

Putting People First

Shaping your future, choosing your care

Hampshire County Council Commission of Inquiry to help shape future services for people needing support and care

Briefing Paper 5 : Partners and funding- summary of pre-existing evidence from experts and research



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Adult social care - who will pay? The need for reform

There has been growing concern that the adult care system is failing people in need, their families and their carers. Despite local councils spending more money on services, demographic changes, changes in health care and changes in user expectations have meant that demand exceeds resources and fewer people are able to obtain state-funded social care. As a result, more people are having to try to find and pay for their own care. However, there remains a perception that there is no incentive to plan and save for old age as those who have done so find themselves paying for care whilst others who have not saved have obtained care for free. Older people want 'low-level' packages,ⁱⁱ which could delay the need for more intensive and costly interventions at a later date, but help around the home is too expensive for many people on modest incomes to be able to pay for it from their private resources alone.ⁱⁱⁱ People who are not eligible for council-arranged services and cannot afford to purchase their care privately are often left struggling with fragile informal support arrangements and a poor quality of life.^{iv} As discussed in Briefing Paper 1, it is arguable whether personalisation will make funds go further or instead cost even more than current services.^v

Currently around half of the expenditure on personal social care for older people comes from private contributions, either in the form of charges and top-up fees on council-supported care, or from spending on privately purchased care. As the population ages and councils must meet higher demand with decreasing resources, the necessity to pay for care privately will increase.^{vi} Two major independent reviews published in 2006, *Securing Good Care for Older People* and

Paying for Long Term Care: Moving forward, concluded that the current funding system was unsustainable. By 2025 20% of the population will be over 65.^{vii} By 2036 the number of people over 85 will have increased by 180%.^{viii} Projections suggest that an increase in life expectancy will result in more people living for longer in ill health.^{ix} The numbers of people aged 50 and over with learning disabilities are projected to rise by 53% between 2001 and 2021. This means demand for support across the continuum of need will increase.^x Local authorities are expected to meet the requirements for further efficiencies^{xi} and continued outcome and performance improvement.^{xii} During the next three years there will be a 1.5% growth for Local Authority Budgets which “will fund demography” plus a 2.3% increase in Department of Health contributions to Area Based Grants and through new specific grants. However, local authorities will be expected to deliver 3% cashable efficiencies each year. Spending on adult social care would need to double in real terms over the next 20 years just to keep pace with the growing number of older people and the rising costs of care provision. As has been suggested in Briefing Paper 2, unless more money is found to pay for social care, personalisation of care will be of benefit to only the small and decreasing proportion of people who are in need that meet increasingly restricted eligibility criteria.

- During 2007, the Caring Choices coalition of 15 organisations across the long-term care system obtained views on how care should be funded in the future from over 700 older people, carers and other people with experience of the care system at events and via a website. It was found that there is almost no support for the current funding system.^{xiii} Almost all (99%) of the participants in the study believed more money needs to be spent on long-term care regardless of where that money comes from.^{xiv}
- A survey of 2000 adults commissioned by the Resolution Foundation had similar results: respondents were strongly in favour of reform of the care system and only 4% of respondents believed the way we pay for care should stay the same.^{xv}

The Government is currently exploring options for the long term funding of the care and support system, and the way forward will be set out in a Green Paper later this year. Outcomes of the Commission will contribute to the determination.

How the system could look

71% of the 2000 respondents to a December 2007 survey by the Resolution Foundation said they would be willing to pay an extra 1p in the pound in income tax in order to raise funds to improve the quality and provision of elderly care. This rose to 75% among those respondents who were low earners.^{xvi} Having publicised making a 2p cut in the basic rate of income tax, from 22 per cent to 20 per cent, which will take effect on 5 April 2008, for the 2008-09 financial year, and having increased National Insurance contributions to shore up the NHS, and it seems highly unlikely that the Government would consider taxation to be the right way forward.

Free personal care does not seem to be considered as an option. The Government did not implement recommendations of the Royal Commission on Long-Term Care to provide free personal care at point of use for all in 1999 and the Secretary of State for Health, Alan Johnson, has criticised the free personal care system in Scotland as unaffordable and unsustainable.^{xvii} Indeed, leaked council documents have revealed that local authorities in Scotland are up to £60m a year short of being able to maintain the policy of free social care and may have to systematically ration the care available to the elderly. The local authorities have already held private talks with ministers about creating a new watered-down version of the legislation.^{xviii}

Partnership between people and the state

The new system for funding for care will need to be affordable and be consistent with principles of universalism, i.e. although there will not be a system of entirely free social care for all, it is possible that all will be entitled to some free care, whilst those who are most in need will continue to receive the most care. In most other countries access to social care is based on universal principles - it is equally available to poorer and better off people. Though co-payments, based on income levels, may subsequently also be required, eligibility to access care is not determined by an individual's financial situation.^{xix} The model proposed by Sir Derek Wanless in *Securing Good Care for Older People* sets out the funding of adult social care as a partnership between individuals and their families and the state. It is considered to be favoured by the Government in principle though is not a fait accompli in terms of its specifics.^{xx}

The Local Government Association recently commissioned a survey of 16-75 year olds, which looked at the willingness of people to make a bigger contribution towards their care:

