

# 9 Tackling disadvantage: Care

## Meeting the growing demand for long-term care

Richard Best

Poverty remains one of the distinguishing features of old age for many people. Retirement from the labour market typically brings with it a very substantial drop in income and an accompanying change in lifestyle. But the degree of disadvantage faced by many older people also depends on the quality, availability and affordability of care. While most older people will not encounter the requirement for expensive long-term care, for the minority who do the costs are unpredictable and can be immense. The effects can dramatically reduce the standard of living of many who have lived on relatively comfortable incomes for much of their lives, as well as for the persistently poor.

As this century progresses, the UK seems likely to face a considerable shortage of care resources. The resulting 'care inequalities' between those able to pay for a scarce resource, and those unable to do so, could well become one of the most pressing social issues in the years to 2022.

This chapter looks at the current position, at demographic projections for the future, at factors affecting demand for, and supply of care, and at ways of meeting the resulting costs. It concludes by urging more concerted action today to head off very serious social problems 20 years from now.

### The current position

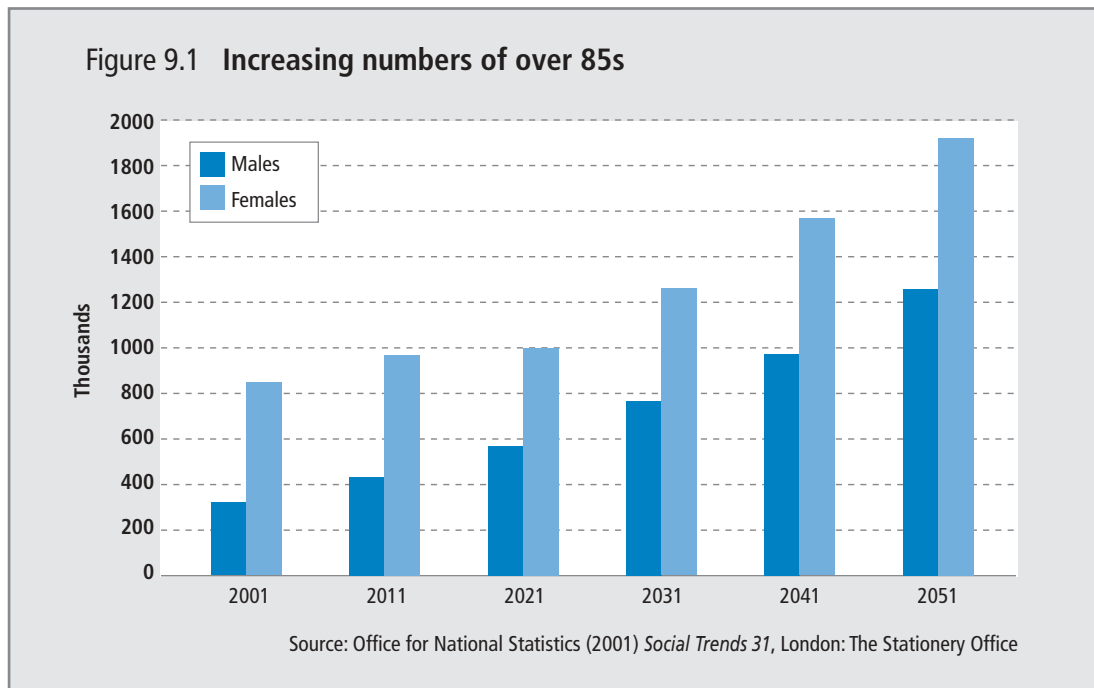
The UK is not yet experiencing the impact of a 'demographic time-bomb' and dramatic increases in the number of people over 75 or over 85 are not expected in the next decade or so. But the numbers of people aged over 75 are projected to increase more rapidly after 2020, as the post-world war II 'baby boom' cohort turn 75. There is likely to be a near doubling in the numbers of those over 75, and a near three-fold increase in the numbers of those over 85, by the middle of this century.

There is now a 'window of opportunity' in which to build up some of the financial resources for long-term care, which the population projections indicate will be needed later on.<sup>1</sup> However, despite the absence of an immediate crisis caused by demographic change, there are already signs of considerable strain on current resources for the provision of continuing care.

### Residential and nursing care

Costs of care have been increasing by substantially more than the rate of inflation because of:

- *Higher staffing costs*, caused in some areas by the rise in the minimum wage (to £4.20 per hour for workers aged 22 and over, in January 2003) and elsewhere by competition for



staff. Vacancy rates for local authority care staff in 2001 were in excess of 20 per cent with turnover of 16.9 per cent.<sup>2</sup> With near full employment in many areas, the care sector can only recruit and retain staff by increasing wages.

- *Improvements in standards* required by government, in line with rising expectations. The Care Standards Act 2000 does not require full compliance until 2007, but some of the new standards will apply earlier and those operating nursing and residential care homes are looking ahead to substantial increases in costs, not least for undertaking major physical improvements to their buildings (for which public funds have been scarce).

