

Take Care

The Future Funding of Social Care

Detailed
Report

Mark Weston
Eleanor Winpenny
Julia Manning
June 2011



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About This Publication

The future funding of social care and proposals for a change to our current funding system have been the subject of many papers and reports in recent years. Currently, state funded care is delivered to those with the highest level of need and low ability to pay, but in many cases it fails to provide early preventative interventions which might ultimately allow people to live more independently for longer. In addition, future increases in the numbers of elderly are predicted to lead to a funding gap, with the current system unable to fulfil requirements.

In this publication we study the current care funding system, as well as the predicted need and cost of social care in the coming decades. We then review options which have been suggested for alternative funding systems, and make international comparisons. We make recommendations on how to approach the reform of social care funding and on factors to consider when reforming care funding.

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Executive Summary

Social care funding: the need for change

The funding and provision of social care in England is widely acknowledged to be in need of reform, and over the past decade a variety of papers, committees and reports have made suggestions for what reform should look like. Two major challenges accentuate the need for change. Firstly, as a result of the “baby boomer” population approaching retirement and old age, a large increase in demand for social care is predicted over the next two decades. Secondly, the current economic situation and government attempts to reduce the deficit are resulting in funding cuts to local government budgets, which are responsible for a large proportion of social care funding.

This review of studies provides an overview of the state of social care today and the many suggestions for reform. Predictions of demographic changes over the next 20 years show that the size of the over-70 population, those most likely to be in need of care, will rise from 6.2 million in 2010 to 9.6 million in 2030, an increase of over 50%. People of working age fund a large proportion of care provision through taxes, and the ratio of those of working age to those aged 70 or over is projected to fall from 5.3:1 in 2010 to 3.7:1 in 2030. There is evidence that as people live longer lives they are also living healthier, and that the years lived with disability are declining, but it is highly likely nevertheless that the increased numbers of older people will lead to increased demand for social care, and hence funding.

The current funding system is complex and is split between several funding streams. Local authorities are the largest source of funding, but funding for social care is also derived from benefits and from the NHS budget. Local authority funding of social care is provided on the basis of both need and the ability to pay. In recent years, councils have increasingly focused their funding for social care on those with the greatest need and the least ability to pay. This has resulted in smaller numbers of older people receiving more intense care, and many with moderate needs receiving no publicly-funded care at all. For those who do receive publicly-funded care, the quality of services varies across the country, with significant minorities of providers failing to meet Care Quality Commission standards.

Consideration has been given to the benefits and drawbacks of the current funding system, together with a range of alternatives. Each system has been assessed under the following criteria:

- **fairness**
- **transparency**
- **sustainability**
- **efficiency**
- **personalisation**

The current system’s advantages are that resources are targeted to those most in need and, in the short term, it places only limited demands on public funds. However, the system is not transparent and is unlikely to be sustainable as the population of older people increases. In the longer term, its focus only on those in greatest need is likely to lead to larger numbers of people falling into dependency who could have been prevented from doing so by earlier access to care.

All of the options have advantages and disadvantages, and ultimately the choice of funding system will depend on broad societal decisions about the balance of public services needed, how far the state should and can afford to fund them in straitened economic times, and what exactly we want social care to do. It is likely that, as in many other countries, the system that is eventually chosen will combine aspects of two or more of the models below.

Executive Summary

Alternative funding options

1. Pay for yourself

No state funding of social care. Individuals would be responsible for their own care funding, through savings and private insurance.

2. Partnership

All those judged to have a care need would have a fixed proportion of their care funded from the public purse, with the remainder paid for by the individual. Those on lower incomes would have a higher share paid for by the state, with those with the lowest means having all care paid for.

3. Insurance

A similar model to the partnership model but with voluntary insurance to fund the private share of care costs.

4. Comprehensive

This would impel all those over retirement age to take out compulsory insurance to cover social care costs. The contribution could be a flat rate or vary in accordance with an individual's means. Payments could be by lump sum, spread over time or deferred until after death. In some countries, compulsory social care insurance is levied on people of working age as well as on older people.

5. Tax-funded

This system would be similar to current NHS funding. Care would be free at the point of use and funded out of general taxation. This would require either increased taxation or diversion of funds from other budgets into social care.

Recommendations

- Given the scale of the problem there is an urgent need for public debate and public education around the need for change and what form that change should take.
- More emphasis needs to be placed on prevention or delay of dependency, thereby reducing overall costs within both social care and the NHS.
- Technological innovations which reduce the cost of care, such as telecare, assisted living housing and retirement villages, should be supported and their further development encouraged.
- A review of the financial model needs to facilitate better integration between the NHS and social care.
- Support for voluntary carers must be improved, both through respite care and with financial assistance. Increased voluntary care could be encouraged through programmes such as Time Banks.
- In the longer term, given that the boom in the numbers of elderly is not yet upon us, time should be taken to build a consensus among the public and policy-makers, with a view to building a system that will endure.

1 Introduction

Social care for older people, for so long neglected by policy makers, has become the subject of growing discussion and debate over the past two decades. As the influential baby boomer generation has found itself having to care for or arrange care for elderly relatives, and as the boomers themselves approach the age at which they might need care, questions around how to improve and fund services have risen up the policy agenda. In the past fifteen years alone, a Royal Commission, two House of Commons Select Committee Inquiries, at least a dozen think tanks and charities, half a dozen universities, and a range of government bodies from the Department of Health to the Local Government Association have examined the state of social care and produced recommendations for future funding.

So far, the only consensus to emanate from all these studies is that reform is needed. There are many ideas for how that reform should be designed, without any single solution emerging at the top of the pile. And while the policy community has begun to engage with the subject, the UK population as a whole, other than those in direct need of care or with family members in need, continues to show little interest; many have no knowledge of what social care is, and few believe they will ever need it. Without broad public support for improved care for older people, (and in an economic context where cuts are being made in many areas, social care will continue to have to compete with other services for funds), even the most carefully thought out suggestions for future funding will be difficult to translate into effective policy.

The importance of social care for the elderly is evident to those who use it. One in three people in the UK will need personal care in old age, and many of those who do not need care themselves will have close family members in need of support.¹ 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.’² It includes practical help, such as with eating, dressing, going to the toilet, washing, domestic cleaning and shopping, and social support, such as providing companionship and helping people to remain part of the community. It takes place in people’s homes, in community venues such as day care centres, and in residential or nursing care homes, and is provided by the state, charities, private enterprise and volunteers (many of

whom are family members). In addition to helping people to negotiate the day to day tasks which are sometimes made more challenging by old age, therefore, good care combats the loneliness many elderly people would otherwise feel, and enhances their psychological as well as physical wellbeing.

Social care’s importance goes beyond its direct effects on the quality of life of those it benefits. Social care can have impacts on many other policy areas. In an era of spending cuts and straitened public and personal finances, the provision of care for older people affects the demand for healthcare, housing, public transport, the emergency services and benefits. It creates jobs for carers, and reduces the burden on relatives of those in need of care, allowing them to stay in work or providing relief from the stress of caring. It can enable older people to continue to play a part in society, whether as workers, volunteers or as family members. By reducing inter-generational tensions, family conflicts and the isolation and insecurity of individuals, moreover, and by strengthening the capabilities of older people and the younger people who are close to them, social care for the elderly can play a vital part in building cohesive, self-reliant communities.

1. Joseph Rowntree Foundation (2010): Funding care: how can each generation pay its fair share? JRF Viewpoint Paper. March.
2. Department of Health (2006): Our health, our care, our say: a new direction for community services, Cm 6737, January.

1 Introduction

The Coalition Government, like its predecessor, has recognised the role of social care in enhancing quality of life and community resilience. In the October 2010 Comprehensive Spending Review, the government announced a £2 billion increase in the adult social care budget by 2014/15 (although this is not specific to older people's care).³ In July 2011 it will receive suggestions for reform from the Commission on Funding of Care and Support, a new body hosted by, but independent from, the Department of Health.

In this review of the literature on social care funding, we bring together the main themes and ideas developed in recent studies of the subject. Focusing on care for those aged 65 and over in England, it is designed to act as a guide for policy makers by presenting in one place the various estimates of likely need, calculations of the funding that might be required, and ideas for how funds should be raised. The second chapter of the report looks at the demographic situation and at how this is likely to alter over the next two decades. Chapter three describes social care today – how it is delivered, to whom and by whom – and assesses its effectiveness. Chapter four examines how social care is currently funded, and chapter five discusses how efficiency can be increased in future, and how funding can be increased. This final part of the paper lays out the various suggestions for reform and describes how other countries are tackling the issue.



3. Department for Communities and Local Government (2010): Letter from the RT Hon. Eric Pickles MP. 20 October. Available at: <http://www.communities.gov.uk/documents/localgovernment/pdf/1745945.pdf>

2 The Demographic Background

Robust demographic data, covering both the absolute numbers of older people and the proportion of older people relative to those of working age, are essential for formulating social care policy. Establishing such data for today's population is straightforward; predicting how that population will look in twenty years' time is more complex. In this section of the review, we first look at the population of England today, then at forecasts for 2020 and 2030, and finally at the factors that could complicate such forecasts.

The older population today

In 2010 the population of England, according to the Office for National Statistics, was 52.2 million.⁴ Of this total, 8.6 million people, or 16.4%, were aged sixty-five or over.⁵

People of working age are the primary source of the taxes which currently fund a significant part of older people's social care (older people pay taxes too, of course, for example on pensions and value added tax), and there were 32.2 million, 62% of the population, in this age group in 2010. For every one person who had reached pension age (age 65 for men, 60 for women), there were 3.2 people of working age.

It is those who are aged seventy or over who are most likely to need social care, however. Social care is provided to older people with disabilities – that is, those who cannot self-care or who have difficulties performing certain activities of daily living.⁶ It is after the age of seventy that such disabilities increase most sharply. On average, men in the UK spend the last 7.2 years of their lives and women the last 9.4 years with a disability.⁷ With average life expectancy in England in 2007-9 standing at 78 years for males and 82.1 years for females, it can be seen that the greatest likelihood of an individual needing social care occurs after the age of seventy.⁸ In 2010, there were 6.2 million people aged seventy or above living in England (11.7% of the total population).⁹ The ratio of this age group compared to the working-age population was 1:5.3.

While the seventy-plus age group is likely to contain a large number of people in need of some level of social care, the most acute needs are felt by those in their eighties. The average age of care home residents is above eighty,¹⁰ and whereas only 4% of people in England who are aged 65 or over are in residential or nursing care homes – the most expensive form of social care - the proportion rises to 11% of those aged 80 or above.¹¹ The eighty-plus age group numbered 2.4 million in 2010, or 4.6% of the total population of England, and for every individual aged eighty or over there were 13.5 people of working age.¹²

4. Figures rounded to one decimal point.

5. Office for National Statistics (2009): 2008-based National Population Projections: 2008-based principal projection. ONS, London.

6. According to Crimmins (2004), 'The most severe disability is generally defined as inability to provide self-care, and this is measured by the inability to perform what are known as activities of daily living (ADLs). These include eating, bathing, dressing, toileting, transferring from bed and chairs, and sometimes walking around the house. Somewhat less-severe disability is indicated by the inability to perform or difficulty in performing instrumental activities of daily living (IADLs), which often include doing housework, shopping, preparing meals, using the telephone, managing medications, managing money, or using transportation.' (Crimmins EM (2004): Trends in the health of the elderly. *Annu. Rev. Public Health*;25:79-98.)

7. Office for National Statistics (2010): Statistical Bulletin: Health expectancy at birth and at age 65 in the United Kingdom, 2005-2007, London: Office for National Statistics: 2.

8. Department of Health (2010): Mortality Monitoring Bulletin: (Life expectancy and all-age-all-cause mortality, and mortality from selected causes, overall and inequalities): update to include data for 2009. Department of Health. 28 October.

9. ONS (2009) op. Cit.

10. Centre for Social Justice (2010): The Forgotten Age: Understanding Poverty and Exclusion in Later Life. CSJ. London. November.

11. A Cangiano, I Shutes, S Spencer, G Lesson (2009): Migrant Care Workers in Aging Societies: Research Findings in the United Kingdom. COM-PAS (ESRC Centre on Migration, Policy and Society). Oxford. June.

12. ONS (2009) op. Cit.

2 The Demographic Background

Table 1. Population projections for 65+ years from 2010 - 2030

	Age group (years)	Number of people in age group (millions) (Percentage of total population)	Ratio of age group population to working age population
Actual population 2010 Note: working age population 32.2 million (62%)	65+	8.6 (16.4%)	1:3.2
	70+	6.2 (11.7%)	1:5.3
	80+	2.4 (4.6%)	1:13.5
Projected population 2020	65+	10.6 (18.9%)	1:3.5
	70+	7.9 (14.1%)	1:5.3
	80+	3.1 (5.5%)	1:11.4
Projected population 2030	65+	12.9 (22%)	1:2.8
	70+	9.6 (16.1%)	1:3.7
	80+	4.5 (7.5%)	1:8

2 The Demographic Background

Tomorrow's older population

The reliability of projections

Recent studies on the future of social care funding in England and in the UK more broadly have focused on the period up to 2035, when the large post-war baby boom generation will have reached an age when many are in need of long-term care.

The Office for National Statistics, the primary source of demographic projections in the UK, which took over the job from the Government Actuary Department 2006, produces long-term population projections for the UK and its constituent countries every two years. These are modelled using estimates of the current population and expectations of future fertility, migration and mortality. The ONS produces a principal projection and a number of variant projections, which take account of the possible impacts on age structure of increased or reduced fertility, for example, or an increase or decrease in life expectancy. It might be expected that projections of the composition of older age groups twenty or thirty years hence would remain stable, since all those who will reach the ages of sixty-five and over have already been born. However, ONS projections have changed significantly in the past ten years. The 2000-based principal projection for the 65-plus age group in 2031, for instance, was 12.5 million.¹³ By 2008, this had risen to 13.2 million, a 5.5% increase. For those aged seventy or above, the projection had climbed by 10.7%. The greatest difference was in the 80-plus group, however. In 2000, the ONS projected that there would be 3.7 million people aged eighty or above living in England in 2031. By 2008, this projection had risen by 27%, to 4.6 million.

In 2007, the ONS published an assessment of the accuracy of its past projections from 1955 to 2004, and found a mean absolute error in the projections for the total population of the United Kingdom twenty years ahead of 2.5%.¹⁴ This declined to under 2% if the projections from before 1975 were excluded. If carried over to the latest, 2008-based projections, this would mean a difference in the total population of 1.4 million people in 2028. The ONS found the greatest discrepancies between projected and actual population sizes in the youngest and oldest age groups.

Demography, therefore, is not an exact science, and projections should be treated with caution. We discuss below some of the important factors that could confound projections, and particularly those that relate to the potential demand for social care. However, a projection that is accurate to within 2% (and therefore within at most a few hundred thousand older people) is a useful guide to future care requirements, at least in the event that there are no dramatic changes in health or migration, and it provides a baseline from which to begin planning policy.