- Seven in ten people are not worried about spending their children's inheritance to pay for care in old age;
- Only one in five children are worried their parents will spend their inheritance;
- Four in five people in the South East are prepared to pay for their parents care compared to two in five people in the North of England;
- Nearly three quarters of people are not worried about selling their homes to pay for care, one quarter is afraid;
- Nearly three in five people are willing to match what the council pays for care.^{xxi}

Caring choices participant's largely supported a partnership approach:

- Just under three-quarters of all participants believed that the costs of long-term care should be shared between the government and the individual;^{xxii}

- *“Many older people would be happy to pay a contribution, so that they feel they are not a burden” (Caring Choices participant, Leeds)^{xxiii}*
- *“It means you are buying a service and can act as consumer rather than as a passive recipient of a state service” (Caring Choices participant, Birmingham)^{xxiv}*

Participants supported a universal entitlement to some level of state support:

- Almost three-quarters said that the state should contribute to the cost of personal care for everyone, no matter how rich or poor. At each of the Caring Choices events, when voting after a discussion, at least 90 per cent of the participants voted for a system in which everyone gets some contribution from the state;^{xxv}
- There were many calls for older people and their families to have control over the service they obtain with the help of this support,^{xxvi} which implies that personalisation is the right way forward.

The key features of the Wanless partnership model are:

- A free-of-charge minimum guaranteed amount of care. Wanless sets this as the equivalent of a current high dependency package or 66% of a benchmark care package (the benchmark care package is one where the highest levels of personal care and safety are met, 70% higher cost than current levels of care but not sufficient to achieve well-being for all). He states that this percentage could potentially be set at less or greater;
- Individuals then make contributions matched by the state. Every pound people contribute is matched by a pound from the state until the benchmark care package is achieved. Thereafter extra private contributions are not matched;
- Those on very low incomes would be supported in making additional contributions through the benefits system;
- The model costs more than the current means-tested system. However, direct state expenditure in this model would cover care-related uses of Attendance Allowance and Disability Living Allowance (care component), thus these benefits could be significantly scaled-down or stopped. If the model was adopted and two thirds of the AA and DLA funds were transferred to social care, this would provide an increase in public social expenditure of £1.7 billion, as well as achieving a system that provides better outcomes than the current one;
- Almost everyone would be required to make some form of contribution to the costs of their care. This puts important incentives in place for people to save to provide for their needs in older age;

- Lack of means-testing will provide clarity over what people are entitled to and what they are expected to pay;
- People who have made financial provision for old age will no longer be penalised as they are in the current means-testing system, a system which is skewed towards the very poor. Middle income groups will receive equal access to care. Universal access should reduce the stigma of using social care;
- Fewer people will have to dispose of assets to pay for care;
- One feature of the model that could be perceived negatively is that wealthier people would pay less than they do under means-testing and the state would be contributing towards the cost of care for some people who could afford to pay for care themselves.^{xxvii}

Amongst Caring Choices participants there was an unresolved debate about whether and to what extent existing general and non-means tested disability benefits, such as Attendance Allowance, should be brought in to any reform of long-term care funding;^{xxviii}

Berthoud and Hancock have recently argued against using the AA and DLA funds to pay for care. They suggest that these benefits are intended to contribute to the general extra cost of living faced in the long-term by disabled people and their families, such as incidental costs of hospital visits, etc., not necessarily to be used on care services and that taking these benefits away would be likely to lead to an increase in deprivation amongst disabled people.^{xxix}

Mechanisms to enable private contributions

Most participants of Caring Choices were in favour of the idea that the state should support schemes, such as equity release, that help unlock private resources or encourage private contributions towards the cost of care. Participants felt that a variety of options should be encouraged rather than a single 'solution'.^{xxx}

Compulsory savings schemes

46% of respondents to the 2007 Resolution Foundation survey supported the idea of a compulsory savings scheme to enable individuals to prepare for their future care costs.^{xxxi}

Wanless explored the feasibility of potential savings schemes as an *exclusive* mechanism for paying for long-term care (as opposed to making a partial contribution to the care system). However, his comments about the issues involved with such schemes are also relevant to a scenario where they might be a means of making a co-payment towards care with the state. In savings schemes the individual would put money, whilst they were of working age, into an earmarked savings pot that would then grow and could be used to pay for care when needed. The state could make a contribution towards this for example through a tax break. The Pensions Bill will ensure that employees will be

automatically enrolled into the new low-cost national savings scheme from 2012. This is 'soft-compulsion' so that employees will have to opt out rather than opt in. Wanless suggested that saving towards long-term care could be grafted on to this.^{xxxii} Another model is expected to be proposed by the NHS Confederation in a paper for their June conference. This is a compulsory scheme of 'social insurance', similar to a scheme in the Netherlands where people must pay 12% of wages in contributions. There could be an opt out from the most wealthy and tax-funded top-ups for the poorest. Those who did not need care could bequeath the money. Gill Morgan, the CEO, has said "...the model we are looking at would not feel like another tax. It would be more like a savings account..."^{xxxiii} This is highly debateable. The seven million people who are not currently saving enough for their retirement,^{xxxiv} may well find such savings schemes unaffordable. Wanless argued that savings schemes would be poor as exclusive mechanisms for funding social care as they are dependent on people's ability to pay and do not allow money to be directed to those most in need. The individual nature of such a system would also result in poor coordination in terms of prevention, early intervention and engagement with the health care system. Wanless concluded that care saving accounts would be the least attractive model of all for paying for long-term care. How would those who are already impoverished be able to afford to have whatever income they have top-sliced by a compulsory scheme and put enough away to accrue sufficient funds to pay for care in the future? Given the shortfalls in state and company-run pension funds that have resulted from falls in stock market returns and from people living longer, the payments required to accrue sufficient funds would potentially be very high, resulting in the under-provision of care for those with higher needs.^{xxxv}

