Careless

Funding long-term care for the elderly

Henry Featherstone
and Lilly Whitham

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Policy Exchange

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Executive Summary

A fundamental demographic shift is taking place. The number of older people is growing rapidly while the number of young people and those of working age is shrinking. As people age, the likelihood of them requiring some form of care and support increases. Most of this help is provided by friends and family; many individuals pay for themselves, while the State covers the costs for those that cannot afford to pay. Long-term care for the elderly ranges from help with cleaning and shopping to high intensity care for elderly people in care homes.

For over 15 years politicians and interested stakeholders have advocated the need to reform the way we pay for long-term care of the elderly. For those outside the debate the argument seems compelling: it makes sense to reform a system that is widely considered to be unfair and unnecessarily complex; one which penalises home owners and which no-one really knows much about. Most people think long-term care services are free, but they are not. The 'cradle to grave' promise of the NHS has set the default position across healthcare to dependence on the State.

But while there is agreement on the need for reform, there is no agreement on what that reform should look like. The 2010 General Election highlighted the polarised views about how we should pay for long-term care of the elderly. The political parties' actual proposals on how we pay ranged from Labour's unaffordable National Care Service to the Conservative's unrealistic £8,000 to cover the costs of all future residential care. The reality is that with care home fees of £40,000 per annum, long-term care is expensive for individuals or the State.

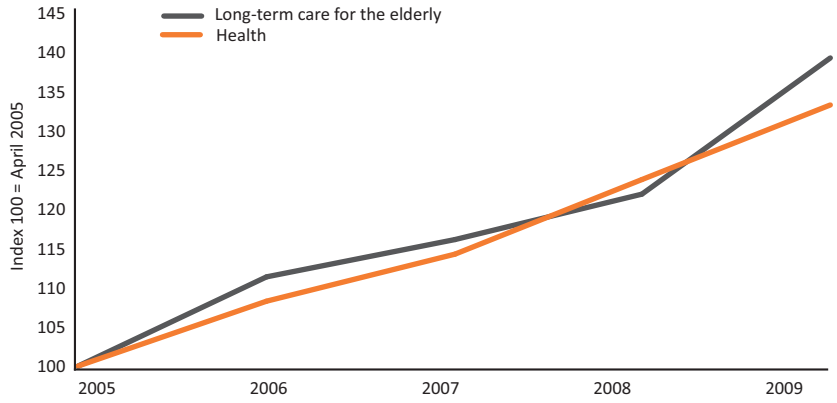
The total cost to the State is not given in Government accounts since funding streams of public money are fragmented and routed through many different Government departments. Most funding is distributed through local authorities (£7.21 billion) and the benefits system (£4.73 billion), although it is surprising to discover that the NHS spends about 4% of its budget (£4.23 billion) on long-term care for the elderly. We calculate that total public spending on long-term care for the elderly was £16.17 billion in 2008-09.

Table 1: Total public spending on long-term care for the elderly

Area of public spending	2008-09 £ (billion)
Local Authorities (net)	7.21
NHS Social Care	3.16
NHS Continuing Healthcare	1.07
Attendance Allowance	3.92
Carers Allowance	0.81
Total spending on long-term care	**16.17**

In the last 15 years, reform of the way we pay for long-term care for the elderly has been the subject of a Royal Commission, two House of Commons Select Committee Inquiries and three major reports by the previous Government. On this evidence, it is seemingly an important issue for the country. But when faced with various options for reform the previous Government rejected them as not being the best use of taxpayer resources. Instead, the choice was to increase resources for the NHS which has seen its funding almost double in real terms from £55 billion in 2000-01 to £101 billion in 2010-11. Although over the last four years total public spending on long-term care for the elderly has grown at the same rate as that of the NHS.

Figure 1: Increase in public spending on long-term care for the elderly and health since April 2005



We believe that the formation of the Coalition Government offers a unique opportunity for politicians and stakeholders to agree a funding solution for long-term care. Indeed, the Coalition's Commission on the Funding of Care and Support will consider a range of ideas for funding. But the ideas, options and models of financial reform are well known, each having both good and bad elements. The hope that the Coalition offers is one for consensus.

We believe that ensuring the new Commission considers the right questions is critical to achieving a consensus and a lasting solution for long-term care. And fundamental to its role is understanding that the impact of demographic projections and their interplay with healthy life expectancy in the UK remains largely open to conjecture. While it is true that reform is required for when the Baby Boomers start to require long-term care from mid-2030 onwards, there is no certainty that as life expectancy increases people will spend more of their lives in poor health. At present, it is unclear whether the predicted gains in life expectancy will be spent in good health – a 'compression of morbidity' – or in poor health – an 'expansion of morbidity'. A third possible scenario is where life expectancy and healthy life expectancy continue to increase in a steady state – 'dynamic equilibrium'.

The obvious concern in policy terms is that most of the increase in life expectancy will be spent living in poor health – 'expansion of morbidity' – and so demand for social care services will increase substantially. This scenario is

favoured by the Department of Health, but is seemingly at odds with international studies which indicate that ageing processes are modifiable and, on the whole, people are living longer without severe disability – i.e. there is a compression of morbidity. The Cognitive Function and Ageing Study is the only means of calculating nationally representative health expectancies at ages 65 years and above. **We recommend that the Department of Health commissions more research into modelling the future care needs and that the forthcoming Commission should use the Cognitive Function and Ageing Study to inform its thinking.**

If we accept that more immediate reform of the system is necessary in order to address unmet need, promote fairness, and prepare for the changing future demographics posed by the Baby Boomers, then a politically acceptable funding mechanism needs to be found. But finding such a solution requires a framework which balances fairness with the realities of public finances and recognition of the fact that those likely to require the burden of care – the Baby Boomers – will be the richest age cohort in history.

The Commission's remit on funding long-term care for the elderly is to, "*consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless*." Despite the fact that the partnership scheme was originally proposed by Julian Le Grand in 2003,* this is too broad and we are concerned that the Commission might, once again, focus on free personal care which would be funded out of general taxation, as recommended by the Royal Commission for Long-Term Care a decade ago. Although this recommendation was rejected by the previous Government as unaffordable, it was introduced in Scotland in 2002. Indeed, people in Scotland pay for and access social care just like they do the NHS, but costs have soared. Scottish government figures show that the cost of free care in care homes has risen by 22% and the cost of free domiciliary care has doubled.

> "To ensure that health and social care provision continues to remain affordable for the State, we believe that it is more important to extend the principle of top-up and co-payment in the NHS, rather than free care at the point of need into long-term care"

Creating a National Care Service which provides care free at the point of need, like the NHS, would of course address any unmet need, but it would also see all private expenditure and the costs which are currently borne by informal carers fall on the State. **We calculate that free personal care would cost the State an additional £106 billion per annum.** Furthermore, it would cement the unreal expectation that all healthcare cost are free and erode the role of care giving in our society. **Given the reality of the public finances we believe that the Commission should not consider as an option funding long-term care exclusively from general taxation.**

Instead, we believe that the Commission should focus its attention on analysing how three specific funding models could be adopted in England. **The options to be considered are the Partnership model where the State funds 50% of everyone's care and then matches every £2 of contributions from the individual with £1 from the State. The second option for consideration should be a full social insurance model as used in other parts of Europe.**

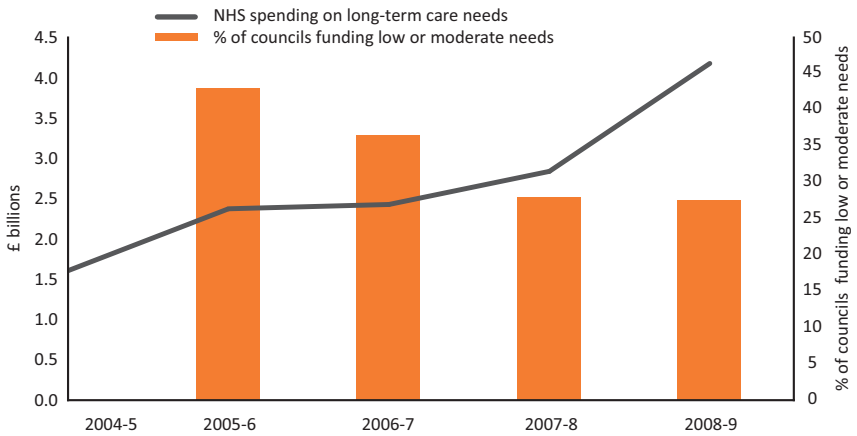
* Le Grand J, *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens,* Oxford University Press, Oxford, 2003

Social insurance type models for the UK have already been suggested by the Joseph Rowntree Foundation and the International Longevity Centre. **In addition, a third hybrid model should be explored where the State guarantees some level of care – as in the Partnership model – but people are required to co-pay for their long-term care through insurance or annuity backed products, rather than by a matched funding system which commits the State to further increases in costs.**

In addition to considering the above funding models, we also recommend that the Commission should consider a much more fundamental question in health and social care: whether the two services should be merged. An obvious perceived conflict to considering that health and social care is delivered as one service is the fact that the NHS is free at the point of use, whereas long-term care is not. In reality this is simply not true; the NHS is not completely free at the point of use. Those with relatively limited means already pay for prescription and dental charges, the so-called co-payments. In addition, top-up payments – where people pay for treatments (mainly cancer drugs) – are also permitted under current NHS guidelines. To ensure that health and social care provision continues to remain affordable for the State, we believe that it is more important to extend the principle of top-up and co-payment in the NHS, rather than free care at the point of need into long-term care.

The NHS and the part of the social care system which provides long-term care for the elderly are interdependent services. Indeed, the NHS currently spends 4% of its budget (£4.23 billion) on long-term care – and as local authorities tighten eligibility criteria for long-term care funding costs shift into the NHS, as is shown in the graph below. For decades there has been a confused arrangement where NHS and social care services have tried to co-operate at a local authority level, yet funding streams are split at Government Departmental level. **The Commission should consider whether fundamental reform of the financing of health and long-term care is necessary and, in particular, whether social care budgets, currently with local authorities, should instead be joined with the NHS.**

Figure 2: NHS spending on long-term care needs increases as local authority eligibility criteria tightens



Much of the discussion on reform of funding elderly care focuses on long-term solutions, but more consideration needs to be given to short-term measures, the 'quick wins', that could immediately address some failings in the current system. Indeed, the Commission on the Funding of Care and Support will take a year to report and there will be an inevitable consultation before any primary legislation. In the intervening period there are a number of policies that the government could adopt which will both reduce demand and costs, as well as increase public awareness about the need for making their own arrangements for long-term care.

We recommend expanding the Partnerships for Older People Projects (POPPs) approach to prevention across all local authorities and PCTs. In addition to delivering better services and improving the well-being of elderly people, evaluation of these POPPs projects have been found to have a significant effect on the use of hospital emergency beds. Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. **Low-level interventions that provide information services, help around the house, fall prevention and physical activities should be the focus of POPPs prevention efforts.**

We also believe that financial advice should become an integral part of the long-term care system. The Baby Boomers – those currently 55-65 years old – will age with more money, mainly housing wealth, than any older group before. In addition, there are a significant number of people that begin as self funders of care, but run out of money and then turn to their local authority for financial assistance – at an estimated cost of £1 billion a year. All these groups could be helped by making financial advice an integral part of the long-term care system. **This should be achieved by compelling local authorities, to signpost people to regulated financial advisors once they have conducted an eligibility test.**

And finally, the lack of a decisive solution in England over the last decade has created considerable uncertainty as to what level of financial support the State would provide. Many people have continued to believe that free personal care for all will soon be introduced in England, as it was in Scotland, but this is simply not economically viable. This political uncertainty caused the private care insurance market to fail, with the main provider of insurance plans actually leaving the market in 2004. We believe that the political uncertainty needs to be resolved. **This requires a clear statement from the Coalition Government that free personal care for the elderly cannot be provided entirely by the State.** This is consistent with both their manifesto commitments and continues the position of the previous government which had ruled out a tax payer funded option. The only question is what level of support the State should provide.

1
What is Long-Term Care?

The way we care for elderly and vulnerable people is the benchmark of a compassionate society. The Department of Health defines social care as, "the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships."[1] These services range from high intensity full-time care for someone with profound physical or learning disabilities, through to lower level care for the elderly who might need help with washing or shopping. We should be clear that in this report we are primarily concerned with long-term care for the elderly and that in the UK most of this care and support is provided by friends or family, not by the State.