Meanwhile, pressure on Social Services budgets led them to plan an overspend in 2001/02 of some 12 per cent (£900m) above the amount expected by government in the Standard Spending Assessments. Even then, a further overspend above budgets was expected of over £200m.<sup>3</sup> These constraints led many local authorities to refuse to pay for the actual costs of care provision, sometimes failing even to increase the fees paid in line with inflation.

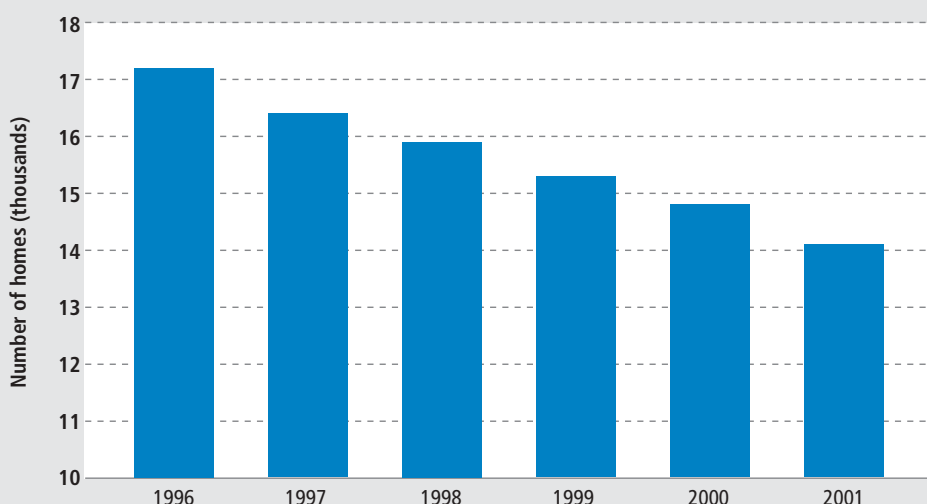
Work by Laing and Buisson for the Joseph Rowntree Foundation, published in June 2002, showed councils are paying between £75 and £85 a week, on average, below the costs of running a decent care home.<sup>4</sup> Nationally, this adds up to an annual gap of around £1 billion between the amounts paid and the amounts required.

Rising costs and under-funding, unsurprisingly, have led to closures of residential and nursing homes without their replacement by new providers, with a net loss of some 10,000 places in 2001.

Although such closures might be seen as reflecting consumer demand for care at home, they deny the option of residential care as an option for many who would choose this.

Following recommendations from the Royal Commission on Long Term Care, government provided subsidies to cover the healthcare costs for those in nursing homes (but not personal care or the 'board and lodging' fees) and to pay for 'intermediate care' for those needing

Figure 9.2 Total number of care homes



Source: Laing & Buisson Ltd (2002) *Care of Elderly People UK Market Survey 2002*, London: Laing & Buisson Ltd

### Joseph Rowntree Housing Trust care homes

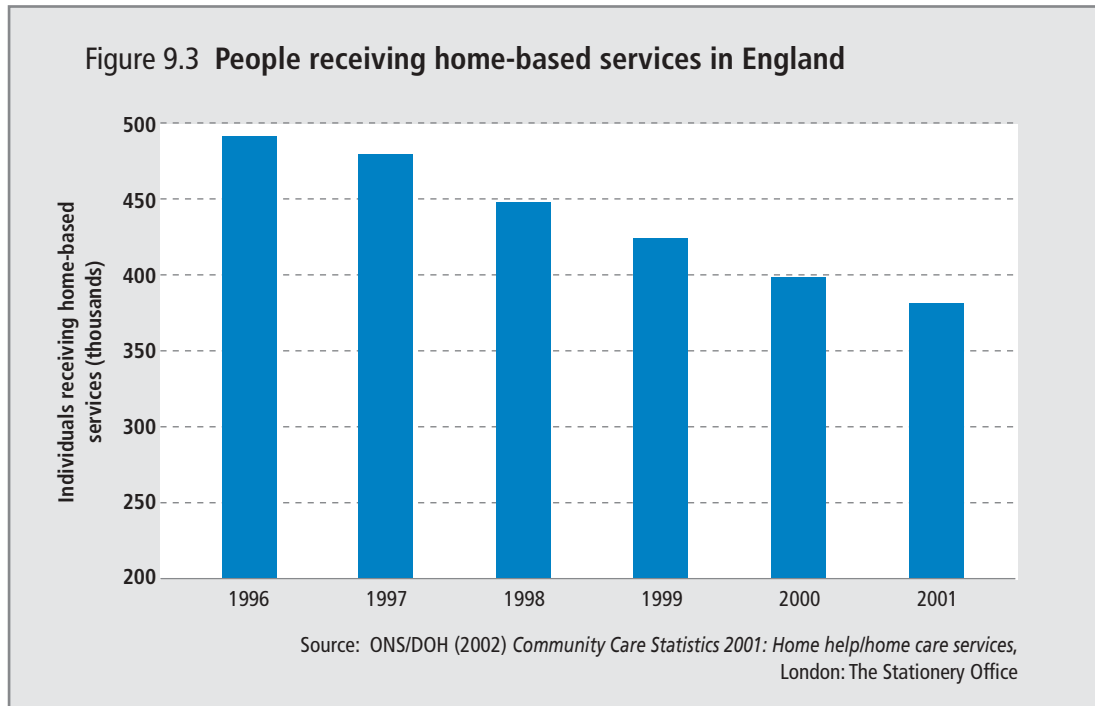
An example of the shortfall experienced by care-home providers comes from the Joseph Rowntree Housing Trust (JRHT), which provides residential care in York. The costs of providing satisfactory care are some £75 per week higher than the amount available from the Social Services Department (SSD); the funding gap for nursing care is around £115 per week (2001).

