aspects of service delivery. These categories reflect the main themes that emerged from the data and provide a coherent structure for reviewing the focus of Parliamentary debates on long-term care.

In summary, the review of the parliamentary debates shows that political attention to the three systems has been concentrated primarily on immediate service delivery a006Ed benefit provision (see Figures 6 – 8) – namely, the scope and provision of care in long-term care, operational issues in healthcare, and Pension Credit and State Pension compensation in the pension system. These short-term priorities stand in contrast to the broader long-term system sustainability, which has received comparatively limited attention.

Sustainability Check of the Scheduled Changes

In this section, we explore the extent to which the scheduled changes may contribute to the sustainability of the three old-age support systems. Sustainability, defined here according to the

Cambridge Dictionary,[8] is "the quality of being able to continue over a period of time." This definition aligns with the integrative review by Nizalova et al., (2026), which characterises sustainability as a system's ability to maintain its capacity to achieve intended goals and core purpose through continuous adaptation over time.

Based on these foundations, we define the sustainability of the three old-age support systems as their collective capacity to support people in living well in old age, which is maintained across generations. We identify four groups of factors which affect sustainability, which serve as a checklist for analysing changes to these support systems:

(i) A clear definition of what the system promises to deliver and under which conditions (e.g. the amount of the state pension and the eligibility criteria, or the guaranteed healthcare or long-term care package).

(ii) The level of contributions into the system (e.g. the number of employed working-age people who are able to pay NICs, the amount of tax revenue allocated to healthcare funding).

(iii) Factors that contribute to a more efficient conversion of the available funds into the delivered services (e.g. improvements in productivity within the healthcare sector), and

(iv) Factors that reduce the level of need (e.g. disease prevention that reduces healthcare demand and the number of years in need of care).

For the pension system, sustainability is influenced by clarity about the size of the guaranteed package of services, such as the defined level of the State Pension and Pension Credit. It is also influenced by the adequacy and stability of funding through the labour supply and higher productivity that sustain general taxation and national insurance contributions (Cribb, Emmerson, Johnson, et al., 2023b). More so, it is also influenced by improved financial literacy among the

[8] https://dictionary.cambridge.org/dictionary/english/sustainability

population and stronger incentives for savings and investment, as well as reduced risks to accumulated wealth, particularly for private pension arrangements (International Network of Pensions Regulators and Supervisors & Organisation for Economic Co-operation and Development, 2004; J. A. Turner & Rajnes, 2014).

For the healthcare and long-term care systems, first of all, sustainability is influenced by the clarity on the guaranteed package of services and the defined provision of LTC services, since vague promises of "free at the point of care" (for healthcare) services generates risks of funding scarcity in the face of costly medical advancements and increasing longevity. Evidence from other contexts shows that a lack of clarity of coverage creates a gap between what is promised ("de jure") and what is actually delivered ("de facto"), resulting in rationing and increased inequality in access to services (Nguyen & Strizrep, 2019; Sheiman et al., 2018; The World Bank, 2019).

Table 3: Checklist for the Effects of Scheduled Changes on Sustainability of the Old-Age Support Systems

Pension	Healthcare	Longterm care
• Clarity about the level of state pension	• Clarity about the guaranteed package of services	• Clarity about the guaranteed package of publicly provided services (how much services are guaranteed and the eligibility criteria),
• Increased labour supply and productivity at work	• Disease prevention	• Reduced care needs (improved independence in activities of daily living and instrumental activities of daily living, and timely medical care)
• Improved financial literacy	• Access to timely diagnosis and treatment (sufficient number of GPs, technology)	• Improved availability of informal care
• Better incentives for savings and investment	• Increased funding	• Increased funding
• Reduced risk of losses to savings and investments	• Improved productivity in the sector	• Improved productivity in the sector.
• Fair regulation of the market for private pension.	• Fair regulation of the market for healthcare	• Fair regulation of the market for long-term care.

A second dimension is reducing the health and care burden on the two systems, through disease prevention, timely medical care (including diagnosis and treatment) (Docteur & Oxley, 2003;

Wilson, 2009). A third dimension concerns adequate funding and productivity, ensuring that resources are used effectively and that productivity gains in service delivery translate into better outcomes. Finally, effective regulation of service providers is essential to protect the public from the risk of harm (Department of Health & Social Care, 2022). To achieve sustainability, such regulations must also be fair (Pu, 2021).

Table 2 offers a checklist across the three systems, which can serve for a quick analysis of any debated changes to split the changes into groups:

(i) changes which unambiguously lead only to improvements in sustainability across one or more systems (e.g., if the change only improves productivity within the healthcare sector and has no effects on other entries);

(ii) changes which unambiguously undermine sustainability of the three systems (e.g., reduced funding to one or more systems holding other factors constant);

(iii) changes which lead to improvements in sustainability through some factors but undermine through the others (e.g., increase in the state pension age increases labour supply but reduces the availability of informal care).

