

## **Facing the cost of long-term care**

### ***Towards a sustainable funding system***

*Donald Hirsch*

A review of issues facing the current system of paying for long-term care for older people, asking how this system could be improved to deliver better outcomes for clients and their families.

Over the past decade it has become ever clearer that the UK lacks an adequate, coherent and fair basis for paying for long-term care for older people. As a result, services are already under strain, not all needs are being met, and we are ill prepared to meet future challenges as the population continues to age.

This study brings together evidence and discussions assembled by the Joseph Rowntree Foundation. It identifies some key challenges that need addressing in order to start moving towards a fairer, more rational and adequate system of funding. It deliberately avoids proposing a radical redesign of the whole system, though there is a case for that. Rather it provides a platform for sensible discussion of how to design improvements in the funding system.

In setting out the challenges, the paper gives illustrations of policy options, for discussion and further development.



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# Foreword

How best to pay for the cost of providing long-term care for older people is one of the wicked issues to set alongside the even bigger issue of adequate pensions. How a country treats its retired citizens is a touchstone of its claim to be civilised. What will happen to them if they become incapable of looking after themselves in old age is a matter of concern and worry to many, especially as they approach that condition.

The issue has already been the subject of a Royal Commission, which used to be the traditional way in this country of seeking to build consensus around difficult questions. But the Commission was divided in its conclusions and its main recommendation – free personal care for all – has been taken forward only in Scotland.

The Joseph Rowntree Foundation (JRF) has already produced one report on the subject, in 1996, *Meeting the Costs of Continuing Care*. This document is part of a programme that is intended to help move the debate forward by providing a platform for sensible discussion based – as is the JRF way – on evidence and reasoned argument. A number of research papers have already been published under the programme. A further important paper evaluating the initial impact of the decision by the Scottish Parliament to provide free personal care is to be published in November 2005.

This paper by Donald Hirsch brings together the outcome of a series of discussions of an advisory group established by the Foundation to help steer the programme. The members of the advisory group are listed in Appendix 2. I am very grateful to all of them for their help in supporting the programme and contributing to the ideas in this paper.

The paper is not a report in the sense that it does not necessarily represent the agreed views of all the members of the advisory group, nor the organisations from which some of them come. It is intended more as a discussion document drawing on their deliberations to produce a number of suggestions for further debate. It is grounded in a set of principles that we are confident would command general acceptance.

There is no doubt in the advisory group's mind that, as a nation, we will have to pay more for long-term care in the years ahead. Indeed there is considerable evidence that the system is underfunded already. The issue is whether the additional resources will be provided within a system that is generally regarded as fair, transparent and consistent as between different types of care, different types of need and the balance between what is provided by the State and what is paid for by individuals or their families out of their own resources. If the system is not regarded as fair, it is unlikely to prove to be sustainable.

The Joseph Rowntree Foundation would welcome comments on this paper and the ideas contained within it. Responses should be addressed to Sue Collins at Joseph Rowntree Foundation, The Homestead, 40 Water End, York YO30 6WP.

**Christopher Kelly**

Chairman of the advisory group



# 1 Introduction

Over the past decade, it has become ever clearer that the UK lacks an adequate, coherent and fair basis for paying for long-term care for older people. As a result, services are already under strain, not all needs are being met and we are ill prepared to meet future challenges as the population continues to age.

This paper, bringing together evidence and discussions assembled by the Joseph Rowntree Foundation (JRF), argues that the present system is simply not working. Not only is it providing inadequate resources overall, but also some fundamental ambiguities in the funding system need resolving. In particular, it is not clear to the public to what extent they can expect to get help with the cost of care based on need, as provided by the NHS, or to what extent services will be restricted only to those who are least able to pay for it themselves. Nor do we have a clear-cut view of how much we expect of unpaid family carers, or of how to deploy resources in a way that explicitly supports their contribution.

The paper identifies some key challenges that need addressing in order to start moving towards a fairer, more rational and adequate system of funding. It deliberately avoids proposing a radical redesign of the whole system, though there is a case for that. Rather it provides a platform for sensible discussion of how to design improvements in the funding system. It argues the following.

- Reports in the 1990s clearly set out an agenda for reform, but were only partially implemented, and the response did not solve the underlying problems that were identified.
- The future costs identified by those reports might prove to be underestimates, given new demographic projections that indicate a larger growth in the very old population than was then forecast.
- If we wait until the sharpest growth in the elderly population in the 2020s before acting, we will do so in a crisis situation rather than being able to make a smooth and rational transition to an improved system. Moreover, inadequacies in the system are already causing problems that need addressing now and could soon worsen with, for example, growing workforce shortages.
- Over the long term, we will not be able to avoid paying more for care: the main question is whether we can do so under a system that is fairer, and seen to be fairer, than the present arrangements.

- Structural improvements in the system and the injection of more resources are closely linked. If the system seems unfair and arbitrary it will be harder to raise the money to fund the public share, whether through taxation or national insurance, and those paying for their own care will resent it more. Over the long term, if people feel that we have a good system of providing for our future needs, it will become easier to raise the necessary resources.

Informing the discussions in this paper are some basic principles identified by the Joseph Rowntree Foundation that should be embedded in any system for funding long-term care (see Box 1). The purpose of this paper is to identify some of the features of our present system that are most clearly in need of improvement in relation to these principles, especially with regard to *adequacy, consistency* and *fairness*. It is therefore inevitably selective, and focused primarily on action that could be taken within the broad context of existing arrangements in the UK.<sup>1</sup>

### **Box 1 Six core principles for a system of long-term care funding**

- 1 *Be fair and be seen to be fair* – in the way money is raised and allocated.
- 2 *Support preventative measures* – through a system that encourages early intervention, rewarding rather than penalising measures that reduce the amount of care needed.
- 3 *Recognise the diversity of needs and allow recipients of care to retain their dignity* – through the care provided and resources left to individuals after paying for their care.
- 4 *Promote personal and family responsibility* – through an appropriate balance between family and State.
- 5 *Be sustainable* – by commanding general public support and by being responsive to demographic, medical, economic and other changes.
- 6 *Encourage an efficient supply response* – through adequate resourcing for a range of types of care.

In setting out the challenges, the paper gives illustrations of policy options, for discussion and further development.

## 2 What is the problem?

### We have not yet confronted projected increases in costs

In the late 1990s, the Joseph Rowntree Foundation's *Inquiry into Meeting the Costs of Continuing Care* (Joseph Rowntree Foundation, 1996) and the Royal Commission on Long-term Care (1999) both concluded that the UK's arrangements for funding long-term care for older people were inadequate. They argued that the resources available would be insufficient in future to cater for the growing number of people needing long-term care and that the arrangements were deficient in terms of allocating resources fairly, ensuring access to good-quality services based on need and protecting against catastrophic risk.

Both JRF and the Royal Commission proposed that nursing and personal care should be provided free at the point of use for those needing it. The JRF Inquiry proposed funding this from compulsory care insurance, the Royal Commission from general taxation.

### *New resources have been limited ...*

Since these reports were published, some additional public resources have been provided, but not on the scale recommended.

In 2001–02, all parts of the United Kingdom introduced non-means-tested, fixed-rate contributions towards the costs of *nursing* care in nursing homes, regardless of income. The contributions vary by country. In England, they are paid in three bands according to need. In other parts of the UK, there is only one rate. In addition, in Scotland, and only there, non-means-tested payments are made by the State for *personal* care in residential homes and personal care is provided free in people's own homes to those assessed as requiring it.