The following figures demonstrate the worsening position over the last three years for the JRHT's main care homes:

	2000	1999	1998
<i>Residential</i>			
JRHT charges	315.00	303.00	291.00
SSD payment rates	238.50	234.40	230.37
Funding gap	<b>76.50</b>	<b>68.60</b>	<b>60.63</b>
<i>Nursing care</i>			
JRF charges	446.53	429.45	411.46
SSD payment rates	331.00	326.00	320.39
Funding gap	<b>115.53</b>	<b>103.45</b>	<b>91.07</b>

This funding gap has resulted in the JRHT taking a policy decision to offer no further places to those referred from Social Services Departments. This is despite the fact that it is a charity with a particular interest in supporting people on low incomes. The JRHT is unwilling to cover the shortfall out of charitable funds.

Such shortfalls mean other charities are pulling out – or have already done so – from care provision; by one estimate, charities are topping up the fees they receive from local authorities to the tune of £184 million p.a. from charitable sources.<sup>5</sup>



temporary residential support before returning to their own homes. These changes were welcomed – the first producing extra money for nursing home operators as much as savings for residents, and the latter reducing NHS costs of bed-blocking – but these measures have failed to make a noticeable difference to the availability and cost of residential and domiciliary care.

In response to these pressures, the government announced in the 2002 Budget and Spending Review that social services resources will rise by 6 per cent in real terms in 2003/4. By 2006 there will be an extra £1 billion for services for older people in England. Extra resources could head off an immediate crisis by enabling higher fees to stabilise the residential and nursing home market in the short term. Extra resources will go toward rehabilitation services, intensive home-care services and support for informal carers. The outstanding question is whether the extra funds will prove of only very short-term consequence set against the likely escalation in future costs.

### **Domiciliary care**

It is not the case that the decline in residential and nursing care is being mirrored by a growth in the number of people receiving support for care in their own homes. Indeed, in the five years to 2001, the number of residents receiving home care reduced by 22 per cent (to 381,200).<sup>6</sup> Costs have not fallen commensurately, because the number of hours of care for each home visited has gone up by around 11 per cent over this period: this follows a policy of targeting those in the greatest need of the highest levels of care at home. But this brings the danger that Social Services Departments are failing to supply the lower level care that can prevent a more intensive service becoming necessary.

The Chancellor's Public Spending statement in the autumn of 2002 talked of narrowing the gap between the requirement for Social Services spending and the revenues available from central government; but it remains uncertain whether this will make sufficient difference to resolve this growing problem.

The current position, therefore, hardly represents an attempt to get ahead while demographic trends are still relatively favourable. On the contrary, it shows rising costs – propelled by spending on staff and on higher standards to meet growing expectations and government requirements – coupled with significant levels of under-funding by the State (principally via local authorities).

## Demographic change

In Part I we noted the ageing of the population throughout the developed world. Longer lives represent one of the great benefits of advanced societies. While those born at the turn of the last century could expect to live only 45 or 49 years (for men and women respectively), these figures will soon reach 80 and 84 years.<sup>7</sup> New research indicates that a girl born today stands a 50:50 chance of reaching 100 years; the same will be true for a boy, well before 2022.<sup>8</sup> The key reasons for the greater proportion of older people in the UK results from:

- The ageing of two ‘baby boom’ generations, one from the immediate post-war years and, more significantly, one from the 1960s; this will include a significant proportion of people from minority ethnic backgrounds who arrived in Britain in the 1950s and 60s.
- Fewer babies being born, proportionately, leading to fewer young people as a proportion of the total population.
- Improvements in hygiene, diet and health care, leading to longer lives.

As a result, the average age for those living in the UK is expected to reach about 42 years by 2022, compared with about 38½ years today.<sup>9</sup>

However, the UK has already experienced a shift in the percentage of older people and it is in other countries – particularly Japan – that this trend will now become most dramatic. In the UK the number of older people increased by 400 per cent during the last century and has doubled since 1931. The more significant changes yet to come relate to the dramatic rise in the numbers aged 85 or over: already almost half of those who are over 65 are aged at least 75.