Private insurance schemes

15% of low earners who responded to the 2007 Resolution Foundation survey favoured a private insurance scheme option.^{xxxvi} Private insurance schemes for long-term care enable policyholders to claim benefits if they can no longer perform a specified number of activities of daily living or are cognitively impaired. The policyholder is given a choice about the type of care they receive. Premiums are set according to an individual's circumstances. The various types of insurance schemes include 'Pre-paid' - where sums are paid before long term care is needed and claims are met with pre-agreed annual sums; Investment-based bonds, purchased with a lump sum - where there is risk that the value may not increase sufficiently to meet the intended benefit amount; Immediate needs annuities, purchased with a lump sum to pay for immediate care- these policies guarantee future payments, at pre-fixed levels, towards the cost of care for as long as necessary and there is no income tax payable provided that they are paid direct to a formal care provider.

Availability

Immediate care annuities were seen as the only viable part of the long-term care insurance industry when Wanless undertook his 2006 study and then only 4 UK providers were willing to offer them.^{xxxvii} The market for long-term care insurance products in the past has been small and most major providers such as Norwich Union and BUPA withdrew their products in 2004. One of the main reasons for the

lack of take-up was because of the high cost of the policies. Insurers were taking on high risks because of the uncertainty of the costs of future care and the length of time care might be needed.^{xxxviii} Another reason is the regulation of the market:

“The market is highly regulated and current regulation requires separate and complex exams regardless of the level of risk attached to products. In consequence, few advisers offer long-term care insurance, further reducing customer access to this market.”^{xxxix} (Stephen Haddrill, Director-general of the Association of British Insurers

Ways forward

It has been suggested that a new funding settlement which more clearly identified individuals' obligations such as the partnership model, could help to bring down the risks associated with long-term care insurance for the insurer, thereby lowering the costs of premiums.^{xl} Kent County Council worked with a leading insurance provider in 2004 to draw up a scheme and found that premiums would be too high. They asked the Department of Health and the Treasury for some funding to explore a case for obtaining a Government subsidy to bring down the price. However, the government refused to sponsor this work.^{xli}

Haddrill has recently proposed some means by which risk could be shared between the public and private sectors, encouraging insurers to re-enter the market and offer more affordable products:

- *“A passport system– whereby a person could transfer part of their entitlement to state support to a care provider of their choice, topped up by private provision. For example, a person could choose to pay for a private nursing home using their own private funds and the money they would have got for a state-run home. The state’s money would only be transferable if agreed rules were met, for example, that the private nursing home was a registered accredited provider.*
- *Time-bound arrangements– whereby the private sector would pay for the first period of care (say, the first two years) and the public sector would take over the cost thereafter if required. To make this successful, a seamless transition over the funding changeover would be needed, with common criteria for assessing the need for care.*
- *Pooled risk– whereby the overall cost of a group of individuals would be shared financially in an agreed proportion between the public and private sectors.*

The options could be to have:

- *products that underwrite care costs for a set period, or an alternative means of capping risk, along with the state;*
- *products that meet costs up to a given level, with the state providing a safety net beyond that;*
- *models in which care is provided alongside investment in retirement housing equity, such as partial equity release products that enable care costs to be met [through purchasing an impaired equity or an immediate needs insurance*

product to fund care fees]^{xliii} *without the housing resource having to be totally surrendered ;*

- *or models where the housing equity of members of a community scheme might be pooled to share risk [through purchasing an impaired equity or an immediate needs insurance product to fund care fees] while retaining some equity for members of the scheme on death. This would be a development of the Joseph Rowntree Foundation's Hartrigg Oaks scheme [a retirement village based on an actuarial model - working in a similar way to insurance schemes, so that a need for care does not lead to an increase in fees]. "*^{xliii}

Haddrill states that In order to make the insurance market viable for contributing to the funding of long term care there needs to be:

- a more proportionate regulatory system, which would help build public confidence but avoid disproportionate cost;
- clarity about where the boundaries of public provision would lie in order to help define the target market beyond it;
- a clear framework and time scales for the working out the nature of the contribution and responsibilities of partners in local or central government;
- support from the government in promoting awareness of the need to address long-term care costs among individuals.^{xliv}

In addition, he recommends other measures to be considered:

- The insurance industry believes people will need more incentives to make private contributions if they are not compelled to do so by the state. Haddrill suggests that an incentive could be a higher threshold for means testing and/or some exemption for their main residence if they make appropriate provision (such as insurance) for themselves;
- Pension rules could be changed to allow people who have sufficient pension funds to purchase policies to cover the cost of care directly from the fund, or to allow pension annuities where a person would give up a proportion of the pension fund at retirement to provide benefits to pay for care benefits later in life:

"For example, say someone has a pension that could provide an income of £20,000 a year in retirement from age 65. He or she chooses to take a lower initial income (say, £18,000 a year) so that when he or she reaches age 85, or meets agreed criteria if needing care sooner, the income increases to £40,000 a year. "^{xlv}

Equity release schemes

Rising property prices meant that by 2005 the average wealth of the household of a 60 year old had increased by £70,000 since the previous decade. There has been much debate on how this gain could be unlocked to improve well-being for older people.^{xlvi}

Joseph Rowntree Foundation, for example, have identified equity release schemes

as one of the best ways to solve the problems of lack of funds for domiciliary care. They have recommended that the Government pilots a voluntary equity release scheme so that home owners could use some of the value of their homes to pay for care whilst staying in their own homes for longer.^{xlvii} Counsel and Care agree that this is a good way forward.^{xlviii}

Perceptions

Research shows that older people are becoming more willing to deploy assets for their own benefit, rather than expect to pass all of them on.^{xlix} However, people tend to be suspicious of existing mechanisms allowing them to access their housing equity. Equity release schemes are shown to be unpopular and perceived as risky and untrustworthy particularly by people with low incomes.ⁱ Only 6% of respondents to the Resolution Foundation survey supported an equity release method for paying for their future care costs, but support slightly increased in line with decreasing age of the respondent- suggesting opinions regarding use of property equity in later life may be becoming more favourable.ⁱⁱ

Availability and quality

According to one report by Joseph Rowntree Foundation, equity release deals are now readily available for most older home owners, on flexible terms, and at prices only slightly higher than those for mainstream mortgage lending.ⁱⁱⁱ However, in 2006, *Which?* looked at 39 products from 24 providers and concluded that equity release schemes can be expensive, inflexible and leave people with little or no equity in their home'. It recommended that equity release should only be used as a 'last resort'.ⁱⁱⁱⁱ In April 2007 home reversion equity release products came under Financial Services Authority Regulation, offering greater protection for the consumer. In contrast, 'sale and rent back schemes' remain unregulated. Age Concern and Citizens Advice, among others, are concerned about this. Age Concern are also worried about the use by people in their 50s of equity release to pay consumer credit incurred earlier life and feel this trend may mar the potential of equity release to contribute to the costs of care for many.^{lv} Recent research by Bristol University commissioned by Help the Aged and Barclays found that one in four people are approaching state retirement age with outstanding consumer credit commitments, owing four times as much as their counterparts did ten years ago.^{lv} In addition, equity release involves significant setting-up costs, particularly if the amount to be raised is relatively small, thus there are relatively few schemes available. The biggest high street banks and building societies have been slow to enter the market while its size remains very small (in their terms), and there is concern that reputations could be damaged by adverse publicity about equity release deals done by others.^{lvi} People in some kinds of property, such as some former council housing, low value properties in a bad state of repair, or accommodation with substantial service charges, still face difficulty in securing a deal.^{lvii} Nonetheless, the value of equity release sales rose 23% in 2007 and seven new providers went into equity release that year. 41% of financial advisers see equity release as 'the next big thing'.^{lviii} As the Wanless report states, there is the potential to use equity release *if* the right products and providers are on offer.^{lix}

Information and support

General information on equity release is available from several sources. But once an older home owner seeks to pursue an equity release deal to pay for additional care at home, they usually have to orchestrate the professionals and contractors themselves. This is a complicated and unfamiliar task, and help in doing so is very patchy. So it is perhaps not surprising that a large proportion of initial enquiries about equity release deals are never carried to completion.^{lx}

Tax and benefits

An even bigger barrier to take-up relates to tax and benefits. At present there is a large disincentive for use of equity release schemes to pay for care as, under current tax law, people have to pay tax on the income generated by such schemes if they receive a lump sum. The income generated by such schemes could curtail or remove entitlement to means-tested state benefits.^{lxi} Older home owners qualifying for means-tested benefits could potentially lose so much in benefits when drawing on equity that they are little better off. It is sometimes possible to release equity for repairs and improvements without losing benefits but it can be more difficult to do so to pay for additional care at home.^{lxii} The Department for Work and Pensions advise that when people draw on equity in the home to make regular payments for care and support (e.g. help with shopping) this is taken into account in their Pension Credit calculation so that any adverse effects on their benefits could be minimised. Equity release deals that allow smaller drawings on demand have increased to make up nearly half of the equity release schemes available.^{lxiii} However, those on Pension Credits will still need good guidance to make sure they draw the money in the *right way* to retain this benefit if they obtain such a deal.^{lxiv}

Ways forward

- In order to make equity release schemes more attractive and viable to fund care, Joseph Rowntree foundation and Counsel and Care have suggested that a state supported equity release scheme could be piloted.^{lxv} The involvement of Government could increase public confidence. It could be set up on a similar basis to the Students Loans scheme and would enable people to defer costs until their home was sold. Loans would be secured on housing equity. Anyone assessed as in need of care would be entitled to draw down a payment per week to pay for home care or residential care. The Government would guarantee the loans and would charge preferential interest at or below the base rate. The care expenditure would need to be tax deductible for those who are self-funding private care but are paying income tax on personal pensions.^{lxvi} Moderate amounts (perhaps up to £3,000 a year) of equity in people's homes would need to be able to be used without affecting entitlement to benefits, and the Government would need to make a corresponding change in the requirements for local authorities' charging policies for their home care services.^{lxvii}