While the changes in the first group are definite winners and this quick analysis is sufficient to proceed with those changes to the next step, the ones in the second and third group require further, more sophisticated, investigation. Changes in the second group may have significant benefits outside of the three old-age support systems, which sometimes may be social, political or distributional. If it is possible to measure those benefits, the next stage of the analysis would be to compare the negative and positive effects. However, even when the benefits or costs are difficult to measure, such analysis is helpful to understand the motivation for the changes and show the path for future action when the circumstances change. The third group of changes requires fully fledged cost-effectiveness analysis across the dimensions of the three systems to assess whether they lead to an improvement in the overall sustainability of the three old-age support systems or not.

We rely on this crude analysis to explore how the scheduled changes may contribute to the sustainability of the three old-age support systems. Two scheduled changes that target the pension system focus on including unused pension funds and death benefits in an individual's estate for inheritance tax purposes and on consolidating the private pension market (see Table 2). The first policy change has been argued to be an important tool for raising additional government revenue (Advani & Sturrock, 2023), part of which may be directed towards increased funding of the healthcare or LTC system. However, it may act as a disincentive to save, which speaks directly to one dimension of pension system sustainability.

To counteract such disincentives, there is a need to further encourage pension saving through mechanisms that reflect individual pathways (Agunsoye & James, 2024) - for example, time off the labour market due to childbirth and childcare, health shocks, or caregiving responsibilities. In essence, the disincentive to save created by taxing private pensions should be considered alongside policy changes on inheritance tax, while also addressing individual circumstances in saving for the future. Such an approach would make the policy more inclusive and equitable.

The second policy change concerns the consolidation of the private pension market, aimed at boosting investment, increasing private pension savings, and improving saver returns. This scheduled change to the pension system has the potential to incentivise both savings and investment, reduce the risk of losses, and ensure fair market regulation by consolidating smaller schemes into fewer, better-governed large funds. These are the three factors which are improving the pension system's sustainability.

Other related policy options from the reviewed literature suggest that achieving equity in the pension system would depend on the interaction between private and state pensions. For instance, while the scheduled changes to the private pension market may improve savings and returns, this alone would not ensure equity. However, the adjustments suggested by Cribb et al., (2025) – such as reducing or removing State Pension entitlements for those with higher private

retirement incomes and basing eligibility on past UK residency rather than National Insurance contributions - could create a system in which low-income pensioners benefit from the changes. Nevertheless, it remains unclear to what extent this policy option would align with the Pay-As-You-Go model that is currently in place for the State Pension system. Moreover, by reducing State Pension entitlements for those with higher private retirement income, this option could unintentionally discourage additional retirement saving, thereby weakening incentives to save.

The scheduled changes targeting the health and care sector include the "Fit for the Future" 10-year health plan for England, intended to transform the current structure of the NHS and the social care sector – i.e., the long-term care system (see Table 2). The plan has three broad pillars that target localising health and care services, improving the workforce, and focusing on prevention. Regarding the potential of these planned changes for the sustainability of healthcare and the long-term system, most policy actions overlap with all the dimensions of sustainability described in this paper. More so, extant studies support the broad approaches to localise healthcare and make services more targeted or accessible to the local communities (Blamire & Rees, 2025; Britteon et al., 2024; Lo et al., 2025; Mou et al., 2025; Power & Baxter, 2025; Simpson et al., 2025) and harness innovative approaches towards more efficient and productive health and care service delivery (Damant et al., 2024; Malkowski et al., 2024; Walters et al., 2025; Winder et al., 2024).

The Public health measures aimed at early disease prevention align with policy options in the healthcare literature, which emphasise that a broad-based proactive approach, which identifies high-risk groups and intervenes early, can generate long-term cost savings. (Bajwa et al., 2025; Mukadam et al., 2024). Although not explicitly articulated as a policy goal, the planned changes also implicitly acknowledge fair regulation as part of their policy actions.

The crude sustainability analysis applied in this section does not address the clarity regarding the guaranteed package of services, including publicly provided. For example, while the universalist

principle of healthcare delivery, free at the point of need, was further expanded to free at the point of risk (see UK Government, 2025: 119), the policy remains unclear about these packages. It is unclear which specific aspects of care users are entitled to, how levels of risk are to be defined and assessed, and who will be deemed eligible to access such care. As noted earlier, ambiguity around guaranteed service packages creates such expectations and, thus, demand for services among population that the long-term sustainability of the system may never be achieved (Nguyen & Strizrep, 2019; Sheiman et al., 2018; The World Bank, 2019).

Conclusion

This paper examines the three old-age support systems in England, pensions, healthcare, and long-term care, their historical developments, and the scheduled changes aimed at ensuring sustainability. Our review of policy changes and their clustering around significant events suggests two major patterns of policymaking concerning the three old age support systems. The first is a siloed approach to addressing issues related to one of the three systems. Approximately four out of every five policies that we identified between 1908 and 2023 targeted issues related to a single system.

The second pattern is that policies made for each system coincide with significant events, consistent with reactive policymaking. While we do not conclude that these significant events directly drove policy changes, the overlapping timing of these policies suggests that they may have been influenced by pressures arising from these events.