The significance of the expected increase in the over 75s and, in particular, the over 85s, lies in the association between older age and increasing dependency. In general, the oldest cohorts are most likely to have health and care needs, and least likely to have surviving partners or other close family members to provide support. As noted in the introductory paper of this series, over 70 per cent of those who are more than 80 years old have a disability and, in particular, the incidence of dementia rises exponentially with age, and doubles in each five-year age-band over 65. Thus although only one in 60 of those aged 65 are affected, one in five people aged over 80 are likely to have problems with dementia, so the numbers affected could well double over the next 50 years.

But will this change? Is it likely that the extension of *life* expectancy could be accompanied by an extension of *health* expectancy?

## Other factors affecting the demand for care

### Health education

Some put their faith in improved health education, and this is clearly of importance. The health needs of the older population could be improved not only by preventive interventions, but also

by younger adults learning to lead healthier lifestyles. The growing affluence of the population overall gives more people the resources to afford healthy living; but one of the paradoxes of growing wealth is the increase of both obesity and of malnutrition. Moreover, the resources to live healthy lives are not distributed equally; people who have poor access to other financial and material resources are also less likely to have access to the resources that contribute to the healthiest lifestyles.

### **Medical and technical change**

There has been a long-standing academic debate about the potential for the 'compression of morbidity'.<sup>10</sup> In reviewing the evidence, the Royal Commission on Long Term Care concluded that there is some evidence that the onset of morbidity and disability may be compressed into a brief period towards the end of life, and may not last much longer even if life itself is longer. The Commission's underlying assumptions, therefore, were based on the premise that the proportion of years spent with some disability will remain roughly the same in relation to overall life expectancy.<sup>11</sup>

The extent to which we will need care in old age will be greatly affected by further scientific developments. Scope for advances in medical science is considerable. We are on the cusp of developments in the use of stem cells and other genetic interventions that could transform the pattern of morbidity. Currently, much of the debate around such matters has focused on issues relating to fertility, and to ante-natal interventions. Alongside these applications (and their profound ethical considerations) is the scope for intervention in many chronic and debilitating diseases that so often accompany old age. Major scientific breakthroughs in the treatment of dementia, and of conditions such as Parkinson's disease *could* transform the future pattern of care needs relating to old age.

However, this remains an area of much uncertainty. For example, initially promising results with Parkinson's disease have so far been set back by experimental treatments that have led to irreversible deterioration, rather than improvements, among people treated with implanted foetal cells.<sup>12</sup>

### **Technological advances**

Some important progress is being made in exploiting new technology to enable older people to maintain their independence for longer. The Joseph Rowntree Foundation has experimented with Smart Home technology, which can allow independent living to be sustained for longer, with less recourse to costly home-care services. Many day-to-day chores can be automated and remotely controlled, and conditions in the home can be monitored from afar to allow speedy intervention when – but only when – it is needed. The downside of enhanced technology in the home, however, is that it cannot substitute for the benefits of personal contact, which many older people value highly.

The design of new homes, following the Joseph Rowntree Foundation's work in creating *Lifetime Homes*, will now always incorporate easier access into and around the accommodation, as required by the government's extension of Part M of the Building Regulations. These changes, affecting all new homes in the future, mean that wheelchairs users, or those with mobility difficulties, will be able to enter the accommodation and move around within it with relative ease. The hazards of unnecessary front steps, narrow corridors

and an absence of toilet facilities on the ground floor, are removed, making it easier for frailer older people to stay longer in their own homes.

### **Preventive support**

The need for long-term care would also be reduced if preventive, low-intensity support was available before people reached crisis point. As noted above, however, this is currently a low priority for cash-strapped local authorities, and the traditional home-help service is being run down in many areas. While there is good evidence that a relatively modest input of early support can save the substantial costs – to the State as well as to individuals – of residential care, this lesson has not yet been learnt. A body of work by the Joseph Rowntree Foundation has demonstrated that low level help – e.g. with housework – can sustain self-respect and confidence, which in itself may prevent or delay the need for residential care.<sup>13</sup>

An understanding of the real priorities for older people themselves may emerge from the monitoring of how Direct Payments are used in place of prescribed services. This approach also extends choice and autonomy, which in turn can reinforce independent living.<sup>14</sup>

Promisingly, in terms of the preventative factors that may reduce the need for care, the government is investing in 'intermediate care'. As noted in the box below, Joseph Rowntree Foundation work on this theme indicates that the availability of places in residential care for those discharged from hospital not only reduces expenditure on hospital beds and cuts the number of emergency re-admissions for those discharged where insufficient help is available, but may well prevent the need for permanent admission to residential care. Such services also give respite to carers who might otherwise be unable to sustain their important work.

#### **Joseph Rowntree Housing Trust non-residential care**

The Joseph Rowntree Housing Trust's (JRHT) Continuing Care Retirement Community has provided an opportunity to see the extent to which residential and nursing care can be used for short periods of 'intermediate care'. The community has residential care and nursing care provision at the centre of a complex of 152 individual bungalows.