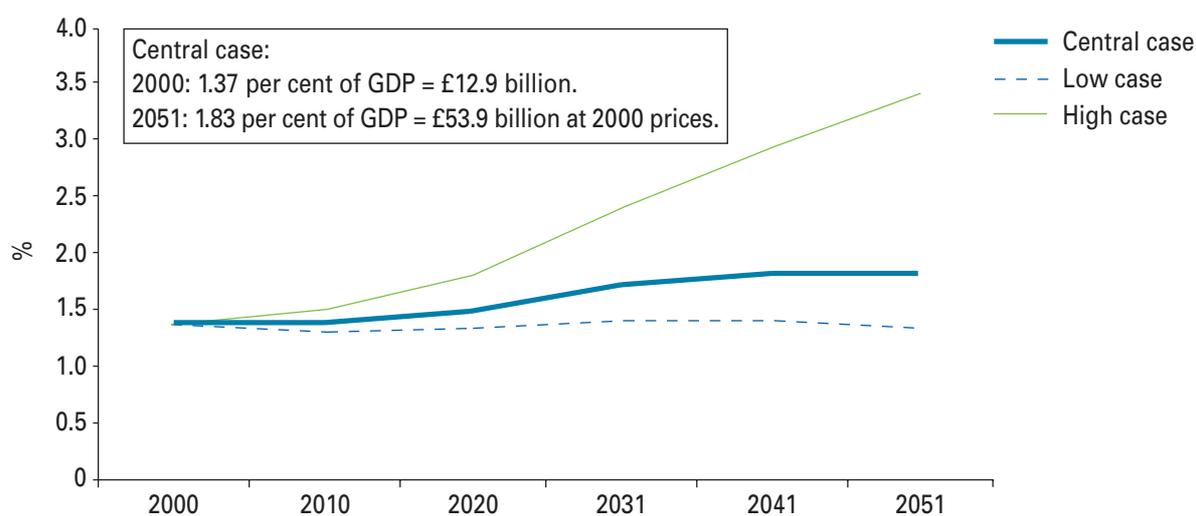
These changes have increased, to varying degrees, the public contribution to the cost of care. They have not always reduced the private contribution by as much, since care home fees have risen, potentially to make good shortfalls on quality.<sup>1</sup>

### ... even longer lives are being predicted ...

Meanwhile, projections of long-term demographic trends are showing even greater population ageing than previously expected, although huge uncertainties remain. New official population forecasts based on assumptions of longer life expectancy have caused estimates of the future cost of long-term care to be revised upwards. Although demand is not at present rising fast in the UK compared to some other countries, because of slower population ageing, this will change after 2020. By the middle of this century, the best guess, based on estimates produced for JRF (Wittenberg *et al.*, 2004), is that spending will quadruple in real terms and rise by a third relative to GDP. If policy remains the same, the private contribution will have to rise by nearly a half relative to GDP (see Figures 1 and 2).

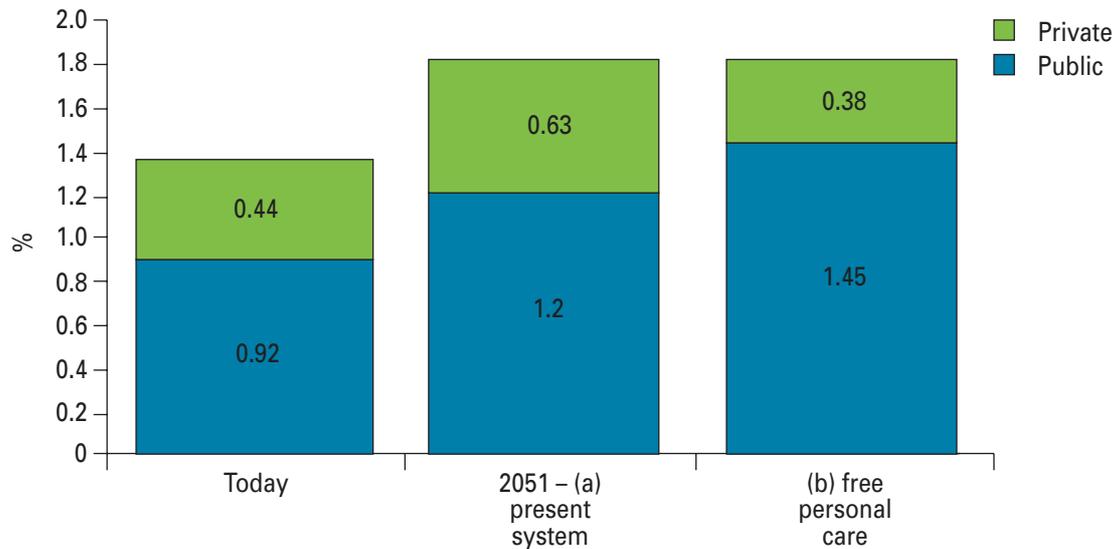
These estimates are highly sensitive to uncertainties about how long people will live, how long they will stay healthy and the future cost of given care levels. At one extreme, it is conceivable that care needs will not rise any faster than national income. But, at the other, they could rise to two-and-a-half times their present share of GDP. The low estimate relies on the assumption that people living longer will not need care for longer. It seems more reasonable to expect that they will, and therefore to prepare for a substantial rise in the cost. Thus, a higher than expected increase in cost seems more probable than a lower increase.

**Figure 1 Percentage of GDP spent on long-term care: three scenarios**



Source: Wittenberg *et al.* (2004).

**Figure 2 Public and private spending on long-term care (central scenario)**



Source: Wittenberg et al. (2004).

Figures 1 and 2 also show how, without policy change, the private cost rises particularly sharply even in the central case. The introduction of free personal care would shift this extra burden to the public sector.

**... and we cannot avoid confronting the cost of an ageing society**

The problem of paying for care needs to be seen in the wider context of how society might reorder its priorities in responding to a change in the age structure of our population. Providing ourselves with adequate pensions, health treatment and care in old age has become an important part of maintaining quality of life. Dignity, citizenship, choice and control for older people are at the heart of the vision contained in the Green Paper on Adult Social Care (Department of Health, 2005).

The challenge is to design a system that is adequate, fair and rational. As with pensions, doing nothing is not a neutral option. Whether we like it or not, we have a choice between:

- an underfunded system in which those unable to pay suffer by not receiving the care that they require, or deserve
- an underfunded system in which spending is targeted on the poor, but the private cost for everyone else is high and the minority with an extended period of high need have to pay for it with their life savings

- a system that raises sufficient resources to avoid these two scenarios, but would require some combination of greater taxation, insurance contributions and private cost sharing.

### **Even today, the system is showing strains that point to underfunding**

On the central case, an increase of a third relative to GDP in the cost of long-term care by the middle of the century is unlikely in itself to provoke a funding crisis – though it would come on top of the additional cost of providing adequate pensions for the increasing size of the retired population.

But the starting point today is already far from satisfactory. Part of the problem is structural – there is not a clear rationale for who gets what. However, it is doubtful that the inadequacies of the system could be solved simply by redistributing entitlements within existing resources. There are good reasons to think that there are already insufficient resources devoted to long-term care.

### ***There are clear tensions between quality and cost ...***

First, there are big concerns about the quality of existing care services, especially in care homes. The sector is characterised by low pay, inadequate training, high staff turnover and ‘a damaging preoccupation’ to contain costs rather than raise quality, according to a study by the King’s Fund (2001). Some efforts have been made by Government to improve quality by raising minimum quality standards. But the rising costs to which this has contributed have not been matched by greater public resources to pay for them. Staffing costs, which account for the bulk of expenditure and have been exacerbated by staff shortages, have risen by 28 per cent in the past four years (Laing & Buisson, 2005). As a result, it is becoming harder for individuals and local authorities to afford residential care services where they are needed. The problem has been exacerbated by a concentration of the building of care homes in certain more affluent areas and a shortage of places in some areas at fee rates that local authorities are willing to pay.

