

foundations

Meeting the costs of continuing care

After more than a year of deliberations, the Joseph Rowntree Foundation's **Inquiry into Meeting the Costs of Continuing Care** has reported. It analyses the difficulties with the current system and recommends the creation of a new scheme which recognises that: 'every citizen should be entitled to continuing care at standards to be defined at the national level'. This should be funded in a way which strikes a fair balance between individual responsibility and state provision, and between current and future generations.

Immediate difficulties

- A complex funding system has shunted the costs of care from services which were free at the point of delivery to more means-tested provision.
- A small number of people face a 'catastrophic risk' - all their assets are at risk from means testing.
- Many people expected social care, like health care, to be provided free and now have a sense of a 'broken contract' with the State.
- There are inadequacies in the provision of domiciliary care.

Long-term difficulties

- There is a funnel of doubt as to the cost of meeting the future health and care needs of older people.
- Although no funding crisis is imminent, it would be imprudent to take no action, because:
 - the number of over-85s will double between 2011 and 2041;
 - changes in family structures and roles, and greater geographical dispersion mean that there may be less informal, unpaid care.

Recommendations

- Both health care and social care should be free at the point of delivery for all older people. The 'accommodation costs' of residential/nursing care should continue to be paid for on a means-tested basis.
- We should act now, taking advantage of the current opportunity to build up funds for the time when the number of older people rises sharply.
- A funded **National Care Insurance** scheme should be established. Contributions would be compulsory at a rate which would ensure that someone on average earnings for all their life would pay for insurance cover against the full cost of their continuing care. The rate would be about 1.5 per cent of earnings.
- A **National Care Council** should be established both to set and review national standards of continuing care entitlements and to regulate the insurance scheme, making corrections to contribution rates as and when required.

Public expenditure implications

The immediate net cost of the scheme would be about £540 million per annum, but the National Care Insurance contributions would generate £3 billion annually. Payments from the insurance fund will be small in the first 20 years, so a substantial capital fund of at least £50 billion is likely to be accumulated in this period.

The entitlement to continuing care

In the spring of 1995 the Joseph Rowntree Foundation began an Inquiry into the ways of meeting the costs of continuing care for older people. It reviewed difficulties with the current situation and made recommendations to create a system which could significantly improve the quality of life of older people, recognising:

Every citizen should be entitled to continuing care at standards to be defined at the national level. These should be set out clearly for all users and providers of services and applied consistently, with proper appeal procedures.

Continuing (or 'long-term') care is defined as 'all forms of continuing personal or nursing care and associated domestic services for people who are unable to look after themselves without some degree of support, whether provided in their own homes, at a day centre or in an NHS or care home setting'.

The immediate concerns

The shunting of costs of continuing care

The funding for continuing care is currently very complex. Funds come from the NHS, local authorities and from the social security system. Care in the Community policies, together with medical advances, have reduced the length of time people stay in hospital. The independent and residential nursing home sector has grown. The provision of care has been shifted increasingly from the NHS, free at the point of delivery, to a means-tested provision organised by local authorities. Perverse incentives have developed which encourage local authorities to place individuals in residential care, despite the national policy to keep people at home as long as possible. In addition, local authorities are having to charge for the provision of care services in people's own homes, much of which was previously free.

The 'broken contract'

Many people perceive continuing care to be an aspect of health care and expected it to be provided free by the NHS. More of the costs, however, are now falling on the individual household. A study commissioned for the Inquiry revealed widespread disquiet about this trend amongst those who have saved during their working lives. The change has led to people having a sense that their 'contract' with the State has been broken.

The 'catastrophic risk'

Many people are anxious that they will have to sell their home in order to fund their care. Although research indicates that the requirement to sell the house in order

to fund care is only likely to fall on a small proportion of the total population, for those individuals for whom this is necessary, the risk is 'catastrophic' - i.e. almost all their assets are at risk.

Inadequate domiciliary care

There is mounting concern about the adequacy and quality of domiciliary care, and a number of studies suggest that many people feel they are not getting enough services or that there are significant gaps in the kinds of services they receive. Nine per cent of the population aged 65 and over, for example, could not get up and down stairs on their own, but half of those were receiving no help from social services (although they may have been receiving informal care).