- Twenty-nine of the community's 200 bungalow residents spent at least one night in this community's Care Home over the 12 months to December 2000.
- They paid 41 visits to the Care Homes, staying a total of 714 nights.

The JRHT estimates that the availability of this facility within the community saved 374 'bed nights' in hospital last year. This is of considerable importance to the York Health Trust, which estimates that the number of people who are unwillingly 'bed blocking' rose from 52 to 70 at the York District Hospital, 2001.

In the majority of cases, the saved hospital bed nights came from people being discharged from hospital earlier than would have been possible but for the provision of this 'intermediate' care. Additional hospital bed nights were saved because of provision of *short-term nursing care* (although in the above calculation only a third of the nights have been counted when beds were occupied by bungalow residents for this reason).

It is worth noting that admissions from our sample into the intermediate care facilities

represent a *lower* take-up than would apply to a general intermediate care scheme elsewhere. This is because the JRHT offers an alternative to residential care by providing high quality domiciliary care (for up to 21 hours per week) for those who prefer to return directly to their bungalow, rather than going into intermediate care.

This suggests that even greater savings in relation to bed blocking could be expected for those not living in a 'retirement village', if good domiciliary care was readily available.

There is scope, therefore, for reducing the scale of demand and needs that an older population presents to health and care services. But advances in medical care, even if they extend life expectancy, are not certain to cut the number of years of ill health. As things stand, the relationship between dementia and old age leads to predictions of considerable increases in the number of people with dementia; dramatic breakthroughs in the relevant medical science may not be imminent. Technology too can help; but this is a 'high touch' – rather than 'high tech' – service industry, and so much care provision depends entirely on the availability of human resources.

## The supply of care

### Workforce shortages

The social care sector is already experiencing acute shortages of nurses and insufficient care workers of other kinds.<sup>15</sup>

A recent King's Fund Care and Support Inquiry highlighted the difficulties of recruiting and retaining the employees – often unqualified and poorly paid – who are responsible for the vast bulk of care to people, both in the community and in residential and nursing homes. It concluded that this is an enduring and intensifying problem. Imaginative and innovative solutions are required if the care crisis is not to be compounded.<sup>16</sup> Part of the solution must lie in paying realistic remuneration for hard and often highly demanding work. Pay and conditions must compete with other areas of the service sector. Moreover, if people are to choose such work in preference to, for example, working in a supermarket or DIY outlet, there needs to be a change to the image and status of these roles. Adoption of the more person-centred approaches advocated by the JRF and others may increase the opportunity for job satisfaction for support workers and personal assistants. But wider recognition of the importance of these employees is also needed.

The government has set a target of 50 per cent of care home staff and 50 per cent of domiciliary staff being properly qualified within five years. This contrasts with the current position, where 86 per cent of care staff in local authority homes have no qualifications.<sup>17</sup> The approach of the General Social Council and TOPSS<sup>18</sup> is to reduce barriers to access, including for those with educational disadvantage: but nothing will change unless there is adequate funding for education and training.

The need for more training will increase costs, as will the necessity for pay to rise to the levels necessary to attract and retain staff. But there is a growing realisation that essential staff in care support roles must be more highly valued.

Among the changes needed is an encouragement for a richer and more diverse mix of staff than has been traditional. This will involve recruiting men as well as women, and not only

middle-aged but both younger people and those who may have retired early but have experience and skills to contribute, as well as people from a variety of cultural and ethnic backgrounds.

And finally, in easing the problems of an absence of staff, there is scope for better and more imaginative use of volunteers, not as a cheap substitute for a fully trained and skilled workforce, but in support roles where time spent in personal contact – even just sitting and talking – can make such a difference.

### **Changes to informal care**

At present, over 70 per cent of care is provided on an unpaid basis. Changing this balance has very significant financial implications. There are some reasons to take a favourable view of the outlook of the supply of informal care over the next two decades. The proportion of older people with a surviving spouse is predicted by the Government Actuary's Department to rise. And women reaching late old age will have lower levels of childlessness over these two decades. But these factors look less positive after 2020.

There are several grounds for expecting the amount of informal care – nearly half provided by spouses and most of the remainder by (elderly) children – to diminish:

- Increased mobility means children living further from their parents. But already the number of older people receiving care from children who live in the same household has fallen from some 42 per cent in 1962 to 14 per cent in 1986 and a good deal less today.<sup>19</sup>
- Demographic change means there are fewer middle-aged women, who have traditionally acted as the main carers of their parents, compared with the numbers of older people.
- Culturally, older people increasingly express the desire 'not to be a burden' to their families, avoiding the past practice of moving in with relatives and increasing the expectations of receiving paid help.
- More women go out to work and a smaller proportion are prepared to devote themselves to becoming full-time carers.
- There are signs of cultural change within some minority ethnic communities where there has been a stronger tradition of expecting the next generation to look after parents in their old age.
- The higher age of having a first child, and the greater period spent in education, means more people who might have been carers of parents in their 80s still have dependent children.
- Some observers also predict less support in old age as a result of more people never marrying and the higher incidence of marital/relationship breakdown.<sup>20</sup>