For the scheduled changes aimed at ensuring the sustainability of the three systems, their potential effects fall short on some of the metrics defined in our sustainability analysis. For instance, we identified two scheduled changes to the pension system, including changes to inheritance tax on unused pensions and death benefits, as well as the pension investment review. While these policies are designed to expand government revenue and reduce risks to savings and investment, they may also have unintended consequences. Such as, the inheritance tax on unused

pensions could create disincentives to save.

With respect to the scheduled changes targeting the healthcare system, although they align with all the sustainability dimensions described in this paper, they lack clarity regarding the guaranteed package of services and the scope of publicly provided services. In summary, while these scheduled changes represent important steps toward sustainability of the respective systems, they require more elaborate cost-effectiveness analysis to assess their sustainability potential.

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Appendix A

Table A1: Evolution of Policies in the Old-Age Support Systems

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
2nd Industrial Revolution Period (1870 - 1914)	Pensions Act	1908	Pension System	A Means-tested and non-contributory pension scheme that relies on central taxation for funding.	Introduced the first state-funded, non-contributory pension scheme in the UK by establishing the principle of government responsibility for supporting old-age people and reducing poverty for this group (Thurley, 2008).
	National Insurance Act	1911	Pension and Health System	Health and unemployment insurance are funded by contributions from workers, employers, and parliamentary subsidies.	Laid the groundwork for a national health insurance scheme by creating a contributory scheme to health and unemployment benefits, and shifted part of the welfare burden to workers and employers (Digby, 1999).
World War 1 (1914 - 1918)	Ministry of Health Act	1919	Health System	Established the Ministry of Health to oversee public health service provision. Brought a clear distinction between primary and secondary health centres.	Commissioned the report that advised on the systematised provision of health services in England (Socialist Health Association, 2025; The Health Foundation, 2025). It proposed a distinction between primary and secondary health centres, with their roles and responsibilities varying according to the services they provided (Socialist Health Association, 2025).
Stand Alone	National Insurance Act	1925	Pension System	Old-age mandatory pensions are linked to contributions.	Institutionalised contributory pensions based on earnings (Pensions Policy Institute, 2016; Morgan, 2024). Made retirement income conditional on prior contributions and deepened the link between labour market participation

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
					and pension entitlement (Fleisher and Kocher, 1939).
	Local Government Act	1929	Health System	The Act made local authorities responsible for Poor Law hospitals (including workhouse infirmaries) and allowed them to charge individuals who could afford to pay for treatment.	It moved towards the principle of free healthcare by allowing those who couldn't pay to receive treatment without the direct Poor Law stigma (The Health Foundation, 2024)
World War II (1939 - 1945)	National Insurance Act	1946	Pension System	Established a comprehensive social security system that covered a wide range of individual health and social needs, including old-age pensions.	Created a universal, comprehensive social security system covering pensions, healthcare, and unemployment (Timmins, 2024). Established the foundation for the modern welfare state and promoted social cohesion and reduced inequality (Gladstone et al., 1999; Crafts, 2024).
	National Assistance Act.	1948	Long-term care System	Created a national public assistance system.	Provided the means-tested safety net. The objective was to ensure that all citizens attained an acceptable minimum level of income regardless of their contribution history or the need to pay high rents (Crafts, 2024). It replaced the 1929 Local Government Act.
	Founding of the National Health Service.	1948	Health System	Assumed responsibility for managing hospitals and infrastructure that were previously under the control of other institutions, such as Poor Law hospitals and voluntary hospitals. Tasked with managing hospital	Nationalised hospitals and centralised management of health services, by offering free healthcare at the point of use (Greengross et al., 1999; Delamothe, 2008; Smith and Tudoe, 2018; Clement, 2023). Created universal healthcare and reduced health inequalities, while also improving healthcare access (Delamothe, 2008).

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
				beds, as well as medical officers and consultants, which had previously been under the management of voluntary hospitals, local government hospitals, and Poor Law hospitals. The goal was to ensure that healthcare services were free for the population when needed.	
Global recession (1973 - 1975)	NHS Reorganisation Act	1973	Health System	The re-organisation of the tripartite system upon which the NHS was founded to improve service delivery and accountability.	Created a more integrated and efficient healthcare system by abolishing the initial tripartite structure of the NHS and introducing a unified management system (Begley and Sheard, 2019; Maile et al., 2022). The re-organisation established Regional Health Authorities (RHAs) and Area Health Authorities (AHAs) to oversee the delivery of healthcare services and ensure better coordination and standardisation across the NHS (Battistella and Chester, 1973; Price et al., 2018). Integrating local health services into the NHS structure, with the goal of enhancing the NHS's role in community healthcare and promoting a more uniform provision of services across England (Jonas and Banta, 1975; Begley et al., 2017).