The Inquiry's recommendation: free care at the point of delivery in all settings

The Inquiry concluded that distinctions between 'health care' and 'social care' - with different funding requirements on the individual user - were artificial and should be rejected. Both should be free at the point of delivery, without the imposition of means-tested charges, for all older people who are assessed as needing domiciliary, residential or nursing care. This change would not be extended to include accommodation costs in residential/nursing homes (since meals, heating, rent or maintenance, etc. would have been paid for by the individuals had they remained in their own homes).

Table 1: Institutional care, Great Britain 1991

Percentage of all people in each age band who are in institutional care

Age	Men	Women	All
65-69	1.1	1.0	1.0
70-74	1.6	1.9	1.8
75-79	3.0	4.4	3.8
80-84	6.2	10.3	8.9
85+	15.2	26.3	23.7
All 65+	3.0	6.4	5.0

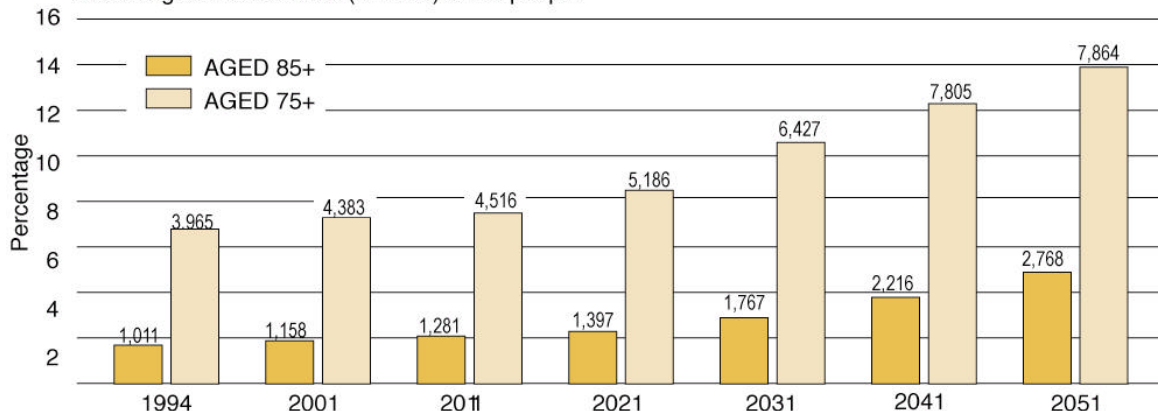
Percentage of those in institutional care (aged 65+) in each age band

Age	All	Men	Women
65-69	6.4	13.1	4.2
70-74	9.0	14.6	7.2
75-79	15.7	19.8	14.4
80-84	24.5	23.5	24.9
85+	44.4	29.0	49.3
All 65+	100.0	100.0	100.0

Source: OPCS, 1991 Census: Communal Establishments, Great Britain 1993

FIGURE 1: PROJECTED CHANGES IN THE AGE STRUCTURE IN THE UK POPULATION 1994-2051

Percentages and numbers (millions) of old people



Source: Government Actuary's Department, Population Projections

The long-term concerns

The 'funnel of doubt'

The Inquiry agreed with the recent House of Commons Health Committee conclusion that there was no immediate funding crisis, but there was a 'funnel of doubt' as to the future health and care needs of older people. However, the Inquiry concluded that it would be imprudent to assume that costs in the future might fall or increase only gradually. It identified a number of factors indicating a strong possibility that costs are likely to be higher in the future, including:

- A large increase in the number of over-75s and over-85s
Even if steps are taken to develop preventative and rehabilitative services in the future, it is likely that very elderly people will still need more care than younger age groups. In 1991, one in twenty people aged 65 and over were living in some kind of institutional care, but one in four of those aged over 85 were doing so. The numbers of very elderly people are expected to increase sharply during the first half of the next century (as shown in Figure 1). The number of people aged 85 and older will grow from 1.15 million in 2001 to nearly double that - 2.21 million - in 2041. While there is no immediate crisis in terms of a 'demographic time bomb', the number of people requiring continuing care by the middle of the next century is likely to be very much higher.
- Informal care
There is no evidence that families and neighbours will be less willing to care for their dependent older relatives and friends in the future. However, with a decline in the number of middle-aged women (who are the main care providers) at the

same time as the numbers of older people are rising, with an increasing tendency for such women to be in work, fewer family members live close to each other, and with a larger number of single, divorced, and widowed people with no children, it is likely that there will be an increase in the demand for care from professional services.