State funded social care services are provided through local authorities; however, they are not free at the point of use like the NHS. Instead, there is an intricate process of needs assessment and means testing for elderly people or their families to navigate. An assessment of needs is carried out by local authorities against a national set of eligibility criteria, the Fair Access to Care Services (FACS) framework which has four different bands of need for care: low, moderate, substantial or critical.[2] These national criteria have been found difficult to apply consistently[3] and local authorities are free to choose whether they provide funding for one or more of the bands.[4] As a result, 72% of local authorities only provide support for people whose needs fall into the "substantial" or "critical" bands.[5] This system has been criticised as creating local variation in access to care services where someone with a specific care need may receive free care in one council, but not in another.[6]

Table 2: The Fair Access to Care Services (FACS) framework

Low needs	? Someone cannot carry out one or two personal care or domestic routines. ? One or two work, social, or family responsibilities cannot be sustained.
Moderate needs	? Someone is unable to carry out "several" personal care or domestic routines. ? "Several" work, social or family responsibilities cannot be sustained.
Substantial needs	? The individual only has partial control over their immediate environment. ? The "majority" of work, social or family responsibilities cannot be sustained.
Critical needs	? Someone's needs are life threatening or will result in the development of severe health problems. ? "Vital" personal care or domestic routines cannot be sustained. ? "Vital" work, social or family responsibilities cannot be sustained.

Source: Department of Health – Social Care Policy & Innovation, *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care –Guidance on Eligibility Criteria for Adult Social Care, England 2010.*

1 Department of Health, Our health, our care, our say: a new direction for community services, Cm 6737, January 2006, para 1.29. Adults social care helps people aged 18 and over.

2 Department of Health – Social Care Policy & Innovation, *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care – Guidance on Eligibility Criteria for Adult Social Care, England 2010*, 2010.

3 Commission for Social Care Inspection, *Cutting the care fairly: CSCI review of eligibility criteria for social care*, 2008.

4 Poole, Teresa, *Briefing: Funding adult social care in England*, The King's Fund, 2009.

5 Care Quality Commission, *The State of Care*, 2009.

6 Poole, Teresa, *Briefing: Funding adult social care in England,* The King's Fund, 2009.

To qualify for publically funded long-term care in a care home requires a means-test, and the limit for receiving State support is set at £23,000 worth of assets, including the value of any property.[7] The means-testing rules are complex, but this effectively results in everyone who owns a property having to pay for their residential care – i.e. receiving care in a care home. However, people that do not wish to sell their property to pay for care home fees can apply to their local authority to defer payments, until the property is eventually sold, or up to 56 days after death.

The rules for charging to receive domiciliary care – care provided in an individual's home – are set by local authorities rather than nationally. However, all local rules should comply with the Department of Health's Fairer Charging guidelines,[8] which recommend that it would be unfair to reduce someone's net income below the Pension Credit,[9] plus 25%.[10] Generally speaking, elderly people with assets over the national threshold of £23,000 will have to pay the full cost of their domiciliary care.[11]

In addition to the above there are two other ways in which elderly people can receive social care services. First, the State provides support for long-term care through the benefits system: Attendance Allowance is a benefit provided to people over the age of 65 when they need someone to help look after them because they are physically or mentally disabled. It is worth either £70 or £47 a week, depending on the level of need.[12]

Second, because it is free at the point of use, the NHS ends up being the care provider of last resort to many elderly people, which generally arises before they can be transferred into appropriate social care facilities, such as a care home. Examples of this include admissions to hospital for 'reduced mobility' because the long-term care system does not offer an out-of-hours service. There is, however, a debate as to what aspects of long-term care should be met by the NHS and which by the individual. In the past, people requiring long-term residential care were cared for in NHS long stay community hospitals, entirely funded by the NHS, although there are now far fewer of these hospitals providing such care. This has been widely viewed as a positive change, since more people can now be cared for in their own homes; however, it has also meant that increasing numbers of people who would previously have received free NHS care, are now cared for in private, fee-paying residential or nursing homes.

The reality is that the distinction between health and social care is very blurred and the result of maintaining an artificial division between the two has been the creation of a little known service called NHS Continuing Care, which is free home nursing care for people that need ongoing healthcare outside of a hospital setting. NHS Continuing Care eligibility criteria were originally designed to identify and provide free care only to those who had a high level of need for ongoing healthcare, which was distinct from help and support for the daily activities of personal care, such as washing, dressing and eating. Although a High Court judgement in 2000 means that where a person's primary need is for healthcare, and that is why they are placed in nursing home accommodation, the NHS is responsible for the full cost of the care home package.[13]

7 HM Government. Shaping the Future of Care Together. 2009

8 The Department of Health, *Fairer Charging Policies for Home Care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities*, 2003.

9 The Guarantee Pension Credit is £132.60 if you are single and £202.40 if you have a partner.

10 The Department of Health, *Fairer Charging Policies for Home Care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities*, 2003.

11 Poole, Teresa, *Briefing: Funding adult social care in England,* The King's Fund, 2009.

12 Directgov, *Attendance Allowance – rates and how to claim,* accessed on March 23rd 2010, available at: http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/AttendanceAllowance/DG_10012442

13 R v North and East Devon Health Authority, ex parte Coughlan (2000) All ER 850

2
No Political Appetite for Reform

The case for reform of the long-term care system has grown, principally, from users concerns about the injustices and intricacies of the current system. The general critique offered by the Royal Commission on Long-Term Care for the Elderly in 1999 remains valid today:

> *"The current system is particularly characterised by complexity and unfairness in the way it operates. It has grown up piecemeal and apparently haphazardly over the years. It contains a number of providers and funders of care, each of whom has different management or financial interests which may work against the interests of the individual client.*
>
> *Time and time again the letters and representations we have received from the public have expressed bewilderment with the system – how it works, what individuals should expect from it and how they can get anything worthwhile out of it. We have heard countless stories of people feeling trapped and overwhelmed by the system, and being passed from one budget to another, the consequences sometimes being catastrophic for the individuals concerned."*[14]

The origins of the long-term care system can be traced back to the National Assistance Act 1948 which set out a duty on local authorities to provide residential care to elderly people who cannot secure care themselves.[15] During the late-1980s, the Griffiths Review of community care found that the division of responsibilities for providing social care between various levels of government created a fragmented and inefficient system.[16] With the aim of making social care services more coherent local authorities were given the role of planning community care, including social care in the Community Care Act 1990.[17] While the 1990 Act attempted to promote better working relationships between health and social care, the King's Fund has commented that the failure to fully integrate health and social care left "loose ends...[that] would eventually unravel and require more fundamental attention."[18]

Since mid-1990, a consensus has emerged in a plethora of reports on long-term care that growing demographic pressures combined with the current system's complexities, inadequacies and unfairness makes necessary reform of the way we pay for long-term care.[19,20] In 1997, the Labour manifesto committed to establish a Royal Commission on the issue. This Royal Commission explored the "short and long term options for a sustainable system of funding of Long Term Care for elderly people" and reported in 1999 emphasising that the system was unfair and penalised homeowners. It recommended that "Personal care should be available after assessment, according to need and paid for from general

14 Royal Commission on Long-Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, Chapter 4, Para 4.1-2 1999.

15 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People, Taking a long-term view.* The King's Fund, 2006.

16 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People, Taking a long-term view.* The King's Fund, 2006.

17 The Department of Health, *Caring for people, community care in the next decade and beyond,* 1989.

18 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People, Taking a long-term view.* The King's Fund, 2006: pp 15.

19 Health Committee, *Third Report of Session 1995-96, Long-term care: Future provision and funding*, HC 59-I

20 Diba, R, *Meeting the costs of continuing care.* Joseph Rowntree Foundation. 1997.

taxation."[21] But, a Minority Report from the Royal Commission suggested that a more generous means-test would be a more appropriate solution.[22] Nevertheless, both these recommendations were rejected by the Government a year later as not being the best use of taxpayer resources.[23] Instead, the Government chose to increase resources for the NHS which has seen its funding almost double in real terms from £55 billion in 2000-01 to £101 billion in 2010-11.[24]

The debate around long-term care reform was largely quiet until 2006 when both the King's Fund and the Joseph Rowntree Foundation (JRF)[25] produced reports which suggested that the current system was unable to support the needs of an ageing population. The King's Fund report, *Securing Good Care for Older People*, led by Sir Derek Wanless was widely seen as the most in-depth independent analysis into social care since the Royal Commission. It backed Julian Le Grand's Partnership model for funding social care, where both the State and individuals contribute to long-term care needs.[26] This model would see everyone, irrespective of wealth, receive the same amount of care up to a certain threshold. Beyond the threshold level those more able to pay for their own care would receive matched funding, while those unable to contribute would have all their care costs covered. The liabilities for matched funding and covering those without means would be met by the State. Both the Wanless Review and the JRF Report suggested that spending would need to double in real terms over the next 20 years just to keep pace with the growing number of older people and the rising costs of care provision.[27, 28]

In 2009, three years after the Wanless Review, the Government launched a national consultation on the future of social care funding in England, with the publication of the Green Paper, *Shaping the Future of Care Together*. The paper set out various models for funding reform, but, sadly, the options were uncosted, which did not allow a free and informed debate on how to pay for long-term care.[29]

In March 2010, the Health Select Committee published a report that largely reiterated its findings from 14 years earlier: social care (including long-term care for the elderly and disabled children and adults) is chronically under-funded, unfair, incomprehensible, penalises homeowners and "Pervading the whole system is a persistent ageism".[30] The Committee concluded that political parties must come to a consensus on a way forward because establishing long-lasting reform will take time to implement.[31] Immediately before the 2010 General Election the previous Government released a White Paper, *Building the National Care Service* which set out a three-stage process they would follow if elected. It pledged to implement a National Care Service with universal entitlement free at the point of use and funded through compulsory contributions. However, as with previous Government reports it failed to outline any details of how this would be paid for, deferring instead to a Commission that was to be convened after the General Election.

In the run up to the General Election long-term care for the elderly became a hot political issue with each of the three main political parties putting forward distinct policies. Labour was edging towards a collectivist approach with the announcement by the Prime Minister at the 2009 Labour Party Conference that free domiciliary care would be available to everyone and paid for out of general taxation.[32] This announcement was unexpected and appeared to undermine the Green Paper process. One member of the Royal Commission, Labour Peer Lord

21 The Royal Commission on Long Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities,* The Stationary Office, 1999.

22 The Royal Commission on Long Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, The Stationary Office, 1999.

23 The Department of Health, *The NHS Plan: The Government's response to the Royal Commission on long-term care*, 2000.

24 Authors calculations from HM Treasury Public Expenditure Statistical Analyses 2000, 2007 & 2009

25 Hirsch, *Paying for long-term care: Moving forward,* The Joseph Rowntree Foundation, 2006.

26 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People, Taking a long-term view.* The King's Fund, 2006.

27 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People, Taking a long-term view.* The King's Fund, 2006.

28 Hirsch D, *Paying for long-term care: Moving forward,* The Joseph Rowntree Foundation, 2006.

29 HM Government. *Shaping the Future of Care Together*. 2009

30 House of Commons Health Committee, *Social Care,* Third Report of Session 2009-10, Volume 1. 2010.

31 Commission for Social Care Inspection, *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care*, 2008.

32 Gordon Brown's speech to Labour Conference, Labour, see: http://www2.labour.org.uk/gordon-brown-speech-conference, 2009-09-29

Lipsey, remarked that the plan amounted to, "an admiral firing an Exocet into his own flagship".[33] The Conservatives favoured an individualist approach with their voluntary insurance model which proposed to protect the assets of those that require long-term residential care for just £8,000.[34] While the Liberal Democrats favoured the partnership approach as devised by the King's Fund.[35]

What would a fair funding settlement look like?

Achieving a fair social care funding system has been at the heart of the reform discussion for 15 years, but, as Justin Keen, Professor of Health Politics, at Leeds University points out, no one has defined what fairness actually means.[36] Politicians and the third sector can agree that the current system is unsustainable and wildly unfair, but they can't agree on what a 'fair' system would look like. Both the Royal Commission and the Green Paper, a decade later, have referred to fairness and argued that achieving a fair funding system is required, but neither Report was clear on what that would look like.

To help us conceptualise fairness in long-term care funding, we adopt the same theoretical framework as Professor Keen. From a Utilitarian perspective any new policy would be fair if it increases the overall benefit to society; meaning there are more winners than losers. Second, Rawls' theory of distributive justice argues that new resources should be distributed to improve the circumstances of the least well off in society. And third, Amartya Sen's notion of capabilities essentially looks at how a policy can improve people's quality of life.[37] In reality applying these theories to measure the impact of any proposed new policies is difficult, although the four priorities identified by Professor Keen to evaluate the fairness of different social care funding models have been repeated to us by numerous stakeholders while researching this project. Senior figures in the long-term care debate have also suggested similar principles for reform.[38]

Whilst mindful of the concerns about local variation in access to long-term care services, we believe that consciously chosen variation between communities should also be permitted. Local democratic accountability exists at local authority level, and is being introduced to a greater degree with the Coalition's duty on GP Consortia to cooperate with their respective local authorities. Therefore we suggest that a new system of long-term care funding would be fair when:

1. Access to care is uniform regardless of income;
2. Funding arrangements between health and social care are consistent to prevent local interpretations of what qualifies as a social care need;
3. The responsibility of paying for care is distributed between the government and the public; and
4. Generations equally share the burden of paying for care.