### ***... the system appears to be neglecting low-level domiciliary support ...***

Second, a strategy of making as much possible use of home-based services wherever this is a viable alternative to residential settings enjoys widespread support

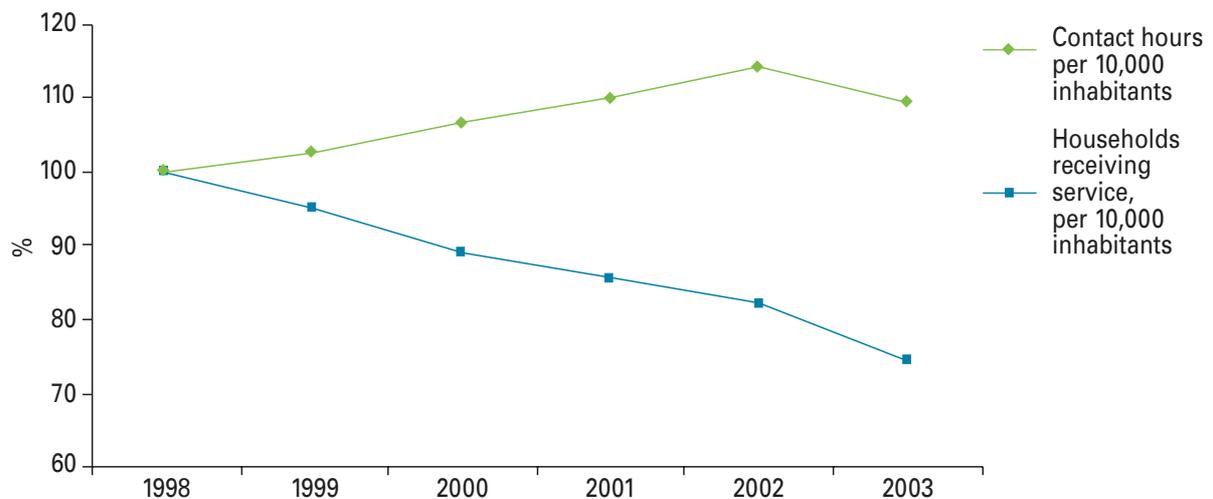
and has been reinforced by the recent Department of Health Green Paper (Department of Health, 2005). More resources are now being devoted to helping older people to receive care at home than was the case a few years ago. However, in order to cater properly for people with higher-end care needs in their own homes, public resources have been concentrated on intensive care packages for these groups. The number receiving lower-level packages has fallen. Figure 3 shows that, in the five years to 2003, the number receiving local authority home support fell by a quarter, although the total hours provided rose by 10 per cent. The reduction in low-level care is likely to have adversely affected quality of life for many older people. Moreover, there is a widespread belief (backed by some examples but not as yet by generalised evidence) that early intervention in the form of relatively low-level care packages can often prevent or delay the need for much more intensive and costly intervention at a later date.

A decline in the number of people receiving council help with home care services does not necessarily lead to unmet need if people use their private resources to make up the shortfall. But many are not in a position to do so.

**... the domiciliary costs faced by some people on modest incomes appear inequitable ...**

Third, local authorities are prohibited from levying charges for care provided to those with incomes not more than 25 per cent above the income guarantee for pensioners (i.e. those with incomes presently below £136.81 a week for a single pensioner).

**Figure 3 Home help and home care services purchased by local authorities**



England, 1998 = 100 per cent.

Yet this does not mean that everyone not covered by means testing can comfortably afford to pay for services at home. A recent Age Concern (2004) report on charging policies demonstrated both the huge variability among such policies across local authorities and the extent to which people on very modest incomes can be charged large amounts. In an illustrative case, local authorities were asked about how much they would charge an imaginary single woman with ten hours of home care and a weekly income of £230. The average charge across local authorities was £45, amounting to nearly 20 per cent of the person's income, with two authorities charging over twice that amount. Only a handful charged under £30 a week. In some local authorities, moreover, people living at home are having to pay for all of their care out of their life savings, as they can be charged the whole cost of care packages if they have non-housing assets above £20,500.

### *... and few people in residential care are fully protected against its cost*

Around 400,000 older people in the UK are today living in care homes – either residential homes or nursing homes providing extra nursing support. Many of these people face high costs and the majority get at least some public support in helping to meet these costs. Yet, as shown in Box 2, only the minority covered by the NHS under continuing health care funding are fully covered; the rest have to dig into life savings or give up most of their income to pay for care if they face high costs. This system appears to accept that some people with very high medical needs should receive free services regardless of income, as they do in hospital, yet declines to pay for many others who also have expensive care needs, and in some cases medical needs hard to distinguish from those fully funded by the NHS. Quite apart from the issues of fairness discussed in the following section, the failure to provide for one group with similar needs to another deemed to require support can be seen as indicating an overall shortfall in funding.

#### **Box 2 Categories of funding for residential and nursing care**

There are three main ways in which people get help from the State in footing the bill for residential and nursing care (the following applies to England).

- 1 Those requiring a high degree of ongoing health care have all of their care and accommodation costs paid for by the health service, regardless of their means. Such funding for 'continuing health care' is also available for those who require 'after care' under the Mental Health Act 1983, who have their care and accommodation costs paid, either by the health service or by social services.

*Continued*

- 2 Those who require nursing care but do not have such a high degree of health need have a contribution made to their care home fees for the registered nursing element of the cost. Some of these people might also qualify for help with funding from local authorities.
- 3 People with below £20,500 in capital (including the value of their own home unless a spouse or certain other categories of people are living in it) are eligible for local authority help towards their costs based on a means test of their weekly income and 'tariff income' on any capital above £12,500. However, the local authority pays only for the *residual* cost of the care after the recipient has used all of his or her income, minus a small weekly allowance for personal expenses (currently £18.80) to pay for it.

### Today's system does not appear to be fair or consistent

An essential requirement of any system of public provision, regardless of its overall generosity, is that it allocates resources in a way that is seen to be fair. The very complexity of the funding of long-term care in the UK is an obstacle to this requirement. People simply do not understand the basis on which some users seem to get generously funded by the State and others have to foot most or all of the bill themselves. Certainly the public do not make the same distinction as the system between 'health needs' and other forms of care. In a high-profile BBC evening on issues facing the health service in 2002, viewers were invited to state their top priorities for the NHS and far more mentioned free personal care than any other item.

#### *The rationale for meeting different kinds of need is incoherent ...*

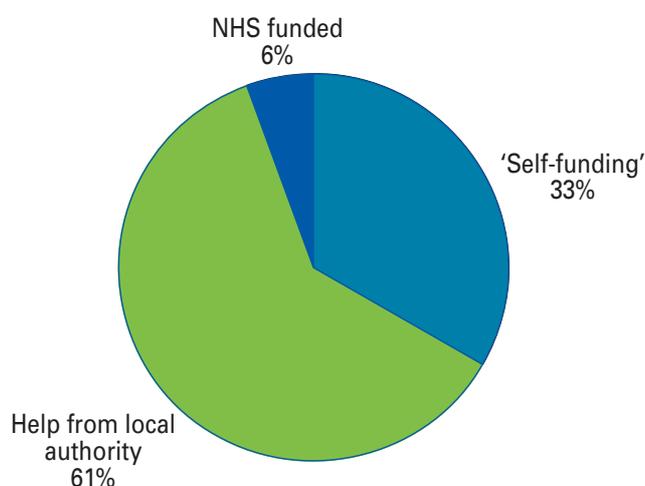
The UK has tended to create arbitrary distinctions in the way it treats people requiring medical and social forms of care, originating in the distinction between health and social services. The present system for people in care homes (summarised in Box 2 above) draws a line between health care, which is provided free, and other aspects of personal care, for which state help is generally means-tested, outside Scotland. People requiring fully funded, continuing health care, because they have high medical needs even outside hospital, have all aspects of care paid for by the State, as they remain the full responsibility of the NHS. Yet many people with severe conditions requiring high levels of care, especially those with dementia and neurological conditions, do not receive such help. People with Alzheimer's, for example, tend either to be on the lowest band of nursing care or are considered to have only personal care needs, which they must pay for themselves.

While many people receive help from local authorities in paying for care, these people are not exempt from the burden of charges. Unlike those covered by the NHS under continuing care funding, they must give up most of their income before receiving help. Thus, the arbitrary effects of the assessment system have consequences for this group as well as for 'self-funders'.