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
					Improved accountability in the system by creating the Health Service Ombudsman to investigate NHS bodies, including AHAs and hospital management committees (The Health Foundation, 2025).
	Social Security Pensions Act	1978	Pension System	State Earnings-Related Pension Scheme (SERPS) as a top-up to the basic state pension, which increased pension benefits. This Act stipulated that the amount of SERPS pension an individual can receive would be determined by their earnings history, with those who contributed more to National Insurance receiving a larger pension.	Introduced SERPS, which increased pension adequacy by linking benefits to earnings (Scottish Public Pensions Agency, 2025). Strengthened the contributory principle, as people built up entitlements following this policy (Hobson et al., 2024). Increased future liabilities for the state, making the system more earnings-sensitive and less redistributive (DWP, 2006).
Privatisation	Social Security Act	1980	Long-term care System	Played a significant role in the privatisation of social security systems in England	The Act led to fewer older people being able to access social care.
	Social Security (contributions) Act	1981	Long-term care System	The Act led to a shift in the funding and provision of social security.	The Act led to poor targeted provision and an increase in spending.
	Health Services Act	1980	Health System	The reorganisation of the administration of the NHS.	The Act contributed to the outsourcing of NHS services.
	Financial Services Act	1986	Pension System	The promotion of private pensions allows individuals to contribute to their own retirement.	The Act contributed to the mis-selling of private pension plans by persuading individuals to switch from occupational pension schemes.

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
	Social Security Act	1988	Pension System	A significant Act that led to the privatisation of the Social Security in the UK	The Act introduced changes to income-related benefits and the structure of public and private pension provision.
	Pensions (Miscellaneous Provisions) Act	1989/1990	Pension System	Introduced changes such as the substitution of the term 'widow's pension' in the 1971 Pensions (Increase) Act, affecting the conditions.	The provision aimed to ensure that pension schemes remained fair and equitable for all members.

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
Stand Alone	National Health Service and Community Care Act of 1990	1990	Health and Long-term Care Systems	Reform the provision of health and social care services in England, with the aim of modernising the NHS, promoting collaboration, enhancing care quality, and improving access to community-based services (The Health Foundation, 2025).	Created the NHS trusts and changes to the way in which local authorities carried out their social care functions. • Assume responsibility for the ownership and management of hospitals or other facilities previously managed or provided by regional, district or special health authorities. Authorised GP practices can now manage their own budgets for practice expenses, drugs, and some hospital services. The Act established Family Health Services Authorities to plan and deliver primary care. The Act made changes to the way in which local authorities carried out their social care functions by: • Obligated local authorities to carry out a needs assessment of older people and people with disabilities before accessing community care services, including housing and healthcare. • Obligated local authorities to allocate funding for places in residential homes as well as domiciliary care services.

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
	Pension Act	1995	Pension System	- Changes in SPA - Introduction of minimum funding requirements for pension schemes as an insurance mechanism to cover future liabilities and payments to beneficiaries. - Established a compensation fund to provide protection to members of occupational pension schemes in the event of insolvency. - Ensuring that existing benefits in occupational pension schemes cannot be reduced without member consent.	- Equalisation of the retirement age for men and women. - Protection of private pension fund.
The War on Terror	Pension Commission	2002	Pension System	Laid the foundation for future reforms, including: - Raising the SPA - Earnings link for SP indexation. - Automatic enrolment. - Pension protection (for private pension)	Led to a major strategic reform plan for pension sustainability (Turner et al., 2004; Massala and Pearse, 2021). Introduced automatic enrolment, recommended the raising of the State Pension Age (SPA), and stronger protection and regulation (Turner et al., 2004). Promoted long-term planning for ageing population challenges (DWP, 2006).
	Payment by Results	2002	Health System	Introduced in 2002 to improve efficiency and productivity within the health system.	This system linked a hospital's income directly to the number and case mix of patients treated, using a fixed price system (Charlesworth et al., 2014).
	NHS Act	2006	Health System	This reform aimed to modernise and streamline the legal framework governing the NHS by	Consolidate previous legislation related to the health system in England (such as the Health and Social Care Act, 2003), with the goal of simplifying and updating the

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
				consolidating previous legislation, enhancing healthcare quality, and promoting patient choice.	legal framework governing the NHS (The Health Foundation, 2025). Promote comprehensive health services in England to ensure continuous improvement in the quality of healthcare provided to individuals by involving patients in their care (NHS England, 2017).
Global financial crisis (2007 – 2009) and subsequent Era of Austerity	Pensions Act	2008	Pension System	Introduced Automatic Enrolment for individuals between 22 and state pension age and earning over £10,000 a year.	Increasing private pension coverage, leading to improvement in pension participation among lower and middle earners (DWP, 2022; Kennedy, 2023).
	Health and Social Care Act	2008	Health and LTC Systems	The establishment of the Care Quality Commission (CQC) as the independent regulator of health and social care services in England in 2009.	Strengthened oversight and accountability in care delivery (DHSC, 2022). Improved service standards, transparency, and public trust in health and social care providers.
	Tripple Lock	2010	Pension System	Increase in state pension payments at the start of each fiscal year, which is determined by the highest of three criteria: 2.5%, average wage growth, or inflation rate.	Improved state pension adequacy by ensuring real-term growth in state pension earnings (Kirk-Wade, 2023; Hobson et al., 2023; DWP, 2025). Protected retirees from inflation and stagnating wages but increased fiscal burden on the state (Cribb et al., 2023).
	Pensions Act	2011	Pension System	Brought forward the completion of the increase in women's SPA to 65 to November 2018, and the increase to 66 for both men and women to October 2020.	Accelerated SPA increases to manage rising life expectancy and fiscal pressures (DWP, 2023; Hobson, 2023). Shifted more responsibility to individuals to plan for longer retirements (Hobson, 2023).