33 Lister S and Elliott F, "Gordon Brown fights for his elderly care reforms as objections grow",The Times, 20 November 2009, http://www.timesonline.co.uk/tol/news/politics/article6924288.ece

34 The Conservative Party, "Ending the scandal of forced home sales to pay for care", Conservatives press release, 2 October 2009, see: http://www.conservatives.com/News/News_stories/2009/10/Ending_the_scandal_of_forced_home_sales_to_pay_for_care.aspx

35 Liberal Democrat Policy Briefing, *Health*, see: http://www.libdems.org.uk/siteFiles/resources/PDF/Election%20Policy/08%20-%20Health.pdf

36 Keen J and Bell D, "Identifying a fairer system for funding adult social care", *Viewpoints: Joseph Rountree Foundation* 2009.

37 Nussmbaum M, "Capabilities as fundamental entitlements: Sen and social justice", *Feminist Economics*, vol 9, pp: 33-59, 2003.

38 Social Market Foundation, *Long-Term Care for the Elderly: Shaping the Future*, 2010.

3
No-one Knows About Long-Term Care

One of the fundamental problems – and, perhaps, one of the main reasons why there has been no reform in the last 10 years – is that people don't really know much about long-term care. The key message from the Government's six month engagement exercise conducted in 2009 was that, "Members of the public typically had limited understanding of the care and support sector beyond their direct or indirect experiences of services."[39] This comes as no surprise as previous surveys record: 51% of people find the system of social care for older people "confusing";[40] 69% say they don't feel sufficiently informed about the financial implications of long-term care,[41] and 39% 'in the system' say it is difficult to understand what is free and what has to be paid for.[42]

The 'cradle to grave' promise of the NHS has set the default position across healthcare to dependence on the State. For 60 years people have been confused by the distinction between health and social care, believing that their obligation to pay taxes and National Insurance meant they would have free care in old age.[43] Without advertising or public awareness campaigns, this misconception persists – 48% of people responding to the Government's engagement exercise think that their care would be free.[44] In the table below we see how nationally representative surveys consistently find that the majority of people think social care services in old age will be provided by the State.

Table 3: Who should be responsible for your social care needs when you are older?

	(% of respondents)				
	Ipsos MORI 2006[45]	YouGov 2007[46]	GfK NOP 2008[47]	CELLO mruk 2009[48]	ComRes 2009[49]
Friends & Family	50%	-	63%	25%	49%
Local authority	57%	42%	48%	27%	59%
NHS	-	47%	-	23%	44%
Personal/Private Spending	50%	44%	38%	20%	-

This default position of dependence on the State is reflected in people's financial planning for future long-term care needs. The table below shows that, in general, people are not saving, or even planning to save, for their care.

39 HM Government, *The case for change: why England needs a new care and support system – engagement findings*, 2009.

40 Right care, Right deal: Counsel and Care, Carers UK and Help the Aged, "Scary", "Depressing" and "Confusing" – England's voters share their views of social care as new research published", Online poll prepared by ICM, 1,385 random adults, released September 2008.

41 ippr and PricewaterhouseCoopers, *Expectations & aspirations: Public attitudes towards social care*¸2009.

42 CELLO mruk social & market research. Cost and Provision Adult Social Care Survey. 2009. Prepared for London Councils, see: http://careandsupport. direct.gov.uk /wp-content/uploads/ 2009/06/ mrukfinalreport20may091.pdf

43 Diba R,"Meeting the cost of continuing care: public views and perceptions", *Social Care Research* vol 84, 1996.

44 Director General of Social Care at the Department of Health confirmed that almost half of respondents thought social care in old age would be free. House of Commons Health Committee, *Social Care*, Third Report of Session 2009-10, Volume 2: Oral and written evidence. 2010.

45 Ipsos MORI, *General Public's High Expectations of Adult Social Care*, July 2006, available at: http://www.ipsos-mori.com/ researchpublications/researcharchive/poll.aspx?oItemId=447

46 Caring Choices, "New survey reveals gap between expectations and reality in long-term care funding",YouGov Plc. Survey for Caring Choices coalition, 2007, see: http://www.caringchoices. org.uk/ index.php/new-survey-reveals-gap-between-expectation-and-reality-in-long-term-care-funding.

47 GfK NOP, *Two thirds of people won't put money aside for social care in older age*, July 2008. http://www.gfknop.com/pressinfo/releases/singlearticles/002721/ index.en.html

48 CELLO mruk Social & Market Research, *Cost and Provision Adult Social Care Survey*, Prepared for London Councils and survey of London residents rather than nationally representative sample, 2009.

49 ComRes, *Social Care Survey*, Prepared for the Local Government Association, 2009, see: http://www.comres.co.uk/ resources/7/Social%20Polls/LGA%20SocialCarePoll%20Results%20(England%20only)%20Mar09.pdf

Examining the detail of these surveys confirms that, intuitively, older age cohorts are more likely than their younger counterparts to be saving for old age care needs: 73% of people aged 16-35 say they've made no plans to pay for their social care, whereas this figure falls to 57% for those aged 51-70 and 56% for those aged over 71.[50]

Table 4: Do you have plans to put money aside for your long-term care?

	(% of respondents all age groups)		
	ICM 2008[51]	GfK NOP 2008[52]	CELLO mruk 2009[53]
Already doing so	5%	3%	14%
Yes	6%	32%	20%
No	87%	64%	61%

There are a number of possible reasons behind the low level of public understanding of social care, particularly for the care of older people. First, as a nation we have an uneasy relationship with death and the fear of dying.[54] Sociologists believe we tend to be 'death-denying' as a way of managing our fears about death, so that we can live a normal life.[55] Indeed, anxiety about death tends to stop people from making plans about how they would like to die, as well as dealing with long-term health care.[56, 57] Second, surveys suggest that there is an element of denial about the likelihood of needing care: 93% think that *most people* will require care in their old age, whereas only 71% think that *they* will require care in old age.[58] Third, the influence of the media is important. Tragic failures of social service departments in respect of children make front page headlines; whereas the social care failure that results in the death of an elderly couple in their home is barely news at all.[59]

The most important issue facing Britain?

In the last 15 years, long-term care for the elderly has been the subject of a Royal Commission, two House of Commons Select Committee Inquiries, three major reports by the previous Government and now a forthcoming Coalition Government review. On this evidence, long-term care is seemingly an important issue for the country.

Since 1974, the polling company Ipsos Mori has tracked the public's view of the most important issues facing Britain. The aptly named 'Most Important Issues Facing Britain' Index is compiled through a monthly survey where people are asked "*What would you say is the most important issue facing Britain today?*" Their unprompted answers are then recorded. Over the years, key issues have been the NHS, crime and education, with other age related issues such as pensions having only moderate importance which, incidentally, has reduced in recent years. Only once an issue is mentioned repeatedly (the threshold is 0.5% of responses) does it then appear in the Index as a specific category and this process has seen new

50 GfK NOP, *Two thirds of people won't put money aside for social care in older age*, July 2008, see: http://www.gfknop.com/pressinfo/releases/singlearticles/002721/index.en.html

51 Right care, Right deal: Counsel and Care, Carers UK and Help the Aged, "Scary", "Depressing" and "Confusing" – England's voters share their views of social care as new research published", Online poll prepared by ICM, 1,385 random adults, released September 2008.

52 GfK NOP, *Two thirds of people won't put money aside for social care in older age*, July 2008 http://www.gfknop.com/pressinfo/releases/singlearticles/002721/index.en.html

53 CELLO mruk Social & Market Research, *Cost and Provision Adult Social Care Survey*, Prepared for London Councils and survey of London residents rather than nationally representative sample, 2009.

54 Bowling A, Illiffe S, Kessel A and Higginson I, "Fear of dying in a ethnically diverse society: cross-sectional studies of people aged 65+ in Britain", *BMJ*, vol 86, pp 197-202, 2010.

55 Becker E, *The Denial of Death*, Collier-Macmillan, New York: 1973.

56 Sanders C, Rogers A, Gately C and Kennedy A, "Planning for end of life care within lay-led chronic illness self-management training: The significance of 'death awareness' and biographical context in participant accounts" *Social Science and & Medicine*, vol 66 no 4 pp 982-993, 2008.

57 Seymour J, Gott M, Bellamy G, Ahmedzal S and Clark D, "Planning for the end of life: the views of older people about advance care statements" *Social Science & Medicine* vol 59 no 1 pp 57-68, 2004.

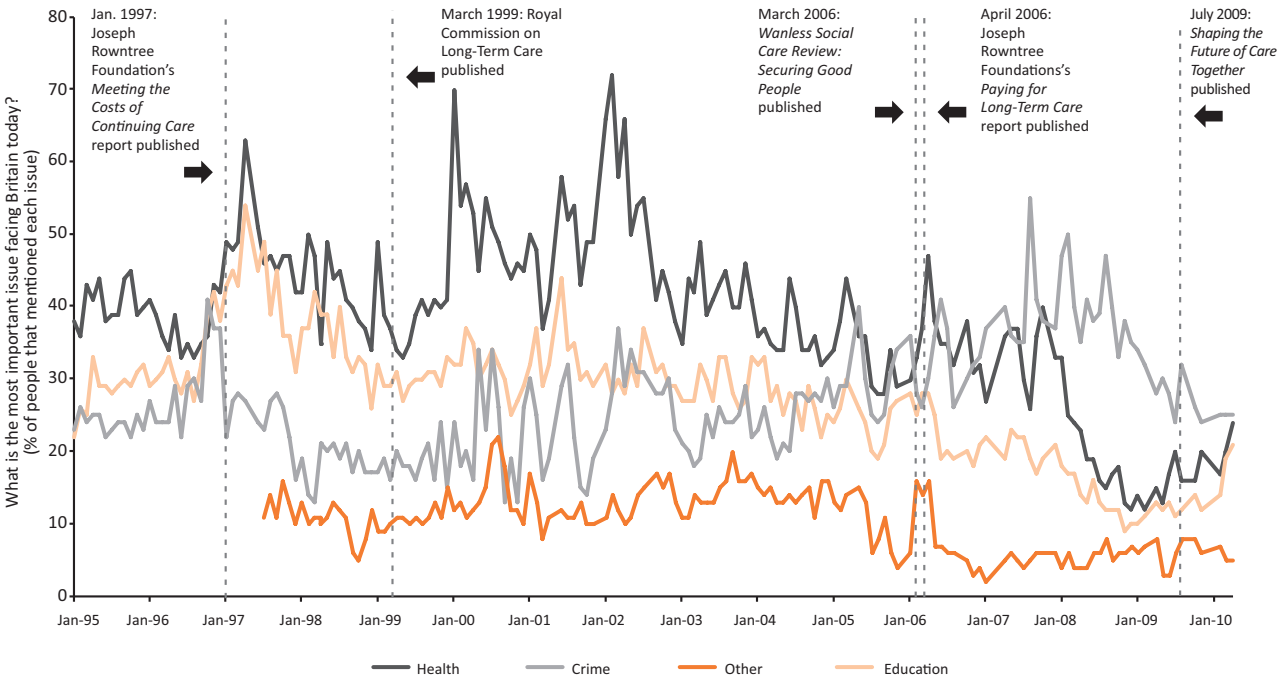
58 ComRes, *Social Care Survey*, Prepared for the Local Government Association, 2009, see: http://www.comres.co.uk/resources/7/Social%20Polls/LGA%20SocialCarePoll%20Results%20(England%20only)%20Mar09.pdf

59 Wardrop M, "'Neglect' fears after elderly couple die in freezing home", *The Daily Telegraph*, 12th January 2010, see: http://www.telegraph.co.uk/topics/weather/6970522/Neglect-fears-after-elderly-couple-die-in-freezing-home.html.

topics such as AIDS; genetically modified foods and bird flu emerging briefly as categories, but then falling away once media and headlines and Government information campaigns recede. Throughout the Index's 35 year history long-term care and age related issues have not been mentioned frequently enough to warrant their own category. Instead, when concerns without a specific category are mentioned – such as long-term care – they are placed in the grouping marked 'other'.[60]

In the graph opposite, which tracks four selected issues from the Ipsos MORI Index – crime, education, NHS and 'other' – we see how, over the last decade, the importance of the NHS as an issue has reduced significantly, while crime and education are consistently considered amongst the most important issues facing Britain. Despite many important reports from Government and influential bodies like the King's Fund and the Joseph Rowntree Foundation on the need for reform, long-term care has not been mentioned frequently enough for it to become a separate category. Of course we have no way of knowing whether complaints about long-term care for the elderly blend into concern about the NHS – especially as most people think both are essentially the part of the NHS.

Figure 3: Some of the most important issues facing Britain, 1995-2010



Source: Ipsos MORI. The Most Important Issues Facing Britain Index.

