

Rethinking social care and support: What can England learn from other countries?

Viewpoint
Informing debate

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This *Viewpoint* draws on the experiences of other countries and sets out a number of principles that should underpin reform of care and support arrangements in England. The authors argue that:

Key points

- Responsibility for funding and providing social care is a collective, welfare state responsibility rather than an individual, private responsibility.
- Social care arrangements in many other countries are founded on principles of universality – those who are not poor as well as those who are poor are eligible.
- Equity – between people with similar levels of disability and regardless of where they live – is a key feature of arrangements for funding and providing social care in other countries.
- Reforming social care requires changes in the relationships and responsibilities of local government, the English and UK governments.
- Ensuring choice for people needing social care support involves the provision of services as well as cash.
- Support for family care-giving is an integral part of overall social care policy; however, eligibility for collectively provided social care should not depend on whether or not a carer is available.

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Introduction

In May 2008 the Government announced a period of consultation on future arrangements for the funding and delivery of care and support for disabled adults and older people in England (Department of Health, 2008). This consultation will inform a Green Paper to be published early in 2009.

The aim of this *Viewpoint* is to draw on the experiences of other countries –within the UK and internationally – in order to identify a set of principles that should underpin the reform of care and support in England. The paper:

- summarises some of the key features of social care; these features are important in determining the appropriate balance between collective, welfare state responsibilities and individual or market responsibilities for social care;
- spells out a number of principles that should underpin the funding and organisation of social care and support in England, illustrated with lessons and examples from other countries.

The nature of social care

Social care is characterised by *uncertainty, inequalities, lack of information*, and has vitally important *emotional and relationship* dimensions.

Uncertainty

It is difficult for any individual to anticipate whether they will need care and support in the future and, if they do, how extensive and long-lasting those needs will be. Moreover, the types and levels of support needed will change over time as health and other circumstances alter. Prior to needing care and support, individuals may also be unclear about whether, and what kinds of, unpaid care from friends and family will be available. Individuals are also unlikely fully to appreciate the potential financial implications of needing care, whether these arise from restrictions on employment or earnings; the costs of purchasing care services; or the financial losses experienced by family carers. Those seeking social care either for themselves or for relatives are frequently beset by doubt and uncertainty.

Inequalities

The need for social care is very likely to be accompanied by other forms of social and economic disadvantage, such as difficulties in working and earning or reliance on lower, post-retirement incomes; poor access to information and advice; or the depletion of savings because of the extra costs of disability and care. The close alignment of health and income inequalities means that individuals experiencing the greatest lifetime economic disadvantage are also likely to be at higher risk of needing care and support.

Those needing prolonged periods of residential care rapidly deplete any capital they may have saved; those without savings generally receive fully-funded state support. Conversely, those with capital who happen not to require long-term care are able to retain it and use it for any purpose they see fit. This deters individuals from saving and encourages them to deplete their assets. The disincentives associated with long-term care contrast sharply with those associated with health care. Because health care is free to all, it is entirely neutral in respect of savings- and asset-related behaviours. Put another way, the state pools risk across the population in respect of health care, but fails to do so in respect of social care. The resulting distribution of the costs of care is widely perceived as unfair.

Lack of information

Potential users of social care are profoundly disadvantaged relative to providers in their knowledge of available options. Few people will seek out information in case of the unpredictable and unwelcome future eventuality of needing social care (compared, for example, with plans for future retirement). As needs for social care often arise suddenly, for example as a result

of accident or stroke, this leaves potential users very unprepared.

Potential social care users are also likely to be unwilling or unable to 'shop around', either for information or for the 'best' service. Indeed, such consumer-related behaviours may be impossible where needs are very specialised, or in remote rural areas where few services are available. In such situations, choices of 'exit' from an unsatisfactory service may also be limited (Glendinning, 2008). Moreover, decisions on care are sometimes made by third parties, when the individual cannot articulate his/her own needs – for example, a relative seeking appropriate residential care for an older parent with dementia or a parent seeking respite care for a child with cognitive impairments.

When potential users of social care are restricted by poor information in making informed choices, service providers may act in ways that decrease, rather than enhance, the welfare of service users. Lowering costs and increasing production efficiency in line with market imperatives may impact on service quality. Scarcity of supply also risks choice by providers rather than consumers – 'cream skimming' the most profitable or the least difficult users.