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
	Health and Social Care Act	2012	Health and LTC Systems	The Act aimed to modernise and improve the efficiency, quality, and outcomes of health and social care services in England by extending the market-based principles and introducing more competition into the NHS.	Commissioning reforms: The establishment of the NHS Commissioning Board and Clinical Commissioning Groups to manage NHS funds at the local level (The Health Foundation, 2025). Patient choice and involvement: Emphasised patient choice in accessing care and promoted greater involvement of patients and carers in decision-making (Department of Health, 2012). Provider freedoms and accountability: Giving NHS providers more freedom to innovate and improve the quality of care, while also establishing mechanisms for accountability and regulation[9]. Public health focus: Strengthening public health services by giving local authorities greater responsibility and resources in this area (The Health Foundation, 2025). Robust regulatory framework: Established a robust legal framework for regulating health and social care, including local Healthwatch and Healthwatch England (The Health

[9] https://assets.publishing.service.gov.uk/media/5a7a47eced915d1fb3cd6bde/A1.-Factsheet-Overview-240412.pdf

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
					Foundation, 2025).
	Care Act	2014	Long-term care System	Overall system overhaul by promoting wellbeing, preventing care needs, and giving more control and influence to those in need of support.	According to CarersUK (2020) and Care Quality Commission (2022), the Act clearly outlines: • the way local authorities should carry out carers' assessments and needs assessments (for the looked-after person). • how local authorities should determine who is eligible for support • how local authorities should charge for both residential care and community care • if they should charge for carer support and • the local authority obligations.
	Pension Act	2014	Pension System	Placed duties on the Financial Conduct Authority (FCA) to oversee private pensions and the governance of firms that provide pension services and financial advice.SPA is expected to rise to 67 between 2026 and 2028 and it introduced a mechanism for regular reviews of SPA every 5 years.	Enhanced oversight of pension providers and improved transparency, accountability, and consumer protection in the pensions and financial advice sectors, particularly non-workplace pensions, workplace pensions, and retirement income (DWP, 2014; The Pensions Regulator/ Financial Conduct Authority, 2018).
Stand Alone	Single-tier state pension	2016	Pension System	Both SERPS (from the Social Security Pensions Act of 1978) and S2P (from the Child Support, Pensions and Social Security Act	Simplified the state pension to beneficiaries and improved transparency in the state pension earnings by reducing earnings-based variation in benefits (DWP, 2013).

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
				2000) were abolished, and the new single-tier State Pension was created. The new single-tier payment is a flat-rate pension, based on National Insurance contributions, not earnings.	
Covid-19 Era	Health and Care Act	2022	Health and LTC Systems	The broad aim is to modernise the NHS and integrate health and social care by making it more accountable, less bureaucratic, and more integrated (Holmes, 2022; Murray, 2022; DHSC, 2025)	The aim was to improve health outcomes by integrating health, social care, and public health services at the local level. Creation of Integrated Care Systems, a partnership between NHS providers, local authorities, and other stakeholders to ensure coordinated and efficient healthcare delivery. Established the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) to plan and design health and care services tailored to local needs. Removal of the competition rules introduced by the 2012 Health and Social Care Act, by ending automatic tendering of NHS services that created excessive bureaucracy and service fragmentation. Introduced Public Health Measures, targeted policies to

Key Overlapping Shocks	Policy changes	Year	System affected	Key changes	Some System impact
					improve public health (e.g., restrictions on junk food advertising to tackle obesity). Policies to improve NHS accountability by clearly laying out that NHS England is to report to the Secretary of State for Health and Social Care, and strengthening national oversight. Cap on Personal Care Costs by introducing a new £86,000 cap on the amount individuals in England would have to pay for personal care over their lifetime.
	Pensions Act	2023	Pension System	Extending automatic enrolment to more individuals and lowering the qualifying earnings threshold.	This initiative aims to increase inclusion, especially for younger and lower-income workers, to boost equity in retirement savings (Mirza-Davies and Cunningham, 2025).

Note: These timelines and clusters do not imply that all the policies highlighted are directly linked to the overlapping global events. They are mere descriptions of overlapping global events around the time of the policy change. The only cases with evidence of direct or indirect causation are represented in the Table as "direct link." In this column, "yes" means that there is evidence that the policies were directly influenced by the overlapping event and "no" otherwise. For example, due to rising unemployment resulting from the 2nd industrial revolution, the National Insurance Act of 1911 was passed.