The Inquiry's recommendation: act now

Although there is no crisis in terms of the number of people needing care now, there is great uncertainty about the longer term. The combination of the need for more services, linked to rising expectations, would suggest that a real increase in the amount of expenditure on continuing care will be required. The Inquiry concluded that the nation should begin to build up some of the financial resources for long-term care which are going to be needed in the future. The years ahead represent a 'window of opportunity' which should be used.

The scheme recommended by the Inquiry

The scheme recommended by the Inquiry to address long-term concerns has two key components - the establishment of **National Care Insurance** and the creation of a **National Care Council**.

National Care Insurance

Only a minority of people will need long-term care in the future, but for those who do, the cost may be very high indeed. A prudent way of preparing for this is for individuals to pool the risk by taking out insurance. Since the Inquiry advocates an entitlement to care, free when it is needed, few would take out insurance unless the scheme was compulsory.

The National Care Insurance scheme

A funded scheme involving the private sector

The Inquiry recommended a *funded* scheme so that contributions are accumulated over time, probably with individuals having their own contribution records. The contributions paid in would be kept at arm's length from central government to ensure public confidence that the money would not be used for other purposes. Private sector fund managers and investment institutions would need to be employed to look after the contributions as they accumulate.

If there are concerns about a single monopoly insurer (the State) becoming inefficient or insensitive, there may be grounds for also involving the private sector in providing alternative schemes to the State's, into which individuals could opt if they wished (with a Regulator licensing all participants).

The division of care and accommodation payments

The scheme would need to pay out separately for *care costs* and *accommodation costs*:

in the case of *care costs*, if the individual's contribution record is insufficient to meet the full costs, the balance would be met in full from general taxation.

in the case of *accommodation costs*, any balance would remain the responsibility of the individual and a means test would determine whether this should be met from the individual's own resources or by the State (probably through the local authority).

The rate of insurance contributions

The rate of contributions would be set on the basis that someone who had been on average earnings for their whole working life would raise sufficient sums to pay for insurance cover against the full costs of their continuing care. On this basis the contribution level would need to be set at around 1.5 per cent of earnings (currently about £250 per year), but this would need regular review by the *National Care Council*. Upper and lower earnings limits are recommended, as with National Insurance schemes, to prevent a disproportionate amount falling on those with low earnings and those with high earnings.

Assessments and payments from the scheme

A variety of operating procedures can be envisaged. If the current arrangements are continued, local authorities would have the central role, making an assessment of the individual's care needs.

Those who qualify for care in their own home would receive it without charge. Payments due to the individual from the *National Care Insurance* scheme would be drawn down by the local authority to cover costs. Where the payment from the insurance scheme for the individual was insufficient to pay for the level of care to which the *National Care Council* had determined every citizen would be entitled, the balance would be made up by the local authority, drawing on resources allocated by central government for community care costs.

For those needing to go into residential or nursing establishments, separate payments would be due from the *National Care Insurance* scheme for *care costs* and *accommodation costs*. If there were insufficient funds from the insurance payments for the former, the balance would be made up by the local authority (i.e. from general taxation) and the balance for the latter would be made up by the individual (or, if a means test indicated it was required, by the State).

Additional Voluntary Contributions (AVCs)

As *accommodation costs* would remain means-tested, those who did not have a full contribution record (and those who wanted a higher standard of accommodation than that set as the national standard by the *National Care Council*) could lose personal assets. The Inquiry recommended AVCs as a way of enhancing the sums available for these individuals to meet *accommodation costs*. One way of home owners raising funds for this would be to use *partial equity release*, which may be more attractive if this extra insurance was linked to a *National Care Insurance* scheme. The Government's plans for *Partnership schemes* could also be used to encourage AVCs.