The projections - 2020

In 2020, the ONS projects that there will be 10.6 million people aged 65 or over living in England, compared to 8.6 million in 2010.¹⁵ Older people will comprise 18.9% of the total population, up from 16.4% in 2010. By 2020, the retirement age will have increased, from sixty-five to sixty-six years for men and from sixty to sixty-six years for women. The ratio of pension-age to working-age people will therefore decline slightly over the next ten years, from 1:3.2 to 1:3.5.

The number of people in England who are aged seventy and over is projected to increase to 7.9 million by 2020, from 6.2 million in 2010. The ratio of those in this age group to those of working age will increase to 1:4.5, from 1:5.3 in 2010.

A similar increase is seen in the ratio of those in greatest need of social care, the eighty-plus age group, to those of working age. By 2020, there will be 3.1 million people aged eighty or over, compared with 2.4 million in 2010. They will make up 5.5% of the total population. The ratio of the oldest old to those of working age will have shifted from 1:13.5 in 2010 to 1:11.4 in 2020.

13. Office for National Statistics (2001): 2000-based National Population Projections: 2000-based principal projection. ONS, London.

14. C Shaw (2007): Fifty years of United Kingdom national population projections: how accurate have they been? *Population Trends*, vol. Summer 2007, 128: 8-23.

15. ONS (2009) op. Cit.

2 The Demographic Background

The projections – 2030

By 2030, the ONS projects that there will be 12.9 million people aged sixty-five or over living in England. This is approximately a 50% increase on the 2010 figure. This age group will make up 22% of the total population, and the ratio of those of pension age to those of working age will be 1:2.8, compared with 1:3.2 in 2010.

The size of the 70-plus age group is projected to increase to 9.6 million by 2030, a 55% increase on the number for 2010. For every individual in this age group, there will be 3.7 of working age, a sharp slump from the 1:5.3 ratio of 2010.

The oldest age group will also exhibit rapid growth by 2030, although it should be remembered that projections for this age group have historically been the least accurate. According to the ONS, there will be 4.5 million people living in England who have reached the age of eighty, an 88% increase on 2010. The ratio of oldest old to those of working age will stand at 1:8, compared with 1:13.5 in 2010.

The variants on the ONS principal projections can show small but significant differences. In the variant which assumes a high life expectancy scenario, for example, with mortality rates lower than expected, the projection for the size of the 80-plus age group in 2030 is 4.8 million. For the low life expectancy scenario it is 4.3 million. With the high migration scenario, on the other hand, there is little projected change in the ratio of those aged eighty or above to those of working age.

Known unknowns

England is likely to experience a significant shift in the structure of its population between 2010 and 2030. Increases in life expectancy and reductions in fertility mean that the older age cohorts will grow faster over the next twenty years than the young and middle-aged. Demographic projections are not bombproof, but those for England point to a sharp increase in both the numbers and proportion of pension-age individuals, and a relative reduction in the numbers of working-age people. Even if Office for National Statistics projections prove less accurate than in the past, the country can still expect to see large changes.

The likely impact of these changes on the provision of social care for the elderly is uncertain. Both the extent of demand for care and the ability of society to meet that demand are important.

Determinants of future demand for care

The extent of demand for care will largely depend on the health of the swollen cohorts of older people (ill health and disability are very reliable predictors of demand for social care¹⁶). If people in their latter years are healthier than previous generations, demands for social care will rise less sharply than the size of the older population. If they are less healthy than their predecessors, on the other hand, the demand will accelerate.

There has been much debate over whether or not illness and disability are rising hand in hand with life expectancy. So far, the evidence for a compression of morbidity (that is, that the number of years lived with a disability or illness is increasing more slowly than total life expectancy) outweighs that favouring an expansion of morbidity. Of thirty-two studies of people aged at least 55 in high-income countries reviewed by Christensen and co-authors (2009), only six found increases in disability over time, compared with twenty-six which found that disability is decreasing.¹⁷ In Finland, for example, a four-year study of approximately 2000 men and 2000 women aged 65-84 found year on year reductions in disabilities that affected basic activities of daily living of 5% for men and 6% for women.¹⁸ A United States study of people aged 65 or over which continued from 1982 to 2004 found falls in chronic disability over the period of 1.52% per annum, with the rate of decline increasing over time. The decline was sufficiently rapid, according to the authors, 'to contribute significantly to the long-term fiscal stability of the Medicare (and Medicaid) programs.'¹⁹ Analysis of health care expenditure, moreover, has shown that age is an insignificant risk factor for increased expenditure if proximity to death is taken into account - health costs rise in the final years of life regardless of one's age, so population aging may defer per capita costs rather than increase them.²⁰

16. D Wanless (2006): *Securing Good Care for Older People: Taking a Long-Term View*. King's Fund. London.

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

18. Sulander T, Martelin T, Sainio P, Rahkonen O, Nissinen A, Uutela A (2006): Trends and educational disparities in functional capacity among people aged 65-84 years. *Int J Epidemiol*. 2006 Oct;35(5):1255-61.

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2 The Demographic Background

In the United Kingdom, data from 2006 suggested that while men born in 1981 could expect to spend thirteen years at the end of their life in ill health, this had increased to fifteen years for men born in 2001. For women the increase was from sixteen to eighteen years.²¹ In other words, morbidity in the UK was expected to expand rather than contract. More recent data, however, which cover England specifically, indicate that disability-free life expectancy is now increasing more quickly than total life expectancy. For males, disability-free life expectancy rose by 1.5 years between 2003-2005 and 2006-2008, whereas life expectancy rose by only 0.4 years.²²

As with population projections, health projections can be overtaken by events. Dietary improvements or deteriorations; lifestyle trends such as in the amount of exercise taken, new diseases or new treatments; policy changes that invest greater or fewer resources in health care; environmental shifts such as climate change; and the impact of technology are likely to be key determinants of future morbidity but are all hard to predict decades in advance. The World Health Organisation is worried that the obesity “epidemic,” for example, may reverse recent health gains in developed countries.²³ Technology, meanwhile, has led to huge advances in health in the past few decades; its impact may accelerate in years to come, or it may wane, and its costs, too, may mushroom or decline.²⁴

The most rigorous study of the social care system in England, *Securing Good Care for Older People*, conducted by Wanless (2006) for the King’s Fund, projects that the number of older people in need of care will increase by up to 54% between 2005 and 2025.²⁵ This was based on the assumption that the number in need of care would rise faster than those with no need, but the data published on disability-free life expectancy since the Wanless Review give cause for more optimism. Policy Exchange, a think tank, argues that under the worst case scenario, 49% more older people will require care in 2025 than in 2010.²⁶ Because the older population will grow much faster than the rest of the population, this scenario would place a heavier burden on people of working age than is placed on today’s working age cohort. On the other

hand, if disability is reduced, the increase in costs will rise more slowly and therefore be easier for tomorrow’s workers to bear.

Determinants of the ability to meet demand

Demand for care, then, is likely to increase even if health improvements continue or accelerate. Society’s ability to meet that demand, notwithstanding many doom-laden predictions, is difficult to predict. The demographic picture, for example, is not one-sided. While the ratio of workers to older people will fall, if fertility rates remain low so will the proportion of children to working-age adults, thereby mitigating the strain on public finances. The average number of workers per person, as indicated by the total ratio of youth and elderly to people of working age, is projected to change only slightly in the next two decades, from 1:1.6 in 2010 to 1:1.5 in 2030.²⁷

Beyond 2030, increases in fertility in the next few years would add to the supply of workers and shift the ratio of workers to older people. Policy will play a vital role in strengthening society’s ability to pay for care. Child-friendly policies could boost the size of the workforce; policies to allow increased immigration, particularly from developing countries that have large cohorts of young people, will have a similar effect. Conversely, policies that reduce immigration or that deter childbearing will increase the burden placed on those of working age.

Retirement policy is likely to be especially important. Survey data in a number of countries suggest that as life expectancy rises, people intend to retire later, and that the proportion of life they plan to spend in retirement does not increase. This is not translating into reality, however. According to Bloom and co-authors (2011), ‘if anything, labour force participation among the 60-plus age groups has decreased, rather than increased, in most OECD (Organisation for Economic Co-operation and Development) countries despite the substantial improvements in life expectancy over the last decades.’²⁸ Retirement policy in most countries discourages later retirement by penalising those who continue to work after

21. House of Commons Health Committee (2010): *Social Care, Third Report of Session 2009-10, Volume 1.*

22. Office for National Statistics (2010): *Statistical Bulletin: Health expectancy at birth and at age 65; United Kingdom 2006-08.* ONS. London. November.

23. Visscher, T. L. and J. C. Seidell (2001). “The Public Health Impact of Obesity.” *Annual Review of Public Health* 22: 355-75.

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25. Wanless D (2006): *Securing Good Care for Older People: Taking a Long-Term View.* King’s Fund. London.

26. Featherstone H, Whitham L (2010): *Careless: Funding long-term care for the elderly.* Policy Exchange. London.

27. ONS (2009) op. Cit.

28. Bloom et al (2011) op. Cit.

2 The Demographic Background

state retirement age. In England, for instance, if an individual chooses to work part-time, his or her pension credit has been jeopardised. Raising the retirement age will help bolster the size of the workforce, and policies to promote lifelong learning and reduce age discrimination in the workplace are additional options for encouraging people to work longer into older age.

Increased labour productivity can also help societies meet the demands placed on them by aging populations. Ongoing training for older workers, wellness programs, and more flexible working arrangements that place fewer demands on stamina can increase productivity in the latter years of a career. Investment in technology can help compensate for diminished workforces by making remaining workers more productive. And investment in the education of younger generations can also bear fruit. The swollen cohort of baby boomers was followed by a smaller successor generation as fertility rates slumped. Parents therefore had more money to invest in fewer children, meaning that each child received a better education than those of earlier generations, where family resources had to be spread more thinly. Lee and Mason (2010) have argued that the effects of population aging may be reversed as 'large cohorts of less productive members are replaced by small cohorts of more productive members.'²⁹ A study of 120 countries by Lutz and co-authors (2007) found that as fertility fell between 1970 and 2000, the average years of schooling of the population aged twenty-five and over increased by 64%.³⁰ As Bloom and co-authors (2011) observe, 'more productive young cohorts will not only directly contribute to economic growth, but also reduce the tax burden necessary to sustain growing older generations by increasing average income levels.'³¹

Policy, therefore, will play a key part in determining whether England can meet the increasing demands for social care for older people (policies developed elsewhere will also have an impact – global economic conditions, the costs of coping with climate change or wars, and other unforeseen events may all affect our capacity to fund social programs). Social and attitudinal change will have an influence, too. If businesses, for example, begin to value older staff more highly for their experience and knowledge, people will be encouraged to work for longer. If families become closer, the need for the state to take responsibility for caring will be less acute than if society becomes more fragmented and the isolation of the old increases. Policy can make a difference in these areas, too, but it is difficult to predict what effect policy and attitudes will have on the resources available for care twenty years hence.

Summary

There is much uncertainty surrounding the likely extent of future demand for social care and society's ability to meet future needs. While the number of older people is certain to increase in the next two decades, and the absolute cost of social care will therefore rise, it is not yet clear how much the cost will climb relative to the economy's capacity to fund it, and there are many ways policy makers, older people themselves and society as a whole can help the country cope with population aging. The most rapid increases in the numbers of those likely to need social care will not be seen until the late 2020s; there is time enough, therefore, to prepare for demographic change. In the next chapter, we look at the baseline from which preparations must be made, and discuss how social care is delivered today.

29. Lee, R. and A. Mason (2010). Fertility, Human Capital, and Economic Growth over the Demographic Transition. *European Journal of Population* 26: 159-182.

30. Lutz, W., K.C. S., Goujon A and Sanderson W (2007). Reconstruction of population by age, sex and level of educational attainment of 120 countries for 1970-2000. *Vienna Yearbook of Population Research*, vol. 2007, pp 193-235.

31. Bloom et al (2011) op. cit.

3 Social Care Today

In this chapter we briefly discuss the numbers and composition of those receiving care and the type of care they receive. We then look in more detail at how the care system is performing in terms of access and quality.

Who receives care?

Professional care

Social care for the elderly is provided either in people's homes (known as domiciliary care), in community venues such as day care centres, or in residential or nursing homes (the principal difference between residential and nursing homes is that the latter must have registered nurses on-site at all times, while those living in residential homes rely on off-site District Nurses). The responsibility for providing publicly-funded care lies at the hands of local authorities, which receive funding for it from central government and from local council tax.

90% of places in residential and nursing homes are provided by the independent sector (either for-profit or not-for-profit), with only 10% provided by councils, which in recent years have moved towards contracting out care rather than providing it directly.³² In addition, the independent sector provides 81% of publicly-funded domiciliary care. There were nearly five thousand domiciliary care agencies in England in 2008, of which 84% were independently-run.³³

In 2008-2009, 1.2 million people aged 65 or over in England - approximately 14% of the total number of older people - were receiving a service through their local authority.³⁴ This includes 473,000 receiving domiciliary care; 173,000 receiving residential care; and 87,000 who were cared for in nursing homes. Other services provided to older people included equipment and adaptations

carried out in homes (provided for 423,000 older people); professional support (243,000); day care (115,000); meals (112,000); and short term residential placements (59,000). The profile of care home residents is increasingly old and frail, as resource-strapped councils have focused resources on the most needy. Of the 260,000 who received care supported by their local authority in residential or nursing homes, 96,500, or 37%, were aged 85 and over.³⁵ The average age of care home residents is over eighty, while 75% of care home residents are severely disabled.³⁶ As the age of residents has increased, the average length of stay in a care home has shortened, to under two years.³⁷

As well as those receiving publicly-funded social care, many older people pay for their care privately. In 2006-2007, it was estimated that 150,000 older people buy their own domiciliary care from private sector providers,³⁸ while 100,000 self-fund their stays in residential or nursing homes.³⁹

Unpaid care

The majority of care for the elderly is provided on a voluntary basis. Large numbers of older people receive unpaid care from family members, friends or other volunteers. The value of this care has been estimated at £87 billion annually, equivalent to a significant part of the entire NHS budget.⁴⁰ In 2000, there were four million unpaid carers of older people in England, over half of whom were the children or children-in-law of the cared-for person.⁴¹ 1.8 million older people with disabilities receive unpaid care in their homes.⁴²

Three out of five of unpaid carers are women, and one-quarter are themselves aged sixty or over.⁴³ 16% of people aged 65 and over provide care.⁴⁴ People from ethnic minority backgrounds are more likely than others to provide unpaid care to the elderly.⁴⁵

32. Centre for Social Justice (2010): *The Forgotten Age: Understanding poverty and exclusion in later life*. CSJ. London. November.

33. United Kingdom Home Care Association (2010): *An overview of the UK domiciliary care sector*. UKHCA, Sutton. December.

34. NHS Health and Social Care Information Centre (HSIC) (2009): *Community Care Statistics 2008-09*.

Social Services Activity Report, England. 28 April.

35. NHS HSIC (2009) *op. cit.*

36. CSJ (2010) *op. cit.*

37. CSJ (2010) *op. cit.*

38. Commission for Social Care inspection (2008): *The State of Social Care in England 2006-2007*. CSCI.

39. Wanless (2006) *ibid.*

40. Carers UK, ACE National and The University of Leeds (2007): *Valuing Carers – Calculating the value of unpaid care*. Carers UK. London.