Emotions and relationships

Whether provided by close kin, friends or paid workers, good quality care and support are embedded within close interpersonal relationships. Being respected and treated as an individual are important dimensions of good quality paid care; care provided within families often has profound emotional dimensions as well. Care may involve emotional labour – working on and through the feelings of others with the aim of affecting their emotional state (Hochschild, 1983). Providing care and support is also generally a very private activity, usually occurring within the home and involving intimate bodily contact (Twigg, 2000).

Thus social care is embedded within, and is a product of, close interpersonal relationships. These characteristics are as applicable to good quality professional care as they are to care provided by close kin. They place major constraints on the extent to which care can be commodified and distributed through market-type transactions. They indicate the need for significant regulation of the conditions within which care is accessed and delivered, so that these conditions can foster and sustain the appropriate interpersonal relationships for the provision of good quality care and support. Such regulation should encompass the conditions in which both professional and family care is provided.

Balancing private and public responsibilities

These features of care – its uncertainty and unpredictability; the impact of inequalities; the lack of information about short and longer-term options; and the importance of the relationships within which good care is given and received – strongly indicate that it is not appropriate to assume social care to be an individual responsibility in which the private market can provide a socially optimal outcome. Uncertainty at the personal level strongly deters individuals themselves from seeking insurance-style solutions, particularly for care-related products bought well in advance of need. Such behaviour is amplified by uncertainty over the future policy environment and, in particular, over future levels of state support. Current incentives are perverse and inimical to efficient private savings solutions.

At the same time, the promotion of social and inter-generational solidarity strongly indicates an active role for government in promoting the conditions in which risks are shared and good quality care can flourish. For informal and family care-givers, this means that the costs – financial, emotional, health-related – of providing care are not disproportionate. In any case, some of these initially private costs may subsequently become costs to the state if, for example, family carers find themselves facing poor health or inadequate provision for their own old age. Moreover state involvement is needed to create and regulate the conditions under which people access and receive care.

A further argument for public responsibility is that, like health care, social care is widely accepted to be a 'merit' good. From a societal perspective, this is a good which under normal market conditions is not being consumed in sufficient quantities to maximise either individual or collective well-being. Possible reasons for under-use are because individuals are too poor or because they are not 'sufficiently' concerned about their own care needs. A merit good differs from an 'entitlement' in that it need not be free to everyone, but individuals should not be excluded because they are unable to pay.

Having argued that the state has a major role to play in the funding, supply and regulation of social care, the next sections outline a number of principles that should underpin that role, illustrated with examples from Scotland, European and other developed countries. We begin with the issue that we have just alluded to – whether social care should be treated simply as a merit good or an 'entitlement' that is universally available.

Universality

Should access to publicly funded social care and support for people with appropriate levels of need be equally available to both those who are poor and those who are not poor? England is very unusual in that access to public funding for non-health related institutional care rests on an assets test; people with assets (including housing) over £21,000 cannot access any public funding, however great their care and support needs. Although the USA also uses an assets test, this does not include the value of the home. Moreover, in England access to other care provided by the NHS or in people's homes depends upon a complex range of eligibility criteria that variously take into account medical and nursing care needs; capacity for self-care; risks of harm; and the availability of informal care. Eligibility criteria vary between the countries of the UK and between the local authorities within them (Glendinning, 2007).

As a consequence of these complex and restrictive eligibility criteria, about half of all spending on social care – about £5.9 billion in 2005-06, equivalent to 4.3 per cent of gross UK income tax receipts for that year – comes from private sources: the means- and assets-tested charges paid by users of local authority-funded services; and the payments made by people purchasing care privately (Commission for Social Care Inspection, 2008).

However, most other developed countries have universal social care arrangements, accessible to all those with defined levels of care and support needs, regardless of income or age. The following principles underpin universal schemes that offer equal access to affluent and poorer, older and younger people (Brodsky et al., 2000; Brodsky et al., 2003; Gibson et al., 2003):

- Needs for substantial amounts of support and care, regardless of whether these result from physical, sensory or mental impairment, are treated as a 'normal risk of life' that the population as a whole is insured or otherwise protected against.
- Individuals' ability to meet those risks through private means (such as private insurance or private purchase) are very unequally distributed. Moreover, those who can initially afford to pay privately risk long-term catastrophic costs and impoverishment.
- Maximising risk pooling, whether through taxation-funded or universal social insurance programmes, increases efficiency. Risk sharing also enables responsibility for financing to be shared between working-age and older populations.
- Universal schemes protect families against the catastrophic costs of long-term care and against the health and economic consequences of providing unsupported informal care.

