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with Parkinson's disease. The Polkinghorne committee decided that professional self regulation overseen by research ethics committees offered the public sufficient reassurance about the proper collection and use of aborted fetuses. The following year, parliament gave human embryos in vitro the protection of the criminal law by passing the Human Fertilisation and Embryology Act 1990.

The Polkinghorne guidelines rest on the principle of separation and operationalise it in four ways. Firstly, decisions relating to abortion and to the subsequent use of fetal tissue must be made separately, and consent for the use of the fetus in research or therapy can be sought only after a woman has agreed to the termination. Secondly, a woman's consent to the use of the fetus in research is general: she is not allowed to specify how her fetal tissue may or may not be used. Thirdly, the practice of abortion must be physically separate from the use of fetal tissue in research or therapy. Fourthly, separation of source and user must be complete: the source records the identity of the woman but does not divulge it to the user, thereby ensuring that the user knows nothing of the provenance of the material. An intermediary is recommended as the best way of achieving separation.

Review of the Polkinghorne guidelines is long overdue. In excluding clinical investigators from the clinical care of women undergoing pregnancy termination the guidelines codified distrust of clinicians who undertake research, and, according to the Royal College of Obstetricians and Gynaecologists, inhibit the progress of modern fetal medicine and the collection of stem cells at the time of termination.³ The Polkinghorne approach of non-specific consent is also "increasingly out of step with modern expectations."⁴

The Medical Research Council (MRC) fetal tissue bank until recently acted as intermediary between the abortion clinic and the laboratory. A study of stem cell scientists' views on the ethics of stem cell science in the laboratory noted that they trusted the MRC tissue bank for ensuring that fetal material had been ethically sourced (S Wainwright et al, BSA Medical Sociology Conference, 2005). However, the bank was closed in 2005.

The Human Tissue Act 2004 established the Human Tissue Authority as the regulatory body responsible for overseeing of the collection, storage, and use of human tissues. Embryos are not covered by the act, but, although not explicitly specified, aborted fetuses seem to fall within it and qualify as "relevant material." New standards and practices relating to con-

sent, donation, and storage of human tissues are being implemented, but how these relate to aborted fetuses is unclear and clarification by the Human Tissue Authority would be welcome.

The MRC is seeking to standardise procedures for seeking informed consent for donation of human embryos in assisted conception clinics in order to meet the ethical requirements of the UK stem cell bank.⁵ However, termination of pregnancy takes place in different clinical environments from fertility clinics and so far no fetal stem cells have been deposited in the stem cell bank.

If fetal stem cells are to be used in stem cell therapy then procedures for dealing with traceability, quality control, and risk management at the point of tissue collection need to be considered in order to comply with European Union's regulatory requirements on clinical grade tissue banks⁶ and advanced cell therapies.⁷ As the UK's authority responsible for implementing these European regulations, the Human Tissue Authority's remit with regard to abortion practices and the collection of fetal material for stem cell derivation remains to be clarified and the implications for clinical practice widely discussed.

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The care of older people

Wanless might offer a politically acceptable compromise to paying for care

The latest "Wanless report" on securing good social care for older people in England¹ is a welcome contribution to the debate about caring for older people, and in particular about paying for their care. It completes a trilogy of reports by Sir Derek Wanless, a former banker who was initially commis-

sioned by the Treasury to provide an evidence based assessment of the long term resource requirements of the NHS² and later reviewed the wider determinants of health.³ The latest report attempts to find a middle way between complete state funding of social care for older people and strict means testing.

At present most older people in England who need personal care face tests of their financial means and will have to pay for their own care if they can afford it. The Wanless report supports critics of the government who argue that means testing has led to inequities in payment for care. Politically, the most controversial aspect of the problem lies in people having to sell their homes to pay for care: anyone with assets over £20 500 has to pay for his or her own personal care, whether they are living in their own homes, a nursing home, or sheltered accommodation. The costs for personal care for anyone with assets below this threshold are paid for by the state.

The Wanless report proposes that all social care, which includes personal care (care provided to an individual) and other services that enhance wellbeing and social inclusion, should be free at the point of delivery. Everyone who needs personal care should be provided with a specified minimum level of publicly funded care. The need for a means test would be removed, and people may no longer have to sell their own homes to pay for personal care. Nevertheless, the report supports the government and previous inquiries in insisting that people will still have to pay for the “hotel” costs of care, which in nursing homes are substantial.

Shortly before the Wanless report was published, the Commission for Health Care Audit and Inspection (responsible for assessing quality and value for money) produced a joint report on services for older people in England, which provides a sharp reminder that the care of older people is not all it should be.⁴ The auditors said that the overall quality of health care was simply not high enough,⁴ and there are significant gaps in provision, particularly in community based services.⁵ The prescription from both these reports is thus for more, and more equitable, provision of care.

In the seven years since the Royal Commission on Long Term Care first proposed making personal care free for elderly people, the government has resisted this proposal. On the face of it this is puzzling, not least because the government has emphasised its commitment to a fair settlement for older people.⁶ But the government has interpreted fairness in a particular way, arguing that resources should be targeted more aggressively at people in greatest need—and this has necessitated means testing. Implicitly it means that the poorest members of society are supported at the expense of some homeowners. The government’s notion of fairness is defensible, but in practice means testing creates as many problems as it solves.⁷ It can lead to a failure to claim entitlements, and the stigma of means testing can lead to anger and distress among older people and their families.

Wanless offers a possible resolution of this problem. He proposes a “partnership model” where individuals have the option of topping up payments to achieve a more desirable level of care by making personal contributions, which would be equally matched by the state up to a set limit. That is, it guarantees a basic level of care to everyone, while at the same time suggesting a mechanism whereby people who can afford it contribute to the costs of care—a scheme the government may find attractive. Publicly funded systems of care for elderly people also carry popular

support.⁸ Crucially individuals can decide not to buy care or buy less care if they think they cannot afford it or that they are being asked to pay too much. Thus moving away from means testing would change the amount of care consumed and the total public and private costs. Indeed, the government could vary the level at which it sets the minimum care package, and one obvious disadvantage is that it could set a pretty basic package.

The government also objected to the original royal commission proposal on the grounds that free personal care was not affordable. The Wanless report notes that the Scottish Assembly has made personal care free in Scotland, and early evidence suggests that the increased costs are lower than the government in Westminster feared.⁹ The partnership model brings a significant increase in both total levels of spending and the contribution by the state to the costs of care compared with the current means tested system, but the total is less than the totally state funded option adopted by Scotland.

The Wanless report provides a timely contribution to the debates about fairness and justice in older age. These debates are important given concerns over the standards of care for older people,⁴ at a time when the number of older people receiving care in their own homes has almost halved since 1994 as available resources are focused on those most in need.⁵ They are also opportune given that the government is considering how best to provide social security in later life.¹⁰ However, New Labour’s commitment to social justice and tackling pensioner poverty may mean that it continues to resist helping those with moderate means in order to concentrate taxpayers’ funds on the poorest of the old.

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