41. Maher J, Green H (2002): *Carers 2000*. London. The Stationery Office.

42. Wittenberg R, Pickard L, Malley J, King D, Comas-Herrera A, Darton R (2007) *Future Demand for Social Care, 2005 to 2041*:

Projections of Demand for Social Care for Older People in England. Report to the Strategy Unit (Cabinet Office) and the Department of Health. PSSRU Discussion Paper 2514.

43. CSJ (2010) *op. cit.*

44. Wanless (2006) *op. cit.*

45. Young H, Grundy E, Kalogirou S (2005): 'Who cares? Geographic variation in unpaid caregiving in England and Wales: Evidence from the 2001 Census'. *Population Trends*, vol 120: 23-34.

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Three-quarters of unpaid carers devote fewer than twenty hours per week to caring, but a significant minority, primarily spouses and adult children, spend more than twenty hours per week caring, with 4% allocating more than 100 hours per week to caring duties.⁴⁶ Much, but not all, of this care, covers practical tasks such as shopping and laundry, or providing company and 'keeping an eye' on the older person (whereas professional care focuses more on the delivery of medication and personal care tasks such as washing and dressing).⁴⁷

More formal voluntary care is also important. Over sixty-seven thousand people are employed by the voluntary sector to provide care for the elderly. This accounts for 11% of the total care workforce for older people.⁴⁸ Voluntary sector organisations run three thousand care homes and almost four hundred domiciliary care agencies.⁴⁹

With such a significant proportion of social care provided by volunteers and family, the country is having to absorb significant productivity losses and opportunity costs as a direct consequence; to make an accurate assessment of the sustainability and associated cost-effectiveness and affordability of the current and possible future systems, any evaluation should take into account these wider "withdrawals".

How is the current system performing?

Access to care

As the numbers of older people grow over the next twenty years and demand for social care increases, policy makers and service providers will be tasked with ensuring widespread access without diluting quality. Even today, however, well in advance of the expected intensification of demand, there are problems in both areas.

Recent years have seen two major policy shifts in the field of social care for older people. The first is to encourage and support people to stay in their own homes for as long as possible. Domiciliary care is less expensive than residential care, and most older people would prefer to

stay in their homes than move to long-term care institutions. The second is to focus resources on those with the greatest need for care and the least ability to pay – 72% of councils only fund social care for people whose needs are "substantial" or "critical," and neglect those with "moderate" needs.⁵⁰ In practice, the second of these policies has won out, resulting in small numbers of older people receiving more intense care, while the overall number of people receiving any form of care has declined. Between 1994 and 2006, while contact hours increased by 40%, the proportion of households containing people aged seventy-five or over who were in receipt of domiciliary care almost halved.⁵¹ According to the Wanless Social Care Review:

*'The proportion of all people in their own homes who have care needs and who have those needs met is low, and has been falling. Budget-limited public resources are successfully being aimed at those with the highest levels of need but, even among this group, services are only being used by a relatively small proportion of people... The Review also finds that unmet need is particularly high among moderately dependent people.'*⁵²

The Commission for Social Care Inspection (CSCI), which until recently was responsible for regulating social care provision in England, estimated in 2007 that 450,000 older people in need of care faced shortfalls, while 275,000 with moderate needs received no council-funded care at all.⁵³ A year later, the CSCI found that just 30% of those who met eligibility criteria for council-funded social care received 'all the help they needed,' while half received some, but not an adequate level of help.⁵⁴ An indication of the neglect of those with moderate needs of care was revealed by a Sunday Telegraph investigation in May 2010, which found that one-third of local councils had 'left infirm and disabled people waiting for more than three years for disability adaptations to their homes... Many elderly people waited so long for help that they were moved into care homes before help was provided.'⁵⁵

46. Wanless (2006) op. cit.

47. Ibid.

48. Ibid.

49. Department of Health (2009): Shaping the Future of Care Together: Department of Health. July.

50. Care Quality Commission (2010): The state of health care and adult social care in England, London: The Care Quality Commission: 15

51. CSJ (2010) op. cit.

52. Wanless (2006) op. cit.

53. Commission for Social Care Inspection (2008): The State of Social Care in England 2006-2007. CSCI. London, cited in United Kingdom Home Care Association (2010): An overview of the UK domiciliary care sector. UKHCA. Sutton. December.

54. Commission for Social Care Inspection (2008): Cutting the cake fairly: CSCI review of eligibility criteria for social care. CSCI. London. October.

55. Sunday Telegraph (2010): Frail and elderly people wait years for basic disability equipment. Sunday Telegraph, London. May 2.

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Access to care in England is low by international standards. 5.5% of those aged 65 and over are receiving domiciliary care, and 3% long-term care in residential or nursing homes. These are lower proportions than are found in all but one of the other fourteen developed countries in a 2003 study by Gibson and co-authors (2003). The levels in England are much lower than the proportions receiving care in Australia, Austria, Canada, Denmark, the Netherlands and Norway.⁵⁶

Care quality

The Care Quality Commission (CQC), the independent regulator for health and adult social care services in England, released its first report on the state of adult social care in February 2010.⁵⁷ The CQC assesses services against a set of national minimum standards, which providers of care services are legally bound to meet. It draws on its own performance assessments of regulated care services and on consultations with recipients, families and carers, and with providers and commissioners of care. The minimum standards are:

- **You can expect to be involved and told what's happening at every stage of your care**
- **You can expect care, treatment and support that meets your needs**
- **You can expect to be safe**
- **You can expect to be cared for by qualified staff**
- **You can expect your care provider to constantly check the quality of its services**⁵⁸

There are important caveats surrounding the CQC's report. The CQC is developing a new system for assessing the quality of adult social care, which will be rolled out in May 2011. As well as using new ways of measuring excellence, this will take account of providers' record of compliance with essential standards and of 'any regulatory action we have taken.'⁵⁹ From 1 October 2010, moreover, the Health and Social Care Act 2008 decreed that all providers of adult social care that carry out regulated activities (including personal care and nursing care) had to be registered with the CQC. Registration requires compliance with CQC quality and safety standards, and the CQC states that future inspections will

be short and unannounced, involving direct observation of care, rather than 'set piece inspections that require a great deal of preparation.' There are two implications here – firstly, that not all providers were registered prior to this date, and therefore that not all are included in the February 2010 report, and secondly, that inspections might not have been as informative in the past, when providers had ample time to prepare for a visit and the provision of care was not observed directly. The findings below should therefore be approached with caution – it is possible that the true picture of care is less positive than that painted by the CQC. Until the CQC rolls out its new system, however, the February 2010 report is the most rigorous assessment available.

The key findings from the report for the period 2008-2009, with additional evidence from the CQC and other sources we have reviewed, are summarised below. The report covers all the above standards except the final one, on quality checking.

56. Gibson M, Gregory S, Pandya S (2003): Long-term Care in Developed Nations: A brief overview. Washington: AARP.

57. Care Quality Commission (2010): The state of health care and adult social care in England, London: The Care Quality Commission.

58. Care Quality Commission website: www.cqc.org.uk

59. Ibid.

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Information provision and choice

Social care services are on the whole performing well on both information provision and choice, but significant minorities of service providers do not meet minimum standards:

- **In 2008-2009, over 80% of care homes for older people met minimum standards of information provision.**
- **90% of domiciliary care services for adults (both old and young) met the information provision standard.**
- **Approximately 90% of both care homes for older people and domiciliary care providers for all adults meet standards related to choice and control over care.**

Although the above findings are positive, 30% of recipients of domiciliary care consulted by the CQC reported that they were rarely, if ever, informed about changes to the service. The CQC's predecessor, meanwhile, found major shortfalls in the tailoring of information to the needs of disabled people, with the result that large minorities of users could not understand the information they were given.⁶⁰

The findings on choice and control are also positive overall, but are somewhat undermined by the CQC finding that one of the councils' main tools for giving people greater control over the care they receive – direct cash payments which care recipients can spend on services of their choosing, which are supposed to be offered to all potential users – has been used by only 3.6% of older care users. In only 30% of councils, the CQC observes, are self-directed support and personal budgets a “strength.” 20% of councils, moreover, were judged to be providing insufficient support to help older people make decisions over their care.

Care tailored to needs

As with information provision and choice, there is a sense that while in general care is effectively tailored to users' needs, there are small proportions of providers which fail to meet expectations:

- **96% of councils met minimum standards of adult social care.**
- **60% of adult social care services (including care homes and domiciliary care agencies) received an overall rating of “good” and 17% “excellent.” 17% were “adequate” and 2% “poor.”**
- **25% of councils were rated “excellent” in terms of improving quality of life for adults receiving social care.**
- **Overall, 58% of older users of domiciliary care were extremely or very satisfied with the service they received (this, of course, leaves many who were less content).**

The quality of domiciliary care, residential care and nursing home care was broadly similar. 77% of home care agencies and residential homes and 73% of nursing homes were rated good or excellent. On the other hand, over 4,000 regulated social care services only achieved “adequate” ratings, while 426 were “poor.”

Several other studies have found inconsistencies in quality of care. Evidence gathering by the Centre for Social Justice (2010) found uneven provision across geographical areas, and highlighted in particular the brevity of domiciliary care visits, which often lasted less than fifteen minutes.⁶¹ The King's Fund (2005) found serious deficiencies in care in London, with limited access, restricted choice, unsafe procedures, and poorly trained and qualified staff.⁶² During the consultation phase for its 2009 Green Paper on adult social care, meanwhile, the Department of Health found inconsistent quality of care across different parts of the country. It also found that people are confused by the care system, particularly with regard to the funding individuals can expect to receive and the assessment criteria for measuring need, and that many services are not tailored to individual requirements.⁶³

60. Commission for Social Care Inspection (2009): *Putting People First: Equality and Diversity Matters 3: Achieving Disability Equality in Social Care Services*. CSCI, London. February.

61. CSJ (2010) op. cit.

62. Robinson J, Banks P (2005): *the business of caring: King's Fund inquiry into care services for older people in London*. King's Fund. London.

63. Department of Health (2009) op. cit.

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The above findings only apply to those who received care, but as discussed above, the majority of councils only provide social care to people with substantial or critical needs. This means that hundreds of thousands of people with needs defined as “moderate” are not receiving any publicly-funded care – it is likely that the needs of many in this group (those who do not fund themselves or who lack access to unpaid carers) are not being fully met.

Safety

The CQC has highlighted safety as one of its ‘key areas of concern,’ and notes significant failings in safeguarding those in receipt of care:

- **While over 85% of care homes for older people and domiciliary care services met protection standards, in only 10% of councils were safeguarding procedures noted as a strength.**
- **In over one-third of councils that provided adult social care, safeguarding training was in need of improvement.**
- **3,268 services did not meet safeguarding standards.**

The CQC found that standards of safety were uneven across the country, and noted that no council ‘could point to robust evidence of outcomes’ in improving safety in recent years. On the other hand, 55% of councils had made recent efforts to train staff on and raise public awareness of safety issues.

Staff

Staffing, according to the CQC, ‘is the one aspect of performance in which all types of provider and commissioner were least likely to meet minimum standards.’

- **In only 16% of councils were staff training and qualifications a strength.**
- **81% of care homes for older people complied with standards on training and development.**
- **Only 71% of care homes for older people complied with standards on staff supervision and support.**

Other reviews, too, have found deficiencies in staffing. These encompass both the quantity and quality of care workers. In a 2008 survey of employers of care staff by Cangiano and co-authors (2009), 58% reported serious difficulties in recruiting nurses to work with older people, and 50% in recruiting care workers.⁶⁴ As the numbers of older people increase over the coming decades, the dearth of workers will become more acute if nothing is done to make the profession more attractive. Already, many residential and care homes have low ratios of carers to residents (sometimes as low as 1:10), which has serious impacts on the quality and extent of care that can be provided.⁶⁵

Care work has a bad reputation among staff themselves, the general public and the media, whose portrayal of care workers is overwhelmingly negative.⁶⁶ According to the Centre for Social Justice, the care home workforce is ‘highly demoralised and badly paid.’⁶⁷ The majority of care workers earn the minimum wage, with significant minorities claiming to earn less than that.⁶⁸ Staff turnover is high, at over 20% per annum. As the CQC pointed out, moreover, training is deficient. Many providers do not meet minimum standards, training courses are time-consuming and expensive, and qualifications are not closely linked to pay, thereby reducing the incentives for care workers to upgrade their knowledge and skills.⁶⁹

64. Cangiano et al (2009) op. cit.

65. CSJ (2010) op. cit.

66. Wanless (2006) op. cit.; Eborall C, Garmeson K (2001): Desk Research on Recruitment and Retention in Social Care and Social Work. London: Department of Health; Alcock S (2003). The Domiciliary Care Sector Today. Southampton: The Quinn Centre.

67. CSJ (2010) op. cit.

68. Ibid.

69. Wanless (2006) op. cit.

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Summary

The social care system is struggling to keep up with demand. Access to care is very low by international standards, and many older people who have moderate, but far from negligible needs receive no publicly-funded care at all.

Those who receive care are in general provided with a good service. They are well informed, have some choice, and are generally cared for in a way that improves their quality of life. There are several areas in need of attention, however. Good provision is not universal, and significant minorities of providers fail to keep users well informed, fail to ensure their safety, and fail to invest in staff. Large numbers of older people across the country therefore receive inadequate care. As demands on the system intensify, it is likely that the shortfalls will grow more serious. In the next chapter, we look at how social care is funded, and at the funding that will be required for the care system to keep up with the increase in the number of likely users.



4 Social Care Funding

Social care funding today

A recent report by the Policy Exchange calculated that total public spending on long-term care for the elderly was £16.2 billion in 2008-09. This was divided between Local Authorities (which spent a net £7.2 billion), NHS Social Care (£3.2b), NHS Continuing Healthcare (£1.1b), Attendance Allowance (£3.9b), and Carers Allowance (£0.8b).⁷⁰ In addition, it has been estimated that an equivalent amount to the total public expenditure may be spent privately on social care.⁷¹ Finally, a large amount of care is performed by volunteers, and thus provided free of charge.

In this chapter we examine the current players in the funding of social care, and the precise nature of their provision. Unlike health care, the contribution of the state to funding of social care currently depends predominantly on means assessments, with separate assessments needed for different types of care funding.

Care funding through local councils

The 152 councils with social services responsibilities include County Councils, Metropolitan District Councils and Shire Unitary Councils in England, London Borough Councils, the Common Council of the City of London and the Council of the Isles of Scilly. There is often an expectation by the public that councils provide social care free of charge, in a similar manner to healthcare, but provision of care by councils depends on an individual's level of need and is means-tested to determine to what extent private payment will be required towards the care provided.

The total gross expenditure on Personal Social Services (including on younger adults) by councils in 2009-10 was £16.7 billion. Expenditure on older people (aged 65 and over) accounted for 56% of total adult expenditure, giving a total expenditure on older people of £9.3 billion in 2009-10.⁷² This total spend on adult social services derives funding from three streams - central government grants, council tax charges and charges made to individuals for social care provision.