Britain's most important issues and their costs

Given the relative importance attached by the public to crime, health, defence, education and social care, it is interesting to compare the amount of public spending in these areas with the level of public concern. In the table below we show how the average score of the Ipsos MORI Index over the last Parliament (2005-2010) for each of these issues compares to the amount of public spending in each area in 2008-09.

60 Personal communication with Ipsos MORI.

Again, it would be simplistic to expect some form of direct correlation; but the point to note is the complete uncoupling of a significant and growing area of public spending and the level of public understanding.

Table 5: Britain's most important issues and their costs

	Most important issue facing Britain* (ave. % of respondents)	Total public spending in 2008-09** (£ billion)
Crime	34	28.5 ***
Healthcare	26	106.8 ****
Defence	24	36.7
Education	18	82.6
Social care	<0.5	16.17 *****

Sources: * Ipsos MORI. The Most Important Issues Facing Britain Index. Average responses for the last Parliament.
** HM Treasury. Public Expenditure Statistical Analysis, 2010 Table 5.1.
*** HM Treasury. Public Expenditure Statistical Analysis, 2010 Table 5.1. Total cost of public protection, minus the costs for immigration and fire services.
**** HM Treasury. Public Expenditure Statistical Analysis, 2010 Table 5.1. Total cost of healthcare, minus £3.16 bn as the published costs of social care provided by the NHS.
***** Author's calculations on page 20

4
The Costs of Long-Term Care

Spending on long-term care for the elderly comes from an array of different sources: individuals paying themselves; friends and family; local authority budgets; the NHS, as well as cash payments through the benefits system.

The largest tranche of public funding is routed through local authorities via the Revenue Support Grant, although local authorities are not required to spend a set amount of the Grant on social care – i.e. the funding is not ring-fenced.[61] Typically, local authority departments cover the welfare of children and families, as well as for older people and disabled adults of working age through separate departments. In 2008-09, the net spending by local authorities on care for the elderly was £7.21 billion (a net figure is used since income is raised by local authorities through the existing system of fees and charging).[62] The total gross expenditure was £9.47 billion.

Separate from local authority spending, the NHS also provides for some elderly care needs and these cost an additional £3.16 billion in 2008-09, which was an alarming 52% increase from the previous year, although the NHS says that the majority of this increase was due to methodological changes as budgets were reassigned from mental health spending.[63] Nevertheless, this spending on social care includes NHS categories such as 'reduced mobility'; 'assistance with personal care' and 'holiday relief care'. This figure of £3.16 billion will also be an underestimate since spending by Primary Care Trusts (PCTs) on 'NHS Continuing Healthcare' are not normally included.[64]

NHS Continuing Healthcare covers the care needs that arise as a result of disability, accident or illness and are provided free of charge by the NHS outside of hospitals.[65] Indeed, the Health Select Committee report on NHS Continuing Healthcare found that the majority of recipients are older disabled people.[66] There are few published statistics on the number of people in receipt of it, and astonishingly the Department of Health says that it does not collect information on the total costs.[67] We have used available data from Parliamentary Questions[68] and the Department of Health[69] on the number of people in receipt of NHS Continuing Healthcare and used a conservative figure of £482 per week[70] as a measure of the unit costs of providing this care. There were 40,449 people in receipt of NHS Continuing Care in 2008, which cost the NHS in the region of £1.01 billion per year.

Included in our analysis is public expenditure on Attendance Allowance (AA) because it is a non-means tested tax free benefit available to people aged 65 or over. The benefit is awarded to those who need someone to help look after them because they are physically or mentally disabled. Spending on AA totalled £3.92

61 The Department of Health, *Use of Resources for Adult Social Care: Putting People First Transforming Adult Social Care – A guide for local authorities*, 2009.

62 Department for Communities & Local Government , *Annex A6 Local Authority Revenue Expenditure and Financing England: 2008-09 Final outturns*, 2009.

63 Department of Health, *Programme budget data*, 2010, available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_111236.pdf

64 Department of Health, *Programme Budgeting FAQs Updated October 2009*, 2009.

65 Department of Health, *NHS continuing healthcare and NHS-funded nursing care: Public information booklet*, 2009.

66 House of Commons Health Committee, *NHS Continuing Care*, Sixth Report of Session 2004-2005 Volume 1, 2005.

67 House of Commons Hansard. 7 Jan 2010 : Column 611W. PQ: 309313

68 Parliamentary Question on NHS Continuing Care by Norman Lamb MP. 261495. 9 Mar 2009 : Column 134W—continued.

69 Department of Health, *The National Framework for NHS Continuing Healthcare and NHs funded Nursing Care in England*, 2010, pg 9.

70 NHS information Centre. Personal Social Services Expenditure and Unit Costs England, 2008-09. Table 6.1

billion in 2008-09. There is no requirement that this benefit be spent directly on care and support and this flexibility is seen as a particular advantage by its recipients. It is a contested point as to whether AA should be included in reform of the care system, with respected authorities such as the King's Fund arguing for it to be included, although the then Shadow Secretary of State for Health opposed this suggestion ahead of the election.[71, 72]

Carers Allowance is a taxable benefit payable to carers that provide more that 35 hours of care per week to someone who is in receipt of disability benefits such as AA. It was introduced in 2003 and in 2008-09 Carers Allowance cost £1.15 billion,[73] although that figure included providing care for those under 65. The UK is one of only four European countries (Ireland, Denmark and Finland) that provide direct financial support for carers. We have adjusted the figure in our total of public spending on long-term care for the elderly to account for the fact that the General Household Survey finds that 70% of care from carers is provided for those over 65 years old.[74]

Total public spending on long-term care for the elderly in 2008-09 was £16.17 billion.

Table 6: Total public spending on long-term care for the elderly

Area of public spending	2008-09 £ (billion)
Local Authorities (net) *	7.21
NHS **	3.16
NHS Continuing Healthcare	1.07
Attendance Allowance***	3.92
Carers Allowance***	0.81
Total spending on long-term care	**16.17**

Sources: * Net Personal Social Services Expenditure. Annex A6 Local Authority Revenue Expenditure and Financing England: 2008-09 Final outturns. Department for Communities & Local Government. 2009.
** Estimated England level gross expenditure by Programme Budget 2008-09. Department of Health. 2010.
*** Benefit Expenditure by Country, Region and Local Authority. Department for Work and Pensions. 2010. Adjusted to account for 70% of carers provide care for those over 65 years old.

Most care and support to elderly and vulnerable people is not provided by the State, but by millions of carers, be they friends, family or neighbours. The informal care and support provided by carers is said to amount to £87 billion annually.[75]

Private spending on paid long-term care for the elderly is difficult to quantify since there are no recorded measures. In 2006, a partial estimate of £5.86 billion (£6.18 billion at 2008-09 prices) was produced by the Personal Social Services Research Unit (PSSRU) in work commissioned by the Commission for Social Care Inspection; this was approximately 51% of total spending on long-term care for older people.[76] We speculate that total private spending on long-term care for the elderly could easily be as high as the total public spending of £16.17 billion, if not more, since a whole range of costs are not covered in previous estimates like that of the PSSRU. For example, ad hoc purchase of care arranged independently, and the capital costs associated with making adjustments to family homes to accommodate elderly relatives.

71 Humphries R, Forder J and Fernández J-F, *Securing Good Care for More People: Options for reform*, The King's Fund, 2010.

72 Andrew Lansley, "Tories will not scrap attendance allowance", Speech to National Children and Adult Services Conference, 22 October 2009, see: http://www.communitycare.co.uk/Articles/2009/10/22/112947/andrew-lansley-tories-will-not-scrap-attendance-allowance.htm

73 Department for Work and Pensions , Benefit Expenditure by Country, Region and Local Authority, 2010. http://research.dwp.gov.uk/asd/asd4/expenditure.asp

74 National Statistics. Maher J and Green H, *Carers 2000*, London Stationary Office, 2002.

75 Carers UK, ACE National and The University of Leeds, *Valuing Carers – Calculating the value of unpaid care*, 2007, see: http://www.carersuk.org/Professionals/ResearchLibrary/Profileofcaring/1201108437

76 Forder J (2007). *Self-funded Social Care for Older People: An analysis of eligibility, variations and future projections*. PSSRU discussion paper 2505. London: Commission for Social Care Inspection.

Creating a National Care Service which provided care free at the point of need, like the NHS, would of course address any unmet need, but it would also see all this private expenditure and the costs which are currently borne by informal carers fall on the State – this would be in the region of an additional £106 billion. Furthermore, it would cement the unreal expectation that all healthcare cost are free and erode the role of care giving in our society.

Recommendation: Future long-term care needs cannot be paid for entirely from general taxation. This option should be specifically excluded from consideration by the forthcoming Coalition Commission into long-term care.

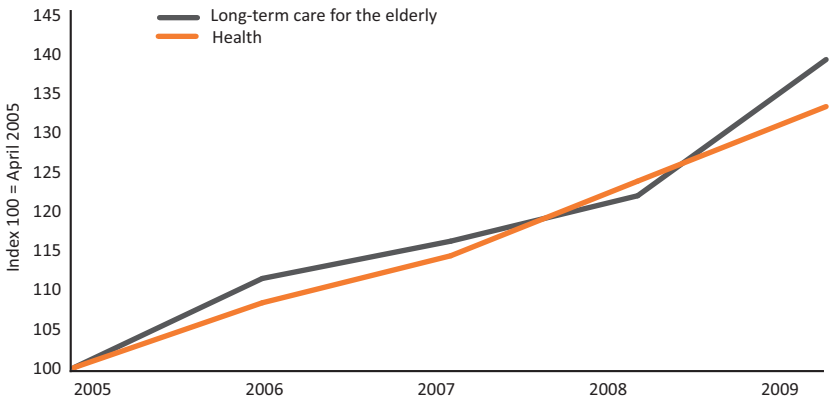
Table 6: Total public spending on long-term care for the elderly

	2004-05 £ (billion)	2005-06 £ (billion)	2006-07 £ (billion)	2007-08 £ (billion)	2008-09 £ (billion)
Local Authorities (net)*	6.40	6.70	6.90	6.90	7.21
NHS **	1.61	1.75	1.72	2.07	3.16
NHS Continuing Healthcare		0.63	0.77	0.77	1.07
Attendance Allowance***	3.03	3.23	3.43	3.70	3.92
Carers Allowance***	0.64	0.67	0.70	0.75	0.81
Total	**11.68**	**12.98**	**13.52**	**14.19**	**16.17**

Source: as above.

Unfortunately, it is not possible to show how our measure of total public spending on long-term care has increased over any significant length of time, since historical data does not exist across all the sources used. Available information is included in the table above.

Figure 3: Increase in public spending on long-term care for the elderly and health since April 2005



Source: author's calculations & HM Treasury PESA 2010.

The repeated allegation against the previous Government's policy on long-term care is that inadequate funding resulted in a tightening of local authority eligibility criteria for State funded care services. Indeed, surveys support this

increase in unmet need for care: a Government commissioned survey conducted by the Commission for Social Care Inspection (CSCI) found that only 30% of those who met eligibility criteria actually received the help they needed.[77] Moreover, the 2010 report by the King's Fund, *Securing Good Care for More People*, suggested that the costs of meeting existing unmet needs would be greater than the costs faced by demographic pressures in the future.

> "Protecting departmental spending in the NHS will mean that other departmental spending – including that on social care for disabled adults and children – will face a spending cut in the region of 25% a year"

However, it would appear that total spending on long-term care for the elderly has kept pace with the record increases seen in the NHS, as seen in the graph above. This observation throws up two important points: first, that ring-fencing the NHS budget while cutting part of the funding stream to long-term care for the elderly by up to 25% would inevitably increase the burden on the NHS since these are interdependent services; and second, that all areas of public spending on long-term care for the elderly should be included in funding reform.

Recommendation: We believe that all areas of public spending on long-term care of the elderly should be considered by the Commission in any new system of reform – this includes both Attendance Allowance and Carers Allowance.

Future funding challenges

In arguing for long-term care reform the previous Government stated that by 2026 a £6 billion "funding gap" would exist if the system did not change.[78] Detailed modelling, conducted by the King's Fund suggests that the current care system for older people will require a funding increase of at least 3.2% a year just to keep up with demand, although the King's Fund analysis includes services both for the elderly and for children and adults with a disability.[79]

Because of the increasing survival rate of profoundly disabled infants and children, it is known with some certainty that the costs of caring for children and adults with a disability will increase year on year.[80] Therefore, political promises to protect spending on the NHS have the potential to cause unintended consequences in the wider social care system. That is to say, protecting departmental spending in the NHS will mean that other departmental spending – including that on social care for disabled adults and children – will face a spending cut in the region of 25% a year. Since social care spending for the elderly or vulnerable disabled people is not ring-fenced within local authority budgets the short to medium term prospect for these services is bleak. Moreover, spending on long-term care for the elderly will face pressure from spending for services on disabled adults and children, as well as changes in demographics.