Figure 4 shows approximately how many people in the UK are funded fully by the NHS, how many get local authority help and how many are 'self-funding'.<sup>2</sup> Only 6 per cent get their full costs paid under continuing health care. Among the one-third who are 'self-funders', roughly four in ten (in England) receive help with nursing care. The majority of care home residents who have few enough assets to qualify for local authority help do not get care free. They must spend most of their income on care before getting a local authority top-up to cover the rest (minus any nursing care contribution from the NHS).

The House of Commons Health Committee (2005) has recently argued that the 15,000–20,000 people eligible for the top band of nursing care (who must pay for their own personal care and accommodation) have needs not easily distinguishable from the 20,000 or so people fully paid for through continuing health care. This anomaly seems to make the system work in perverse ways. One recent study (Olsen and Regan, 2005) has shown some evidence that there might be pressure on nurses to put people on the middle band of nursing care rather than the upper band to avoid social workers questioning whether they should in fact be fully funded through the NHS. The House of Commons Health Committee (2005) report also points to a lack of clarity between the different nursing bands.

**Figure 4 Care home residents by funding category (estimates, UK)**



*Source: Laing & Buisson (2004)*

A reformed system, which treated consistently a wider range of people with serious health conditions requiring high levels of care, would need to make a fundamental resourcing choice. Either it would have to impose substantial charges for accommodation and/or personal care on people with conditions that have traditionally entitled them to wholly free provision by the health service, or it would have to provide considerable additional resources to those not entitled to continuing health care at present.

The present system thus creates a lottery in terms of whether an individual requiring a particular overall amount of care will have to foot the bill. The Health Ombudsman as well as the Commons Health Committee have criticised the arbitrary nature of such a system and pointed out that the assessments focus unduly on physical ailments rather than mental health needs. Dementia is estimated to affect as many as 70 per cent of people in care homes.

The underlying problem for the UK is that we have not fully made up our minds to what extent long-term care, like health treatment, should be part of 'universal' public provision or, like housing, be paid for primarily by private individuals except for those who cannot afford to do so. Some countries have taken the 'universal' approach (see Box 3), while setting out standardised criteria for what can be accessed on this basis. The UK's attempt to have universal care provision only for those with high health needs has created ambiguity because of the difficulty in drawing such a line and the attempt to run two systems of finance (for continuing care and for nursing care only) in parallel. The Government's present attempt to define national assessment standards may improve consistency within this structure, but, without better integration and a reduction in complexity, the basis of funding will continue to seem arbitrary and unfair to many.

### **Box 3 Methods of rationing care resources – approaches from around the world**

In a number of countries, the allocation of care is not based on income (since redistribution is achieved through the tax/contribution system), but rather through 'universal' criteria allocating given resources to given needs. Two approaches to this are the following.

- National eligibility criteria, particularly associated with insurance programmes in, for example, Germany and the Netherlands, but also with those based on general taxation as in Austria, France and (in part) Japan. These criteria set thresholds of an individual's level of disability or low cognitive functioning and

*Continued overleaf*

allocate resources to those coming above the threshold. One difficulty with such systems is making them sufficiently sensitive to a wide range of medical conditions and disabilities.

- Individualised, needs-led assessments, allowing a level of discretion to respond to the particular requirements of an individual. This system prevails in Denmark, and Scotland's new system of paying for personal care is based on individual assessments of needs. One potential difficulty with this system is the possibility of local variations and hence inconsistencies in the 'fairness' of the system. However, Austria, the Netherlands and France have all found ways of making individual assessments within the framework of national criteria, thus combining advantages of both systems.

Standard criteria can help Government to project future calls on public expenditure, but, on the other hand, an entitlement-based system can sometimes be hard to contain, especially where insurance contributions give access to specified benefits, as the Netherlands found in 2001 when a legal ruling stopped the Government from capping expenditure. Nevertheless, Germany's insurance-based system, for example, is containing costs by ensuring that assessment criteria are aligned with projections of expenditure and future need, and also by promoting cash benefits as an alternative to in-kind services. These initially proved popular with users and a boost to informal care, despite being cheaper to the Government than direct provision.

### *... while the basis for making people pay for services varies across the country ...*

The range of care services provided for people at home by social services departments varies greatly from one local authority to another. This 'postcode lottery' is to some extent a product of local decision making. Where local government runs services, one should not expect service levels to be identical across authorities. But one dimension of difference that seems particularly unfair is the very different basis on which people are charged for services according to their means. The Government has taken one step to standardise means testing by setting a common income threshold below which nobody should pay for services (25 per cent above the 'guarantee' minimum income level credit provided by Pension Credit). However, above this level, charging practices continue to vary widely. In an Age Concern (2004) survey, for example, the maximum weekly charge was found to be below £50 in the most generous 16 per cent of local authorities, but above £300 in the least generous 14 per cent. This means that people with high home care costs can be

paying more than six times as much in some parts of the country than in others, for the same service. Further standardisation may involve, for example, a standardised charging structure linked to income, without implying that the service level that every local authority chooses to provide should be identical.

*... and there are disincentives to get better*

It is not always easy to maintain the principle of avoiding perverse incentives in a care system. To some extent, people who are less well should get more resources because their needs are greater. However, the Health Select Committee's recent report, cited above (House of Commons Health Committee, 2005), pointed out that, particularly within residential homes, the structure of incentives in this respect could be improved. In particular, if a care home provides good nursing that contributes to someone's well-being, they may be taken off continuing care or put on a lower nursing care band. Yet good rehabilitative care also costs money. Thus, our present system tilts funding towards medical needs and could be structured in a way that is more favourable to a wider set of interventions.

## **We have not resolved a satisfactory way of sharing responsibilities and costs**

*The contribution of informal care is essential, yet is not supported in a clear-cut way*

Most care is provided unpaid, largely by family members. Carers UK (2005) estimates that there are six million informal carers providing care worth as much in value as total spending on the NHS, representing approximately 70 per cent of all care. While those who care for friends and relations do so without expecting remuneration, people's willingness and ability to provide such care may be changing, especially as the cost of providing for a growing older generation increases and as other pressures grow, including the financial pressure on middle-age women to work. Preliminary evidence from Scotland suggests that giving people reimbursement for some of the costs of professional social care may reduce the amount of some forms of care given by family, but on the other hand increase the degree to which informal carers, freed from some personal care tasks, can make wider contributions to older people's well-being, such as helping with shopping or taking them on outings.

This army of unpaid carers makes an essential and welcome contribution to caring in the UK. Yet public support for them is patchy. Some receive the Carers' Allowance and Attendance Allowance may be seen by some families as a compensation for care services provided without payment. However, most family carers do not receive explicit public back-up for the care that they give. Stronger recognition of and support for the 'informal' carers may be needed if this vital source of care is not to be put at risk. Informal care makes a crucial contribution to older people's well-being.

### ***The current basis for restricting local authority help with care home costs causes deep resentment ...***

The extent to which local authorities help people pay for living in care homes is restricted both by the level of the individual's assets and the cost of the care home charges. Most users of residential care in the UK are required to pay for accommodation and (except in Scotland) personal care if they surpass asset limits exceeding £20,500 (£21,000 in Wales), excluding a home in which a partner or certain other specified people are still living. Local authorities will fund only up to a level that the local authority considers appropriate to their needs, normally negotiating a standard price locally with care homes. If the person chooses to go into a home that is more expensive than the local authority thinks is required to meet their needs, they will have to find a third party to top up the fees to pay the difference. Recently, there have been complaints that, in spite of government guidance to the contrary, local authorities routinely expect people to find third parties to make up the difference by setting ceilings below which it is often difficult to find a home with a vacancy.

Since much care for older people used to be provided free in hospitals, people in the UK still tend to feel resentful that they should have to pay for their own care. The reality is that a sustainable system is likely to depend on cost sharing, rather than the State paying everything. But the sharp divide between 'self-funders' and those paid for by the health service makes it harder to accept this responsibility. There is also a strong resentment by those who saved for their old age that they do not get help from the State whereas those who did not make any provision are eligible for means-tested help.