Funding from central government is provided through the Revenue Support Grant, which is allocated to each council as calculated using Relative Needs Formulae. This calculation takes into account local need, including, for older people's social care, factors such as the social structure, area costs, levels of deprivation and numbers of older people.⁷³ Central government funding is augmented by funds raised by councils locally through council tax. In 2008-9 this amounted to 33% of the provisional total gross current expenditure on social care.⁷⁴ Finally the means-testing of social care means that a large proportion of those accessing social care will be required to contribute towards the cost of their care.

Provision, and therefore funding, of social care by councils is restricted to those with a certain level of need. A formula for assessing individuals' level of need was formalised in the 2003 guidance on Fair Access to Care Services,⁷⁵ providing four standard threshold criteria for need. These are labelled critical, substantial, moderate and low. Councils can determine the range of need for which they will provide care, and in the past this has been strongly dependent on the amount of funding available. With funding shortages, the level of need for which care is provided has become progressively more restricted over the years. The most recent data for the eligibility thresholds set by councils show that in 2009-10, 73% of councils set their eligibility threshold at substantial or critical,⁷⁶ an increase from 72% in 2007-8 and 53% in 2005-6.⁷⁷ This means that care will only be provided in cases where life is in danger, where serious abuse or neglect has occurred or might occur, or where the individual is unable to carry out the majority of personal care activities (that is, activities such as washing, dressing, going to the toilet, and eating) or domestic routines and there is no-one available to assist. Those with lower levels of social care need do not receive any social care provision through local councils and, unless they can obtain care through the NHS, will not receive any state contribution towards the cost of their social care.

70. Featherstone and Whitham (2010) op. cit.

71. Ibid.

72. The Information Centre (2010): Personal Social Services expenditure and unit costs: England - 2009-10 – Provisional Council Data (2010). November. Available at: <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-expenditure-and-unit-costs-england-2009-10-provisional-council-data>

73. House of Commons Health Committee (2010): Third Report - Social Care. House of Commons. March. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/2205.htm>

74. Ibid.

75. Department of Health (2003): Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care. January. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019641.pdf

76. Hall L (2010): Report on Adults' Social Services Expenditure 2009-2010. ADASS. April. Available at: <http://www.adass.org.uk/images/stories/rpt-LGA%20ADASS%20Survey%202009-10%20final.pdf>

77. Commission for Social Care Inspection (2008) Cutting the cake fairly: CSCI review of eligibility criteria for social care. CSCI. London. October. Available at: http://collections.europarchive.org/tna/20081105165041/http://www.csci.org.uk/pdf/FACS_2008_03.pdf

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Those who meet eligibility criteria on need must then be means-tested to determine whether and how much the state will contribute towards the care funding. The extent to which the state will contribute towards the funding of council-provided social care is dependent upon the individual's ability to pay. This is governed by a series of rules, which differ between residential and non-residential services. In 2008-9 20% of gross expenditure (£1.8 billion) on older people's services came from client contributions.⁷⁸

The level of individual contributions towards residential care depends upon an assessment of the resident's assets and income. The assets assessed are cash, investments and property, including the client's own home, except when a current spouse or partner is still living there. Anyone with total assets worth more than a given threshold (£23,250 from April 2010) receives no public financial support and must pay the entire cost of their care. Those with assets below this threshold receive public support, but are required to contribute almost all of their assessed income, a figure calculated from their income and assets, according to national rules. They are allowed to retain a weekly personal expenses allowance of £22.30.

For non-residential care, councils can apply charges as they see fit, within the Fairer Charging guidelines issued by the DH in 2003.⁷⁹ These guidelines state that a means test should always be carried out when total assets are less than the level for the residential care means test (£23,250 in 2010-11); the value of the person's own home cannot be included. The guidelines also state that charges should not reduce an individual's net income below basic levels of Income Support or the Guarantee Credit of Pension Credit, plus a buffer of 25%.⁸⁰ However within these guidelines there is a wide variation in the level of individual contributions that must be paid, as highlighted in a recent report by Which?. Whereas some local authorities charge around £20 per hour for care, in others care costs are much lower, or care may even be free. Many authorities have a weekly maximum charge for home care, however in some cases these have been raised or removed in 2010-11, so that charges can be much higher.⁸¹

The recent Health Committee report on social care commented: 'There is a great deal of variation between local authorities in their operation of charging for home care services. A small number of councils choose to provide free services for all or for certain groups of people. Some charge a flat rate (i.e. it applies to all, irrespective of relative ability to pay) to those who fail the means test; this is a highly regressive policy, imposing the greatest relative burden on those who are relatively worst off. Most councils, however, levy "stepped" charges, with a series of means thresholds to take account of relative ability to pay.'⁸²

78. Health Committee (2010): op. cit.

79. Department of Health (2003): op. cit.

80. Ibid.

81. Which? (2011): Home care charges lottery revealed by Which?. Which?, January. Available at: <http://www.which.co.uk/news/2011/01/home-care-charges-lottery-revealed-by-which-242460/> (accessed 24.1.11)

82. Health Committee (2010): op. cit.

4 Social Care Funding

Care funding through the NHS

A substantial amount of additional funding for social care is provided through the NHS. These funds are directed to those who require assistance due to a health need. For example, NHS funding for social care includes spending on reduced mobility, assistance with personal care and holiday relief care.

Funding is also delivered through NHS Continuing Healthcare.⁸³ This is provided in situations when the main need for care relates to health, and is arranged and funded by the NHS alone. Eligibility is dependent upon a needs assessment but is likely to relate to a complex medical condition, the need for highly specialised nursing support or a terminal condition. When an individual is eligible for NHS Continuing Healthcare, this is provided and funded by the Primary Care Trust, although further services may also be provided by the local authority.

Data presented by Featherstone and Whitham (2010) show that, in 2008-9, total social care funding from NHS Continuing Healthcare was £1.1 billion and £3.2 billion was derived from NHS Social Care. The 2008-9 figures for NHS social care spending were an increase of 52% from the previous year, although it is unclear to what extent this increase is due to a change in budget categorisations.⁸⁴

Benefits

Funding for social care is also provided through two benefits relating to those with disabilities. Attendance allowance is a non-means tested benefit, available to those aged 65 and over who need care due to physical or mental disability. Attendance allowance is worth either £70 or £47 per week, dependent upon the level of need, and added up to a total expenditure of £3.9 billion in 2008-9. Carer's Allowance is a taxable benefit available to carers providing more than 35 hours of care per week to someone in receipt of disability benefits.⁸⁵ In 2008-9 spend on Carer's Allowance was £0.8 billion.⁸⁶

Private funding

As is clear from the discussion above, public funding for social care is restricted and eligibility criteria complex. Many of those who have social care provided through local authorities are required to pay contributions towards their care, and those not eligible for state care must purchase care privately. A report by the Personal Social Services Research Unit (PSSRU) estimated that, in 2006/7, approximately half of all spending on social care came from private sources.⁸⁷ Policy Exchange have suggested that total private spending on long-term care for the elderly may be as high as £16.2 billion, matching or possibly exceeding public spending.⁸⁸

83. Department of Health (2009): The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, July 2009 (revised) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103161.pdf

84. Department of Health (2010): Estimated England level gross expenditure by Programme Budget (Updated 15.04.10), Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_general/@dh/@en/documents/digitalasset/dh_118577.pdf

85. Featherstone and Whitham (2010) op. cit.

86. Ibid.

87. Forder, J (2007): Self-funded social care for older people: an analysis of eligibility, variations and future projections. CSCI. October. Available at: <http://www.pssru.ac.uk/pdf/dp2505.pdf>

88. Featherstone and Whitham (2010) op. cit.

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Future funding challenges

Recent policy changes

The economic crisis, along with the change in government, has led to changes in the funding available for social care. The Government Spending Review, presented on 20 October 2010, fixed spending budgets for departments up to 2014-15. The Department for Communities and Local Government, which provides central government funding for social care, will see a reduction in overall resource of 33% in real terms by 2014-15, although £6.7 billion is being devolved to local government over this period. This has in turn led to a reduction of the Local Government formula grant by an average of 26% in real terms over the Spending Review period. It is thought that this will cause councils' budgets to decrease by around 14% once the Office for Budget Responsibility's projections for council tax are taken into account.⁸⁹

Since spend on adult social care represented 12% of local authorities' total net current expenditure in 2008-9, it is likely that the reduction in total council funding will have an impact on social care spending. To attempt to alleviate this funding deficit, the government has pledged £1 billion of additional social care funding through the NHS Resource budget and has committed to increase the Personal Social Services grant for social care by £1 billion to £2.4 billion a year by 2014-15.⁹⁰ The major change to grant funding for social care, however, is that those elements that had previously been protected areas of spending have now had their ring fences removed.⁹¹ The only funding that will be 'effectively ring-fenced'⁹² is that provided through the NHS. With remaining social care funding rolled into the formula grant, it will be up to local councils what level of priority is given to funding of social care.

Funding gap

There has been much discussion in recent years about the disparity between the level of funding that will be available for social care in the coming years and the level of funding needed for a competent social care system. The funding needs of social care in the future will depend upon several factors. These include the number of people requiring care, the level of state funding for care needs, and the cost of care.

The way people are cared for will of course impact on the cost of care. In recent years there has been a move away from care home admittance towards care in the community, except for those with very high levels of need. According to the Saga Annual Cost of Care Report, in 2008 nursing homes typically cost around £30-40,000 per annum, but over the previous three years the cost had risen by 1.5% more than the Retail Price Index.⁹³ Care in the community is usually a cheaper option; however, given the differences in means testing for residential versus non-residential care, the client may be required to make a smaller contribution towards non-residential than residential care, as the property value of their house will not be included in the assessment of ability to pay.

Most recently, the Kings Fund, in their evidence to the Health Committee report on Public Expenditure, used three different scenarios to estimate the likely funding gap in 2015. Under the first scenario social care spend is protected, under the second it is partially protected, and cut by 7%, and under the third it is not protected, and is cut in line with the 14% cuts in local council budgets. By 2015 it is estimated that in the worst of these cases there will be a £2.2 billion funding gap between 'required funding to meet needs' and the funding available. If there were no cuts to social care funding, there would be a £267 million deficit, due to the increase in need, and with 7% cuts, the shortfall would be £1.2 billion. In this partial funding cut scenario, the King's Fund analysis calculates that efficiency savings of around 2% per year for the period of the Spending Review would be needed to close the funding gap.

89. House of Commons Health Committee (2010b): Second Report Public Expenditure. House of Commons. December. Available at: <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51202.htm>

90. HM Treasury: Spending Review 2010. London. The Stationery Office.

91. House of Commons Health Committee (2010b) op. cit.

92. Ibid.

93. Saga (2008) Annual Cost of Care Report 2008. Saga UK.

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In the short term the increased need for funded social care may be exacerbated due to the economic slowdown. A report by ADASS showed that many local councils had already experienced reduced income due to people defaulting on social care charges, and charging being levied on fewer people. These changes were anticipated to continue and increase in the coming months.⁹⁵ In addition, local councils will see an increased demand for other services such as welfare advice services, debt counselling and employment-related service, which may deplete the resources available for social care.

The above calculations assume that the level of state funding for care will remain constant over the time periods considered. However, changes to the social care system have been proposed, both by the previous government, who put forward plans to introduce a 'National Care Service,' and by the Conservatives, who in their 2010 election manifesto suggested a voluntary social insurance scheme, in which advance payment of around £8000 would offset future residential care costs.⁹⁶ There have been many criticisms of the current level of care provision, with the increasingly tightened eligibility criteria imposed by councils meaning that many who require care but cannot afford to pay for it are unable to access the services they need. Many of these people end up in hospital, thereby increasing the pressure on the NHS.

According to the Commission for Social Care Inspection, several groups in particular are marginalised by the current system. These include:

- (i) People with long-term conditions – where it is argued that the criteria do not include sufficient requirement to take account of the long-term impact of a condition.**
- (ii) People with fluctuating conditions whose needs over time are not properly taken into account.**
- (iii) Blind and partially sighted people who are disadvantaged by assessors who are unaware of the impact of loss of vision, leaving many outside the top two eligibility bands.**

(iv) Young adults who move from children's services where they may have been well supported "into the adult's world where they may find availability is restricted".

(v) People with Asperger's syndrome/autism whose support needs are often not properly understood.

(vi) Carers – who are those most frequently referred to as a 'hidden' group.⁹⁷

In addition, the current system favours those who already have a high level of healthcare need over the provision of preventative support. The Commission for Social Care inspection has argued that raising eligibility thresholds without providing adequate preventative strategies leads to a short term dip in the number of people eligible for social care, followed by a long-term rise.⁹⁸ As we discuss in chapter five, this suggests a need for increased investment in preventative services aimed at reducing the growth of the population with high-level care needs.

Summary

The way funding is allocated by the local council and NHS system means that only those with a very high level of care need are currently eligible for state funding. Among this high need population, funding is means-tested and only provided to those unable to pay for social care from their income, savings or assets. Changing demographics and the recent reduction in the Local Government formula grant are likely to cause a funding gap in years to come. It is as yet unclear how local councils will react to this shortfall, but previous years have seen an increasing restriction of eligibility criteria. As discussed in chapter three of this review, such restrictions reduce the effectiveness of the care system and pass on costs to the NHS. In the next chapter, we look at ideas mooted for tackling the funding gap and building an effective care system for the future.

94. Ibid.

95. Hall L (2010): Report on Adults' Social Services Expenditure 2009-2010. ADASS. April. Available at: <http://www.adass.org.uk/images/stories/rpt-LGA%20ADASS%20Survey%202009-10%20final.pdf>

96. The Conservative Party (2010): The Conservative Manifesto 2010. Conservative Party. London. Available at: <http://www.general-election-2010.co.uk/2010-general-election-manifestos/Conservative-Party-Manifesto-2010.pdf>

97. Commission for Social Care Inspection (2008) Cutting the cake fairly: CSCI review of eligibility criteria for social care. CSCI. London. October. Available at: http://collections.europarchive.org/tna/20081105165041/http://www.csci.org.uk/pdf/FACS_2008_03.pdf

98. Ibid.

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Although there is uncertainty over demographic projections, an increase in the numbers of older people over the next two decades is inevitable. Barring a radical liberalisation of migration policy, moreover, that increase will occur at a much faster rate than the increase in working age people. If current rates of social care usage continue, therefore, and if the economy grows less rapidly than the demand for care, funding as a proportion of gross domestic product will need to rise.

There are ways of reducing the demands on the social care system, however, and of making more efficient use of current funding. In thinking about the effects of an aging society, two concepts more commonly used in discussions of climate change – mitigation and adaptation – are useful. Policy makers will benefit from considering how to mitigate the need for increased social care, as well as how to adapt to the inevitable changes brought on by population aging.

Prevention

We discussed the potential impacts of improved health in mitigating the need for social care in chapter two. Wanless (2006) estimates that under three different health scenarios – worsening health among older people, improved health, and no change from today (whereby disability increases in proportion to the numbers of older people) – the size of the population in need of care will vary greatly. Under the no-change scenario, Wanless calculates that there will be a 67% increase in the number of older people with disabilities in 2025 than in 2006. In the improved health scenario, the increase will be just 57%, and in the worsening health scenario, 69%.⁹⁹

Prevention of dependency will therefore make a large difference to the funds needed for social care. Until recently, however, prevention has been low down providers' and policy makers' lists of priorities. The neglect by councils of those with "moderate" needs in favour of those with "substantial" or "critical needs" means more people are likely to fall into the care net earlier; given the high cost of residential and nursing care relative to domiciliary care, this may increase rather than reduce costs in the long-term. The last government acknowledged this risk in its 2009 Green Paper: "Too often our existing system makes poor use of limited resources.