- Alternatively, local government and equity release providers could work together to make equity release deals more trustworthy, appropriate and widely available. This could involve:
 - national endorsement of a commercial product; or

- undertaking a detailed feasibility study on developing a private sector solution for local authorities to arrange equity release deals. The feasibility study would examine the support and practicalities for deals on a national or regional scale involving a newly created or existing not-for-profit company, such as ART Homes, sponsored by local government and funded by the private sector,^{lxviii} and would need to involve representatives of local government and equity release providers.^{lxix} Local authorities would have to make it clear that they did not want to use the existence of equity release schemes as a reason for restricting the range of care services that they provide or raising their charges;^{lxx}
 - the private and public sectors sharing some of the risk on those properties the providers will not accept for an equity release deal;
 - the private and public sectors sharing some of the costs of setting up deals, where only small sums are required.
- In addition, local authorities should provide more support and guidance with regards to paying for care so that people are more aware of equity release as an option and are able to make informed decisions on whether or not equity release will benefit them.
- **Hampshire County Council** is working with the Joseph Rowntree Foundation, Ministers and Government officials, the Local Government Association and other interested bodies in a Task Group which aims to develop mechanisms that would help less well-off older home owners to draw on the equity in their home simply, cost-effectively, and with confidence, if that would enable them to improve their quality of life substantially.

Care vouchers

In 2005 Counsel and Care suggested that there could be a system of employer-supported vouchers for care that would be similar to current systems of vouchers for child care. This idea has been taken up by the Care Vouchers Campaign, a campaign supported by Counsel and Care, Carers UK, the Princess Royal Trust for Carers and many other leading charities and major employers, who are trying to get the scheme implemented. Under the scheme, staff with caring responsibilities would have the option of contributing a weekly sum in return for vouchers which could be used to purchase care services for older or disabled relatives from a range of accredited and approved sources. Their contribution would be exempt from income tax and national insurance. The employers would meet the administrative costs of the scheme and be exempt from employer national insurance contributions on the amount contributed by their workforce. Though this may help carers back into work and help provide 'low-level' preventive services such as telecare, cleaning, respite care and home maintenance, it is not intended and would not be able to provide 'extra' funds towards long-term care. It would provide the preventive services currently not wholly provided by the government and subsidise existing private funding of social care. ^{lxxi} Research by LSE predicts

that for only £37m investment from government, £83m could be generated for preventative care services. This would mean an extra 5.5 million hours of home care.^{lxxii}

More information on other options for funding long-term care can be found in *Funding options for older people's social care, a background paper to Securing good care for older people.*^{lxxiii}

Relationship with NHS continuing care

Lord Bruce-Lockhart, former Leader of Kent County Council and former Chairman of the Local Government Association, has stressed the relationship between health and social care is the central issue to funding. While the NHS has had a 90% increase in funding in real terms during the past decade, local government services including social care have had an increase of just 14%.^{lxxiv}

Personal care is charged for and subject to means-testing, yet NHS continuing health care is free at point of access to everyone, regardless of means. This is a cause of major controversy. Henwood has argued that: *"it is impossible to consider the issue of paying for long-term care without also considering the relationship with NHS continuing healthcare."*^{lxxv}

Lord Bruce-Lockhart explains his perspective of the current situation:

"On the one hand, local authorities have been working in close partnership with the health authorities. A number of social services departments, working with their health authorities, set themselves a target of reducing by 20% hospital admissions for people older than 75. Most of those 10 authorities achieved that target, but through additional cost to the local authority. However, it brought financial benefit to the health authority and real benefit to elderly people. That is encouraging but, on the other hand, because of the current cost pressures within the NHS, many local authorities are reporting cost shunting by the health service. In my own local authority, the East Kent Hospitals NHS Trust closed 180 beds last year, which has resulted in earlier discharges and the need for higher and more intensive levels of social care. It also brought reductions in primary care services, which the health service would not wish for. However, cuts are being made in respect of district nursing, community matrons, community physiotherapists and the NHS equipment provided to residential homes... To give an example from my local authority, in the case of NHS continuing care, it is estimated that 24% of those in nursing homes in Kent have care needs that should be the responsibility of the NHS. We urge the government to develop a test of eligibility with clear criteria that are understood by all, so that we can resolve that issue."^{lxxvi}

Henwood explains that, when the Health Select Committee of the House of Commons undertook an inquiry into NHS continuing care in 2005:

"They drew attention to the fact that reductions in the number of long-stay hospital beds over two or three decades "has meant that people who would previously have been looked after without charge in a hospital are now instead being cared for in fee paying nursing or residential homes, or in the community"... the committee remarked, "care that was previously provided in the NHS [...] is increasingly being provided outside the NHS", with the costs of that care being "shunted from the NHS to local authorities and individual patients and their families". ...The committee argued that as long as there are two systems (health and social care) operating according to different principles, "the highly controversial issue of which patients qualify for fully funded NHS care, and which have to contribute some or all of the costs of care, will remain". Accordingly, the committee recommended that the government remove the "wholly artificial distinction" between a universal and free health-care service operating in parallel to a means-tested and charged-for system of social care. "

Henwood continues:

"The government's response to this recommendation was to point to the fact that the separation of health and social care has stood since 1948, and "to dismantle this would be a fundamental and costly change to the structure of the welfare state". This is a poor argument – the idea that simply because something has existed for almost 60 years it should remain in place for ever more, regardless of whether it is fit for purpose, is nonsensical. Indeed, the opposite argument could be made; precisely because the system has been in place so long while the context in which it operates has changed substantially, there could be a case for revisiting the fundamental principles and structures. "lxxvii

A national health and social care service?