Perhaps surprisingly, the available evidence suggests that the provision of informal care by family members is not petering out. Support for carers – paying for respite care to give people a break, providing support and services specifically for the carer, and giving financial and fiscal incentives – could prevent a collapse of this vital work. But relatively small changes to the level of care provided informally – because it represents such a high proportion of the whole – could have disproportionate impacts on the costs of paid-for care. Based on the (contestable) thesis that each hour of informal care would be replaced by an hour of paid-for care, the

current split of costs at roughly 70 per cent informal and 30 per cent formal implies that a drop of just 10 per cent in informal care would lead to expenditure on formal care rising by a third. Even if this is an exaggeration, it is clear that there will be severe consequences of falling levels of family/informal care.

### **The quality of care**

In thinking ahead to questions of service quality 20 years hence and beyond, there are various dimensions that need to be addressed. First is the question of the quality of staffing (i.e. appropriately skilled and trained staff). Second is the issue of objective and material standards of service.

National developments, including the Care Standards Act 2000 (which for the first time provides a framework for the regulation of social care), and the publication of minimum national standards (such as in care homes), are welcome and significant steps forward. Some of the elements of how quality will be defined in the future can be anticipated: greater comfort, improved privacy, and higher physical standards are obvious candidates, and the speed of change over the last decade or so is apparent.

There has been a transformation in attitudes to the quality of care that should be provided in care homes. In the past, a bed in a geriatric hospital might have been deemed sufficient to meet the need for residential care; then a shared room in an old people's home was enough; but today most people want to look forward to their own room with en suite facilities.<sup>21</sup> This development has directly paralleled the experience of consumers in other areas, and the rising material expectations of society as a whole. If this trend continues, a logical extension will be from an expectation of a bed-sitting room in a residential care home to having your own front door. The need for institutional care will be increasingly questioned. Demand will rise for alternatives, such as retirement communities – like the JRHT's continuing care retirement community north of York – where care is delivered from central facilities, or better domiciliary care in people's own homes.

We cannot begin to second-guess all the dimensions of quality that may emerge in the future. An obvious example would be the increased expectations stemming from the spread of ownership of 'white goods' within the home. The massive expansion of ownership of microwave ovens, video recorders, home computers, and mobile phones is apparent to all. The transition from luxury good to essential equipment is a rapid one, and the profile of what is 'normal' in 20 years will probably be very different. In the same way as we have argued in previous chapters that the incomes of the most disadvantage must be considered in relation to contemporary living standards, so must the provision of care.

But material standards are only the beginning of the story. The National Minimum Standards for Care Homes for Older People focus on the impact of facilities and services in a home under a number of key dimensions on the people living there. These include dimensions of: choice of home, health and personal care, daily life and social activities, complaints and protection, environment, staffing, management and administration.<sup>22</sup> The standards are intended as proxies for judging the *quality of life* of service users. High material standards are not good enough without parallel attention to the issues that service users have identified as the things that matter most.

The last decade has seen a substantial growth in research evidence about what matters to service users, and the outcomes that are of most importance. The evidence is consistent in highlighting, issues such as:

- staff reliability and continuity
- kindness and understanding of care staff
- cheerfulness and demeanour of staff
- competence in carrying out care
- flexibility to respond to individual needs
- being treated with respect and feeling valued
- choice and control resting with the service user
- activity and engagement.<sup>23</sup>

Such considerations are likely to become more explicitly demanded with the ageing of cohorts who are used to 'having it all' and being assertive in ways that may be less true of current older groups (particularly older women). A further factor that is likely to be a major determinant in driving the changing pattern and quality of services is the rise of the consumer, and the power of the service user. User-led and person-centred services will cost more because of the extra quality and benefits they will deliver, although the evidence suggests they are better than traditional models from a cost–benefit perspective. Increasingly, Direct Payments – given a boost by the Secretary of State for Health's statement in July 2002 – and similar schemes that place the service user at the centre of the process, are likely to see services obliged to respond more directly to the individual needs of users.

Questions of cultural responsiveness, and services that are sensitive to the diverse needs of black and minority communities, men and women, and people of different sexual orientation will also become of growing importance if further inequalities are to be avoided. Despite good examples of locally developed specialist services often evolving out of grassroots activity, overall the evidence indicates that many groups are significantly disadvantaged as service users (and often as care providers). Mainstream services typically provide a poor range and choice of provision, and are often unable to make culturally appropriate responses (whether in relation to food, culture, language, or gender considerations). While local black and minority ethnic groups have often been at the forefront in developing innovative and highly valued services, there remains an urgent challenge to ensure that mainstream services are able to meet the needs of people from all backgrounds.<sup>24</sup>

Changes in the composition of the older population will create significant pressures in this area as black and minority ethnic groups age and grow as a proportion of the older population. Future cohorts will include many more minority ethnic older people and there will be growing challenges if the issues of 'triple jeopardy' – the cumulative disadvantage due to race, age, and social class – are not to become of greater significance.<sup>25</sup>