Ever-increasing pressures on local authorities mean that resources are increasingly used to offer care and support when people's needs are highest. Money could often be better invested in prevention, rehabilitation and keeping people active and healthy."¹⁰⁰

There are a number of examples of cost-effective prevention methods. Reablement services – short, intensive blasts of home care after an illness or an accident – have been found to reduce the need for residential home stays, as has Extra Care Housing, which allows older people to stay in specially designed self-contained homes with the safety net of 24-hour on-site staff. Extra Care Housing is much cheaper than residential care, but its availability is currently limited. In 2006, there were just 20,000 people living in these homes, compared with over 200,000 living in care homes.¹⁰¹ Although many people wish to remain in their own homes for as long as possible during old age, it is important that those homes are suitable for their needs. One aspect of elderly care which is well developed in New Zealand is the retirement village, in which people have their own well-adapted homes and also have access to care services if needed. These villages contain everything needed for daily living, but also typically offer residential care or domiciliary care options. The concentration of those who need care in one location is thought to lead to greater efficiency of care provision. In England, the Lovat Fields Village in Milton Keynes is well established, and further retirement villages are now planned in this region.

The Supporting People program is another effective prevention tool. This aims to delay admission to care homes by providing nearly a million older people with domiciliary services including information and advice on housing, care and finance issues, a benefit toolkit, handypersons for jobs around the home, and home improvement services. The services are delivered primarily by the voluntary sector and housing associations. An evaluation found that the annual expenditure on the program of £1.6 billion generates savings to public funds of £3.41 billion.¹⁰²

99. Wanless (2006) op. cit.

100. HM Government (2009): *Shaping the Future of Care Together*. London. The Stationery Office.

101. Centre for Social Justice (2010) op. cit; Wanless (2006) op. cit.

102. Department for Communities and Local Government (2010): *Supporting People*. DCLG website. Available at: <http://webarchive.nationalarchives.gov.uk/20100402130812/communities.gov.uk/housing/supportandadaptations/supportingpeople/> Last accessed 31 December 2010.

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Another program with proven cost-effectiveness - Partnerships for Older People Projects (POPSS) - highlights the importance of integrating social and health care in reducing demands on both these key public services. Many older people require both health and social care, and reducing social care costs will be futile if those costs are merely passed on to the health service. At present, however, there are few incentives for social care practitioners to find ways of cutting health care expenditure, and vice versa. POPSS was a pilot study in 29 local authority areas which brought councils together with primary and secondary care trusts, ambulance services, the police, fire services, housing associations and organisations from the voluntary and private sectors. The scheme provided 260,000 older people with health advice and information, exercise classes, gardening and home help and visits from social workers for a three year period. An evaluation by the Personal Social Services Research Unit found that POPSS reduced overnight hospital stays by 47% and use of Accident and Emergency departments by 29%. Each extra £1 invested in the program produced a saving of £1.20 on emergency bed days.¹⁰³

A scheme that runs along similar lines to POPSS operates in the United States. PACE is an integrated health and social care system which is designed to keep frail elderly people in the community for as long as possible, with care packages tailored to individual needs. The model pools the finances of Medicare, the state health insurance program, and Medicaid, which provides the bulk of public funding for social care. Each case is managed by a multi-disciplinary team working from an adult health day centre. Participants, who must be eligible for nursing care, are among the frailest members of the community, but according to a study of its effectiveness the program's focus on prevention and rehabilitation has led to large declines in hospital admissions and a significant reduction in costs compared to a control group who did not participate in the scheme.¹⁰⁴

As the POPSS and PACE examples show, integrating health and social care could save both services substantial sums in the years to come. A 1998 government White

Paper described a "Berlin Wall" separating health and social care. A major difficulty is that while health care is free at the point of use, social care is means tested and only provided free to those most in need and with the lowest means. Budgets are therefore separate. The NHS spends £4.23 billion per year on social care, on top of the £7 billion spent by local authorities.¹⁰⁵ The 1999 Health Act attempted to remove some of the barriers between health and social care providers. It allowed for the development of pooled budgets, whereby the NHS and local authorities can put resources into the same pot for care services.¹⁰⁶ It provided for lead commissioning, where a health authority and local authority work together but one takes the lead on commissioning services on behalf of the partnership, and it encouraged integrated provision, with health services and local authorities combining their care offering as part of a 'one-stop' package. In 2006 a government White Paper repeated calls for better integration, and pledged to 'move towards fitting services round people, not people round services.'¹⁰⁷ The paper emphasised the need for health services to work closely with local authorities on the prevention of illness and dependency and the promotion of healthful behaviour. Reflecting the lack of progress made since the 1999 Health Act, the White Paper observed that joint commissioning between health care providers and local authorities was not working well, and promised improvements in this area in the future.

Some progress has been made since. For example, an investigation by the Department of Health in 2000, which found that many older patients were remaining in hospital beds much longer than was clinically necessary,¹⁰⁸ led to a large expansion in intermediate care. This entails a short course of combined medical and social care provided in day care centres, homes, or residential care homes with the aim of rehabilitating patients and easing them back to independence, which can help reduce the number of days spent in hospital and speed patients' return to their communities.¹⁰⁹ Intermediate care has been rolled out across England, and an evaluation in 2006 found that although the outcomes of the service are uneven across the country and it is not always cost-effective, it can

103. Personal Social Services Research Unit (2010): National Evaluation of Partnerships for Older People Projects: final report. PSSRU. January.

104. London Councils (2009) Social Care Funding Models: Examples from other countries. London Councils.

105. CSJ (2010) op. cit.

106. Wanless (2006) op. cit.

107. HM Government (2006): Our health, our care, our say: a new direction for community services. Department of Health. January.

108. Department of Health (2000): Shaping the Future NHS: Long term planning for hospitals and related services: consultation document on the findings of the National Beds Inquiry. London: Department of Health.

109. Age Concern (2009): Intermediate Care Factsheet. Factsheet No. 79. Age Concern. November. Available at: <http://www.ageuk.org.uk/Documents/EN-GB/FS76%20Intermediate%20care%20Nov%2009.pdf?dtrk=true>

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contribute to quality of life improvements for patients and produce cost savings.¹¹⁰ The number of delayed discharges from hospital, moreover, has fallen sharply.¹¹¹

Another example of how social care can reduce health care costs is the rapid uptake of telecare services. Telecare devices such as smoke alarms, flood detectors, heat sensors, general buzzer alarms and fall detectors have been shown to prevent both hospitalisation and residential care home stays, and Wanless (2006) recommended that ‘telecare should become an automatic consideration in any care package after a needs assessment.’¹¹² Over 1.7 million people now benefit from telecare services, which have become a core part of care providers’ offering; the UK is one of the world leaders in the field.¹¹³

Following the success of PACE in the US and POPPS in England, Hereford Hospitals Trust received approval in 2010 to establish a new form of integrated care organisation. The Trust will run a joint primary care provider and local authority adult social care service, paid for by pooled funding.¹¹⁴ It is hoped that integrated care provision will reduce waste and improve outcomes for those in need, and that the trust will be a model for future integrated services in other parts of the country.

In too many areas, on the other hand, the disconnect between health and social care is increasing costs for both. In 2009, the Care Quality Commission reported that 17% of care homes were not told whether those discharged into them from hospitals had infections.¹¹⁵ This can increase the burden on care homes, which will have to treat an infected individual and potentially other care home residents who catch infections. One in three people aged sixty-five or older, meanwhile, suffer a fall each year, at a cost to the National Health Service of £1.7 billion, but because social service providers see no benefit from mitigating health care costs, little is spent on assistive equipment in homes, such as handrails, trolleys and fall alarms, which reduce the number of falls.¹¹⁶ In 2004, while 41% of council spend on social care for older people was on residential care home placements, investment in equipment and adaptations accounted for just 1% of the budget.¹¹⁷

In some instances, both health and social care costs are driven up by poor integration. The arrangement whereby general practitioners do not have care home coverage built into their contracts means that residential care homes must either pay a retainer to a local practice to receive visits from a small cadre of doctors (thereby paying for a service which is supposed to be free at the point of use), or register different patients with numerous different GPs, which risks the inefficient and confusing scenario whereby several doctors visit a home on the same day, when one doctor could more cost-effectively see all of those in need. The Centre for Social Justice (CSJ) found that on some occasions GPs refused to visit homes and insisted that elderly patients visit their surgeries, which not only heightens the health risks for frail patients but is costly when specially adapted transport is needed. The CSJ reported that ‘the major consequence of poor primary health care coverage [in care homes] has been services typically defaulting to hospital admission when an emergency arises.’¹¹⁸ The Care Quality Commission has calculated that if all local authorities could match the best performing councils in reducing emergency admissions, this could save NHS hospitals £2 billion per year and cut the number of days spent in hospital by eight million. Emergency admissions for people aged 75 and over, however, continue to increase year on year.¹¹⁹

110. University of Birmingham, University of Leicester (2006): A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People. University of Birmingham Health Services Management Centre, Leicester Nuffield Research Unit, January.

111. CQC (2010) op. cit.

112. Wanless (2006) op. cit.

113. WSD Action Network (2010): Sustaining innovation in telehealth and telecare. The King’s Fund. London.

114. Health Service Journal (2010): Hereford integrated care organisation approved. HSJ. 17 December.

115. CQC (2010) op. cit.

116. Centre for Social Justice (2010) op. cit.

117. Wanless (2006) op. cit.

118. CSJ (2010) op. cit.

119. CQC (2010) op. cit.

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Mobilisation

An additional way of reducing future demands on social care resources would be to make better use of volunteer carers. Already, voluntary organisations and unpaid carers provide the greater part of care in England, and strengthening their abilities and drawing in more people to provide care will ease the pressure on the funded social care system.

Of the 6 million carers in the UK, approximately half are the children or children-in-law of the person receiving care. A further 18% are spouses; one-quarter of carers are themselves aged sixty or over. There is a need for greater support to carers to help them cope with the physical and emotional demands of caring.¹²⁰ Carers are more than twice as likely as non-carers to suffer from ill health,¹²¹ and as the demands on individual carers increase so will the stress and the risk of illness – the proportion of unpaid carers providing over fifty hours of care per week has doubled in the past decade to 22%, as families become more dispersed and fewer individuals have the time or motivation to contribute to caring for family members.¹²²

Respite care, which gives carers a break from their duties by replacing them for a week or a few weeks with a professional carer, can improve carers' health, but although Primary Care Trusts have money to help long-term carers, budgets are not ring-fenced and are reportedly often spent on what are seen as more urgent needs.¹²³ Day care - for both carers and cared-for - can also lighten the load on carers, and has been found to reduce carers' stress.¹²⁴ In October 2010 the government announced a £4.4 million funding increase for schemes that establish early contact with people who have recently become carers, with a view to preventing them falling into ill health and providing them with information about how to access respite care and other services for carers.

Financial help for carers is also important. Many give up paid work to provide unpaid care, and although they relieve the burden on both the NHS and local authorities, they receive minimal compensation for their lost income.

The UK is one of only four European countries that provide direct financial support for carers, in the form of the Carer's Allowance, but the rate of pay is low, at £53.90 per week, and compares unfavourably with the £180 paid to carers in Ireland.¹²⁵ To receive the benefit, moreover, a carer must perform at least 35 hours of care duties, and be caring for someone in receipt of Disability Living Allowance; currently only 500,000 people receive Carer's Allowance. Given the high cost of residential care (the cost of a residential care home room averages £25,000 per year and that of a nursing care home room £35,000), which would in many cases be needed if an older person could not rely on a family member's support, a £2,800 annual Carer's Allowance paid to just a small proportion of voluntary carers seems to many a derisory sum. Carers UK reports that carers whose opinion it has canvassed feel 'insulted' by the low level of payment.¹²⁶

As well as providing more support to carers, there is a need for more people to engage in caring. It has been estimated that by 2041 there will be a shortfall of 250,000 providers of unpaid intense care as a result of demographic trends (although as we have seen, these trends are hard to predict with certainty).¹²⁷ To make up the likely deficit, new ways must be found to enlist people in caring. Family breakdown, the increased mobility of people who live too far away from elderly relatives to care for them, and a weakening of inter-generational bonds and a sense of responsibility towards one's elders mean that society cannot rely as heavily in the past on children to care for their parents and supplement funded social care. Continued decay in this area is not inevitable, however. The Conservative government's "Big Society" idea, which was outlined in its 2010 election manifesto, hopes to encourage wider involvement by individuals in improving quality of life in their communities and in the country as a whole. On-the-ground mobilisation to strengthen social care and ensure that vulnerable older people are cared for and can continue to play a role in society would presumably be a good example of the Big Society in action.

120. Wanless (2006) op. cit.

121. CSJ (2010) op. cit.

122. Ibid.

123. Ibid.

124. Pickard L (2004): *The Effectiveness and Cost-effectiveness of Support and Services to Informal Carers of Older People*. London: Audit Commission and PSSRU.

125. CSJ (2010) op. cit.

126. Ibid.

127. Pickard L (2010): *Informal care for older people by their adult children: projections of supply and demand to 2041 in England*. PSSRU, London School of Economics and Political Science. London.

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The example of “Time Banks” is a promising avenue for exploration. Time Banks originated in the United States before spreading to Europe; there are now around 100 in operation in the UK.¹²⁸ They work on the basis whereby for each hour of time dedicated by an individual to volunteering, an hour’s worth of credit is received, which can be “spent” on services provided by other volunteers. In the case of social care for the elderly, it would be possible, for example, for an older person to spend an hour shopping or cooking for another Time Bank participant, and then receive an hour of gardening in return. Time Banks can also help the relatives of those in need of care. If the child of an elderly person performs a few hours of voluntary work per week, his or her time credits could be transferred so that the parent could receive care services. For working people who live far away from their parents, this could be an attractive proposition.

It is likely that other ways can be found of mobilising society to participate in caring for the elderly and make up the projected shortfall of carers. Even with more widespread involvement in voluntary care, however, students of the field are unanimous in their belief that an increase in expenditure will be needed. The weaknesses in the current system and the inevitability that demand will intensify in future means that mitigation by itself will not be enough; ways will also have to be found to adapt to future requirements. In the next sub-section we therefore examine the options for future funding.