Table A2: Current Policy Debates that Target the Three Old-Age Support Systems

	Commons			Lords		
	Debate	**Year**	**Categorisation**	**Debate**	**Year**	**Categorisation**
	Pensions					
1	Women's Changed State Pension Age: Compensation	2025	State Pension Age and Compensation	State Pension: Triple Lock	2025	Pension Schemes and Funds
2	Women's State Pension Age	2025	State Pension Age and Compensation	Pension Fund Clearing Obligation Exemption (Amendment) Regulations 2025	2025	Regulation and Policy
3	Women's State Pension Age (Ombudsman Report and Compensation Scheme)	2025	State Pension Age and Compensation	Pension Fund Clearing Obligation Exemption (Amendment) Regulations 2025	2025	Regulation and Policy
4	Women's Changed State Pension Age: Compensation	2025	State Pension Age and Compensation	Pension Protection Fund and Occupational Pension Schemes (Levy Ceiling) Order 2025	2025	Regulation and Policy
5	Women's State Pension Age: Compensation	2025	State Pension Age and Compensation	National Insurance Pension Underpayments	2025	Pension Schemes & Funds
6	Pension Savings: Investment Returns	2025	Pension Schemes and Funds	Pension Fund Reliefs	2025	Pension Schemes & Funds
7	Draft Pension Fund Clearing Obligation Exemption (Amendment) Regulations 2025	2025	Regulation & Policy	State Pension: Age Increase	2024	State Pension Age and Compensation
8	Private Pension Pots: Young People	2025	Pension Schemes and Funds	Women's State Pension Age: PHSO Report	2024	State Pension Age and Compensation
9	Pension Funds	2025	Pension Schemes and Funds	Pension Credit	2024	Pension Credit
10	Mineworkers' Pension Scheme	2025	Pension Schemes and Funds	Pension Credit	2024	Pension Credit
11	Pension Credit Uptake	2025	Pension Credit	Women's State Pension Age Communication: PHSO Report	2024	State Pension Age and Compensation
12	Pension Credit Take-up	2025	Pension Credit			
13	Mineworkers' Pension Scheme: Living Standards	2024	Pension Schemes and Funds			

	Commons			Lords		
	Debate	**Year**	**Categorisation**	**Debate**	**Year**	**Categorisation**
14	Pension Credit: Uptake	2024	Pension Credit			
15	Pension Credit: Uptake	2024	Pension Credit			
16	Pension Credit: Uptake	2024	Pension Credit			
17	Pension Credit: Processing of Applications	2024	Pension Credit			
18	Pension Credit	2024	Pension Credit			
19	Women's State Pension Age Communication: PHSO Report	2024	State Pension Age and Compensation			
	Healthcare					
1	NHS Reliance on Private Healthcare Providers	2025	Operations	Primary Healthcare Facilities	2025	Operations
2	Preventive Healthcare: New Technology	2025	Operations	NHS and Care Volunteer Responders Service	2025	Operations
3	Reducing Healthcare Inequalities	2025	Operations	NHS: Single-sex Spaces for Staff	2025	Governance and Regulations
4	Medicines and Healthcare Products Regulatory Agency	2025	Governance and Regulations	NHS Pensions	2025	Funding
5	NHS: Wasteful Spending	2025	Funding	NHS England Update	2025	Governance and Regulations
6	NHS Buildings: Maintenance Backlogs	2025	Operations	NHS Dentistry	2025	Operations
7	NHS Funding: South-west	2025	Funding	NHS: Electronic Patient Record Systems	2025	Operations
8	NHS Funding: Barnett Formula	2025	Funding	Valdo Calocane: NHS England Report (result item 7)	2025	Governance and Regulations
9	Location of the Torbay and South Devon NHS out-of-hours Primary Percutaneous Coronary Intervention Services	2025	Operations	NHS: Single-sex Provision for Staff and Patients	2025	Governance and Regulations
10	Access to NHS Dentistry	2025	Access	NHS: Patients with Allergies	2025	Access
11	NHS and Care Volunteer Responders Service	2025	Operations	NHS Plan: Consultation	2024	Governance and Regulations
12	NHS Reliance on Private Healthcare Providers	2025	Operations	NHS: Dentistry Provision	2024	Operations
13	NHS England: Abolition	2025	Governance and Regulations	NHS: Treatment of Children from Other Countries	2024	Operations
14	Barnett Formula: NHS Funding	2025	Funding	NHS: Anti-obesity Medication	2024	Operations