77 Commission for Social Care Inspection, *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care.* 2008.

78 HM Government, Building Britain's Future, Shaping the Future of Care Together, 2009.

79 Humphries R, Forder J and Fernández J-F, Securing Good Care for More People: Options for reform, The King's Fund, 2010

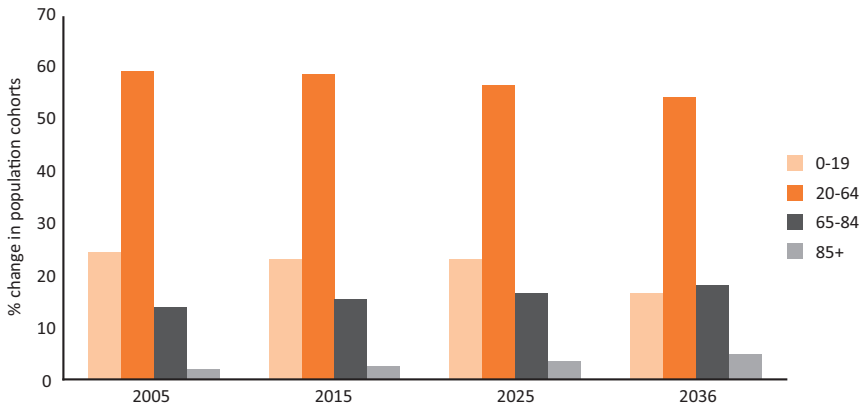
80 Wittenberg R, et al. *Future demand for social acre, 2005 to 2041: Projections of Demand for social Care and Disability Benefits for Younger People in England*, PSSRU, 2008

5
Is There an Urgent Need for Reform?

A fundamental demographic shift is taking place. The number of older people is growing rapidly while the number of young people and those of working age are shrinking. This new demography of low fertility and reduced mortality in old age is forecast to continue.[81]

Traditionally, individuals have had three major periods of life: childhood, adulthood and old age. But old age is dividing into two segments: the 'young old' (those aged 65-85) and the oldest old (those aged 85 and over). The fastest population increases are seen in these 'oldest old': in the last 20 years the number of people over 85 has doubled and is projected to double again by 2033, when the 'oldest old' will account for 5% of the total population.[82] Looking at the most recent population projections which cover the period 2008 to 2033: the number of people aged over 90 will more than triple, the number of people aged 95 and over will more than quadruple, and the number of centenarians will experience a more than sevenfold increase to approximately 80,000 people.[83]

Figure 4: Projected change, over ten year periods, in age cohorts as a percentage of the total population



Source: Source: Office for National Statistics: Key Population and Vital Statistics: Local and Health Authority Areas, 2005. 2008-based National Population Projections, 2009.

However, although these increases in the 'oldest old' are substantial, demographically significant increases in demand for social care in the UK are thought not to begin to arise until the mid-2030's, when the bulge of post-second world war Baby Boomers begin to turn 85 and are more likely to require care.[84] So

81 Office of National Statistics, *Period expectation of life at birth and selected ages, UK and constituent countries*, accessed March 16th 2010, see: http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14459

82 Office of National Statistics, *Ageing*, available at: http://www.statistics.gov.uk/cci/nugget.asp?id=949

83 Office for National Statistics, *National population projections*, 2008-based, 2009.

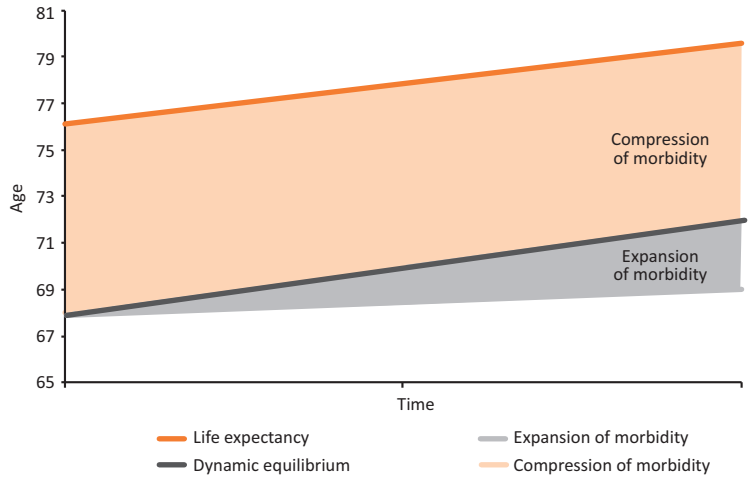
84 House of Commons Health Committee, *Social Care*, Third Report of Session 2009-10, Volume 1. 2010.

although there is growing pressure from interested stakeholders to act now on reforming long-term care funding, there is sufficient time for an informed debate.

The general concern for policy makers is that the shrinking working-age population will not be able to provide sufficient care themselves – or be able to afford the burden of taxation – that will be required to support the growing elderly population. A measure of this concern is seen in the 'old age support ratio' which is the number of people of working age for every person above the state pension age. Currently, there are 3.23 people of working age for every person of pensionable age. This figure will decline to 2.78 by 2033, without the planned changes in state pension age, however, the old age support ratio would have declined to 2.18 by 2033.[85]

The main reason for the demographic shift is the recent, rapid increase in life expectancy which has been caused principally by reduced mortality in older age groups. This trend is projected to continue: over the next 30 years male life expectancy from birth is anticipated to increase by 6.7 years and by 4.9 years for females.[86] However, at present, it is unclear whether these extra years of life will be spent in good health – a 'compression of morbidity' – or in poor health – an 'expansion of morbidity'. A third possible scenario where life expectancy and healthy life expectancy continue to increase in a steady state is called 'dynamic equilibrium'.

Figure 5: Expansion or compression of morbidity?



The obvious concern in policy terms is that most of the increase in life expectancy will be spent living in poor health – 'expansion of morbidity' – and so demand for social care services will increase substantially.[87] This scenario is favoured by the Department of Health,[88] but it is seemingly at odds with international studies which indicate that ageing processes are modifiable and, on the whole, people are living longer without severe disability – i.e. there is a compression of morbidity.[89] Indeed, most studies in the USA suggest that disability is being compressed into a shorter period of time, because while they have more diseases older Americans have been found to have less disability than

85 Office for *National Statistics, National population projections,* 2008-based, 2009.

86 Office of National Statistics, *Period expectation of life at birth and selected ages, UK and constituent countries*, accessed March 16th 2010, see: http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14459

87 Jagger C, Matthews R, Spiers N, Brayne C, Comas-Herrera A, Robinson T, Lindesay J, Croft P, *Compression or Expansion of Disability? Forecasting Future Disability Levels Under Changing Patterns Of Diseases*, Leicester Nuffield Research Unit, 2006.

88 House of Commons Health Committee, *Social Care*, Third Report of Session 2009-10, Volume 1. 2010.

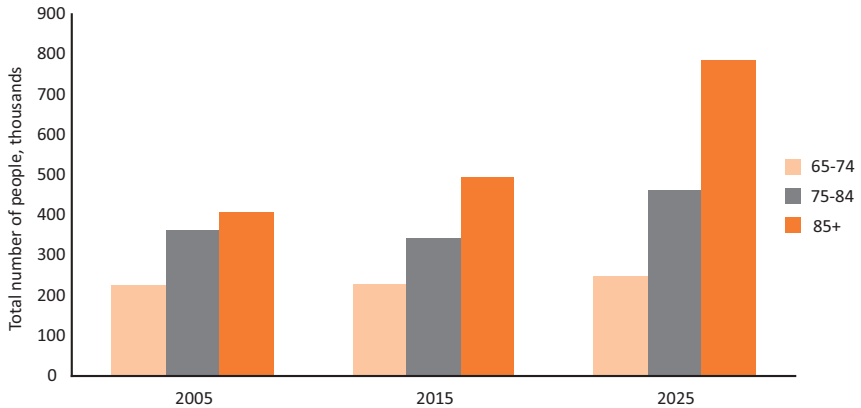
89 Christensen K, Doblhammer G, Rau R, Vaupel J. Ageing populations: the challenges ahead. Lancet. 2009 October 3; 374(9696): 1196–1208.

in the past.[90] Furthermore, other studies across many countries find a postponement of disabilities for the 'young old' even despite an increase in chronic diseases, but for the 'oldest old', the position is less clear because there is little reliable data.[91]

A number of influential bodies have recommended the need for better data on whether the anticipated increases in life expectancy will be spent in good health or poor health.[92, 93] There are two studies – the Cognitive Function and Ageing Study and the English Longitudinal Study of Ageing – which could also be used to help inform policy thinking in the UK. At present the Cognitive Function and Ageing Study is the only means of calculating nationally representative health expectancies such as Healthy Active Life Expectancy at ages 65 years and above.

Nevertheless, the academic modelling preferred by the Department of Health to inform the recent Green and White Papers suggests that there will be an 'expansion of morbidity' – the worst case scenario. With the caveat that projections such as these are highly sensitive to future patterns of disease prevalence and mortality (which themselves are highly variable), the academic work that informs the Department of Health has estimated the number of people in the UK that will need care in the future. Assuming that there were no changes in the population's health status over the next 15 years it is estimated that 1.45 million people over the age of 65 will require some form of care by 2025.[94] However, these projections are based on Office for National Statistics data from 2006, which we have updated below with data from 2008. The worst case scenario by 2025 is that 1.49 million people over 65 will require care and support, compared to about 1 million today. The consequence of this is that, all other things being equal, State spending on long-term care for the elderly would increase by 50% over the next 15 years, increasing from £16.17 billion to £24.26 billion in 2008-09 prices.

Figure 6: Number of people with a severe disability who will require care



Source: Author's calculations based on data from Office for National Statistics, *Ageing*, Fastest increases in the oldest old. August 2009 and Jagger et al, *Compression or Expansion of Disability? Forecasting Future Disability Levels Under Changing Patterns Of Diseases*, Leicester Nuffield Research Unit, 2006.

Whereas the projections for the care needs of older people are still somewhat inconclusive, there is certainty that the care requirements for disabled adults and children are set to increase. This is because more people with profound and

90 Crimmins EM. Trends in the health of the elderly. Annu. Rev. Public Health 2004;25:79-98.

91 Christensen K, Doblhammer G, Rau R, Vaupel J. Ageing populations: the challenges ahead. Lancet. 2009 October 3; 374(9696): 1196–1208.

92 Health Committee, Third Report of Session 1995-96, Long-term care: Future provision and funding, HC Paper 59-I

93 House of Lords, *Ageing: Scientific Aspects*, First Report of the Select Committee on Science and Technology, Session 2005-06, HL Paper 20-I

94 Jagger C, Matthews R, Spiers N, Brayne C, Comas-Herrera A, Robinson T, Lindesay J, Croft P, *Compression or Expansion of Disability? Forecasting Future Disability Levels Under Changing Patterns Of Diseases*, Leicester Nuffield Research Unit, 2006.

multiple disabilities are now surviving well into adulthood, often with increasingly complex care needs. These changes have been driven mainly by decreasing mortality rates, especially in older adults with a profound disability and among children with severe and complex needs.[95] As a result, the requirement for social care services for adults and children with learning disabilities will experience sustained growth over the next 30 years with net public expenditure on social care for disabled adults and children projected to increase by 148% over the same period.[96]

Recommendation: There is no urgent demographic pressure to make hasty decisions regarding reform of the system of financing long-term care. The direction of policy shouldn't be set until there is better understanding as to whether the anticipated increases in life expectancy will be spent in good health or poor health. The Department of Health should, as a priority, diversify its evidence base on future demographic modelling for healthy life expectancy.

95 Emerson E, Hatton C (2008). Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England. Lancaster: Centre for Disability Research.

96 Wittenberg R, et al. Future demand for social acre, 2005 to 2041: Projections of Demand for social Care and Disability Benefits for Younger People in England. PSSRU. 2008

6
How Do We Pay for Reform?

If we accept that reform of the system is necessary in order to address unmet need, promote fairness, and prepare for the changing future demographics posed by the Baby Boomers, then a politically acceptable funding mechanism needs to be found. In general there are three ways in which long-term care funding can be paid for.

General taxation

Long-term care provided by the State is currently funded through general taxation, although there is a small element of contribution through council tax. It has been suggested that future long-term care funding should be met out of general taxation, and this is the case in Scotland where free personal care has been available at the point of need since 2002. Indeed, people in Scotland pay for and access social care just like they do the NHS, but costs have soared. Scottish Government figures show that the cost of free care in care homes has risen by 22% between 2003-04 and 2007-08 from £83 to £102 million and the cost of free domiciliary care has doubled over the same period from £129 to £257 million.[97] Adoption of the same policy in England would see the net costs borne by local authorities increase from £7.21 billion to £12.17 billion in a period of just four years.