Adaptation

Setting the scene

Before deciding between possible funding systems, policy-makers must address three important challenges. The first is to elicit public backing for reform, since it will be easier to implement funding increases if there is public support for them. Currently, few people in the UK are interested in social care. A recent government consultation found limited public understanding of social care’s role,¹²⁹ and in a 2009 BBC survey of 1007 adults in which 73% of respondents wanted health and education budgets to be protected in the upcoming budget, only 2% felt that social services budgets were worthy of protection.¹³⁰

The combination of ignorance of what social care does and many individuals’ belief that they will not need care themselves means that most people make no provision for funding their own care. In a survey by the Centre for Social Justice, half of respondents said they gave little thought to growing old, while only one in ten had planned ‘as comprehensively as possible’ for old age.¹³¹ A series of public surveys discussed by Featherstone and Whitham (2010) found that fewer than one-third of adults planned to put money aside for their long-term care (in one survey only 6% had such plans), and that less than half believed it was their responsibility to fund their care.¹³² Even among those aged 51-70, only 57% had made plans to pay for their care.¹³³ Any attempt to raise social care expenditure, either from government or private coffers, will rely on the same society-wide mobilisation that is needed to engage people as volunteer carers. In the current economic environment in particular, where budgets are being reduced rather than raised, it will be difficult to make the case for increased social care funding if the public does not believe in its importance, and that it is a worthwhile use of government resources. Social care can only be made to work if the system is economically efficient and viable. This requires a clear definition of value, and an appropriate method of measuring that value over time. Convincing people of the value of social care and of the likelihood that they or someone close to them will need it as they age should be a first step towards reforming the funding system.

128. Time Banking UK website. Accessed 3 January 2010. <http://www.timebanking.org/index.htm>

129. COI, Ipsos Mori and Synovate for HM Government (2009): The case for change: why England needs a new care and support system – engagement findings. HM Government. 21 July.

130. BBC News (2009): Tax and Spending Poll. BBC News Online. 19 April. Available at: http://news.bbc.co.uk/2/hi/programmes/the_westminster_hour/8007252.stm

131. CSJ (2010) op. cit.

132. Featherstone and Whitham (2010) op. cit.

133. GfK NOP (2008): Two thirds of people won’t put money aside for social care in older age. July. See: <http://www.gfknop.com/pressinfo/releases/singlearticles/002721/index.en.html>

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Once public approval is obtained (and as we have seen, demographic trends leave sufficient time to build support in a patient and thorough way), the second key challenge for policy-makers will be to reach agreement over what a future care system should deliver and how it should be judged. There is widespread agreement that there are weaknesses in the current system in terms of access, quality, and cost-effectiveness, but there is no consensus over who should receive publicly funded social care or what they should receive.

Wanless (2006) outlined three possible scenarios for future care provision. In the first, the existing model is continued, but extended to keep up with demographic change. Quality would not improve, and the proportion of those receiving care would not change. In the second, the quality of care is improved to ‘achieve the highest levels of personal care and safety outcomes that can be justified given their cost,’ with personal care encompassing help with activities such as washing, dressing, going to the toilet and feeding, and safety including protection from self-induced and other risks. In this scenario, the amount and content of care an individual should receive would be decided by society, perhaps in conjunction with an independent assessment body such as the Social Care Institute for Excellence which would calculate the cost-effectiveness of different levels of care; such a body would perform a similar role to that performed by the National Institute for Health and Clinical Excellence (NICE) in evaluating the cost-effectiveness of health care interventions.

Wanless’s third scenario builds on the second, aiming to achieve the highest and safest levels of personal care and also to strengthen social inclusion and broader well-being. This would include efforts to encourage continued participation by older people in society, for example via clubs or day care centres. Outcomes in the latter areas are more difficult to measure but, as Wanless notes, social inclusion is important to people and is therefore a valuable outcome indicator.¹³⁴

In its 2009 Green Paper, the previous government had little to say on the level of care that it intended to provide. Without agreement on this, calculating likely costs and establishing funding mechanisms will be futile. Wanless’s three scenarios inevitably lack detail, as there is at present no body such as NICE to evaluate social care delivery and

the Care Quality Commission is in the process of revising its methods of evaluating care packages, but they are nevertheless a useful framework for discussion as policy-makers map out a care system for the next few decades. The third key challenge is to estimate the cost of future care. Again, this is difficult given demographic uncertainty and doubts over how much society will wish to commit to caring for older people. The 1997 Royal Commission on Long Term Care described a ‘funnel of doubt,’ whereby projections of need and costs become progressively less likely to be accurate the further into the future they stretch.¹³⁵ Small changes in the short-term can lead to large ones in the longer term, meaning that it is only possible to draw up a range of plausible projections rather than specific numbers.

In 2008-2009, public expenditure on social care for older people was £16.2 billion,¹³⁶ an average per older person of approximately £1,880 per year. With average life expectancy at the age of 65 approximately 19.3 years, this equates to an average lifetime cost of care per older person of £36,200. If demographic projections that there will be 50% more older people prove accurate and if current access to and quality of provision remain unaltered, this would mean expenditure on care of £24.3 billion in 2030, in 2008-2009 prices. The latter figure would mark a 50% increase on current expenditure. Reflecting the rapid growth of older people relative to those of working age, it would also mean a cost per adult (aged 16 and over) of £497 per year at 2008-2009 prices, a large increase compared with the £380 cost per adult today.

These figures provide a rough guide to the funding that might be required, although as discussed earlier there are many factors that could raise or lower the sums demanded. Wanless (2006) and Featherstone and Whitham (2010) broadly concur with our £24.3 billion estimate by the late 2020s. This is the funding Wanless expects will be needed under his first, no-change scenario. The second scenario, which allows for improved levels of personal care, would see costs in 2026 reaching £29.5 billion, and his third scenario, which allows for enhanced personal care as well as care that improves social outcomes and well-being, would cost £31.3 billion by 2026 – a per adult cost of £640 per year.¹³⁷

134. Wanless (2006) op. cit.

135. Royal Commission on Long Term Care (1999): With respect to old age: long term care – rights and responsibilities. London. 1 March.

136. Featherstone and Whitham (2010) op. cit.

137. Wanless (2006) op. cit.

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That cost projections are an uncertain science suggests a need for future funding mechanisms to be sufficiently flexible to adjust to both changes in the numbers needing care and the costs of care provision. Other important criteria when assessing options, as laid out in the various studies of social care and as are currently being considered by the Commission on Funding of Care and Support, are:

- **Fairness** - between generations, between people living in different areas, between people of different gender and ethnic origin, and between people with different levels of wealth
- **Transparency** - so that it is clear who will receive what, and so that the system is easy to use
- **Sustainability** - both economically, so that care remains affordable even as the numbers of users swell and new methods and technologies become available (this criterion relates to flexibility), and politically, so that the funding system retains public support as demographic changes set in¹³⁸
- **Efficiency** - both so that public resources are only spent when private funding will prove inadequate, so that public money does not increase the likelihood of higher costs in future (for example by failing to invest in or encourage prevention),¹³⁹ and so that the highest quality outcomes are achieved with available resources
- **Personalisation** - personalised to individual needs, giving people choice over how much to pay for care and how the funds they receive are spent¹⁴⁰

In the next sub-section, we look at the various suggested funding options in the light of the above criteria. The discussion assumes that the three key challenges mentioned above – garnering public support, deciding what care should be provided, and projecting a likely cost range – have been addressed.

Funding options

The current system

Any discussion of future funding options must start with an analysis of the present system. As we have seen in chapter four, the current needs and means tested system of publicly-funded social care reaches most of those with greatest needs, provided they also lack the means to pay. Similar systems are used in Australia, New Zealand and the United States, where the Medicaid program supports long-term care for those who cannot afford it. Spain, too, has recently implemented a needs and means tested system, although it is also developing insurance systems to help those whose needs will not be fully met out of the public purse to pay for their care.¹⁴¹

When assessed in the light of the five key criteria listed above, the current system scores well in terms of fairness between people of different wealth levels, targeting as it does those in greatest financial need. It is also efficient in that it only spends public funds where private funding would not otherwise fill the gap, and it obliges those who can afford it to pay from their own pockets. The current system is one of the cheapest available in terms of its demands on the public purse, with Wanless (2006) estimating that the state pays only half of total direct care costs (under his improved basic care scenario), compared with much higher proportions under most of the other mooted options.¹⁴² As the Care Quality Commission report outlined, moreover, most people under the current system receive personalised care which is tailored to their needs.

The current approach falls down in many areas, however. Firstly, it is unfair in several ways. As the numbers of older people needing care increase, a heavy burden will fall on those of working-age. The latter group will have to spend a higher proportion of their wealth on social care for the elderly than did the generation receiving care.¹⁴³ Inter-generational fairness is lacking, therefore. There are problems, too, with fairness between people living in different areas. Since local authorities are given autonomy over how to apply eligibility criteria for funding, geographical differences have evolved in who receives funded care. People with similar disabilities may or may not receive care depending on where they live, leading to what

138. Joseph Rowntree Foundation (2009): Response to the Green Paper consultation on Shaping the Future of Care Together. www.jrf.org.uk

139. Wanless (2006) op. cit; Department of Health (2009) op. cit.

140. Department of Health (2009) op. cit.

141. Costa-Font J, Garcia Gonzales A (2007): Long term care reform in Spain. Health Policy Developments. Eurohealth Vol. 13, No. 1: 20-22.

142. Wanless (2006) op. cit.

143. Joseph Rowntree Foundation (2010): Funding Care: How can each generation pay its fair share? JRF Viewpoint. March. www.jrf.org.uk

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has been described as a “postcode lottery.”¹⁴⁴ Finally, the current system penalises those who have saved for their retirement. While those with few assets or savings receive free care, those who have saved, even if during their working lives they earned no more than those who have not saved, must draw down their savings until they sink to the £23,000 threshold for public subsidy.

Secondly, the current funding system falls down on transparency. In chapter three, we saw that many care users are not receiving the information they need in a format that helps them understand it. The funding system has been described as a ‘complex labyrinth,’¹⁴⁵ which many users and potential users do not understand; differences between how local authorities apply eligibility criteria inevitably exacerbate confusion over whether people will receive public support.

On the sustainability criterion, although expenditure on social care in England is low compared with other countries, the present level of funding will become unsustainable as the numbers of those needing care rise. Existing funding leaves many people who need care unsupported, and there are serious deficiencies in the quality of care. The House of Commons Health Committee has described the system as ‘not fit for purpose,’ and there is general agreement in all studies that more funding is required both now and in the future.¹⁴⁶

The fact that current levels of funding are unsustainable, however, does not mean that a means and needs tested system itself is unsustainable. Increased funding using existing criteria could help plug the gaps and ensure continued care provision for the neediest. It is not clear, however, that the current system fully meets the fourth criterion, of efficiency. Although it uses public money only when it is most needed, it is likely that by targeting only those in greatest need, large numbers of people will become dependent who could have been helped to remain independent for longer had they received care when their needs were only moderate. 275,000 people with moderate needs receive no public support at all, and as various White and Green Papers have admitted, this failure to prevent more severe dependency could result in increased costs in the longer term. The current policies whereby on the one hand people are encouraged to stay in their own homes for as long as possible and on the other funding is targeted only at those with greatest need are

contradictory and unsustainable. The latter policy neutralises the former and risks wasting limited public resources. More widespread availability of funded care would delay the need for intense care and allow people to remain in their own homes – a much cheaper option than residential or nursing homes - for longer.

With regard to the final criterion, personalisation to individual needs, although most people receive an appropriate service, there are significant shortfalls. Most obviously, the needs of many thousands who are judged to have low or moderate care requirements are neglected; so too are the needs of those who have substantial or critical care requirements but have assets worth more than the £23,000 threshold. In short, by targeting only the most vulnerable and the poorest, the current funding system does not make it possible to tailor care to everybody’s needs.

Even for those who receive publicly funded care, personalisation is far from universal. Although personal budgets are available, few make use of them and there are concerns over older people’s ability to understand and use them effectively. Eligibility assessments, meanwhile, theoretically ensure that the most dependent older people receive care tailored to their needs, but as the Care Quality Commission found, there are many cases where the most vulnerable are not given adequate care even when they are deemed eligible.

The existing funding system for social care for older people, then, does not fully meet any of the key assessment criteria. It performs well in terms of fairness between different wealth brackets and in using public funds only where most needed, and other problems such as the postcode lottery could be ironed out if eligibility assessments were applied in the same way by all local authorities. Sustainability, moreover, could be improved with a long-term injection of funding. However, problems with inter-generational fairness, fairness to those who save, transparency and clarity, and personalising care for all those who need it are irremediable using the current means and needs tested approach.

144. Department of Health (2009) op. cit.

145. Wanless (2006) op. cit.

146. House of Commons Health Committee (2010): Third Report – Social Care. House of Commons. March. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/2202.htm>

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Options for change

If a method can be found which fulfils more of the five assessment criteria, jettisoning the old system would be justified. The 2009 Green Paper outlined a continuum of types of funding, based on the extent to which individuals and the public purse contribute to the funding of care. The continuum ranges from a system which relies purely on private, self-funding to one where social care is provided out of taxation and is free at the point of use to all those in need. In between are a “partnership” approach, with the individual and the state each paying a fixed proportion of basic care costs; an insurance-backed approach, which is similar to the partnership method but with a state-supported voluntary insurance scheme helping individuals meet their share of the costs; and a “comprehensive” approach, where the insurance is compulsory, as with National Insurance, and all those in need receive free care funded from the insurance pot.¹⁴⁷ The suggestions by governments and think tanks for future funding options fall into one or other of the Green Paper’s categories. Here, we discuss these options in turn. For each, we first describe how it works, then provide examples of how it is used in other countries, then note where other studies have suggested that option, and finally assess it in light of the five criteria listed above.

1. Pay for Yourself

This first approach would be a purely private system, with no public funding for social care, even for the poorest and neediest. People would be able to take out insurance to pay for future care, or draw down savings to fund immediate care needs.

This system scores well, in part, on the transparency criteria, as it is clear that nobody receives any publicly-funded assistance under it; and it is efficient in encouraging people to take measures to prevent their own dependency.

As the authors of the Green Paper admitted in ruling it out, however, there are serious problems with this option, in terms of all five of the assessment criteria. Many people do not believe they will require care, and it is likely that few would take out insurance to cover a future cost they do not believe they will need. Those most likely to need care are the poorest, who suffer more than wealthier people from illness and disability;¹⁴⁸ even if they wanted to take out insurance, premiums would be unaffordable for many in this

group. The House of Commons Health Committee reported that ‘in our evidence we heard that private insurance against care and support needs has long been characterised by “market failure.”¹⁴⁹ The United States is an example of this, where there has been very low take-up of private long-term care insurance due to the complexity of schemes, the many exceptions through which insurers can refuse to provide cover, and high premiums (which average almost £3,000 per year for those aged 70).¹⁵⁰ Under the Pay for Yourself approach, it is likely that large numbers of at-risk people would not be covered for their care.

Without insurance, people under the Pay for Yourself system would have to start paying for care when they need it. Without assets, savings or income, however, and with care costing tens of thousands of pounds per year for those in residential or nursing homes, many would be unable to afford to pay. Social care is a public good – society has an interest in looking after its most vulnerable members, and failing to prevent greater dependency by allowing people to languish without care will in the long term merely increase costs for the NHS. Social care benefits many who do not receive it directly, such as the family members of those in need, and leaving it to the market risks failing to provide all the care required.

For many people, the current system in England is a Pay for Yourself system, which results in thousands of people with low or moderate needs having to either pay for care themselves, rely heavily on family members, or bypass care altogether. If this system were made universal, the poorest, who are also in general the neediest, would be penalised, meaning the system would be unfair; it would lack transparency in that people do not know in advance how much care they will need and therefore cannot plan for how much insurance to take out; it would be politically unsustainable because the public outcries over current episodes of neglect would become more frequent and likely force policy-makers into a rethink, and economically unsustainable because many could not afford to pay; and it would be inefficient because it would increase health care costs and impose a very heavy burden on informal carers, some of whose time might be more productively employed elsewhere. In none of the studies we have reviewed was there support for such a system; all agreed that there should be some element of public funding for social care.