Ham and Glasby of Birmingham University have recently argued that in order to prevent further rationing of social care services, part of the cost of social care should be met by the surpluses the NHS is currently generating. Apparently the NHS is heading for a surplus of £1.8 billion in the current financial year. The NHS has also benefited more than social care from the recent comprehensive spending review. This will result in more blame between local authorities and the NHS, and bed blocking. Like Henwood, Ham and Glasby suggest that ministers should consider the option of bringing health and social care together and paying for them from the same 'pot' to break the current problem that 'health care' is free and 'social care' is not. They suggest this could be achieved not just with pooling of some budgets and the development of care trusts that commission and provide both health and social care,^{lxxviii} but by funding social care nationally instead of through local authorities, separating the assessment of needs by social workers from decisions about the allocation of financial resources to meet those needs. In a national entitlement system to health and social care there would be automatic eligibility for a certain level of support and an end to means testing. They suggest that any thing less than considering radical changes such as this would amount to

“patching up a system already creaking at the seams”.^{lxxxix} Lessons from other countries show that having a single funding stream is easier for users to understand and access, and easier for central government to manage to ensure financial sustainability. This is particularly the case where funding for social care has involved both central and local government and where boundaries with healthcare funding have been unclear.^{lxxx}

State Pensions and prevention

The current Government promised in the Pensions Act 2007 that the link to earnings in the annual cost of living increases will be restored by 2012 at the earliest, making the basic State Pension rise more quickly than it does now.^{lxxxix} Age Concern Hampshire want to make sure this promise is fulfilled in order that older people may have a better quality of life, and ill health can be prevented:

“One hundred years ago the Old Age Pensions Act 1908 led to the introduction of Britain’s first State Pension, paying everyone over the age of 70 years a benefit of five shillings a week- which was equivalent to 25% of the then national earnings. Now... the basic state pension is a meagre 15% of national average earnings and falling... with 2.2. million older people living below the European Poverty line... In order to restore the original value, and before the earnings link was removed in 1981, the basic State Pension would need to increase by £40 per week from £87.30p to £127.30p per week – an increase of 45% - with the earnings link restored to maintain it...[The NHS] has recently been alerted to, and allocated more money for, malnutrition amongst older people. How much better would it have been to allocate that money to improved pensions – dealing with the cause and not the symptom?... Research ...[has] concluded that “occupational class (income) continued to affect the health and functioning of older people well into retirement. A 70 year old retired person from the highest civil service grade had similar physical health, on average, to a lower graded person some eight years younger.” ... by 2012 when the Government may, or may not, reintroduce the earnings link it [the basic State Pension]could as little be as 12% [of national average earnings]. This compares with 70% across much of Europe and the USA..”^{lxxxii}

Financial issues arising from personalisation

Personalisation is not just about the personal care that is funded by local authority social services. The LAC for Transforming Social Care states that we should be looking at resources from mainstream/universal services, the NHS, housing and ‘Supporting People’, the voluntary and private sectors and other relevant statutory agencies, not just those resources spent via the adult social services department and the contributions of individuals.^{lxxxiii} This could mean not only joint commissioning but also pooled budgets and integrated funding between health

and social care, providing the flexibility of funds to be invested in, for example, early intervention and preventative approaches.^{lxxxiv}

Pooling budgets and funding streams

- In the 13 pilot sites for Individual Budgets, a number of funding streams have been brought together including social care funding, Disabled Facilities Grants, Integrated Community Equipment Services, Supporting People, the Independent Living Fund and Access to Work. Sites have found it easiest to integrate funding streams in the assessment process with Supporting People where this is located within the same Directorate as social care.^{lxxxv} The ring-fence around the £1.7 billion Supporting People grant programme will be relaxed in order that budgets can be pooled within Individual Budgets and Local Area Agreements.^{lxxxvi}
- Difficulties have been reported in integrating assessments for funding streams which are considered to be very specialised and require specific information to be gathered (e.g. Access to Work, Disabled Facilities Grants); where there is not a standard approach to assessment in the numerous district councils within one site (e.g. Disabled Facilities Grants); where eligibility criteria and resource allocation are regulated by the funding agency's deeds (e.g. The Independent Living Fund); or where sites are only part way through an existing contract with a particular service and feel that this contract cannot be varied to allow their assessments to be integrated (e.g. Integrated Community Equipment Services).^{lxxxvii} A local authority who was integrating all of these streams had problems with the ILF in particular because the ILF had an 'ultra conservative' approach in what it was prepared to count as eligible funding if it was not being spent on personal care and domestic assistance.^{lxxxviii} More information from the evaluation of the Individual Budgets pilots is due to be published by IBSEN later in the summer.
- It has been very difficult for councils to address Government requirements to develop preventative and early intervention services given that financial constraints emphasise the need to ration care to those in direst need.^{lxxxix} As Age Concern have stated,