Other European approaches

In Austria, a cash Care Allowance funded from general taxation was introduced in 1993. It is paid regardless of age, income or assets. The Care Allowance is paid at one of seven levels, depending on the amount of help needed, and can be used to pay for care at home or in an institution.

Germany's long-term care insurance provides benefits for severely disabled people of all ages, regardless of income or assets. One of the drivers behind the introduction of German care insurance was the widespread stigma associated with 'spending down' assets in order to become eligible for means-tested social assistance to help with care costs. Membership of care insurance is compulsory, with almost the entire population covered – indeed the scheme is popularly known as *Volkerversicherung* – 'people's insurance'.

Since the 1960s the Netherlands has provided universal coverage for long-term care for people of all ages through a non-means-tested social insurance programme, the AWBZ.

Four important points need to be made about universal approaches to social care:

- They require an active role for national governments in collecting and allocating the resources for long-term care, so that access to collective funding is not affected by local variations in levels of available resources. Eligibility criteria and assessment processes are also determined at national levels (although assessments may be carried out by local officers and organisations). The clear role of national governments in generating, distributing and allocating resources significantly reduces the risk of local geographic inequity. We return to the issue of central-local government relationships below.
- Universal schemes involving nationally applicable eligibility criteria and assessment processes are, in the English context, more commonly associated with social security cash payments such as Disability Living Allowance and Attendance Allowance. However, several of the national schemes outlined above provide entitlements to packages of in-kind services, either as the only option (for example, France, Japan) or as an alternative to cash payments (for example, Germany).
- Universal schemes can provide equitable arrangements for both older and younger disabled people and, indeed, for disabled children as well. The Austrian Care Allowance, German long-term

care insurance and Netherlands AWBZ social insurance scheme, for example, have no age limits. In contrast, the Scottish free personal care scheme is limited to those aged 65 and over.

- Universal schemes have vitally important implications for citizenship and inclusion. They can be underpinned by notions of entitlement that, in the English context, are more usually associated with the nature of individual claims on social security benefits.

The Scottish perspective

The recent Scottish Independent Review of Free Personal and Nursing Care (Scottish Government, 2008, section 2) concluded that 'FPNC should be an entitlement for everyone assessed as needing this level of care and support; analogous with the NHS.'

Equity

Equity has a number of dimensions, all of which are relevant to the principles underpinning social care.

- Raising resources – the extent to which a social care system is equitable depends fundamentally on the extent to which the system used to raise funding is progressive. Resources may be raised through general taxation, hypothecated taxation or social insurance contributions. The extent to which any of these systems is equitable depends on the extent to which people with high levels of income and/or assets contribute proportionately more than those with low levels.

Dutch social insurance

Revenue for the Dutch AWBZ social insurance scheme is raised from a premium (13.25% in 2004) levied on income. However, only those with incomes over a given threshold are required to contribute this premium. Additional revenue from general taxation is also contributed to the AWBZ budget.

- Diagnostic equity – this requires that people with similar levels of impairment are treated equally and allocated similar levels of resources, regardless of the cause of that impairment.

Equity in Germany

Diagnostic equity has been a contentious issue in Germany, where the eligibility and assessment criteria for long-term care insurance are based on the help needed with activities of daily living. These criteria are widely believed to disadvantage people with cognitive impairments. Reforms in 2008 will extend eligibility criteria and increase the level of benefits for people with dementia.

- Spatial equity – this requires that people with similar levels of impairment are treated equally and allocated similar levels of resources, regardless of where they live. Almost all developed countries, including the UK, have social protection schemes that are uniform across their territories. Underpinning this arrangement is the argument that social protection benefit transfers are essentially negative taxes and should therefore be the responsibility of the same level of government as the tax system itself. This reduces the inefficiencies associated with inter-jurisdictional beggar-thy-neighbour policies.