Those who have more than £20,500 going into care homes have to pick up the bill themselves. If the home just provides personal care they get no help from the State other than being able to continue to get Attendance Allowance. The cost sharing involved in the State's payment of nursing costs in nursing homes since 2001 makes little difference, as fees have tended to increase, offsetting most or all of the effect of

the payment made to the home, depending on which nursing care band a resident is assigned to.

***... and in particular people fear that, in the worst circumstances, they will be impoverished by the costs ...***

One particular feature of long-term care is the importance of the uncertainties and risks it presently imposes on people as they grow older. The fear is that, with high care bills, one will 'lose everything' and thus either run out of resources for use in one's own lifetime or be unable to pass on to the next generation assets accumulated through life.

Much attention is given to the impoverishment represented by this potential loss of assets by those unlucky enough to have high care costs over an extended period. In practice, a different form of impoverishment affects a much larger number of people: the loss of income. Those who qualify for local authority help must spend the bulk of their income on care home fees before they can receive such assistance.<sup>3</sup> They may keep just £18.80 a week to spend on themselves. Most of life's basic essentials (but not clothing) are covered in care home fees. Nevertheless, having to surrender most of one's income and being left with little spending discretion represents a significant loss of dignity for many people (see, for example, Parker and Clarke, 1997).

***... yet there is no opportunity to insure against such risks***

The risk of using up one's life savings to pay for care is relatively low. While the annual cost of stays in residential care is high, in many cases the duration of such stays is relatively short. The problem is that, unlike in most cases where there is a small chance of a very large loss, it is not possible at present to insure against this contingency. There are not adequate insurance vehicles that protect against the risk of very high costs, because insurers find it hard to face this uncertainty. Most have now withdrawn from this market and seem unlikely to return except in some form of partnership with Government to limit uncertainty over private providers' potential liabilities (Johnstone, 2005).

Thus, when thinking about care costs, people presently think about the risk of facing 'catastrophic' costs that drag them into poverty before they can access state help. So an eventuality that will affect relatively few people causes concern for the many, feeding the lack of acceptance of the basis on which private individuals are presently being required to pay for care.

### **There is not adequate provision to meet diverse needs**

Like other countries, the UK is trying to turn away from an attitude of offering only a single option to people requiring long-term care. In seeking to provide greater choice, we have come to accept that one size does not fit all. This can be a particularly important factor in the case of older people being provided with a service whose character will be central to their lives – especially in the case of residential care. A lack of choice can compel people to live in a home that they do not like the feel of, and hence to a loss of dignity and happiness. Yet, in many cases, people who rely on local authority help to pay fees are offered little or no choice because of a shortage of places available at homes charging a fee that the authority is willing to pay.

A particular issue, when it comes to diversity in provision, applies to minority groups. Long-term care needs vary among different groups in the UK, as elsewhere. A recent study by the Policy Research Institute on Ageing and Ethnicity (2004) found that, throughout Europe, different ethnic groups have differential needs, related to varying prevalence of common disorders including diabetes, respiratory conditions and osteoporosis. Moreover, the study showed that patterns of use and satisfaction with health and social services also vary greatly across groups. Issues such as the ethnic mix of staff, the ability to talk freely about religious needs and having staff of the same gender all arose as important in this research. This underlines the importance of not imposing a single model of social care, but giving a degree of choice and ensuring that, in practice, services are structured flexibly to cater for diverse needs.

### **Users lack sufficient understanding and information about the system**

The preceding sections have described a system filled with ambiguity and complexity. This inevitably leads to a lack of understanding among users about how the system works, which creates difficulties at several levels. At the political level, the debate is confused by misconceptions – such as the idea that most people get their care ‘free’ from local authorities, when in fact they must hand over most of their income before getting assistance. At the level of life planning and expectations, there are false ideas about the degree to which the NHS or other public bodies take responsibility for covering care needs. When it comes to receiving support, a lack of clarity about the purpose, for example, of Attendance Allowance may affect the extent to which people use it to support caring activities. And most importantly, at the practical level, users find it difficult to assemble sufficient information to make the right decisions that allow them to access the most suitable care package.

On this last point in particular, a recent report by the Office of Fair Trading (2005) identified some highly unsatisfactory outcomes of the care home funding system. It found, for example, that there is confusion about local authority obligations to help self-funders to find residential provision, the rules allowing third-party top-ups, pricing and contractual arrangements. Older people facing a difficult decision in the context of declining health need to be presented with clear-cut options, not forced to navigate a murky system whose rules are sometimes unclear even to professionals. There needs to be clear signposting and support to help consumers navigate the current, extremely complex system.

### 3 Challenges in designing solutions

The UK will need to work hard in the years ahead to develop a system for funding long-term care that, on the one hand, is coherent and fair and, on the other, produces sufficient resources overall, both public and private, to pay for older people's care needs.

This involves facing up to three broad challenges.

First, we need a system that adheres to the principles set out at the beginning of this paper for allocating resources to meet different needs across different forms of care. In particular, it must be fair and consistent, while offering choice, encouraging a preventative approach and balancing support for professional forms of care with support for informal carers.

Second, we will ultimately have to find a way of raising more public resources to meet a range of needs that are greater than those provided for at present, for a larger number of people.

And, third, we have to improve the basis on which private individuals help pay for the system. It may not be realistic to think that the public sector will pay for everything. Yet, at present, we lack adequate mechanisms to support private individuals in paying their own costs, while the system for determining who needs to pay what is perceived in a number of respects to be unfair and inconsistent. Other countries have found interesting ways of organising 'co-payment', sometimes with more uniform approaches to the proportion that individuals in various categories should have to pay – set, for example, at 10 per cent across the board in Japan.

In thinking about the design of solutions, we need to consider not just the resources going directly into paying for long-term residential care, but also the considerable amounts of money spent through social services departments and the benefits system. This spending amounts to over £10 billion, as set out in Chapter 4. It may be possible to think of radical new ways of structuring the large amount of public spending in this area. However, the main discussion here looks at possible routes to reform within a system structured broadly as at present.

These three challenges discussed below, are not the only ones facing the social care system. It will also be important, if diverse needs are to be met while allowing sufficient scope for choice, to think imaginatively about the character of care supply. Ideas such as extra care housing, particularly for black and minority ethnic (BME) elders, continuing care retirement communities and the development of culturally

appropriate services need to be pursued. The Green Paper on adult care (Department of Health, 2005) sets out principles for improving choice. However, the three challenges of fair allocation of resources, adequate sources of public funds and strong mechanisms for combining public and private spending on care are particularly important when it comes to funding. Meeting these challenges will be central in moving towards a better system.

### **Improving the ways in which resources are allocated**

The ways in which resources are allocated to people with different needs and to pay for different kinds of care should be consistent and fair, and not unduly favour a particular group or a particular care setting. Designing a system to meet such principles is a complex business and this paper does not seek to suggest a detailed structure. Rather, it identifies some key areas in the present system where change is needed.

#### ***Supporting the cost of residential care for people with different needs***

As discussed earlier, the degree to which the State pays the cost of residential care varies greatly according to the category of user. The result is that five people in the same nursing home in England, whose incapacities necessitate care with the same overall (high) cost, can get very different amounts from the State. One might be entitled to all care and accommodation costs because of an ongoing need for health care. A second might be entitled to the highest band of nursing care, and have £129 a week paid to the home, but need to draw on assets to pay for personal care and accommodation. A third might get only the middle band of £80. A fourth might get only the lowest band of nursing care (£40 a week), even though they might require an extremely high level of support in the form of personal care. A fifth might get some help towards their fees, over and above a nursing care payment, because they have capital less than £20,500, but have to hand over all of their income except £18.80 a week to help cover the cost.

Reform would involve tackling two types of distinction in the current system. The distinction between high level of nursing care and 'ongoing health care' seems particularly arbitrary. It is possible, in principle, to defend the distinction between personal and nursing care. But, in practice, it seems to lead to discrimination against people whose care needs derive primarily from mental rather than physical illnesses. Both distinctions make it much more likely that someone with a physical disability gets funding, even though people with health conditions such as Alzheimer's have high care needs, often persisting over many years.