“Since social care funding is so obviously struggling to keep pace with demand, there is no slack in the system that would allow social services to divert resources away from people with high needs, and towards those who have not yet reached crisis point. The approach set out in Putting People First will therefore only be successful if other agencies contribute to supporting older and disabled people to live independently. Hence the emphasis on Local Partners developing community wide Local Area Agreements that involve the NHS, the voluntary sector and other council functions such as housing.”^{xc}

Anne McDonald of the Local Government Association has suggested that partnerships are not yet going far enough:

“A major obstacle to the shift from acute and institutional care to care and support nearer people’s homes is the difficulty in releasing funds from the hospital sector to sustain such a shift. There are many perverse incentives in the system. Even where health and community services are regarded as a local continuum, where it might be imagined that funding would flow to the most cost effective configuration, acute services continue to exert a draw on funding. In areas where health and social care budgets stay completely separate, in the hands of the primary care trust and local council, there is no incentive for either partner to invest in actions that will save funding for the other.”^{xci}

Indeed, this has meant that the Government has needed to make special grant funding available to counter the problem of the lack of 'low-level' help at home. The recent CSIP guide to integrated working between the NHS and local government cite examples of where this special grant funding has been used:

“The DH Partnerships for Older People Projects (POPP) programme has generated activity ranging from community development, healthy living and access to information to more specialist help with avoiding hospital admission and coping with discharge home. A project in Poole was based on case-finding and early intervention, directly linked to GP surgeries, but with widespread involvement of older people in the community. An integrated model for mainstream change has been worked out as a result and is now being implemented. A combination of new technology and government grants has brought about an expansion in telecare provision in recent years, which has the potential to make a big contribution to prevention services. Now Cornwall, Kent and Newham are taking part in a major national study of the use of telecare and telehealth in the management of long-term conditions. The point here is that commissioners are in a perfect position to promote a shared view of the whole system and to adjust the balance of spending. Evidence from the pilots of Individual Budgets suggests that users prioritise informal neighbourhood support when given choice.”^{xcii}

MacDonald argues:

“A key learning point from the Partnerships for Older People projects is that this type of change takes time and commitment on the part of all the partners involved, with initial investment to enable the change that can deliver savings elsewhere in the system in the longer run. What they have not yet effectively demonstrated is that this change can become sustainable, because they have not, in general, been able to overcome the perverse incentives and move to a long-term shift from reliance on the acute sector to community services that support an improved quality of life for older people. The drive to design services around the individual and consider

wider well-being and the shift to prevention and community services rather than institutional crisis response both mean that local services need to work together with agreed priorities and actions."^{xciii}

"I met some commissioners recently who said the auditors wouldn't let them have joint budgets. This is nonsense - they just lack the will and desire to make the change." (Julie Dent, Consultant, Social Enterprise Coalition)^{xciv}

Closer partnerships between local authorities, primary care trusts and third-sector providers have been developed in recent years through local strategic partnerships. There are many forms of partnership arrangements between local authorities and primary care trusts. They range from joint strategic needs assessments to joint commissioning, the merging of senior management teams in local authorities and primary care trusts, joint appointments of primary care trust chief executives and directors of adult social services, care trusts where local authority and NHS services merge to make a new trust, the 'care trust plus' in North East Lincolnshire where public health has been moved into the local authority, and the new 'super-authority' being developed in Herefordshire with a single chief executive for the unitary council and the primary care trust which intend to merge into a new legal entity.^{xcv} However, clearly more needs to be done. In the LAC for Transforming Social Care, where it was suggested that pooled budgets and integrated funding between health and social care could be invested in early intervention and preventative approaches, the NHS was specifically called upon to release the necessary resources to their local authority partners for this purpose.^{xcvi}

Recent evaluation of a 5-month pilot undertaken in a London GP surgery to reduce unplanned hospital admissions and hospital bed days for over 65s provides evidence suggesting that preventive partnership working between the NHS and local authorities could provide big savings for the NHS. Using the Unique Care approach to practice-based commissioning for care of people with long-term conditions in primary care (based on the Castlefields model of integrated care), the project team consisted of a lead GP and a social worker and community matron seconded from mainstream services for seven hours each per week. The workload was used flexibly between the community matron and the social worker and the matron was based in the local social services office with access to social care records. Patients of the surgery over 65 identified as very high or high risk of unplanned hospital admission were assessed by the matron and social worker and care plans were developed to meet existing and potential needs to avoid a crisis that could mean hospital admission. Hospital in-reach was also undertaken and packages of care were organised to facilitate early discharges and avoid excess bed day charges. Results include: 50% drop in hospital admissions during the pilot compared to the period prior to the project (in a similar practice used as a control example for comparison, there was a 12% drop); cost of excess bed days decreased by 98% (in the control practice there was a 23% decrease); saving on the GP's practice-based commissioning budget of £99,000.^{xcvii} The promise of savings like this for the NHS could be an incentive for redistribution of some NHS funds into such projects.