International attitudes to reform

During the 1980s, major reforms were debated in Austria. Despite the strong principle of subsidiarity within the Austrian constitution and the historic responsibilities of regional governments for social welfare provision, one aim of the reforms was to reduce the very considerable differences in levels of provision between regions. The Care Allowance, introduced in 1993, can be claimed by all Austrian residents (and, indeed, by Austrian citizens living in other countries).

The introduction of long-term care insurance in Japan from 2000 was also partly prompted by concerns of unfairness arising from major differences between localities in the availability of social care services.

In Scotland, although free personal care was introduced in 2002, the 2008 Independent Review of the policy found it necessary to recommend further work on the standardisation of assessment procedures across local authorities to rectify perceived spatial inequities. It also pointed out the anomaly of many of those receiving free personal care at home in Scotland also receiving Attendance Allowance from the UK government, when this benefit is intended to compensate for the costs of personal care

However, although the social security system is uniform throughout the UK, the care system with which it closely interacts is subject to significant local and regional variations. The Fair Access to Care Services criteria that determine eligibility for publicly-funded social care in England are decided in the light of the resources available in individual local authorities. Key determinants of those resources are levels of grant allocation from central government and, crucially, local political decisions about the allocation of resources between competing service priorities (contributions from local taxation play a very small part). Consequently, people with similar levels of need in neighbouring local authorities can be variously eligible or ineligible for social care and receive different levels of social care support. In contrast, because the social security system is uniform across the country, these same people do not differ in their eligibility for social security benefits that support disability and care such as Attendance Allowance, Disability Living Allowance and Carers Allowance.

- Inter-generational equity – is social care policy 'sustainable' in the sense of not placing a penal financial burden on future generations? Pay-as-you-go social insurance schemes funded by the working-age population alone are fair if the demand for care is reasonably constant over time. But if the need for care increases, either because of the increasing prevalence of care needs at the individual level or because the cohort of those requiring care is growing in size, this will place an unfair burden on the working population. When the population is ageing rapidly, as at present, inter-generational equity demands that members of each cohort provide sufficient resources to pay for their own care, so that succeeding smaller cohorts are not forced into 'double-funding' – paying for their own care and contributing to the costs of the previous generation. To smooth lifetime contributions, to control progressivity and to reduce distortions in the labour market, this may mean that payments should come from the retired, through taxation and/or insurance contributions, as well as from those of working age.

Inter-generational equity in Germany

Since 2004, retired people have been required to pay their contributions to the German long-term care insurance scheme in full, rather than these being subsidised by the pension insurance fund.

Inter-generational equity can also mean that individuals with similar levels of need for care but of different ages or generational cohorts are treated similarly. Many of the universal schemes described above are equally available to younger and older disabled people and, in some instances, to disabled children as well. As mentioned previously, the Scottish scheme is a notable exception, since it is limited to those aged 65 and over.

- It is entirely possible to combine universality – care that is available to non-poor and poor people alike – with principles of fairness, so that those who can afford to contribute to the costs of their care do so in proportion to their means. Progressive co-payments or charges contribute to the economic sustainability of social care funding arrangements and also to their political sustainability, in that they reduce arguments that those who can afford to pay are receiving free care.

Co-payments in Japan and France

In 2000 Japan introduced long-term care social insurance for people aged 65+ (and those aged 40+ with age-related disabilities). Eligibility is determined by a 79-item questionnaire of physical and mental status; this is used to calculate which of seven levels of service provision an applicant is entitled to. All beneficiaries pay a co-payment of ten per cent of the value of their care.

In France, the universal Allocation Personnalisée d'Autonomie was introduced in 2002. The APA is paid at one of six levels of 'dependency'. It is a national, universal scheme. People with incomes below a certain threshold pay no charge or co-payment; people with incomes above this threshold pay co-payments.

Local/central roles and responsibilities

As noted above, access to publicly funded care in England is determined by the policies and priorities of individual local authorities; in contrast, cash benefits to support disability and care are available on a universal basis. Moreover, following the devolution reforms of the late 1990s, different parts of the UK have diverged on the funding of social care.

In line with the Royal Commission on Long Term Care for Older People (1999), Scotland has abolished charges for personal care for people whether in their own homes or residential care. This applies only to those aged 65 and over; personal care for younger people and for domestic help for those aged over 65

are subject to co-payment. This has been popular but raises new spatial and inter-generational inequities.