147. Department of Health (2009) op. cit.

148. Wanless (2006) op. cit.

149. House of Commons Health Committee (2010) op. cit.

150. London Councils (2009) op. cit.

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2. Partnership

The partnership system would provide care to all those who need it, regardless of their means. Everyone judged to have a care need would have a certain, fixed proportion of their basic care needs funded out of the public purse, with the remainder paid for by the individual. Those with low incomes would have a higher share of their care paid for by the state, either directly or through the benefits system, with those with the lowest means having all care paid for. In the Green Paper, it is suggested that the state fund a quarter or a third of care for everybody, with a larger contribution for the poorest; different governments, of course, could choose different levels of state support. This approach directly charges only those who use care services, although the rest of the population is charged indirectly because their taxes pay for the share of care funded by the state.

The system for long term social care used in France combines aspects of the partnership model with the comprehensive model we discuss below and the means tested model currently used in England (many countries use a combination of systems). In France, all of those aged 60 or above who are in need of long term care receive an allowance, but the level of the allowance is means tested and varies depending on income, with the wealthiest receiving only 10% of the benefit. The rest of the costs must be paid for out of savings, income or through private insurance schemes. All of those receiving benefits must make a co-payment to cover at least a small share of costs.¹⁵¹

The French system has had mixed results. The private insurance market is strong, with 25% of those aged 60 or above taking out policies to pay for long term care.¹⁵² Take-up of care services, moreover, is higher than in the UK. However, poorer people have been found to be less likely to take out insurance, while those at highest risk (for example, those in poor health or who engage in risk behaviours such as heavy drinking) are more likely to buy cover.¹⁵³ Those without insurance may be vulnerable, with their safety and health compromised; after 15,000 older people died in the August 2003 heat wave, policy-makers began to focus more strongly on prevention of dependency, which had hitherto been neglected.¹⁵⁴

In his 2006 study of funding options for social care in England, Wanless proposed a partnership model whereby all of those in need of care have 66% of their basic needs funded by the state. Co-payments would pay for the remainder, with every pound contributed by an individual matched by a pound from the state 'until the benchmark care package is achieved.' Additional care on top of the basic package would be privately funded.¹⁵⁵ An update to the Wanless report by the King's Fund, which reflects the more difficult economic circumstances in which the country now finds itself, suggests 50% of the package would be provided by the state, with every additional £2 from the individual matched by £1 from the state, up to a defined amount. This reduces the state's maximum potential expenditure from 83% of the cost of the basic care package to 67%.¹⁵⁶ In both cases, the co-payments of those with low incomes would be assisted by the benefits system. The King's Fund claims that with its updated partnership model unmet need would be halved, as many more people would receive care (based on an estimate of a 2/3 increase in those receiving public funding).¹⁵⁷

Wanless calculated that under his partnership model, in 2002 the state would have contributed 71% of total direct care costs, compared with 50% under the current system and 78% under a tax-funded system of free personal care (discussed below). Under his second scenario of improved basic care, direct public spending relative to the means testing system would have risen from £6.2 billion to £9.7 billion, with total spend including Attendance Allowance and Disability Living Allowance reaching £13.7 billion compared with £12.4 billion under means testing. This discrepancy in total expenditure, Wanless posits, could be reduced if these benefits, whose current care-related use would be covered by the partnership system, were scrapped or scaled back for all but the poorest.

With regard to the five assessment criteria listed above, the partnership system is fair in that it does not penalise those who have saved, nor those who lie just above the means-testing threshold in the current system. Those who need care, moreover, will only pay what they can afford.

151. Featherstone and Whitham (2010) op. cit.

152. Ibid.

153. Courbage C and Roudaut N (2008): "Empirical Evidence on Long-term Care Insurance Purchase in France", The Geneva Papers, vol 33: 645-658.

154. Association for the Advancement of Retired Persons (2006): AARP European Leadership Study:

European experience with long term care: France, the Netherlands, Norway and the United Kingdom. AARP. October.

155. Wanless (2006) op. cit.

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

157. Ibid.

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On the other hand, people in need of more than basic care receive no additional public funding – under the Wanless model, this group would have to find other means of paying for advanced care, although it would be possible for the benefits system to help those with highest needs.

In terms of transparency, with means testing transferred to the benefits system, the rules over how much people have to pay towards their care are clearer with the partnership approach than under the current model (although people will still have to engage with the complexities of the benefits system). While the content of basic care will be clear, however, as care needs fluctuate the amount to be paid by individuals will change, thereby reducing clarity. This is likely to affect in particular people with additional needs on top of those catered for by basic packages.

On sustainability, the partnership model is flexible enough to deal with changing demands and changing costs of care; basic care packages can be redesigned to adapt to change, as can the proportion of care funded by the state. However, since the model is much more expensive than the current system, there may be problems with financial and political sustainability. Although unlike a free, tax-funded system it brings in revenues in the form of charges, by providing more publicly-funded care to more people total costs will inevitably rise compared with a means tested approach. The King's Fund has calculated that its latest proposal, where the state provides 50% of funding and matches each additional pound contributed by individuals, would cost £4.3 billion more by 2026 (in public and private funding) than the current system.¹⁵⁸ At all times, but especially in periods of economic hardship, an increase of this size may be a difficult sell to those who are not currently using care themselves.

The partnership model scores well on some measures of efficiency. It would make use of private as well as public funds, and encourage people to save for their care since a contribution would be required of almost everybody.¹⁵⁹ Knowing that they have to foot part of the bill, moreover, people are likely to use care only when they most need it, and also to take steps to prevent their own dependency.

Furthermore, since this system provides care to more people than does the means tested model, it is likely to be a more effective mechanism for preventing dependency and thereby reducing long-term costs than the means tested approach. On the other hand, by providing state support even to people with the means to pay for care themselves, it would use public resources when they might not otherwise be needed.

In looking at efficiency, Wanless (2006) modelled the overall benefits of the partnership approach in terms of improved outcomes for older people. Outcomes are measured by activities of daily living-adjusted years, or ADLAYS, an assessment tool similar to that used by NICE in assessing health care interventions. ADLAYS are a measure of the 'gain for one year of life of having core activities of daily living (ADL) needs improved from being entirely unmet to being fully met.' This is a means of comparing and rating improvements in outcomes as a result of care – in the case of Wanless's second care scenario, improvements in personal care, nutrition and safety.¹⁶⁰ If a person moves from having none of these needs met to having all of them met in a year, he or she is said to have gained an ADLAY.

According to this model, in which an economic worth was put on each ADLAY,¹⁶¹ the ratio of outcomes to costs is highest in the partnership system, at 1.17, ahead of free personal care (1.16) and the current means tested system (1.13). This suggests that the partnership model is efficient in providing value for money, and even if some margin of error is allowed for in the modelling, the model would remain competitive.

With regard to the final criterion, personalisation, the partnership system scores strongly. Matched funding gives people control over how much care they wish to pay for, and because some of the funding comes from their own pockets they have more control over how it is spent and more leverage over the quality of service provided.

158. Humphries et al (2010) op. cit.

159. Wanless (2006) op. cit.

160. Ibid.

161. Wanless set a value for money threshold – that is, the sum society would be willing to spend to achieve an additional ADLAY – of £20,000 per ADLAY, lower than the NICE threshold for health interventions of £20-30,000 per quality-adjusted life year (this threshold would presumably have to be opened up to public debate if such a system were to be put in place). If it costs social care services less than £20,000 per year to achieve an extra ADLAY, they are considered value for money. The improvements in outcomes are based on self-reports by care users.

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3. Insurance

The third option is an insurance model. This is similar to the partnership model, with the state paying for a proportion of care, but with voluntary insurance helping individuals to fund their share of costs. Those who decided not to take out insurance would have to find other ways of paying their share.

As is outlined in the 2009 Green Paper, the state could play a variety of roles in promoting social care insurance. It could work closely with the private sector, to ensure people receive sufficient income should they receive care, and the fact that the government would be funding part of the cost of care would mean premiums would be lower than in a purely private system.¹⁶² Or it could set up its own insurance scheme, with all of those who contribute sufficient sums to the scheme guaranteed free care and support. People could pay into the scheme before or after retirement, or after death, with the funds coming out of their remaining assets. The Green Paper estimated that individuals would have to pay a total of £20-25,000 into the scheme, based on the assumption that the average 65-year-old will face £30,000 of lifetime care costs. The premium could vary, however, depending on the level of the state's contribution to the cost.¹⁶³

In its manifesto ahead of the 2010 general election, the Conservative Party proposed a variation on the insurance scheme to cover residential care in old age. It mooted a proposal for a voluntary insurance scheme under which people aged 65 would pay a one-off levy which would provide them with free, comprehensive residential care should they need it. The proposed levy was set at £8,000. The assumptions on which it was based were firstly that only one in five people would need residential care; secondly, that the average length of care needed was two years; and thirdly, that the average cost of residential care would be £20,000 per year.¹⁶⁴ These assumptions have been criticised. Featherstone and Whitham (2010) draw on insurance industry data to estimate that the average cost is closer to £30,000 per person per year, while according to the Centre for Social Justice the average cost of a single residential care room today is £25,200 per year, and of a nursing home room £35,256.¹⁶⁵

The insurance model's fit with the five assessment criteria is similar in many ways to that of the partnership model, which it resembles. It is fair in that it is needs-based, helps those with lowest means through state support, and avoids penalising savers, and is fairer than the partnership system in that it has the potential to help those with large ongoing costs (although it too does not cap those costs). It is efficient in that like the partnership model it discourages excess use and supports prevention, but it too uses public funds to pay for some people who could otherwise pay for themselves. It is sustainable because, by involving insurers, who can adjust premiums, it has the flexibility to respond to changes in need and cost. Again, however, the expense of the insurance option relative to means testing might prove a hard sell politically. Finally, like the partnership option, the insurance model scores strongly on personalisation, as it gives users adequate control over how much care to purchase and how their money is spent.



162. House of Commons Health Committee (2010) op. cit.

163. Department of Health (2009) op. cit.

164. The Conservative Party (2009): Ending the scandal of forced home sales to pay for care. Conservatives press release, 2 October. Available at: http://www.conservatives.com/News/News_stories/2009/10/Ending_the_scandal_of_forced_home_sales_to_pay_for_care.aspx; see also Featherstone and Whitham (2010) op. cit.

165. CSJ (2010) op. cit.

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The main problem with the insurance model lies in the fact that private insurance for social care is not yet well developed. There are a variety of types of private long-term care insurance (LTCI) schemes. For most plans, benefits can be claimed when the policy holder is no longer able to conduct a specified number of activities of daily living (ADLs). We list the main types of scheme below:

- **Pre-funded LTCI:** A pre-funded insurance plan involves a regular or lump-sum payment by the policy holder before long-term care is needed. Benefits are then paid when the customer can no longer perform a specified number of ADLs. The policy will then pay out a pre-agreed annual amount, which can be index-linked, for example to the retail price index. The insurer is usually able to review payments after a given number of years, or at a certain age. However, this increases uncertainty for the customer, since premiums might rise due to the review.
- **Investment-based plans:** This type of insurance takes the form of an investment bond, purchased with a lump sum. The capital is invested, and the amount needed to pay for the insurance policy is withdrawn by the insurance providers each month from the value of the investment bond. These plans contain significant risks, as well as potential for growth, dependent upon market performance. A decrease in value of the investment may lead to a reduced benefit being paid, or top-up payments being needed. They may face problems with political acceptability, therefore.
- **Immediate needs annuities:** These are purchased with a lump sum to pay for immediate care. The benefit of these annuities is that they provide a fixed level of payment towards care needs for as long as necessary. This removes the worry of the unknown length of time for which care costs will need to be paid. Unlike with pre-funded plans, moreover, purchasers know they need the care the annuity will fund. Immediate care annuities are often used to pay for residential care, since they can be purchased following the sale of a house. An additional benefit is that there is no income tax payable on the immediate needs annuity benefits, provided that they are paid directly to a formal care provider.¹⁶⁶

Following the Community Care Act 1990, the long-term care insurance market in the UK began to develop, as insurers saw an opportunity to present a solution to the problem of care funding. Levels of uptake have been below expectations, however, and without the widespread enrolment needed to spread risk and keep down premiums, such insurance schemes are likely to fail, thereby jeopardising the success of the insurance model for social care funding.

The lack of public enthusiasm has been attributed to a number of causes, including low willingness on the part of the public to think about social care needs in the future; a lack of regulation of insurance plans before 2004, which caused a lack of trust in plans;¹⁶⁷ uncertainty as to what the State would provide;¹⁶⁸ and complex and expensive insurance products (the insurance model, although transparent in that what the state provides is clear, falls down on the clarity criteria due to the complexity of products and the potential variation in premiums). The majority of LTCI products have now been withdrawn from the market, but it is possible that future changes in social care funding, and the support of government under the insurance or other models, may see a reintroduction. As Johnston (2005) has argued, 'An environment where such products might be reintroduced would have to include more intense education of the public on the need to plan for the cost of care in old age and government endorsement of the insurance plans that might assist in such planning. If a public-private partnership were to be considered, then this would certainly rekindle the appetite of the insurers to develop new products for such a scheme.'¹⁶⁹

Tax incentives might also play a part in government efforts to encourage take-up of private social care insurance. The rationale behind such incentives is that they help relieve the state of having to pay for the care of those who take out insurance, and they are efficient if the savings to public resources outweigh the cost of the tax breaks. On the other hand, with private medical insurance concerns have been expressed that since private insurance is likely to be taken up mostly by wealthier sections of society it is possible that removing these influential individuals from the publicly-funded system might lead to a two-tier health care system, with the publicly-funded part neglected by policy-makers whose constituency is primarily the wealthy

166. Wanless (2006) op. cit.

167. Johnston S (2005): Private funding mechanisms for long-term care. Joseph Rowntree Foundation.

168. Featherstone and Whitham (2010) op. cit.

169. Johnston (2005) op. cit.

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and privately-insured.¹⁷⁰ This is less of a concern with social care, however, which is in large part already delivered by private companies, who are contracted to provide social care services by local authorities. The quality of care should therefore be similar for those who buy insurance to pay for it as for those whose care is paid for from public funds.

From the 1980s until 1997, tax breaks were offered for those taking out private medical insurance (PMI). Those aged sixty or above were given income tax relief at the basic rate if they took out PMI, and since employers were exempt from paying National Insurance contributions on PMI, this encouraged them to provide it as a benefit-in-kind to employees. Emmerson and co-authors (2001) modelled the impact of removing this subsidy, and found that the proportion of older people taking out PMI, controlling for factors such as income and educational attainment, fell by 0.7 percentage points between the pre-1997 period, before it was abolished, and post-1998.¹⁷¹ The saving to government expenditure, they found, would far outweigh the cost to the NHS of having an additional 4000 people relying on publicly-funded healthcare rather than private insurance. On a more positive note, the World Health Organisation has found that countries with higher rates of private health insurance take-up generally have better overall health outcomes.¹⁷² It is unclear what the effect of tax breaks would be on take-up of social care insurance, but it is an option worthy of consideration since it can help share the responsibility for funding social care between individuals, employers and the state.