The development of an improved infrastructure of health and care services in the coming years would make a fundamental difference to the lives of millions of older people. This means improving the present system on five key fronts:

- 1 *Coherence*, with the barriers between different types of service breaking down.
- 2 *Responsiveness* to the needs of individuals, whether by putting more resources in the hands of clients or in managing them in ways that are more client-centred.<sup>26</sup>
- 3 *Accessibility* to all who need services, rather than making provision dependent on resources available in a particular area.
- 4 *Quality* of provision, by creating a regime in which incentives are focused much less than at present on low price.
- 5 *Professionalism*, through the development of a well-paid, well-trained set of carers, and an awareness that this is likely to be one of the most important professions of the 21st century.

This brief survey of care quality illustrates the need for planning funding requirements beyond an extrapolation based simply on the ageing population having the current level of provision. The present system survives by creating barriers through eligibility criteria that exclude many who need care, and by paying very low wages to many who provide it. As well as tackling workforce shortage, it is going to be necessary to find much greater resources to meet the costs of care.

### Meeting the costs of long-term care

A major contribution to understanding long-term care costs for older people, right up to 2051, has been published by the Institute of Public Policy Research (IPPR).<sup>27</sup> This uses work commissioned from the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Nuffield Community Care Studies Unit (NCCSU) at the University of Leicester. It suggests a basis for comparing the effects of different assumptions against central base case projections of long-term care expenditure rising by around 260 per cent in the first half of this century. (It does not, however, take account of rising expectations.) It notes the considerable ‘funnel of doubt’ about future long-term care expenditure. But it implies that, with GDP likely to grow by, for example, 2.25 per cent per year, and projected increases in home ownership that could fund care costs, the total level of expenditure need not represent a Doomsday scenario. It is not impossible for the nation to fund future care costs, provided we see this as a major priority and set in place sensible mechanisms.

This chapter has described the strains that will emerge, if these mechanisms are not in place, in that those with high spending power in retirement would be able to afford the quality of care they want. But those dependent on the State – or on friends and neighbours – are already finding it harder to get the services they need.

While the picture overall is one of shortages of resources, the sense of injustice at the situation is felt most acutely by those who have accumulated modest assets in their lifetime and now find themselves unexpectedly having to dispose of these to pay for care. Sometimes the burden falls on the younger generation, but more often the hardship is experienced by those who must sell all they have accumulated in their working lives – often invested in their home – to pay for care.

Many people expected social care, like health care, to be provided free. They have not seen a clear distinction between suffering from dementia and suffering from cancer, as pointed out by the Royal Commission on Long Term Care.<sup>28</sup> The gradual withdrawal of government from

much traditional care provision and the increases in charges as local authority budgets have reduced, has provoked a sense of a 'broken contract' between the citizen and the State.

Amidst an atmosphere of suspicion, there are fears that Social Services Departments deliberately delay assessing older people's care needs; that those assessed as in need of residential care are forced to wait until a sufficiently cheap place becomes available, within unrealistically low limits set by the local authority; that there are perverse incentives on Social Services Departments to move people into residential care so that their vacated home can be sold to pay the bills. Against this background, the Royal Commission's central recommendation to the government was that all personal care, as well as nursing care in residential settings, should be free at the point of delivery and paid for by general taxation.

However, while the government accepted many of the subsidiary proposals of the Royal Commission, it rejected its key recommendation. Instead, it followed the line of two members of the Commission who produced a Note of Dissent. They argued that, partly because of the expense of this recommendation, partly because it could lead to reductions in informal care, and partly because it would not apply additional resources to helping those with the least assets, only nursing care in nursing homes should be available free, without any means-test.

Would the provision of free personal care dramatically shift the balance between informal and formal care in the years ahead? In Scotland, with the impending provision of free care at the point of delivery – including home care – the assessment has been that costs might rise as a consequence by some 12 per cent. But abuse of the system could be avoided by personal care being dependent upon specific medical conditions, with strict definitions and subject to clear and rigid tests.

The passing of the Health and Social Care Act (2001) in England ended the anomaly of health services being charged for in nursing homes. But much of the extra support has not directly benefited the individuals, since hard-pressed nursing home owners have raised their charges in recognition of the availability of these extra resources (and the definition of 'nursing care' has been criticised for redefining as charged-for personal care, much of what nurses have previously provided in nursing homes).

Meanwhile in Scotland, the Scottish Executive announced in January 2001 that it had accepted the case for free personal care for older people. Measures were introduced in 2002 to cover not only the nursing, but also the social and personal care in residential settings, and the costs of domiciliary care. Nevertheless, because the accommodation costs of living in care homes must still be paid for on a means-tested basis, and those costs represent about half of the whole, the changed regime has not represented as dramatic a breakthrough as some had supposed: choice is still restricted for those unable to contribute half the costs of their care; and for those with a home to sell, or other assets to dispose of, it may still be necessary to erode most of a lifetime's savings to pay for care. However, experience from the Scottish scheme will produce significant information, for example confirming or denying the supposition in the minority report from the Royal Commission that free care leads to reductions in informal, family care.