Notwithstanding the fact that the UK has a £156 billion deficit,[98] there are serious equity issues with introducing a system funded through general taxation. If a tax-funded system were adopted the current working-age population would have to pay twice for long-term care: once on behalf of their ageing parents and once for themselves.[99] This dilemma is often referred to as an intergenerational inequality, which is such a significant problem that on this basis funding long-term care for the elderly through general taxation was ruled out by the previous Labour Government in 2000 and again in 2010.[100]

Furthermore, the post-war 'Baby Boom' population (those currently aged 55-65) is the wealthiest age cohort in the UK. Baby Boomers will age with more money than any age cohort before them and are likely to be wealthier than any future generation.[101] Much of their wealth comes from home-ownership as property prices have soared in the last few years. Indeed, in 2007 the majority of people over the age of 50 owned their own home.[102] And four years ago it was estimated that older households (over the age of 60) owned £1 trillion in housing equity, which is projected to rise to £1.4 trillion by 2026, even if house prices

97 The Scottish Government, *Free Personal And Nursing Care*, Scotland, 2007-08, 2009.

98 Office of Budgetary Responsibility, *Pre-Budget Forecast,* Table 4.4, June 2010,

99 Hirsch D, "Funding care: how can each generation pay for its fair share?", *Viewpoints: Joseph Rowntree Foundation*, 2010.

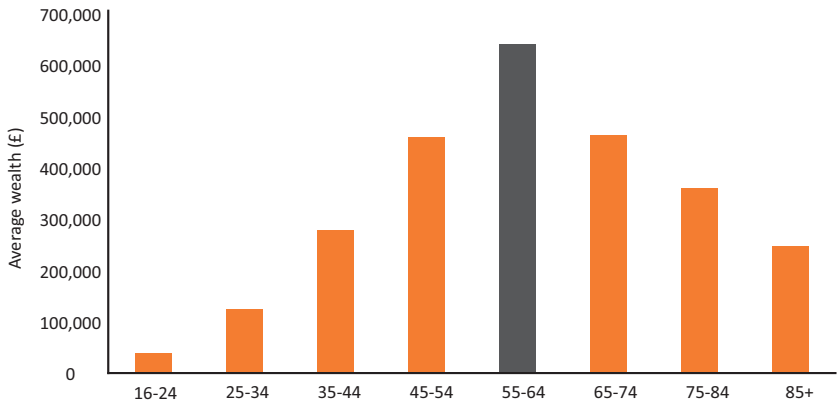
100 HM Government, *Building the National Care Service*,2010

101 Lloyd J, "A National Care Fund for Long-Term Care", *ILC-UK*, 2008.

102 Office of National Statistics, *Housing-half of older people households own their home*, accessed on May 12th 2010, see: http://www.statistics.gov.uk/cci/nugget.asp?id=1265

remain constant.[103] Many people in this age cohort will have the financial means to pay for their own care, especially with the creation of more mechanisms to draw on housing wealth.

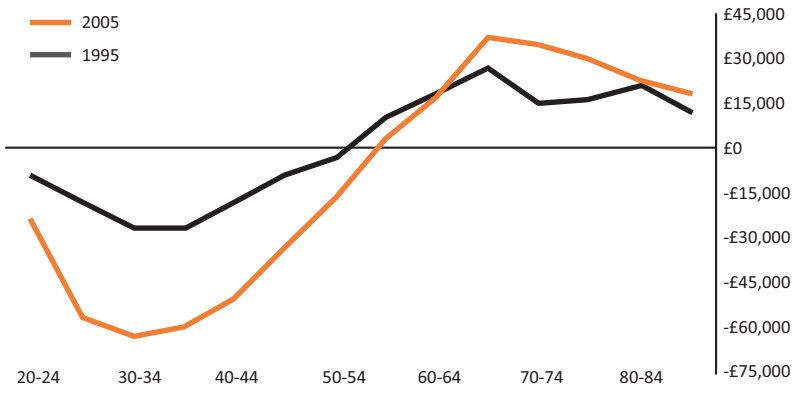
Figure 7: Distribution of wealth across age groups in Britain



Source: Office for National Statistics, *Wealth in Great Britain: Main results from Wealth and Assets Survey 2006/2008*, 2009.

As has been pointed out, paying for long-term care through general taxation "would see the richest cohort in history becoming the first to receive universal free care."[104] Indeed, as can be seen from the chart below, compared to 1995 and more so to 2005, young people are now more indebted, and older people are richer.

Figure 8: Net financial assets and net worth



Source: Bank of England. Working Paper No. 379.

Recommendation: Future long-term care needs cannot be paid for entirely from general taxation. This option would not only be unaffordable, but also be unfair on the working age population.

103 Holmans A, *Prospects for UK housing wealth and inheritance*, The Council of Mortgage Lenders, 2008.

104 Lloyd J, "A National Care Fund for Long-Term Care", *ILC-UK*, 2008.

Social insurance

Social health insurance is a mechanism of funding healthcare used by many Western European countries, and some have extended to cover long-term care for the elderly. In general, social insurance requires compulsory contributions be made into a quasi-independent public body – often called a sickness fund – which manages the purchase of healthcare.[105] A sickness fund is similar to an insurance company, but it is not-for-profit and usually has statutory recognition and responsibilities.[106]

A social insurance scheme to cover long-term care would require everyone, say over retirement age to contribute into a scheme either by a one off payment or by regular contributions. Younger generations would make regular contributions which would be linked to earnings. Intergenerational inequalities are avoided through increasing the quantum of contribution required by those over retirement age. The level of contribution could be set according to what people could afford with the State providing contributions for those with little or no means. Access to long-term care provided by the care fund would be based on need, not ability to pay.

There are particular advantages to adopting a social insurance model. First, contributions based on ability to pay would be seen by all to be fair.[107] Indeed, surveys of European populations have found that people are generally more satisfied with social insurance than voluntary insurance or general taxation.[108, 109] Second, earmarking payments into a separate legal entity or 'care fund' removes the threat posed by changing political preferences and is widely considered to be a more stable funding model compared to general taxation.[110]

A few countries, namely Germany and Japan, have moved towards using the social insurance model to fund their social care systems. In 2000, Japan implemented mandatory monthly contributions for the working population between the ages of 40-65, with a 10% co-payment from the State.[111] In 1994 Germany enacted a universal-coverage social insurance program for long-term care to largely replace its means-tested system. The long-term care insurance premium is uniform and fixed by law at 1.7% of salary, which is shared equally by employers and employees.[112] Both Germany and Japan however, are struggling to ensure long-term financial sustainability of these systems. In Japan, costs of care have escalated and, in 2005, they excluded hotel costs (care home accommodation as opposed to care home nursing costs) from the benefits package. Currently lowering the minimum age of contribution to 21 is under consideration.[113] The German system now only covers about half of the cost of institutional care, leaving some older people forced to pay out-of-pocket to cover their long-term care.[114]

Variations on the social insurance model for use in the UK have been suggested by both the Joseph Rowntree Foundation (JRF) and the International Longevity Centre-UK (ILC-UK). The JRF proposal suggested compulsory contributions to cover long-term care costs from employees be made into a National Insurance type scheme, although hotel costs were excluded from the scheme and would continue to be assessed through a means-tested system.[115] The ILC-UK model limited contributions to the scheme – to a National Care Fund – to those over 65 and suggested they make a one-off, means-tested contribution, which would entitle them to a package of care. This model included the suggestion that

105 Normand C and Busse R, "Social health insurance financing" in Mossialos E, Dixon A, Figueras J and Kutzin J (ed), *Funding health care: options for Europe*, European Observatory on Health Care Systems Series, 2002.

106 Saltman R, Busse R and Figueras J, *Social health insurance systems in western Europe*, European Observatory on Health Systems and Policies, 2004.

107 Normand C and Busse R, "Social health insurance financing" in Mossialos E, Dixon A, Figueras J and Kutzin J (ed), *Funding health care: options for Europe*, European Observatory on Health Care Systems Series, 2002.

108 Mossialos E, *Citizens and Health Systems: Main Results from a Eurobarometer Survey*. Directorate-General for Employment, Industrial Relations and Social Affairs, European Commission, 1998.

109 Ferrera M, *EC Citizens and Social Protection: Main Results of a Collaborative Survey*, European Commission, 1993.

110 Gottret P and Scheiber G, *Health Financing Revisited: A Practitioner's Guide*, World Bank, 2006.

111 London Councils, *Social Care Funding Models: Examples from other countries*, 2009.

112 Cuellar AE and Wiener JM, "Can Social Insurance For Long-Term Care Work? The Experience of Germany" *Health Affairs* vol 19 no 3, 2000.

113 London Councils, *Social Care Funding Models: Examples from other countries*, 2009.

114 London Councils, *Social Care Funding Models: Examples from other countries*, 2009.

115 Diba R, *Meeting the costs of continuing care*, The Joseph Rowntree Foundation, 1997.

contributions could be deferred until after death, which would prevent the forced sale of family homes to pay for long-term care, and tap into the huge pot of property wealth.[116] Both these insurance models proposed compulsory, rather than voluntary contributions.

Voluntary insurance and adverse selection

The Conservatives' 'Home Protection Scheme' proposed to end the forced sale of homes to pay for residential care by introducing a voluntary insurance scheme whereby people could elect to pay a one off fee of £8,000 at age 65, in return for a guarantee that absolutely all fees for permanent residential care would be waived for life.[117] The operation and costing of the scheme was predicated on 3 key elements:

- Only 1 in 5 individuals will require care in the future;
- Once in care, the average length of stay will be 2 years; and
- The average cost of care will be £20,000 p.a.

The scheme also contained an assumption that money received at age 65 would earn interest at 1.5% above the rate of inflation, thereby allowing a surplus to accumulate over time which would cover the inflation of care fees. Although at the time the figure of £8,000 was considered by some industry experts to be an underestimate, no-one has suggested what a more accurate figure might be for a voluntary scheme where the risks of adverse selection are taken into account. Insurance industry data[118] on private payers suggests that the numbers for a voluntary scheme would be slightly different:

- At age 65, 1 in 3 individuals are likely to require care
- Once in care the average duration of current private payers is 4 years
- The average cost of care after allowing for the difference in care fees inflation and the interest on money received is likely to be nearer £30,000 p.a.

Based on these numbers we believe a more accurate reflection of the level of voluntary premium needed to cover care in the future would be £40,000 p.a..

The problem with voluntary contributions into an insurance based model is that not enough people tend to contribute. This creates two problems; first, it pushes up the costs of individual contributions for those in the voluntary scheme, because the financial risk pool is insufficient to cover large and unexpected costs. Second, it encourages 'adverse selection', which is where those buying the insurance have some form of information advantage over the insurer. For example, those with existing diseases would be more likely to buy into the social insurance scheme because they think the chance of them requiring care would be that much greater.

Recommendation: The forthcoming Commission on long-term care should consider a compulsory social insurance model alongside the Partnership model and the Conservative's voluntary insurance scheme.

116 Lloyd J, "A National Care Fund for Long-Term Care" *ILC-UK*, 2008.

117 The Conservative Party, "Ending the scandal of forced home sales to pay for care", Conservatives press release, 2 October 2009, see: http://www.conservatives.com/News/News_stories/2009/10/Ending_the_scandal_of_forced_home_sales_to_pay_for_care.aspx

118 Insurance industry data provided to Policy Exchange by Partnership Ltd.

Table 7: International models for long-term care financing

	GERMANY[119]	JAPAN[120]	FRANCE[121]	NETHERLANDS[122]
FUNDING SOURCE	**Social insurance**	**Social insurance and general taxation**	**General taxation**	**Social insurance**
	Mandatory contribution of 1.7% of income from all people employed. State subsidies for the poor and unemployed.	50% of funding comes from general revenues. Mandatory income-based contribution from people aged 40-65. State subsidies for the poor and unemployed.	General taxation pays for care, but it is severely rationed. Private insurance to cover those ineligible.	Mandatory income-based contributions from all employed people. Annual contribution in 2008 was 12.15% of the first €31,589 (includes significant healthcare coverage). Rate adjusted annually. so revenues meet costs.
ELIGIBILITY	**Universal**	**Universal**	**Steep income based co-insurance**	**Universal**
	Eligibility based on need, not income. Benefit is determined by disability level.	Eligibility based on need, not income. Benefit is determined by disability level, with restrictions on benefits for those between ages 40-64.	Personal cash budgets are given to people 60+ with severe disability. Means-testing and high-income individuals must purchase insurance. People earning over €2,500 a month only receive 10% of the benefit.	Eligibility based on need, not income. Incorporated into national health insurance that includes long-term nursing home care and institutional care for mentally and physically disabled people.
LEVEL OF PRIVATE CO-PAYMENT	**Necessary co-payment**	**Instituted co-payment**	**Instituted co-payment**	**Instituted co-payment**
	No formal co-payment, but as of 2005 benefits did not cover full care costs and private top-ups were required.	State pays 90% of care and support and people over the age of 65 top-up 10%. As of 2005 'hotel costs' were not covered.	A co-payment of approximately 1/3rd of total costs for those receiving benefits. Large private insurance market, with 25% of people 60+ purchasing insurance.	Income related co-payment for home care and home nursing. Overall individuals pay about 75% of total cost annually. Income related co-payment for 'hotel costs' in care homes.