While insurance schemes rely on individuals having enough cash assets to pay for the insurance policy, and schemes such as immediate needs annuities often require customers to sell their homes in order to purchase insurance, home equity release schemes allow the release of housing assets without having to sell a home. Such schemes enable payment for domiciliary care, as the customer is able to remain living in their own home while using its value to pay for care. There are two main types of equity release scheme:

- **Mortgage schemes:** As the name suggests these schemes involve a mortgage charge being taken on the customer's home, in exchange for a lump sum to the home owner. The most popular product is Fixed Interest Lifetime Mortgages, where the interest is added at a fixed rate during the lifetime of the loan, and no repayments are required until the customer either dies or moves into residential care. At this point the mortgage is repaid from the sale of the house. There is usually a guarantee that the total amount owed will not exceed the sale price of the house.¹⁷³
- **Reversion schemes:** In a reversion scheme the scheme provider buys a share in the value of the customer's home, at a discounted price. The discount with respect to the actual value of the share will be higher the younger the customer is at the time, and hence the longer they can be expected to live before the property will be sold. Again once the customer dies or moves to a care home the property is sold and the appropriate share of the income goes to the reversion company.

170. Ibid.

171. Emmerson C, Frayne C and Goodman A (2001): "Should Private Medical Insurance Be Subsidised?" Health Care UK Spring 2001:49-65

172. World Health Organisation (2000): Health systems: improving performance. WHO, Geneva.

173. Ibid.

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While the market for long-term care insurance has collapsed, the equity release market has grown steadily since the early 1990s, encouraged by the continued rise in property prices. With a large proportion of the wealth of the elderly population tied up in property, this is an effective way to enable people to pay for their care while remaining in their own homes.

For those who are likely to receive part of their care funded through local councils, however, there are serious disincentives for taking part in this kind of scheme. Currently, assets tied up in one's own home are not included in the means-test for the ability to pay for domiciliary care, but once these assets are released as equity, they would be included. The advent of equity release schemes makes it more reasonable to expect all those who receive care to contribute towards their care funding, based on an assessment of all assets, including their homes. According to the Centre for Social Justice, people aged over 55 control 80% of the nation's wealth, but account for just 40% of annual consumer spending.¹⁷⁴ This suggests that a large amount of money is tied up in property by this population. Analysis by Sodha (2005) estimates that around 9% of retirees had over £100,000 of housing wealth, but due to being income-poor would still qualify for means-tested social security benefits.¹⁷⁵ A new policy on social care funding could encourage equity release, enabling people with assets to contribute towards the costs of their own care while remaining in their own homes.

4. Comprehensive

Under the comprehensive model, all those over retirement age with the means to do so would have to pay into a state insurance fund. Unlike the insurance model, the contribution would be compulsory, and it could potentially be hypothecated so that all long-term social care for the elderly would be funded out of a ring-fenced pool. The contribution would either be set at a flat rate or vary in accordance with people's means, or a combination of the two could be used, with most people paying a flat rate and the poorest paying different amounts. Payments could be by lump sum, spread over time (before or after retirement), or deferred until after death. Everyone in need of care

would have all of it provided free, thereby capping the amount individuals spend on their care. The Green Paper estimates lifetime payments of £17-20,000, with lower payments for those already aged over 65 at the beginning of the scheme.¹⁷⁶

The comprehensive model has already been rolled out in varying forms in Germany and Japan. In Germany, a social insurance scheme requires all those of working-age to pay 1.7% of their salary to fund long-term social care. The payment is split between employers and employees, and the contributions of those who are unemployed are paid from their unemployment insurance.¹⁷⁷ All those who need care receive it free, with insurance paid out either in the form of a cash allowance or as formal services.¹⁷⁸ The cash benefit can be used however the recipient wishes.

Japan uses a combination of the comprehensive and partnership models. 50% of funding for social care comes from general revenues, and the other 50% from compulsory monthly contributions by people aged 40-65, with state subsidies for the poor and unemployed.¹⁷⁹ The state pays for 90% of care and support costs, from general revenues and the insurance scheme, and care users must pay for 10% of their care in addition to their monthly premiums.

Both the German and Japanese schemes have come under pressure in recent years. Although they pool risk across the entire population and, by providing care to large numbers of people, support the prevention of dependency, the cost of the schemes has proved prohibitive. Japan has had to consider reducing the age at which premium contributions start to 21, and has had to cut back services for those with less severe needs.¹⁸⁰ Germany is reassessing its contribution levels, and private co-payments to fund care have become increasingly common as the cost of care outpaces the insurance fund's ability to pay. Those needing residential or nursing care in particular have found that care insurance benefits fail to cover large proportions of their costs; many have had to resort to social assistance to plug the gap.

174. CSJ (2010) op. cit.

175. Sodha S (2005): Housing-rich, Income-poor; the Potential of Housing Wealth in Old Age, Institute for Public Policy Research. October.

176. Department of Health (2009) op. cit.

177. Featherstone and Whitham (2010) op. cit.

178. London Councils (2009) op. cit.

179. Featherstone and Whitham (2010) op. cit.

180. London Councils (2009) op. cit.

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A recent proposal by the Joseph Rowntree Foundation focuses on a hybrid of the comprehensive and partnership schemes which addresses the problem of inter-generational fairness. A care levy is suggested, which would fund the greater part of social care, with general taxation funding the rest.¹⁸¹ Those who are already retired when the scheme is launched would, since they have not paid into the levy in the past, have to pay the levy from their assets. People of working age would pay additional national insurance charges that build a ring-fenced levy on which they can draw when they need care. The rate paid would depend on one's proximity to retirement age, with those aged in their forties and fifties potentially supplementing the national insurance payment with payment from assets.

The comprehensive funding option performs quite well against the five assessment criteria. It would be fair in that it would spread the risk of paying for the public good of social care widely across society, thereby keeping down the costs for those unfortunate enough to need care. Those who could not afford to pay their contributions, moreover, could be assisted through the benefits system or simply relieved of having to pay. On the other hand, some would have to pay into the system who will never need care themselves (although as we have seen, many people who do not need care have a close relative who does). Convincing society to pay in to such a scheme would be made easier if the public is persuaded of the need to prepare for population aging and mobilised to address the challenge, as discussed above.

The comprehensive system is transparent in that people know exactly how much they must pay in to the fund, and how much care they will receive. Users will also have the reassurance that their payments are capped, and that there is no risk that they will face very high out of pocket costs if they need very intense care.

Transparency, however, might come at the cost of sustainability. As Germany and Japan have shown, the comprehensive model can become prohibitively expensive for the state if contributions are set too low and the cost of care rises. Building flexibility into the system by allowing governments to change the age at which contributions begin or the amount of contributions required would mean reducing transparency, since people could no longer be sure how much they would have to pay. It may also be politically unpopular. The previous

government proposed excluding "hotel costs" – the cost of food and accommodation in residential and nursing homes – from the care people would receive (Japan introduced this exclusion in 2005), but this proved controversial at subsequent consultations as many argued these hotel costs can be extremely high.¹⁸²

The comprehensive option does not score as strongly as other models on the efficiency criteria, since unlike the pay for yourself and partnership systems it does not discourage excess use and it does not incentivize people to delay their need for care through efforts to prevent illness and disability. On the other hand, by reducing the burden on informal carers, it allows the relatives of those who need care more time to work and earn themselves.

Finally, on the personalisation criterion, the comprehensive option does not give individuals flexibility over how much to pay, but if as has occurred in Germany competition is introduced among providers of the insurance scheme it would be possible for consumers to select between packages and providers of care, and therefore have some control over the care they receive.

5. Tax-funded

The final option for future funding is a tax-funded system. This would be similar to how the NHS is paid for, with delivery of care free at the point of use and funded out of the general tax budget. This would require either an overall increase in taxation or the diversion to social care for the elderly of resources from other areas of public spending. This system has been operated in Scotland since 2002, and was suggested as the way forward for social funding in England by the 1997 Royal Commission on Long Term Care.

In Scotland, all those in need receive free personal and nursing care, whether they are in their own homes or in residential homes (hotel costs are not covered, although many of those with limited means are helped with these costs too). An independent review in 2008 found that the policy is popular with the public, that it has led to a large increase in those receiving care, and that care is generally delivered without delay or complication. Social workers, moreover, reported that the new system has helped destigmatise social care for the elderly.¹⁸³ Less positively, the review also projected a funding shortfall of £40 million over the five years from 2008 (a 2006 review estimated

181. Hirsch D, Spiers P (2010): Funding care: how can each generation pay its fair share? JRF. March.

182. House of Commons Health Committee (2010) op. cit.

183. Sutherland S (2008): Independent Review of Free Personal and Nursing Care in Scotland. Edinburgh: The Scottish Government.

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that the program had increased the public cost of care for older people by the equivalent of 0.2% of Scotland's GDP¹⁸⁴), and found significant variations in how local authorities assessed eligibility and in the level of care provided. Overall, the review concluded that 'despite some practical difficulties in its formative years, the FPNC policy remains popular and has worked well in the largest part, delivering better outcomes for Scotland's older people.'

Norway also has a largely tax-funded system. 85% of social care for the elderly is funded out of central and local taxation. Residents of nursing homes pay 75-80% of their public pensions towards their care, but domiciliary care is free at the point of use, and provided through municipalities. 90% of social care provided in institutions is delivered directly by public sector bodies, as is most domiciliary care. This system is popular with Norwegians, most of whom believe social care for the elderly is a public responsibility, but there have been some concerns over the variation in the quality of care provided by different municipalities.¹⁸⁵

In his 2006 review of social care funding, Wanless considered a hybrid model which combined the tax-funded and means tested systems. This would deploy means testing for the first three to four years of care (or an equivalent financial sum) before switching to a tax-funded system thereafter. This limited liability approach would cap an individual's costs and also reduce the costs funded by the state compared with a fully tax-funded system.

The tax-funded model was rejected in the Green Paper because it was thought to place a 'heavy burden' on people of working age, who would have to pay for their own care and that of those already retired (since the latter have not paid for future care during their own working lives). It was also considered unsustainable because of demographic projections, and unfair because older people would receive more from the system than they put in. However, consultations with stakeholders and the public by both the House of Commons Health Committee (2010) and the Joseph Rowntree Foundation (2009) found quite strong support for a tax-funded system (the JRF also found substantial support for the partnership solution

proposed by Wanless), and suggested that it was premature to rule it out.

When assessed against the key criteria, the tax-funded system would potentially be unfair on those of working-age today for the reasons outlined in the Green Paper, although this could perhaps be overcome if it were combined with a levy on those who are already retired or nearing retirement (in a similar manner to the JRF proposal for a comprehensive care levy). On the other hand, the tax system charges people according to their ability to pay, so there is fairness within generations.

In terms of transparency, this system scores strongly in that as with the NHS everybody would receive as much care as they need with no payment above the increase in general taxation, although as Scotland has found, a method would have to be developed to ensure that local authorities use similar eligibility criteria and provide similar levels of care.

The previous government believed a tax-funded system would be unsustainable due to the increased cost. Scotland has seen a substantial increase in costs since introducing free personal and nursing care, and Featherstone and Whitham (2010) estimate that a tax-funded system in England would cost the state an additional £106 billion per year, and rule it out on that basis.¹⁸⁶ In the current economic climate, finding such resources will be difficult, although it is not certain that the country will continue to face such challenging economic circumstances throughout the next two decades, and the cost of a tax-funded care system may become more affordable in the future. Notwithstanding the support for this model in the consultations by the House of Commons Health Committee and Joseph Rowntree Foundation, persuading the public of a need for a tax increase is always a hard sell, and will likely require the broad social mobilisation we discussed above.

The tax-funded system would be efficient in that since their funding streams would be similar it would assist integration with the health care system; if merging of the two systems is to come under consideration, a tax-funded system free at the point of use will remove funding

184. Bell D, Bowes A (2006): Financial Care Models in Scotland and the UK: A review of the introduction of free personal care for older people in Scotland. York: Joseph Rowntree Foundation.

185. AARP (2006) op. cit; Antolin P and Suyker W (2001): How should Norway respond to ageing? Economics Department, OECD. May. Available at: <http://www.oecd.org/dataoecd/32/6/1892017.pdf>

186. Featherstone and Whitham (2010) op. cit.

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differences as an obstacle. Under Wanless's value for money model, moreover, the tax-funded system provided a 1.16 ratio of outcomes to costs, second only to the partnership system in terms of effective use of funds. On the other hand, like the comprehensive system the tax-funded model does not encourage prevention or excess use, and is therefore more likely to waste resources.

Finally, the tax-funded system could be personalized to people's needs if they were given control over their care budgets through a voucher or other tailored scheme, but individuals would have no choice over how much to pay.

One of the major challenges when making an assessment of current funding and comparisons to alternative models is the lack of centralised data covering all those who are purchasing or being provided with care. Any future model of funding should aim to address this challenge, so that future provision of funding can be outcomes based and accountable.

Summary

Various types of funding system have been tried out in different countries. All of them fit one or more of the categories described in the 2009 Green Paper on social care funding. In most countries, a hybrid of approaches is used – England's current system is unusual in being a purely means-tested scheme, and it is likely that whatever system is adopted in future will combine elements of public subsidy, insurance and perhaps means testing and private funding.

Most of the studies we have reviewed conclude that no single funding system stands alone as the optimal solution. As Wanless (2006) observed, 'the choice of funding mechanism depends on value-based choices about the relative importance of containing public sector costs, maximizing equal access to care, and balancing outcomes between high- and low-income groups.'¹⁸⁷ Those for whom affordability is the predominant concern might plump for the current means-testing system or the pay for yourself option, which are the most pared down systems of funding. Those who value simplicity and transparency, or fairness, might prefer the tax-funded system, while those concerned about efficiency and value for money or personalisation might opt for the partnership model. Wanless (2006) alighted on this latter model as his recommended solution; Featherstone and Whitham (2010) shortlisted the partnership and comprehensive models, as well as a hybrid of the two; Hirsch and Spiers (2010) for the Joseph Rowntree Foundation preferred a mix of comprehensive and partnership schemes supporting a care levy; and the 2009 Green Paper itself proposed a National Care Service based on either the partnership, insurance or comprehensive models.

Until now, consensus has not been reached over the model or combination of models which will ensure an effective funding system for the care of older people in years to come. How social care is ultimately funded will depend on broad societal decisions about the balance of public services we need, how far the state should and can afford to fund them in straitened economic times, and what exactly we want social care to do. As we discussed in chapter two of this review of studies, there is ample time to reach agreement on the assessment criteria society values most highly before putting in place a funding system for the future. The Commission on Funding of Care and Support should make use of this time window, and seek patiently to build a consensus among public and policy-makers that will endure for the long-term.

187. Wanless (2006) op. cit.

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Photography

Photographs on page 7, 19, and 36, courtesy of Flickr users: Eggybird, Jonas Boni, and Akash Kurdekar respectively.

**“Cast me not off in the
time of old age;
forsake me not when
my strength faileth.”**

Psalm 71:9

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