Any solutions to this issue would benefit from a unified assessment process. There seems to be a strong case for redefining nursing care to include more of the care needs of those with mental disabilities and illnesses with a psychological character. More radically, reforms might involve reimbursing people for a wider range of defined care activities according to the overall cost rather than from the type of disability from which it derives.

### **Ideas file: policy approaches for debate and development**

Possible ways of restructuring non-means-tested payments for people in care homes

- Merge continuing care criteria with top band of nursing care and give those who qualify one of the following:
  - a free nursing care + free personal care + free accommodation (as at present for continuing care recipients)
  - b free nursing and personal care, but not free accommodation
  - c either (a) or (b) according to a single assessment of need (the above would apply only to people in nursing homes).
- Redraw boundaries between different levels of care needs according to a scale of 'dependency' that gives points for high-end personal care as well as nursing care. Award payments to homes (or individuals) on that scale to replace the present bands for nursing care.
- Assess everybody's care needs according to a weekly standardised cost, taking both personal and nursing care into account. Scale support according to this amount, weighting payments towards those with particularly high levels of need.
- Raise the level of Attendance Allowance paid to self-funders in care homes in England and Wales, to cover some of the cost of personal care. Increasing it by £30 a week would cost £130 million a year. Such a reform would also need to apply to people with high-cost needs living at home, especially as extra-care housing develops, in order to avoid perverse incentives to choose residential care.

### ***The balance between different forms of publicly provided domiciliary support***

It was argued earlier that a serious weakness of the present care system is that it has become much more focused than in the past on providing large care packages for people with serious conditions, at the cost of low-level support. In particular, domiciliary

care is being concentrated on supporting people who would otherwise be in care homes. Yet a broader strategy to maintain independence would involve looking after older people well before they develop chronic health problems. Such a strategy can potentially have a preventative impact (e.g. reducing chances of people having falls, which may trigger a deterioration in their condition). Giving people greater choice over the type of support that they receive can be beneficial in itself. Some people, for example, might appreciate practical help with household chores, which would save them time and energy that they could devote to their own personal care.

It would, however, be risky to try to spread existing domiciliary resources more widely if this meant reducing the amount of high-level support for certain people with high care needs living in their own homes. Rather, a long-term aim may be to spend a bit more on preventative support for people living at home and to make savings in the volume of residential care provided. More evidence, however, is needed on the effectiveness of low-level domiciliary packages for prevention.

### *Co-payments, and the packaging of other forms of support*

At present, the benefit system provides some direct support to carers, plus considerable indirect support to people who may need care.

- £1.1 billion is spent on the Carers' Allowance paid to carers (UK figures).
- £6.7 billion is paid out every year in the form of Attendance Allowance (UK figures)<sup>1</sup>.

Attendance Allowance, administered through the benefits system, appears to users as a supplement to the pension for disabled older people. Yet the amount spent on this item is too large to ignore in any reassessment of how care is paid for in this country, especially given the continuing importance of informal care. There are clearly advantages in the flexibility of the Attendance Allowance in terms of paying for whatever extra support is needed (e.g. taxis, housework). But it is not packaged in a way that makes it clear what it really is – a substantial non-means-tested, non-taxable co-payment from the State towards the extra cost of disability.

It is worth reviewing the ways in which Attendance Allowance is used and looking at other ways of structuring it. One issue is about whether the balance is right between people with higher and lower needs – given that Attendance Allowance does not give anything to people who, if under 65, would have qualified for the lowest level of Disability Living Allowance. Another question to consider is whether paying out six

times as much in Attendance Allowance as in Carers' Allowance represents the best balance between the two approaches to supporting care.

### **Ideas file: policy approaches for debate and development**

#### *Repackaging Attendance Allowance*

- Present the Allowance as a care subsidy rather than as a social security benefit. Link it partly into actual care provided. For example, create a banded system for people requiring and using different numbers of hours of personal care and/or practical assistance. An important issue if the allowance were transferred from the benefits system to local authority social services would be whether it would continue to be an entitlement rather than a cash-limited payment at local authority discretion. Some preservation of national entitlement rules would seem desirable.
- Spread Attendance Allowance more widely by lowering thresholds of eligibility and bringing them into line with those for the Disability Living Allowance, the equivalent for people below retirement age. This would help pay for low-level care when needed. One way of funding such extra provision would be to tax the Allowance for better-off pensioners. This, on the other hand, would make it harder to present the Allowance as a 'co-payment' for care by the State rather than as a benefit.

## **Facing up to raising more public money**

The total cost of care for older people in the United Kingdom will rise slowly in the next 20 years and more rapidly thereafter. With resources already scarce relative to demand, the sooner we make a commitment to increase the resources allocated to care, the less painful the strains on the present system will be. A substantial portion of these extra resources will need to come from public sources. No system in the developed world has succeeded in making adequate provision through a system led by private payments, even though private spending has an important role, as discussed in the section on 'Improving the basis for co-funding' below.

### ***We will eventually have to raise more money either through taxation or through social insurance ...***

There are two main options for raising extra money in the public system – through higher taxation or through an insurance scheme. Different countries have used these two options as alternatives, or in combination, to fund long-term care (see Box 4).

**Box 4 Alternative funding mechanisms: international lessons**

In other developed countries, only through systems with public involvement in funding long-term care has it been possible to pool risks and enable people of all incomes to access services according to need. Voluntary insurance has low coverage, even in the US with public sector involvement.

*Tax-based support* in, for example, Denmark and Australia uses general tax revenues to fund care based on needs, sometimes applying a means test.

*Social insurance*, in which compulsory contributions by employees and/or employers are earmarked for long-term care based on need and possibly contribution records, is used, for example, in Germany and the Netherlands. In these two countries, insurance has proven a useful mechanism for raising new, hypothecated resources for long-term care.

Both of these systems can be designed to be more or less 'progressive' in the way they raise revenue. Insurance schemes generally involve higher payments by better-off groups, as contributions are based on incomes or earnings. However, the progressive element is sometimes limited by an upper ceiling on the income on which contributions are based or a provision enabling wealthier people to opt out of the public scheme on condition that they purchase equivalent insurance privately.

Some countries, such as Japan, combine social insurance with tax finance for long-term care.

There are significant differences between a funded insurance system, such as the one proposed by JRF in the 1990s (Joseph Rowntree Foundation, 1996), and extra taxation, as proposed by the Royal Commission on Long-term Care (1999). The former involves raising contributions of today's working generation somewhat above the amount needed to finance adequate provision for today's care users in order to create a fund to support future generations. The latter is more clearly a 'pay-as-you-go' system (as are some social insurance models, without advance funding), in which today's taxpayers fund today's users.

However, the most important factor, common to both kinds of system, is a willingness to accept the need to allocate progressively more of the working generation's income to paying for older generations' long-term care, whether that comes from increased taxation or from the additional claim on the nation's resources represented by the assets held by a funded scheme. As with the analogous and much more significant issue of pensions, building up public acceptance of the need to divert these

resources depends on starting now to create a fairer and more adequate system, and to remedy existing shortfalls that in future can only grow.

### *... between which the most important difference may be presentational*

The relatively gradual ageing of the population over the next 20 years in the UK means that gradually increasing the amount of resources devoted to long-term care need not be very painful to taxpayers or contributors to insurance. More important than the amounts involved is a building of confidence that extra money allocated to this purpose will indeed produce better care for all of us in our old age. One of the strongest arguments for an insurance system, whether funded or pay-as-you-go, is that linkages between contributions and benefits can be made clearer, and money can be more securely ring-fenced than through increased taxation. However, in the United Kingdom, such an effect would rely on much more clear-cut ring-fencing than has existed in the National Insurance system to date.