A partnership of individual and State contributions

The partnership model, as proposed by Julian Le Grand and supported by the King's Fund, is designed to ensure that all elderly people receive some level of care, but at the same time it encourages personal contributions and not reliance on the State. This idea was originally proposed in 2003, but has recently been updated by the King's Fund to reflect the period of tight public spending ahead.[123.] The new model proposes a 50% guaranteed level of care coverage for everyone combined with a top-up mechanism whereby for every £2 of contributions made by the individual, £1 will be given by the State, up to a defined amount.[124] The partnership model provides both transparency and certainty, in that people can easily predict how much care they will receive. It also promotes the idea of individual responsibility.

With a model that provides a guaranteed minimum level of universal coverage it is suggested that Attendance Allowance (AA) would no longer be necessary, although we believe that Carers Allowance would seem to be open to the same rationale. The King's Fund estimates that £3 billion a year could be saved by

119 London Councils, *Social Care Funding Models: Examples from other countries*, 2009. and Cuellar A and Wiener J, "Can Social Insurance for Long-Term Care Work? The Experience of Germany", Health Affairs, vol 19, pp 8-25, 2000.

120 Matsuda S and Yamamoto M, "Long-term care insurance and integrated care for the aged in Japan", *International Journal of Integrated Care*, vol 1, pp 1-11, 2001, and Tsutsui T and Muramatsu N, "Care-Needs Certification in Long-Term Care Insurance System in Japan", *International Health Affairs*, vol. 53, pp: 522-527, 2005.

121 Association for the Advancement of Retired Persons, *AARP European Leadership Study: European Experiences with Long-Term Care – France, the*

2025/26 if AA were restricted to only new applicants who were in receipt of a Pension Credit.[125]

However, the most significant concern about the partnership model is that costs will be much higher than under the current system of means testing, since more people would be guaranteed care and the burden of unmet need would be addressed. The table below shows that although the partnership model would cost £1.1 billion less than free personal care by 2025, it would still be £4.3 billion more than the current system.

Table 8

	Cost of means-testing (£ billion)*		Cost of Partnership (£ billion)*		Cost of free personal care (£ billion)*	
	2014/2015	2025/2026	2014/2015	2025/2026	2014/2015	2025/2026
Public	6.3	12.1	10.1	15.5	10.7	16.8
Private	6.7	14	8.3	14.8	8.4	14.5
Total	13	26	18.5	30.3	19	31.4

*These costs are in 2006/2007 prices, discounting for inflation levels. Source: Humphries R, Forder J and Fernández J-F, *Securing Good Care for More People: Options for reform*, The King's Fund, 2010.

Hybrid of partnership and insurance based

Clearly no one model is perfect; otherwise we would not still be calling for reform. Experience from other countries demonstrates that in the longer term care costs, especially hotel costs, are typically met from more than one funding source. We believe, therefore, that the Commission should also consider a hybrid model between the Partnership approach on the one hand, and social insurance co-payment mechanisms on the other.

Such a model would ensure that everyone gets something, but that additional and ongoing burden on the State was not entrenched through a matched funding mechanism. The responsibility of paying for care would be shouldered between the State and individuals. Intergenerational equity would be established and a national system of entitlements would ensure that everyone received the same level of care irrespective of where they lived. We accept that such a model would add a level of complexity compared to a simpler social insurance scheme, although it would be hard to design a system that is more complex than the one we have today.

Recommendation: A hybrid model should be explored where the State guarantees some level of care – as in the Partnership model – but people are required to top-up for their long-term care through insurance or annuity backed products.

The Coalition Commission on long-term care

There is widespread recognition of the need for a new settlement between the individual, the family and the State about their respective responsibilities in the provision of long-term care and support services. The Coalition Agreement has committed to establish a Commission on long-term care, which will look into a

Netherlands, Norway and the United Kingdom, 2006, available at: http://assets.aarp.org/www.aarp.org_/cs/gap/ldrstudy_longterm.pdf, and Gleckman H, *Long-term care financing reform lessons from the US and abroad*, The Commonwealth Fund and The Urban Institute, 2010, and Courbage C and Roudaut N, "Empirical Evidence on Long-term Care Insurance Purchase in France", *The Geneva Papers,* vol 33, pp 645-658, 2008.

122 Association for the Advancement of Retired Persons, *AARP European Leadership Study: European Experiences with Long-Term Care – France, the Netherlands, Norway and the United Kingdom*, 2006, available at: http://assets.aarp.org/www.aarp.org_/cs/gap/ldrstudy_longterm.pdf, and Gleckman H, *Long-term care financing reform lessons from the US and abroad,* The Commonwealth Fund and The Urban Institute, 2010., and Bovenber A and Gradus R, "Dutch policies towards ageing", *European View*, vol 7, pp 265-275,2008.

123 Humphries R, Forder J and Fernández J-F, *Securing Good Care for More People: Options for reform,* The King's Fund, 2010.

124 Humphries R, Forder J and Fernández J-F, *Securing Good Care for More People: Options for reform*, The King's Fund, 2010.

125 Humphries R, Forder J and Fernández J-F, *Securing Good Care for More People: Options for reform*, The King's Fund, 2010.

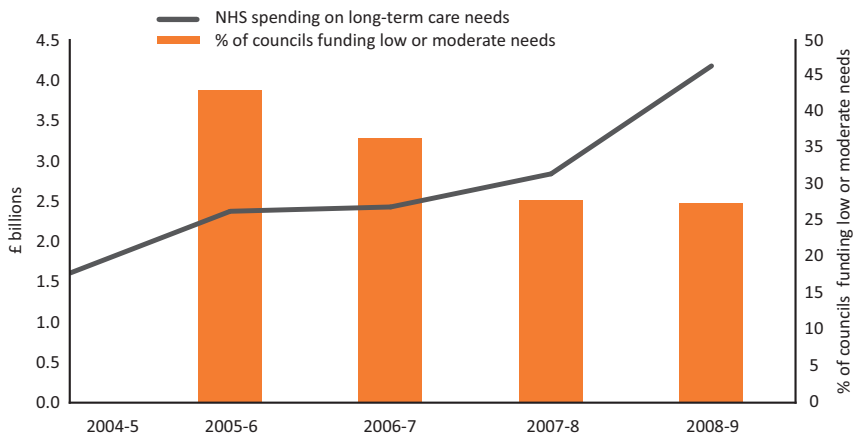
range of ideas for financing long-term care, including both the voluntary insurance scheme proposed by the Conservatives and the Partnership scheme proposed by the King's Fund and preferred by the Liberal Democrats.

We have already suggested that the Coalition Commission on long-term care should consider a compulsory social insurance scheme, alongside the King's Fund partnership model and a hybrid co-payment system of the two. We also believe, however, that the Commission should consider a more fundamental question in health and social care and that is whether the two services should be merged.

In the longer term, it is important to understand that the NHS and long-term care for the elderly are interdependent services. We have identified that the NHS already spends 4% of its budget on long-term care services, which are largely residential care services. This growing interdependence will become acute in a period of tight funding when social care budgets face cuts of up to 25%. It is beyond the scope of this paper to model this future relationship, although a measure of it can be seen from the rise in spending on elderly care in the NHS as eligibility criteria for State funded services have tightened, as shown in the graph below. Our measure of NHS spending on long-term care includes both our calculation of NHS Continuing Healthcare and the amount reported by the NHS for social care services which include spending on 'reduced mobility'; 'assistance with personal care' and 'holiday relief care'. It would be naive to think that reducing spending on a means tested long-term care system will not result in cost shifting to the NHS, where unit costs are typically 30% higher.[126]

As we have already pointed out, funding for long-term care is divided at Departmental level within Government, with the majority of funding going to local authorities and some also administered through the welfare system; but the effect of reducing benefits and means-tested services are seen in the NHS. These separate Departmental funding streams create fragmentation and confusion and as a result there has been primary legislation and a great deal of emphasis on trying to get health and social care services to work together at a local level.

Figure 9: NHS spending on long-term care needs increases as local authority eligibility criteria tightens



126 Unit cost of Local Authority Care Home worker £16; unit cost of nurse on 24 hour ward £22. Personal Social Services Research Unit, *Unit Costs of Health & Social Care 2009*, complied by Lesley Curtis, 2009.

The Local Government and Public Involvement in Health Act 2007 requires Primary Care Trusts and local authorities to produce 'joint strategic needs assessments' (JSNAs) of the health and social care needs of their populations and places a legal duty on partners such as PCTs and NHS Trusts to co-operate in the design and delivery of local area agreements (LAAs). There is an expectation of joint appointments, pooled budgets and commissioning of services. Indeed, the Department of Health commissioning framework for health and well being issued under the previous Government reiterates that these JSNAs will form the basis of a new duty to co-operate for PCTs and local authorities and also proposes that GPs will be able to prescribe social care support.[127] Pooled budgets and joint financing arrangements are central to this co-operation and are considered the central mechanism for achieving greater efficiency and better care, yet the original division at Departmental spending level is artificial and self-imposed.

An obvious perceived conflict to considering that health and social care is delivered as one service is the fact that the NHS is largely free at the point of use, whereas long-term care is not. In reality this is simply not true; fundamentally, the NHS is not completely free at the point of use. Those with relatively limited means already pay for prescription and dental charges, the so-called co-payments. In addition, top-up payments – where people pay for treatments, mainly cancer drugs – are also permitted under current NHS guidelines.[128] To ensure that health and social care provision continues to remain affordable for the State, we believe that it is more important to extend the principle of top-up and co-payment in the NHS, rather than free care at the point of need into long-term care. No work has been done on the savings to the NHS from a properly funded social care system.

Recommendation: The Coalition Commission should also consider whether fundamental reform of the financing of health and long-term care is necessary and, in particular, whether social care budgets, currently with local authorities, should instead be joined with the NHS.

127 Department of Health, Commissioning framework for health and well-being, 2007.

128 Department of Health, *Guidance on NHS patients who wish to pay for additional private care*, 2009.

7
Priorities for the Coalition

Much of the discussion on reform of elderly care looks at long-term solutions, but more consideration needs to be given to short-term measures, the 'quick wins', that could immediately address some failings in the current system. Indeed, the coalition agreement to establish yet another Commission on long-term care will take a year and there will be an inevitable consultation before any primary legislation. There is no doubt that wider reform is clearly required but these 'quick wins' offer temporary solutions.

1. Prevention is better than residential care

Prevention has been on the long-term care agenda for years, although in policy terms it has always been overshadowed by the on-off debate about funding reform. Improving prevention services is important not only because it improves quality of life by delaying entry into residential care, but also because it reduces costs.

There are two distinct concepts in prevention: first, delaying the need for care services by reducing general dependency, disability and ill health – this is primarily a function of the NHS; and second, preventing inappropriate use of intensive services by people that already have a dependency, disability or ill health.[129]

Some of the push for prevention can be traced to 1998 with the White Paper, *Modernising Social Services*, which outlined plans to help people achieve and maintain independence.[130] This need was reiterated in the 2006 White Paper, *Our health, our care, our say* and again in *Putting People First*, focusing on better prevention service and earlier intervention.[131, 132] Because the health and economic benefits of prevention accrue over a longer period of time measuring the benefits of prevention has been difficult.

Prevention works

Meaningful efforts to scale-up prevention have been seen with the scheme called Partnerships for Older People Projects (POPPs). The POPPs were funded by the Department of Health at a cost of £60 million to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care.[133]

POPPs consisted of 29 pilot schemes centered on local authorities, but specifically working with partners including health bodies, such as PCTs, secondary care trusts and ambulance trusts; other bodies, such as the fire service, police, and housing associations; national and local voluntary organisations; and private sector organisations. Interventions ranged from health promotion activities like advice and information sessions and physical activity classes,

129 Wanless, D., *Wanless Social Care Review: Securing Good Care for Older People*, Taking a long-term view. The King's Fund, 2006.

130 The Department of Health, *Modernising Social Services*, 1998, see: http://www.archive.official-documents.co.uk/document/cm41/4169/4169.htm

131 The Department of Health, *Our care, our health, our say: a new direction for community services*, 2006.

132 HM Government, *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*, 2007.

133 Windle et al., *National Evaluation of Partnerships for Older People Projects*, The Personal Social Services Research Unit, 2009.

through household and gardening help, to increased home visits from social care workers.[134] Over a quarter of a million people used the services of POPP projects over three years, with almost two-thirds aged over 75 and coming from areas designated as deprived.

Notwithstanding the difficulties in assessing the impact of POPPs (in general, old and frail service users tend to experience an ongoing deterioration in their well-being) the evaluation found a 12% increase in health-related quality of life for those individuals receiving practical help.[135] However, in addition to delivering better services and improving well-being, the projects were also found to have a significant effect on the use of hospital emergency beds. Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. The effect was such that an additional investment of £1 in POPP services produced statistically significant savings ranging from £0.80 to £1.60 on emergency bed days in acute hospitals. There were also fewer physiotherapy and occupational therapy and clinic or outpatient appointments, with a cost reduction of £2,166 per person.