In contrast, England and Wales continue to require co-payments for personal care, although the Welsh Assembly introduced reforms in 2006 which included increasing the margin above income support levels that clients are allowed to retain before charges apply. While the Welsh Assembly was prepared to reduce charges for personal care relative to England, it stopped short of declaring its provision an entitlement, as has happened in Scotland.

Thus a peculiar policy asymmetry has arisen. Within the present constitutional settlement, England, Scotland, Wales and Northern Ireland can each determine their own policies, resourcing arrangements (including levels of charges or co-payments) and eligibility criteria for social care. Although the NHS was established separately in Scotland from England and Wales, conditions of access to healthcare are still largely common throughout the UK (though details of policy and resourcing differ). But only the UK government can make changes in taxes and benefits that fundamentally affect the structure and overall volume of resources available for care.

Many other countries have federal structures. Tax collection responsibilities and spending powers are distributed across central government, state/provincial governments and local/municipal governments. The delivery of social care is frequently a local or regional government responsibility, but social care policy, resources and eligibility criteria are determined at national level. There are a number of arguments to support this division of responsibilities, with central government taking a lead role.

- Intra-state differences in social security are perceived as inequitable and inefficient because they may induce people to move to increase the state support they receive. Similar arguments apply to social care policy.
- Another argument relates to fiscal policies. Switzerland is unusual in that local government tax revenues account for around 85 per cent of its expenditure. In stark contrast, English local government raises only around 20 per cent of the funds it needs; the remainder comes from central government grants. Local government has virtually no freedom to inject additional resources into social care. If a local authority wished to direct an additional one per cent of its budget to social care, it would have to raise council tax by five per cent. This 'vertical fiscal imbalance' seriously undermines arguments for local autonomy in respect of social care delivery.

- Local government in England is in many respects an agent of central government; its role is to assess, regulate and deliver provision according to rules laid down centrally. In theory, this should have the advantage of ensuring broadly equal provision across local authorities, but in reality this is dependent on local authorities receiving levels of grant that are appropriate to their needs, as well as having broadly similar levels of efficiency in delivery.
- Central government has the capacity to rationalise multiple separate assessments, not only for social care but for other closely linked resources such as social security benefits to support disability and care. Reducing separate assessments has efficiency gains.

Just as in the case of social security and health care, there are therefore strong equity arguments for a stronger central government role in the funding and delivery of social care. Central government responsibility maximises the pooling of risk; enhances budgetary controls; is essential for regulation/quality control; and is consistent with principles of universality. It could be argued that a more extensive role for central government control risks stifling local innovation and undermines the extent to which local arrangements are 'owned' by the relevant stakeholders. However, enlightened central control need not be inimical to flexibility and innovation; properly designed policies should allow for continuous improvement in the process of care delivery.

International local/central relations

In Australia, a country with strong traditions of State and Territory autonomy, the Federal Government has maintained a lead role in allocating resources for 'aged care' and in redirecting those resources away from nursing and residential homes towards community and home-based services.

Similarly, in Canada, though the provinces have considerable autonomy, the federal government has tried to influence national standards in health and care provision by attaching conditions to its fiscal transfers to the provinces.

The Scottish Government has adopted a more arm's-length relationship with local authorities than in England. This was codified in the 'Concordat Agreement' of 2007. Nevertheless its terms include, for example, commitments to an increase of 10,000 extra weeks of respite care to be provided by local authorities by 2010-11.

In many countries, major reforms to social care funding and delivery have involved renegotiations of relationships between local/regional and central/federal governments, with central/federal government taking over responsibilities from provinces/states/territories.

Reforming social care and support in England may therefore also involve reconsideration of the respective roles and responsibilities of the UK government as well.

Choice: services and cash

Funding for social care can be variously aimed at boosting the supply of social care on the one hand and subsidising the demand for care on the other. In the past the standard approach was to increase supply and make provision free for a large proportion of care clients. The disadvantage of this is that provision may become 'service-led' and unresponsive to client needs. With the rise of consumerism (and its implicit assumption that purchasers are in a position to clearly articulate and act on their needs), attention has switched to developing instruments that support the demand side of the market.