## Improving the basis for co-funding

Though neither individual savings nor voluntary private insurance can be sufficient to fund long-term care completely, private resources can play a complementary role to any public scheme. Obstacles to the contribution of private money include, not just a reluctance of individuals to pay, but also a lack of adequate mechanisms supporting them in doing so. New forms of public–private partnership can help remedy this.

### *Public support can help leverage private funding through insurance ...*

First, as long as individuals are required to pay substantial amounts towards their own care costs where they can afford it, there remains a strong case for supporting the development of a better private insurance market alongside the state system. Public support for the revival of this market might involve, for example, coverage of an initial period of disability by insurance, while the State provides a safety net after that period. In exploring such mechanisms further, key issues will be: how to provide a politically sustainable system able to command confidence; how to provide a seamless link between public and private coverage; and how to reconcile assessment procedures to ensure that entitlements are compatible across both sectors.

## Ideas file: policy approaches for debate and development

### *Public support for private insurance*

- A public–private partnership in which individuals self-fund residential care for three years and the State covers the costs thereafter, with the self-funded element protected by a private insurance plan. In this proposal, the State is taking on some of the ‘long risk’ that individuals and insurers are most reluctant to take on – by covering the minority of cases where residential care is the longest duration. An adequate system would need also to take on the risk of expensive and more frequent longer-duration stays in extra-care housing, and this could make such a scheme more expensive for the State than if it applied only to care homes.
- Provide some extra state help for early periods of disability to people who have taken out long-term care insurance with lengthy deferment of benefits – e.g. two years after the onset of disability. This would be the reverse of the previous proposal – the State’s responsibility would precede rather than follow that of the insurer. One advantage of such a scheme would be that insurers are accustomed to offering better terms to those who defer benefits. However, it would still require insurers to take on risks that they would find it hard to assess.

### *... equity release ...*

Many people requiring domiciliary care have a huge asset in the form of their home. The attitudes of older people that emphasise the preservation of assets such as housing for passing on to the next generation may be changing. A new Joseph Rowntree Foundation study (Rowlingson, 2005) provides nationally representative evidence that older people are becoming much more willing to deploy assets for their own benefit, rather than expect to pass all of them on. However, they tend to be suspicious of existing mechanisms allowing them to access their housing equity. These resources could provide an important contribution to the cost of services for people living at home and again public–private partnerships might help unlock them. For example, the public sector could provide loans on relatively favourable terms, to be repaid with the eventual proceeds of the home.

Over the long term, the availability and use of such finance is likely to interact with the adequacy of local authorities’ domiciliary services, in terms both of the extent of provision and of the amount that is charged for services. The existence of arrangements that allow homeowners to defer payments until their homes are sold

can contribute to the affordability of charges, which in turn help pay for a wider range of local authority services than if there were no co-payment. There is a parallel here with higher education, where soft loans are helping to ease the payment of a private contribution to the cost of an expanding service.

### **Ideas file: policy approaches for debate and development**

#### *A national Home Equity Loans scheme?*

Such a scheme, set up on a similar basis to the Student Loans scheme, would enable some people to defer care costs until their homes were sold. Loans would be secured on the housing equity. Anyone assessed as in need of care would be entitled to draw down a payment up to, say, £500 per week to pay for home or residential care. The Government would guarantee the loans, which would charge preferential interest at or below the base rate. This would put more money in people's hands to spend on their own care costs, with the Government underwriting part of the bill by subsidising the loans, but not having to pay the full cost of the extra care delivered.

Note that, unlike the existing deferred payments system for people not wanting to sell their homes after moving into residential care, this scheme would offer a wider set of options, in particular that of staying in one's home and being able to afford co-payments or private payments for domiciliary services. Overall, it would contribute to people's independence in making decisions about how much of their resources they wished to allocate to buying extra care services over and above what is provided by the State. An important issue that would need to be addressed, however, would be the relationship of income derived from releasing equity to the means test that determines eligibility for Pension Credit.

#### **... and help with accessing the best products**

Urgent steps need to be taken to ensure that access to adequate support and guidance is available to care users and their families to help them navigate their way around a very challenging and complex system. Without improved guidance and information, any attempts to improve private decision making about investing in care are likely to fail. In helping to build confidence in new products such as insurance and equity release, there is also a potential brokerage role for the public sector, getting actively involved in negotiating the purchase, and advising on the advantages and disadvantages of such products. The Office of Fair Trading (2005) report

mentioned earlier proposed that the Government should establish a central information source or 'one-stop shop' for people to get information about care for older people.

### ***But who should pay what? We need systems sensitive to people's desires to reduce the worst risks, but which nevertheless are socially equitable ...***

A contentious issue in the funding of long-term care concerns which services users should be charged for, whether these charges should be means-tested and, if so, how income and assets should be taken into account.

Other countries have found various ways of sharing costs with users. One of the most systematic is Japan's where a 10 per cent 'co-payment' is levied on all services. Other countries such as the Netherlands have involved users by giving them personal budgets (direct payments), but at a level 25 per cent lower than in-kind services on the basis that services purchased in this way should be cheaper. One important lesson of international experience for the UK is that a fixed level of cost sharing, or limits on the public contribution, can leave scope for individuals to top up spending privately.

A central concern in the UK, where many people shoulder most or all of the cost of their own care, is the risk of 'losing everything' – for example, using up all of one's assets to pay for care and having nothing to pass on to one's heirs. Any reforms that seek to gain public consent for the broad principle of cost sharing need to address this fear, even though it ends up as a reality for only a small minority of people.

### ***... and this may mean raising capital thresholds ...***

One option that could go some way towards averting the 'catastrophic risk' of losing all one's assets would be to increase the amount that people are allowed to keep and still receive means-tested assistance from the State. This would bring greatest benefit if people who received such support could choose to top up public help with their own resources to buy higher value residential care, as is possible in other countries.

### **Ideas file: policy approaches for debate and development**

#### *Capital limits and top-up*

- Raise greatly the amount of assets that disqualify single people from local authority payment for their care, where these have been realised from the sale of one's home. The idea would be for someone selling an average-priced home not to have to use up more than half its value if care costs were very high. A capital limit of 50 per cent average home-sales values would currently be around £100,000. A complementary measure would be to raise the lower capital limit (presently £12,500) above which people's entitlements are reduced to reflect the income that the capital is assumed to generate.
- Allow people with some assets entitled to local authority payments for residential care to top up these payments to pay for more expensive provision if they so wished. This could involve either a pure 'voucher' system paying a fixed amount to any home with an eligible occupant regardless of its fees, or one that involved some clawback of those fees, for example reducing the payment by 50p for every £1 charged in fees above the voucher value.

#### **... creating more consistent means testing when charging for home-based services ...**

It is inevitable that people in different parts of the country get different levels of access to home support from social services, given that this is a local authority function. Yet what appears unjust is the very different ways in which people are means-tested when determining how much of the cost of such services they pay in fees. As described above, some progress has been made by setting a national minimum income below which charges may not be levied. Yet people on modest incomes continue to be charged much more highly in some authorities than in others. Greater consistency across the country would help reduce some of the most severe forms of hardship caused by the present funding system.

### **Ideas file: policy approaches for debate and development**

#### *Standardising means testing of domiciliary services*

- Create a national scale of maximum fees by bands of income above the minimum; for example, a limit of £30 a week for people under twice the Guarantee level of the Pension Credit. In making such a change, the Government would need to consider how to deal with a potential perverse

*Continued*

effect: an increase in the existing financial incentive for local authorities to move single homeowners with high care needs into residential accommodation so that the assets of the private home become chargeable.

- Create a national limit of the percentage of income above the means-tested level that may be payable by any pensioner. For example, a maximum of 25 per cent of income above £136 to be payable for domiciliary services.