A **National Care Insurance** scheme should be established, therefore, with an obligation to contribute on the part of all those who have earnings during their lifetime. The Inquiry's detailed recommendations on the nature and structure of the **National Care Insurance** scheme are provided in the box on page 4.

The National Care Council

The Inquiry proposes that a **National Care Council** should be appointed by the government to oversee and regulate the system. It should include a balance of experts and consumer representatives and be answerable to Parliament. The **National Care Council** would have responsibilities for setting out and reviewing national standards of continuing care entitlements and determining the basis and levels of payments from the scheme. Importantly, the same body would have responsibility for regulating the **National Care Insurance** scheme, establishing and reviewing contribution levels. It would thus be in a position to make 'in-flight corrections' to contribution levels in relation to the standards set and changing social and demographic conditions.

Implications

For the economy, there are two implications of the Inquiry's proposals - a redistributive effect, and a public expenditure effect.

The redistributive effect

Everyone would be entitled to the same level of care irrespective of their contribution record. It would fall to the State, not the **National Care Insurance** scheme, to redistribute resources between rich and poor. The scheme itself would be redistributive in another way - from men to women. Men and women would be treated equally in terms of contribution while care costs would, on average, be higher for women.

The public expenditure implications

The cost of ending charges for domiciliary care would be about £100 million (net of administration), while health and social care services in residential and nursing homes would cost around £700 million per annum. However, by ending the anomaly of Attendance Allowance being paid to some, but not others who receive care in institutions, the cost to public expenditure would probably be reduced by £260 million. Therefore the immediate, net cost of the

scheme would be about £540 million per annum.

In the longer term the payments by those in work, equivalent to an additional 1.5 per cent on employees' National Insurance contributions, would mean over £3 billion being collected annually. Since payments from the fund would be very small over the next fifteen to twenty years, a substantial capital fund would be accumulated, which in itself would generate further income. In future, therefore, a substantial proportion of the costs of continuing care in the UK could come from the **National Care Insurance** scheme and not from general taxation.

Although the scheme means higher costs for the State in the early years, it would be important that this did not lead to any diminution in resources allocated annually to local authorities, who are already facing difficulties in covering the costs of providing care in the community and meeting the bills of people without assets in residential/care homes. Investment in domiciliary care today and spending on preventative measures, such as more accessible housing, could mean savings on the higher costs of residential care establishments.

Further details of the public expenditure implications are shown on the following page.

Conclusions

The Inquiry's recommendations envisage a new contract between the State and the individual in which there is universal entitlement for social care at home or in residential and nursing care, free at the point of delivery. Although, in the short term, this would necessitate an additional expenditure from general taxation of over £0.5 billion which currently falls to individuals themselves, it should considerably ease the sense of anxiety and outrage caused by the current system.

For the longer term, the **National Care Insurance** scheme would avoid a funding crisis - perhaps when those who are now aged about forty reach their eighties. By making regular payments throughout their working lives, today's generation would ease the cost on the next generation. The scheme recommended by the Inquiry would provide the whole nation with greater reassurance and security that continuing care would be available as needed for every citizen, now and in years to come.

Members of the Inquiry: Sir Peter Barclay CBE, *Joseph Rowntree Foundation*; Dr Kate Barnard, *North & Mid Hampshire Health Authority*; Cedric Dennis, *Joseph Rowntree Foundation*; Andrew Dilnot, *Institute for Fiscal Studies*; Nigel King, *Housing Consultant*; William Laing, *Laing & Buisson Ltd*; Desmond Le Grys, *Munich Re-Insurance Company*; Barbara Meredith, *National Consumer Council*; Professor Ray Robinson, *Institute for Health Policy Studies, University of Southampton*; Paul Seymour, *Continuing Care Conference*; Martin Shreeve, *Association of Directors of Social Services*; Professor Anthea Tinker, *Age Concern Institute of Gerontology, King's College London*; Lewis Waddilove CBE, *previously Joseph Rowntree Foundation*; Professor Gerald Wistow, *Nuffield Institute for Health*. **Observers:** Peter Craig (*Department of Social Security*), Raphael Wittenberg (*Department of Health*). **(Observers have no responsibility for recommendations).** **Editors:** Richard Best and Dr Janet Lewis (*Joseph Rowntree Foundation*). **Inquiry Secretary:** Dr Ann Richardson