One mechanism for strengthening consumer demand is 'direct payments', which clients use to purchase the services they need. In the UK, direct payments have been energetically promoted by organisations of disabled people and Government alike. However, take-up of direct payments remains highly variable, between countries; between the local authorities within them; and between different groups of social care users (Riddell et al., 2005; Priestley et al., 2006; Fernández et al., 2007). In theory, this approach should stimulate a market that offers more choice and is more responsive to the real needs of clients.

Vouchers, or payments that have conditions attached to their use, can be targeted at specific provider organisations who, according to market logic, will be incentivised to increase capacity, quality and efficiency in order to compete with each other for customers.

Particularly where services are under-developed, cash payments can support family care, as in the case of Ireland and Italy. Cash payments can also contribute to long-term financial sustainability of universal social care provision.

International approaches to 'direct payments and vouchers'

The consumerist rationale has underpinned the Personal Budget scheme in the Netherlands – a cash alternative to the services otherwise provided under the AWBZ long-term care insurance scheme. Personal budgets in both the Netherlands and the Flanders region of Belgium also allow close relatives to be employed as helpers. However, as in England, take-up by older people is much lower than by younger disabled people.

In the Netherlands, personal budgets are available as an alternative to services in kind. The level of the personal budget is based on the number of hours care needed; however, a standard deduction of 25 per cent is applied on the grounds that independent and informal providers do not have the same overheads as traditional care services.

In Finland, vouchers for home care services are intended to increase the numbers of domiciliary care agencies.

In Valencia, the introduction of vouchers for nursing home care aimed, among other things, to increase the supply of publicly funded rooms and improve equality of access.

German long-term care insurance offers a choice of cash payment or services in kind. Despite the fact that the level of the cash payment is considerably lower than the in-kind service entitlement, it has consistently proved more popular; this is considered to have contained the costs of the insurance scheme.

However, there are disadvantages to 'consumer-led' approaches. These include the costs, both monetary and psychological, that clients incur in purchasing care. When offered a choice, some people – particularly older people and those with mental health problems – appear reluctant to opt for cash alternatives and prefer to use formal services rather than employ their own personal assistants and care workers. It is also important that people who opt to receive formal in-kind services instead of cash should not be prevented from exercising choice and control over the nature, timing and delivery of their care. Local government may still have an important role in commissioning services and/or assisting vulnerable people with the purchase of care. Other issues such as regulation and inspection may best be dealt with at national level, as is the accepted practice with other industries.

Moreover, there is little evidence that cash payments are effective in stimulating care provider markets, or in regulating or improving the quality of care. They may prove difficult to utilise in rural areas, where choice between providers (or access to any provider) is inevitably limited.

Cash payments alone, without appropriate service options which they can be used to purchase, also risk institutionalising low paid or unpaid informal care and trapping relatives in enforced dependency on the person they are caring for.

Some drawbacks of cash payments

In Austria and Italy, care provision based primarily on cash payments – Care Allowances – has not led to substantial increases in formal service provision. Instead, care for many older people comes from 'grey' labour market migrant workers, employed by families to provide care for their older relatives. While Care Allowances to some extent free family members from direct care provision, they introduce new care management responsibilities for families.

In Germany, the widespread popularity of the cash benefit option has also reduced pressures on formal service providers to improve the volume, range and responsiveness of their service options.

In Japan, insurance benefits in the form of service entitlements rather than cash payments were introduced, in order to relieve daughters-in law, the traditional care-givers for older people, of the obligation to provide unpaid care. In Scotland, the introduction of free personal care has led to the provision of an average of 6.5 hours per week of paid-for personal care to older local authority clients, considerably relieving the burden on unpaid carers and allowing them to help their relatives/friends in other ways.

The place of family care

For many disabled and older people in England, the level and types of social care services they receive are profoundly influenced by whether a family carer is available. Regardless of the preferences of those receiving or providing care and support, this institutionalises the dependency of a disabled or older person on a carer and risks impoverishing carers. Access to collectively funded support and services for an older or disabled person should not be affected by the availability, or otherwise, of family care. An older or disabled person should be eligible for social care, regardless of whether family carers are available; whether relatives wish to provide care; or whether the older/disabled person wishes to receive care from close family members.