### *... and giving a better deal to the poorest*

A final issue around co-financing concerns the living expenses of those gaining means-tested access to care homes. This represents the amount of their pension and other income that a low-income pensioner is allowed to keep; the remainder is surrendered as a co-financing payment with other costs made up by the State. At present, the personal expense allowance is £18.80 a week, representing the total money available for personal expenditure to those living in care homes. Such individuals have most of the essentials of life covered (food, shelter, fuel – but not clothing). Yet being able to spend on oneself less than a quarter the value of the state pension and a sixth of the Guarantee Credit (the minimum income for a single person claiming Pension Credit) threatens the personal dignity of people who have earned their pensions and now have high care needs. The cost of increasing the allowance by £10 a week across the UK would be £132 million and, of doubling it, £240 million.

Nor can the welfare and dignity of the least well-off be looked at only in terms of their personal expenses allowances. A serious difficulty in many areas for those relying on local authorities to help fund residential care is a shortage of available options at fee levels covered by the local authority. An expectation of extra co-financing from friends and relations where such affordability problems exist create a grim situation for those without extra money from this source; the only alternatives may be queuing for an available place, moving away from friends and relations to a home in a different area, or having no choice about which home they end up in locally. So, unless fee rates can be brought into line with the actual price of available places of an acceptable quality, the dignity of the poorest will suffer further.

## 4 What could be done with existing resources under a new system?

The discussion so far has looked at how incremental change to the present system of long-term care could create a fairer, clearer and more adequate basis of funding. But what could be done under more radical changes to the entire system? It is beyond the scope of this paper to design a new funding régime. However, it is worth at least considering what all the resources are that go into our present system, and what kinds of mechanism might be on a menu of options if all of these resources were put into a pot and distributed differently. Ideas are shown in Boxes 5 and 6.

### **Box 5 Main public resources presently going into long-term care for older people (UK figures unless otherwise shown)**

- 1 Attendance Allowance/Disability Living Allowance – £6.7 billion.
- 2 Carers' Allowance – £1.1 billion.
- 3 Local authority spending (in England) totalling £5.7 billion of which:
  - £2.9 billion on residential provision
  - £2.1 billion on non-residential provision
  - £0.7 billion on assessment and care management.
- 4 NHS spending on continuing health care (total not known).
- 5 NHS spending on nursing care – £0.7 billion.

### **Box 6 Potential new mechanisms to support long-term care**

- *A simplified system of cost sharing across all forms of long-term care.* In Japan, the State has become more closely involved than in the past in paying for care, financed by a combination of taxation and social insurance. Here, there is a standard across-the-board 'co-payment' of 10 per cent by all individuals. One route to simplification under a new funding regime would be to abolish distinctions between different kinds of care and instead make funding dependent on the overall level of need.

*Continued*

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## What could be done with existing resources under a new system?

- *The provision of a basic level of care free of charge to everybody who needs it, with individuals able to use their own resources to top this up where desired.* The big advantage of such a scheme (proposed by Julian LeGrand of the London School of Economics) is that it dispenses with the means test and improves incentives to save towards meeting care needs.

## 5 Conclusion

This paper has emphasised that doing nothing is not an option. Sooner or later, we will have to pay for the care that many of us will need as we grow older. The main question is whether we are prepared to make choices about how to make resources available on a fair and rational basis, rather than put off decisions until a crisis occurs, and risk making changes messily and inequitably.

In the 1990s, there was a search for a ‘big-bang’ solution to the inadequacy of long-term care, which in particular would find ways of removing uncertainties to individuals by providing residential and domiciliary care free at the point of delivery. Government has flinched at the thought of paying for this through the tax system, while the JRF’s proposal for a funded care insurance scheme now seems less attractive partly because of poor stock market performance and the failure of financial institutions. Moreover, it may be easier to design a care system with some degree of cost sharing, including at the point of delivery, rather than expecting collective payment through taxation or insurance to cater for every need.

The most pressing challenge now is to improve the fairness and consistency of the present system, reconsidering the ways in which eligibility for home care is assessed and the distinctions between different categories eligible for help with residential care. At the same time, there is scope for removing features considered unfair both to the least well-off (by increasing the spending money of people receiving means-tested residential care) and to people with at least some life savings (by raising capital limits to restrict the degree to which one can be impoverished by long-term care costs).

It is hard to see that such improvements could be achieved without any extra resources overall. There are some ways in which money could be taken from some to give to others, but these will inevitably be politically difficult. For example, one might charge accommodation costs to recipients of continuing care whose care costs were being fully funded by the health service – but the popularity of the recent abolition of pension deductions for people staying in hospital illustrates the difficulty with imposing such charges.

A more fruitful approach is perhaps to look for ways of using extra public resources to leverage extra private spending. One example is public back-up to make private insurance more viable; another is a public loan scheme to provide good-value equity release. Over the long term, such measures could help to make attitudes more accepting of a sharing of the financial responsibility rather than people expecting to receive everything from Government.

A better structure for funding long-term care will not in itself make available the extra resources that are undoubtedly needed. Yet a system that is better understood and accepted by the public is more likely to attract the necessary extra resources, by increasing people's willingness to pay for care both through private contributions and taxes. Thus, a strategy to meet the challenges set out in this paper could help to make the necessary long-term increases in both public and private spending more palatable.

# Notes

## Chapter 1

- 1 The paper concentrates on features that are common to the whole of the United Kingdom. In some cases, it points out where certain parts of the UK have introduced variations in the funding system, but it does not seek to analyse these variations and their consequences in detail.

## Chapter 2

- 1 An estimate of the cost of efficient care homes in Laing (2004) indicates a £1billion shortfall between the cost and the present funding of residential homes.
- 2 In dividing individuals into separate categories to avoid double counting, this representation does not distinguish whether those receiving local authority help are also getting NHS payments towards nursing care. In most cases this makes no difference to the individual; it just shifts some of the cost from the local authority to the NHS.
- 3 People in care homes who have income or savings that would be counted towards the savings credit of Pensions Credit are able to keep an extra £4.85 per week.

## Chapter 3

- 1 This figure also includes payments of Disability Living Allowance to people over 65 who have carried on this entitlement from when they were younger. See [www.dwp.gov.uk/asd/asd4/long\\_term.asp](http://www.dwp.gov.uk/asd/asd4/long_term.asp).

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# Appendix 1: About JRF's Paying for Long-term Care programme

This is an ambitious three-year programme that tackles a huge and complex issue facing all post-industrial societies. The Joseph Rowntree Foundation has brought together a group of key experts and stakeholders to commission analysis and international comparisons, and to help formulate solutions.

The desired outcomes from this programme of activity are:

To identify, encourage and build consensus around the implementation of a sustainable model for meeting the costs of long-term care throughout the UK.

Such outcomes are consistent with the Foundation's commitment to identifying and addressing social inequalities. Meeting the costs of older people's care is, in JRF's view, a key component of a caring, wealthy and civilised society.

## List of papers and reports

*Long-term Care: Statement by Royal Commissioners.* Published by signatories, 2003

*Future Demand for Long-term Care in the UK: A Summary of Projections of Long-term Care Finance for Older people to 2051.* Raphael Wittenberg, Adelina Comas-Herrera, Linda Pickard and Ruth Hancock. JRF, 2004

*Funding Long-term Care for Older people: Lessons from Other Countries.* Caroline Glendinning, Bleddyn Davies, Linda Pickard and Adelina Comas-Herrera. JRF, 2004

*Private Funding Mechanisms for Long-term Care.* Sandy Johnstone. JRF, 2005

## Appendix 2: Policy and Practice Development (PPD) programme Paying for Long-term Care – Advisory group members

Sir Christopher Kelly	Chair
Andrew Barnett	JRF
Professor David Bell	SCOTECON, Stirling University
Richard Best	JRF
Dame Ann Bowtell	JRF Trustee
Sue Collins	JRF
David Gulland	Deloitte & Touche LLP
Professor Ruth Hancock	Essex University
Helena Herklots	Age Concern, England
Glenys Jones	Social Services, Sunderland CC
John Kennedy (observer)	JRF
William Laing	Laing & Buisson
Des Le Grys	Independent actuary
James McCormick	Scottish Council Foundation
Naina Patel	PRIAE
David Stanton	Economist
Robin Wendt	Adviser
Raphael Wittenberg (observer)	London School of Economics
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