### **Care insurance**

In 1996, the Joseph Rowntree Foundation published the results of its Inquiry into Meeting the Costs of Continuing Care.<sup>29</sup> The Joseph Rowntree Foundation, like the Royal Commission, had

advocated that both health care and social care should be free at the point of delivery for all older people (while the accommodation costs of residential/nursing care should continue to be paid for on a means-tested basis). But the Joseph Rowntree Foundation Inquiry made recommendations to cover the costs of this change and to accumulate the resources to meet the accommodation costs as well as the care costs.

The Joseph Rowntree Foundation suggested that the nation should take advantage of the current 'window of opportunity' to build up funds for the time when the numbers of older people rises sharply. We should 'throw forward' some of the resources that are sure to be needed later. To do this, a funded *National Care Insurance* scheme should be established. A *National Care Council* would be established to set and review national standards of care entitlements and set levels of contribution rates – making 'in-flight' corrections to these as and when required.

The JRF Inquiry saw the advantages of a funded, regulated and *compulsory* care insurance scheme of this kind to be:

- A huge reduction in the costs of insuring against the potentially catastrophic risks of long-term care, because of the universal nature of the new national scheme: administration and marketing costs would be kept to a minimum because all citizens would be included as beneficiaries and all those in work would be contributors.
- An avoidance of 'free riders' who were capable of paying for their insurance but chose not to do so, rightly assuming that society will feel obliged to pick up the bill for them.
- Avoidance of 'cherry picking' by private insurers (which is likely to become more of a problem as genetic testing and other techniques reveal levels of individual risk): pooling the risks across the whole population allows everyone to benefit.
- An end to the anxieties about the loss of assets on the part of those who have saved during their working lives, rewarding those who have made provision for their old age and/or wish to pass on an inheritance to the next generation.
- Most important, the generation of substantial extra resources to supplement the input of the tax-payer (who would continue to pay for those unable to make provision for themselves): this would fund more and better care all round.

Contributions to be paid into the scheme recommended by the Joseph Rowntree Foundation would be compulsory at a rate which would ensure that someone on average earnings all their life would put in sufficient for insurance cover against the full cost of their continuing care. The Government Actuary has assessed this level at 1–1½ per cent of average earnings. (And the National Care Council would constantly review this rate in the light of increasing or falling costs.)

Such a scheme does not imply the present generation paying twice – once through their taxes, for today's older people, and once, through their contributions, for their own care later. There are gains to this generation too: those with parents with assets (principally owner-occupiers) would be protected from losing their inheritance, and they would also be able to pass on their own assets to the next generation if they required expensive care themselves.

Although the scheme was costed as increasing public expenditure at about £540 million per annum if introduced immediately – before insurance payments were available – it would

generate £3 billion annually. Payments out of the insurance fund would be small over the next 20 years, since they would relate specifically to those who have paid in: so a substantial capital fund of at least £50 billion would be accumulated in the period to 2022. Thereafter, the ring-fenced fund would pay out around half of all continuing care costs.

Since the 'free' care available would not cover accommodation costs, those wishing to avoid means-testing and loss of assets could top up their own insurance payments (for example by a single payment at the time they receive tax-free funds from their pension provision, or perhaps through partial equity release of a part of the value of their own home).

Whether or not the Joseph Rowntree Foundation's compulsory care insurance is regarded as a 'hypothecated tax by another name' is of little importance: the point is that it would free people at all income levels from the distress and insecurity of wondering how they will pay for potentially enormous care costs. Politicians and the electorate would see a major problem for the future not stored up, but dealt with in advance.

## In conclusion

This chapter identifies serious under-funding of current provision, and the likelihood of substantially higher costs in the future, as a significant national issue. It is one that will cause growing anxiety to rising numbers within the electorate and one, therefore, which may become increasingly relevant to politicians of all parties. The recent research from the IPPR, however, suggests that it would be possible to fund future care costs, if sensible mechanisms are put in place.

The Joseph Rowntree Foundation stands by its earlier recommendations for a regulated, funded, compulsory, *National Care Insurance* scheme. But there may be other ways of squaring the circle and securing the resources that would pay for care free at the point of delivery. For example, for those unable to accept the case for compulsion, a preferable route might lie in the avoidance of means-testing for those who take out private insurance to cover the first £X,000, with the State paying any costs thereafter: but any scheme that is not universal will suffer problems of adverse selection, cherry-picking by insurers, higher marketing and administration fees, etc.

The Joseph Rowntree Foundation Inquiry scheme may not be the only solution, but care costs are set to rise significantly over the next two decades, even while the numbers of older people are not increasing very dramatically. Unless some major initiative is introduced of the kind advocated, we believe care inequalities will proliferate and inadequate care provision will mean insecurity and hardship for very large numbers of older people by 2022.

## Notes

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