The public expenditure costs of continuing care

The context

Contributions by the taxpayer toward the care costs of elderly people in Great Britain (1994/95) are broadly as follows:

In residential/nursing homes:
 net costs paid through local authorities £1.6bn
 paid by DSS ('preserved rights') £1.5bn

Home care costs (net):
 paid through local authorities £1.6bn

Sub-total: £4.7bn

In addition, extra income is provided to elderly people who face additional costs because of a need for care:

Attendance Allowance (DSS): £2.0bn

Disability Living Allowances (DSS): £0.2bn
 (care component)

Residential Allowances (DSS): £0.2bn

Sub-total: £2.4bn

Total: £7.1bn

These figures exclude payments by the NHS for the health care of older people (estimated at about £8bn); the NHS expenditure includes payments for long-stay hospital beds (estimated at about £0.3bn) and for community health services for older people.

Immediate costs arising from the Inquiry's proposals

At present, charges are reducing the cost to local authorities of *home care* by, perhaps, £150 million p.a.; but deductions for administration may mean the actual amount gained is very much lower.

Accordingly, the Inquiry estimates the cost of abolishing charges for domiciliary care at around £100 million p.a.

Turning to the costs of the Inquiry's proposals for making *care in residential and nursing homes* free at the point of delivery, the Inquiry commissioned work from Steve Webb at the University of Bath. In the light of evidence from Laing & Buisson and elsewhere, the split between social care costs, and accommodation costs, was calculated: 38 per cent of costs in residential homes and 56 per cent of costs in nursing homes are estimated to relate to *social care*.

On the basis of known charges, and with 56,000 self-payers in residential homes and 47,000 in nursing homes, costs of £225 million and £415 million were deduced.

In addition, part payers in residential establishments would also see a saving, calculated for 14,600 people in residential homes at £18 million, and 13,000 in nursing homes at £36 million.

The total cost of the JRF Inquiry's recommendations in relation to residential establishments, therefore, would be about £700 million.

However, the Inquiry is suggesting that Attendance

Allowance be withdrawn after 4 weeks for all those in residential/nursing care (as is the case already for those in long-term hospital beds and local authority homes). This measure would lead to a saving of £260 million, leaving net costs of £440 million.

Long-term savings arising from the Inquiry's proposals

The Government Actuary's Department has stated that adding 1.4 per cent to the current level of National Insurance contributions for employees would raise £3 billion p.a. This excludes the self-employed whom the Inquiry feels should be brought within the scheme: if these are included, a lower figure - rather less than 1.3 per cent - might then be sufficient to raise £3 billion.

Allowance must be made for deductions from the premiums to cover the administration of the scheme. These costs are moderated by the fact that collection would be (mostly) on a pay-roll basis alongside National Insurance contributions - and therefore any mean extra costs would be at the margin. The Inquiry concluded, therefore, that 1.5 per cent of earnings represents a sensible starting point.

On this basis, the Inquiry's proposals would seem likely to raise about £3 billion p.a.

However, few claims could be expected for the early years of the National Care Insurance scheme because only those under 65 when it is introduced will join in; few of these are likely to need much care before their late seventies. The contributions paid in each year would build up to a very substantial sum by the time large-scale withdrawals occurred. It could be 40 years before payments out and payments in fell in line. The income from investing this 'cash mountain' in the meantime would add appreciably to the amounts available.

Further information

A full report, *Meeting the costs of continuing care: report and recommendations*, is available priced £11.95 plus £1.50 p&p from York Publishing Services Ltd.

Also available from York Publishing Services is *Meeting the costs of continuing care: Public views and perceptions* by Rebecca Diba (price £11.00 plus £1.50 p&p).

Related Findings

The following *Findings* look at related issues:

Social care

- 78 Regulating residential care for elderly people (Jan 96)
- 80 The impact of charging policy on the lives of disabled people (Feb 96)
- 84 Meeting the costs of continuing care: Public views and perceptions (Apr 96)
- 88 Local authority charging policies for community care (Jun 96)

For further information on these and other *Findings*, please contact Sally Corrie on 01904 615905.