	Commons			Lords		
	Debate	**Year**	**Categorisation**	**Debate**	**Year**	**Categorisation**
15	NHS Pensions	2025	Funding	NHS Hospitals: Apheresis	2024	Operations
16	NHS Waiting Lists	2025	Access	NHS: Independent Investigation	2024	Governance and Regulations
17	Access to NHS Dental Services	2025	Access	NHS: Breast Screening Programme	2024	Operations
18	NHS England Update	2025	Governance and Regulations	NHS Continuing Healthcare	2024	Funding
19	NHS Waiting Lists	2025	Access	NHS Blood and Transplant Service: Blood Stocks	2024	Operations
20	NHS Reform	2025	Governance and Regulations	National Insurance Contributions: Healthcare	2024	Funding
21	NHS Diagnostic Processes: Technological Innovation	2025	Operations	NHS Continuing Healthcare	2024	Funding
22	NHS Waiting Times	2025	Access			
23	NHS Backlog	2025	Access			
24	Dental Healthcare: East Anglia	2024	Operations			
25	Healthcare: Hampshire	2024	Operations			
26	Indefinite Leave to Remain: Healthcare Workers	2024	Operations			
27	National Insurance Contributions: Healthcare	2024	Funding			
28	Healthcare Collaboration	2024	Operations			
29	Access to Primary Healthcare	2024	Access			
30	Healthcare Provision: East of England	2024	Operations			
31	NHS Waiting Lists	2024	Access			
32	NHS Health and Social Care Reform	2024	Governance and Regulations			
33	NHS Dentists: Access	2024	Access			
34	NHS Hospital Equipment	2024	Operations			
35	NHS Dentistry: South-west	2024	Operations			
36	NHS Dentistry: Rural Areas	2024	Operations			
37	NHS Winter Readiness	2024	Operations			
38	Access to NHS Mental Health Services	2024	Access			

	Commons			Lords		
	Debate	**Year**	**Categorisation**	**Debate**	**Year**	**Categorisation**
39	NHS Dental Contracting Framework	2024	Governance and Regulations			
40	NHS Urgent and Emergency Care	2024	Operations			
41	NHS Performance: Darzi Investigation	2024	Governance and Regulations			
42	NHS: Independent Investigation	2024	Governance and Regulations			
43	NHS Waiting Lists	2024	Access			
44	NHS Mental Health Services	2024	Operations			
45	NHS Dentistry: Work Requirement	2024	Operations			
46	Access to NHS Dentists	2024	Access			
47	NHS Dental Contracting Framework	2024	Governance and Regulations			
	Long-term Care					
1	Health and Social Care	2025	Scope and Provision of Care	Adult Social Care	2025	Scope and Provision of Care
2	Spending Review: Health and Social Care	2025	Funding and Finance	Social Care and Special Education Charities: Employer National Insurance Contributions	2025	Funding
3	Health and Social Care Reform	2025	Policy, Reform, and Legislation	Health and Social Care Information Standards (Procedure) Regulations 2025	2025	Policy, Reform, and Legislation
4	Health and Social Care	2025	Scope and Provision of Care	Social Care Reform	2025	Policy, Reform, and Legislation
5	Draft Health and Social Care Information Standards (Procedure) Regulations 2025	2025	Policy, Reform, and Legislation	Health and Social Care Information Standards (Procedure) Regulations 2025	2025	Policy, Reform, and Legislation
6	Health and Social Care	2025	Scope and Provision of Care	Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2025	2025	Policy, Reform, and Legislation
7	Department of Health and Social Care	2025	Governance and Administration	Young Disabled People: Social Care Services	2025	Scope and Provision of Care
8	Health and Social Care	2025	Scope and Provision of Care	Health and Social Care: Winter Update	2025	Scope and Provision of Care

	Commons			Lords		
	Debate	**Year**	**Categorisation**	**Debate**	**Year**	**Categorisation**
9	Draft Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2025	2025	Policy, Reform, and Legislation	Adult Social Care: Long-term Workforce Plan	2025	Scope and Provision of Care
10	Children's Social Care: North-east England	2025	Governance and Administration	Health and Adult Social Care Reform	2025	Policy, Reform, and Legislation
11	Health and Social Care: Winter Update	2025	Scope and Provision of Care	Children's Social Care	2024	Scope and Provision of Care
12	Employer National Insurance Contributions: Social Care	2025	Funding and Finance	Social Care Strategy	2024	Policy, Reform, and Legislation
13	Health and Social Care	2025	Scope and Provision of Care	Independent Review of Children's Social Care	2024	Policy, Reform, and Legislation
14	Health and Adult Social Care Reform	2025	Policy, Reform, and Legislation	Social Care Reform	2024	Policy, Reform, and Legislation
15	NHS Health and Social Care Reform	2024	Policy, Reform, and Legislation			
16	Health and Social Care	2024	Scope and Provision of Care			
17	Children's Social Care	2024	Scope and Provision of Care			
18	Adult Social Care	2024	Scope and Provision of Care			
19	Health and Social Care	2024	Scope and Provision of Care			
20	Children's Social Care	2024	Scope and Provision of Care			
21	Health and Social Care Reform	2024	Policy, Reform, and Legislation			
22	Health and Social Care	2024	Scope and Provision of Care			

Appendix B

Search Terms:

We applied the following search terms in the different databases, as follows: ("health* " AND "policy*" AND “England”) OR ("long-term care" AND "policy*" AND “England”) OR ("adult*" AND "policy" AND “England”) OR ("state pension*" AND "policy" AND “England”) OR ("pension*" AND "policy" AND “England”) OR ("Agei*" AND "policy" AND “England”) OR ("National Health Service" AND "policy" AND “England”) OR ("care*" AND "policy" AND “England”).