Compared with many other countries, England has extensive legislation and support for family carers. Successive legislation has given carers rights to assessments of their own support needs, independent of assessments for an older or disabled person; assessments must now consider carers' employment, training and leisure activities and aspirations. England is also unusual in having a social security benefit for carers to replace lost income when carers leave the labour market because of care commitments; however, the benefit is very low and rigid eligibility criteria mean that many carers do not receive it. Moreover, policies for carers have developed largely separately from those for supporting older and disabled adults.

In contrast, in other countries supporting family care-giving is an intrinsic element of wider social care policy and provision; measures aim to balance the rights and needs of both disabled and older people and family carers.

Moreover, unless accompanied by services that can give carers a break and by social protection measures to safeguard their financial independence in the shorter and longer terms, heavy reliance on informal care is likely to lead to excessive burdens, stress and longer term impoverishment.

International approaches to family care

The Netherlands consumer-directed Personal Budget allows older or disabled people to employ a close relative as a carer. Even where a spouse is employed, a formal contract with minimum labour market terms and conditions is required. This arrangement can formalise, protect and give recognition to an arrangement that both disabled people and carers are happy with; it can also draw new people otherwise on the margins of the labour market into paid care work.

The German cash payment option is accompanied by a range of measures to support care-giving relatives, including rights to four weeks respite care each year; substitute care if the carer is ill; retirement pension and accident insurance cover for family carers who are employed for less than 30 hours a week and who provide at least 14 hours a week unpaid home care. Carers are also offered nursing courses and retraining opportunities if they return to paid employment. 2008 reforms include six months unpaid leave from work for carers, with their pension and sickness insurance protection maintained; and up to ten days emergency unpaid leave from work.

Australia offers an extensive range of concessionary rates for services at State and local authority levels for carers. A two-tier payment system of carer benefits provides a means-tested Carer Payment to carers unable to earn. The Carer Allowance is paid to all carers supporting someone at home, to cover the extra costs of caring. It is neither taxable nor means-tested.

In Canada, carers are eligible for up to six weeks paid leave, with rights to return to their job, in order to care for a terminally ill relative; this is funded through the sickness insurance scheme.

Conclusion

Although this paper has set out a number of principles that should underpin social care and support in England, it is not necessarily the case that a reform programme can meet all of them – or, at least, not to an equal extent. In terms of its demographic profile, England is little different from other developed countries, particularly those in the rest of the UK. However, England's current social care arrangements are widely divergent from many other developed countries and, to a lesser extent, from the other countries of the UK. In particular, virtually no other country restricts access to publicly funded social care only to poorer people; moreover, recent reforms in countries as diverse as Austria, Germany and Japan have increased rather than decreased the universal nature of their social care provision.

Social care policies adopted in other countries reflect fundamental differences in societal attitudes to uncertainty, inequality, transparency, citizenship and the role of unpaid care. On top of these differences are constitutional and fiscal arrangements that influence the way in which social care policy develops in different countries. One particular difficulty with the English approach is that, for reasons of equity, social security and health care are provided on a broadly uniform basis, while social care can be influenced by local factors which produce significant inequity. Further, although some components of care needs are met by social security cash payments on a universal basis, local authority provision comes through a quite different system of assessment and is subject to assets and means tests. This fragmentation creates additional difficulties – for disabled and older people, their families, professionals and policy-makers alike – in managing the interfaces between social care and other essential services such as housing, healthcare and social security benefits. No other country has as disjointed a system for dealing with vulnerable individuals that require social care – nor, indeed, policies and practices that treat the needs of those needing care separately from the needs of family carers. Other countries treat them more holistically.

The key question this paper poses is whether – in the long run – the English government will be prepared to play a more central role in social care policy. Other countries clearly accept that this is a legitimate role for central government. Arguments to support this include those of universality and equity: only central government has the powers necessary to reduce funding, spatial and intergenerational inequalities. Central government can increase risk pooling; can enhance social welfare; and can increase efficiency through being able to realise increased economies of scale. A more enhanced central role should also bring together the resources that are currently separately directed towards social care from the NHS the social security system and from local authorities. Finally, a stronger role for central government will help eliminate the boundaries between social care and health care, which often add to the difficulties experienced by social care users. And if this role for the English government is accepted, it immediately raises the question of whether such responsibility should extend across the whole of the UK.

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