Although the projected saving varied with assumptions about management costs, the researchers from the highly respected Personal Social Services Research Unit chose a headline estimate of £1.20 as the savings that could be achieved by an additional £1 spent on POPP services. If we apply this figure to the £4.23 billion that we calculate that the NHS spending on long-term care, the potential saving is some £645 million annually.[136]

POPPs are a cost effective policy option, however, the main difficulty in establishing a national roll out of these schemes is translating the evidenced cost-reduction into a cashable cost saving: which means reducing the number of acute hospital beds. Despite the close partnership working another stumbling block was the inability to transfer savings from either primary or secondary healthcare budgets to local authorities delivering long-term care services. Nevertheless, some Primary Care Trusts have contributed to the sustainability of the POPPs projects – a total of 20% of the POPP projects being entirely sustained through PCT funding.[137]

The POPP scheme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. However, cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects; and, as the major evaluation of POPPs concluded, "if cashable savings are to be released some degree of financial systems reform is likely to be necessary".

Although it falls outside the scope of this paper to consider, in detail, the range of preventative services, fall prevention is a major area where known health and economic benefits can be seen.[138, 139, 140] Falls are the most common cause of injury among the elderly and injury is a leading cause of death and long-term disability in this group.[141] The cost of these falls to the NHS is substantial, totaling over £981 million in 1999 (£1.24 billion in 2009 prices[142]), 66% of which comes from those over the age of 75.[143] Although there are substantial cost and quality of life improvements to be gained from fall prevention programmes, we should be clear that they decrease rather than eliminate the risk of an older person falling.[144] And furthermore, like the POPPs schemes falls prevention programs will not produce realisable savings without reform of the siloed budgetary arrangements in health and social care.

134 Department of Health, *Description of successful Round 2 POPP site projects*, 2007.

135 Windle et al., *National Evaluation of Partnerships for Older People Projects*, The Personal Social Services Research Unit, 2009.

136 NHS spending of £4.23. Hospital and Community Services spending accounts for 76.3% of total NHS spending – Department of Health PCT recurrent revenue allocations, exposition book, 2008. Potential saving = 4.23 x 0.763 x 0.2 = £645 million

137 Windle et al., *National Evaluation of Partnerships for Older People Projects*, The Personal Social Services Research Unit, 2009.

138 Jensen et al., "Fall and Injury Prevention in Older People Living in Residential Care Facilities", *Annals of Internal Medicine*, vol 136, pp 733-741, 2002.

139 Tinetti ME, "Preventing Falls in Elderly Persons", *The New England journal of Medicine*, vol 348, pp 42-49, 2003.

140 Scuffham P, et al. "Incidence and costs of unintentional falls in older people in the UK", *Journal of Epidemiology of Community Health*, vol 57, pp 740–44, 2003.

141 Kannus P, "Prevention of falls and consequent injuries in elderly people", *The Lancet*, vol 336, pp 1885-1891, 2005.

142 Calculated using the HM Treasury GDP Deflator, available at: http://www.hm-treasury.gov.uk/data_gdp_fig.htm

143 Scuffham P, et al. "Incidence and costs of unintentional falls in older people in the UK", *Journal of Epidemiology of Community Health*, vol 57, pp 740–44, 2003.

144 Campbell AJ, Robertson MC, "Rethinking individual and community 2 fall prevention strategies: a meta-regression comparing single and multifactorial interventions", *Age Ageing* vol 36, pp 656-62, 2007.

Recommendation: The POPPs approach should be expanded to all local authorities and PCTs. Low-level interventions that provide information services, help around the house, fall prevention, physical activities, etc should be the focus of prevention efforts.

2. Better financial advice

As we have shown earlier, most people think social care will be provided by the State and as a result, only a few people have savings or even plans to save money to pay for their care. The Baby Boomers – those currently 55-65 years old – will age with more money, mainly housing wealth, than any older group before.[145] In addition, there are a significant number of people that begin as self funders of their care, but run out of money and then turn to their local authority for financial assistance. This is estimated to cost £1 billion per annum.[146] All these groups could be helped by making financial advice an integral part of the long-term care system.

The care users and experts in the care communities have already identified the lack of information and advice as a serious problem.[147, 148, 149, 150]

Equity release allows those who are capital rich and income poor to tap into hidden assets. It is a loan facility taken over the value of a property which can then be used to pay for care. Equity release allows for care payments to be deferred until the house is sold or the person dies at which point the total owed is taken from the money made on the sale of the house.[151] Often equity release is used to pay for home care, but unfortunately in many cases people cannot transfer the loan to pay for residential care.[152]

Given the amount of housing equity and the fact that the State cannot cover all the costs of long-term care, it is surprising to see that greater use of equity release products has not been a feature of the long-term care market. However, it is not surprising to learn of the consistent concern that elderly people are reluctant to trust this form of financing, especially so given the recent problems with the mis-selling of endowment mortgages.[153] In addition, there are around a million older home-owners who have at least £100,000 of housing equity, yet their incomes are so small that they qualify for means-tested benefits such as pension credit. Equity release schemes are relatively costly to set up and the amounts available tend to be quite high, which does not suit those with relatively modest means, not least because it would reduce the amount of their benefit. Schemes which specifically cater for those on low or modest means are currently being trialed by the Joseph Rowntree Foundation in conjunction with local authorities in Kensington & Chelsea; Maidstone; and Islington.[154]

Other options exist, such as immediate-needs annuities or annuities that draw on pensions. Immediate-need annuities are purchased where an elderly relative is already in either residential care or a nursing care home or is about to be admitted. The annuity is paid directly to the care provider for the life of the individual. Immediate needs annuities are expensive products – in the region of £50,000 depending on age and sex – and are usually financed from the sale of the person's house. However, these annuity products can only produce a sum equal to less than the actual charge made by the care home. This means there cannot be a surplus to the estate, should there be a reduction in the home care fees charged or the individual returns to their home.

145 Lloyd J, *A National Care Fund for Long-Term Care,* ILC-UK, 2008.

146 Partnership , "Over 50s drastically under estimate the cost of long term care, warns retirement specialist Partnership", press release, 7 June 2010, see: http://www.partnership.co.uk/press/2010/June/Press-Release-7-June-20101/

147 Caring Choices, *The Future of Care Funding: time for a change*, 2008.

148 Passingham A, *Care Concerns 2009: the key issues raised by older people, their families and careers with Counsel and Care's Advice Service in 2009*, Counsel and Care, 2010.

149 Collins S, *Options for care funding: what could be done now?*, Joseph Rowntree Foundation, 2009.

150 Resolution Foundation, *Navigating the way: the future of care and wellbeing of older people*, 2008.

151 Lloyd, J. *Funding Long-Term Care – The Building Blocks of Reform*, ILC-UK, 2008.

152 Johnston, Sandy, *Private funding mechanisms for long-term care*, Joseph Rowntree Foundation, 2005.

153 Johnston, Sandy, *Private funding mechanisms for long-term care*, Joseph Rowntree Foundation, 2005.

154 Terry R and Gibson R, *Can equity release help older home-owners improve their quality of life?* Joseph Rowntree Foundation, 2010.

Other annuity products include disability-linked annuities or State-pension deferrals. Disability-linked annuities draw on personal pensions, and pay a higher level of income when the purchaser needs care and therefore gives lower pre-care payments. State-pension deferrals take part of someone's pension payment and move it into a fund for long-term care. However, few people have enough pension income or other assets to forego the whole payment and these products also suffer from low up-take.[155]

Recommendation: Financial advice should become an integral part of the long-term care system. This should be achieved by compelling local authorities, to signpost people to regulated financial advisors, once they have conducted a needs assessment.

3. Improving public understanding

Responsibilities between individuals, families and the State need to be made explicitly clear to ensure all members of society are aware of the financial costs of old age support. We believe that creating greater public awareness of the financial responsibilities and costs in long-term care should be a priority in the reform process.

The Department of Health has for many years engaged media campaigns to raise awareness of certain diseases. For example, the successful national public awareness campaign for AIDS in the 1980s which included a leaflet sent to every household in the country reportedly cost £73 million over a seven year period.[156] There is a wealth of evidence that mass media campaigns are effective in behaviour modification.[157, 158] However, we were surprised to find that none of the Department of Health, the Department for Communities and Local Government or the Central Office of Information had funded any public information or awareness campaigns despite the public misconceptions about financial responsibilities and costs in social care.[159] Indeed, the State incurs costs of up to £1 billion from the lack of information, advice and financial planning for social care, because self-funders regularly use up all their funds and then turn to the State for financial assistance.

We do not believe that in the current economic climate scarce public resources should be diverted to mass advertising campaigns, not least because the key to their success in behaviour change is maintaining a consistent and sustained level over time.[160, 161] Instead, we believe that the Government should set the conditions for private enterprise to operate.

Many leading groups in the care community have recommended that private funding options be promoted to give people more choices when considering how to pay for care. [162, 163] The Joseph Rowntree Foundation recommended that a national equity release scheme be piloted by the government to help keep people in their homes.[164] The Caring Choices Coalition also recommended this option, as they support schemes to help unlock private resources or encourage private contributions towards the cost of care.[165]

Most people will have to contribute financially towards the costs of receiving care in old age and given the high out-of-pocket costs it is surprising that there is virtually no market in private care insurance. There has been no shortage of

155 Lloyd J, *Funding Long-Term Care – The Building Blocks of Reform*, ILC-UK, 2008.

156 BBC News, "The 1980s AIDS campaign", accessed 19 May 2010, see: http://news.bbc.co.uk/1/hi/programmes/panorama/4348096.stm

157 Jepson,R., Harris,F., Rowa-Dewar,N, *A Review of the Effectiveness of Mass Media Interventions which both Encourage Quit Attempts and Reinforce Current and Recent Attempts to Quit Smoking*, NICE, 2006.

158 Bala M et al., "Mass media interventions for smoking cessation in adults", Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.:CD004704. DOI:10.1002/14651858.CD004704.pub2.

159 In response to Freedom of Information requests by Policy Exchange, neither the Department of Communities and Local Government, or the Department of Health or the Central Office for Information know how much is spent on Government spending on advertising social care services.

160 Hyland et al., "Anti-tobacco television advertising and indicators of smoking cessation in adults: a cohort study", *Health Education Research*, vol 21pp 296-302, 2006.

161 McVey D., Stapleton J. "Can anti-smoking television advertising affect smoking behaviour? Controlled trial of the Health Education Authority for England's anti-smoking TV campaign," *Tobacco Control*, vol 9, pp 273-282, 2000.

162 Resolution Foundation, *Navigating the way: the future of care and wellbeing of older people*, 2008.

163 Hirsch D, *Paying for long-term care: Moving forward,* Foundations: Joseph Rowntree Foundation, 2006.

164 Hirsch D, *Paying for long-term care: Moving forward,* Foundations: Joseph Rowntree Foundation, 2006.

165 Caring Choices, *The Future of Care Funding: time for a change*, 2008.

different products over the last 10-15 years; however, uptake has been much lower than expected with the main provider of insurance plans actually leaving the market in 2004.[166] At that time there was still considerable uncertainty as to what the State would provide, with free personal care introduced in Scotland just 2 years earlier. The political uncertainty about the future of social care funding over the last twelve years has caused the private care insurance market to fail. Why pay for something that the State will provide for free?

We believe that the political uncertainty needs to be resolved. This requires a clear statement from the Coalition Government that free personal care for the elderly cannot be provided entirely by the State. This is consistent with both their manifesto commitments and even the previous Government had ruled out a tax payer funded option. The only question is what level of support the State should provide.

166 Johnstone S, Private Funding mechanisms for long-term care, Joseph Rowntree Foundation, 2005.

In the last 15 years reform of the way we pay for long-term care for the elderly has been the subject of a Royal Commission, two House of Commons Select Committee Inquiries and three major reports by the previous Government. On this evidence, it is seemingly an important issue for the country.

But still the system is widely considered to be unfair and unnecessarily complex; one which penalises home owners and which no-one really knows much about. Most people think long-term care services are free, but they are not. The 'cradle to grave' promise of the NHS has set the default position across healthcare to dependence on the State.

So while there is agreement on the need for reform, there is no agreement on what that reform should look like. The issue, as ever, is who should pay and with care home fees of £40,000 per annum, long-term care is expensive for individuals or the State.

We believe that the formation of the Coalition Government offers a unique opportunity for politicians and stakeholders to agree a funding solution for long-term care for the elderly. But ensuring that the Commission on the Funding of Care and Support considers the right questions is critical to achieving a consensus and a lasting solution for long-term care. In this report we consider the central questions to the debate and make recommendations for the Commission to consider.

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