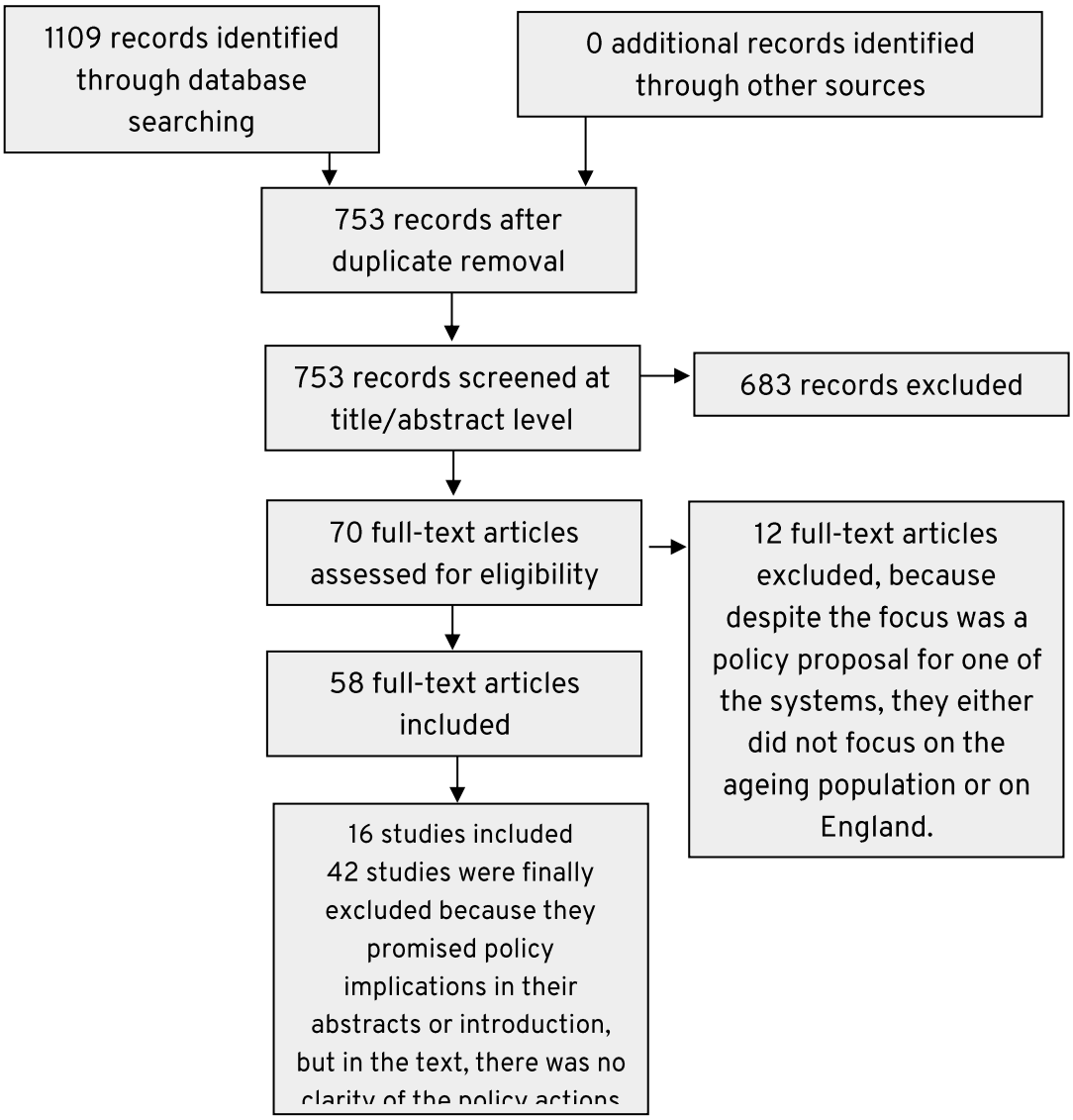
Quality Assessment and Data Extract

We combined the results in Zotero and removed duplicates before beginning the title and abstract screening. The title and abstract screenings were conducted following an a priori list of inclusion criteria (described in Table 1). The studies that met our criteria were further examined to determine whether they advocated or promoted a specific policy for each system. Data were extracted from the remaining studies that met the criteria and entered into our data matrix sheet, including information on the author(s), year of publication, title, the system considered in the paper, journal, policy focus, and the specific policy option or proposal presented in the paper.

Data Analysis

Once the data were collected in the data matrix, we used thematic analysis to identify categories and subcategories for each policy related to the three systems.

Figure B1: Flow Diagram



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