- Direct Payments do not exist in the NHS. Under the Health Act 1999 it is legally possible for Primary Care Trusts to transfer funds to local authorities or to independent living trusts so that NHS resources can be included in a Direct Payment but this rarely happens.^{xcviii} Interestingly, Sutherland Primary Care Trust have recently agreed to make payments directly to the parents of a severely disabled adult for the care they provide to her. The client will not accept care from anyone but her parents. As she has been agreed as meeting the eligibility for Continuing Healthcare, the Primary Care Trust are responsible for ensuring that her health care needs are met. The PCT had argued that it would be unlawful for them to make Direct Payments to the parents. As a way of following the rulings of the Judge reviewing this case, Sunderland PCT have established a contract directly with the parents to provide the care for their daughter. This case does not set legal precedent but local authorities, strategic health authorities and PCTs are in discussions about potential implications for the way care is funded for other NHS Continuing Healthcare recipients whose care is provided by family members, and for those currently in receipt of social services Direct Payments who become eligible for Continuing Healthcare.^{xcix} Alakeson, Glasby and Duffy have argued that to have Direct Payments and Individual Budgets in social care but not health care is unsustainable and a major missed opportunity.^c This is arguably particularly true for users of mental health services - who mostly get their care from the NHS. Evidence from the U.S. has shown self-directed care and direct payments can offer cost-effective improvements in the well-being of people with mental health conditions and it could be suggested that it is unfair to deny people in the UK this opportunity.^{ci} One argument against use of Direct Payments in the NHS is that it would lead to NHS money being spent on non-health related goods and services that should be funded by other public services. Alakeson has argued:

“But housing, say, is known to be fundamental to mental well-being, and housing support can mean someone can maintain a tenancy safely. It should be entirely justifiable to spend NHS resources on non-health-related services where they can be shown to contribute to recovery.”^{cii}

- Proposals were recently announced to give people with the most acute long-term conditions, such as multiple sclerosis, ‘individual health budgets’. This is likely to take the form of a ‘voucher scheme’ (not Direct Payments) to enable people to decide where and on what treatment money allocated to them will be spent. They may be able to choose from over 500 hospitals, including 160 private units, across the country.^{ciii} Information on how this will be piloted will be published in June in Lord Darzi’s review of the NHS. Research shows that some local authority staff think that health funding should be integrated with the Individual Budgets model, particularly for long-term conditions and continuing care situations:

“Why shouldn’t you be able to choose whether or not you have more chiropody help and district nursing help or whatever else you need? Because you know we hear from studies that have actually talked to older

people for example about what is really important to them and it's often things like chiropody." (Chief Executive)^{civ}

However, the conservative example of the potential for Lord Darzi gave in his NHS Next Stage Review Interim report would suggest that the aforementioned Chief Executive's ideal of an integrated menu of health and social care choices is a long way from being realised:

"I have... been impressed by what I have heard about the introduction of individual budgets in social care linked to direct payments and individual budget pilots, which have clearly transformed the care of some social care users. From this, we need to learn how to support and allow eligible service users increasingly to design their own tailored care and support packages. This could include personal budgets that include NHS resources. As a first step, we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual's needs, e.g. through respite care or support, installing grab rails to help maintain independence, self-monitoring equipment for people with long term conditions, supporting carers of terminally ill patients, and so on."^{cv}

- Research shows that some staff feel pessimistic about the scope for engaging with the NHS. They were concerned about the dominance of the medical model of disability in the NHS and about the 'self absorption' and 'introspection' of the NHS. They noted that there did not appear to be any buy-in at all from Health on self-directed support. Comments included:

"The NHS is all about giving doctors the control not patients."

"I don't think Health is ready to give up that financial control to individuals."^{cvi}

Risk - fraud and audit

Personal budgets mean that large amounts of money will be delivered direct to service users and this opens a risk of fraud as people may make fraudulent claims.^{cvi} Users may spend it inappropriately on items not included in their support plan. Though supporters of personal budgets feel that the budgets must not be encumbered with detailed audit trails which limit the holder's freedom of manoeuvre, local authorities have to provide Value for Money. There are perceived to be conflicts between independence on one hand and financial accountability on the other.^{cvi} What little research evidence there is on financial risks of Individual Budgets or Direct Payments shows that unwise use by service users is extremely rare. Examples of abuse of the system tend to be cases where service users have been victims of financial abuse rather than perpetrators.^{cix} There are rare examples of 'misuse' of Direct Payments, though these are often conceded to be exceptional cases.^{cx} Indeed, the very nature of Direct Payments

and personal budgets means people have an incentive to spend the money wisely. The arrangement gives them the opportunity to explore creative ways to organise their care and if they do not use it wisely they have to go back to the normal provider services that they had opted to move away from. Research shows some staff feel any fear of misuse of the money is over-reaction:

"We don't worry about all the money that we waste on crap institutional provision, but yet we will worry about giving someone £20!"^{cxix}

Indeed, some staff feel that there should be no financial monitoring of personal budgets at all:

"If you are saying OK let's put people in the driving seat, well then just give them the money like Attendance allowance or Disability Living Allowance and let them do what they like with it. Don't have this nonsense of we are giving you money, but you have got to produce the support plan and we have got to say it's OK. Because you know ... if you and I wanted to go and buy a wardrobe or plan a holiday, you don't have to go and account to anybody. So why should somebody just because they have some disabilities."^{cxii}

Guidance was produced for the Individual Budget pilots on the appropriate level of financial monitoring and review and further guidance from regulatory bodies may be required to reassure auditors that using a 'light touch' will not put them at risk of being accused of lack of financial probity.^{cxiii}

Eligibility criteria

Arguably perceived 'misuses' or 'abuses' are defined as such due to misunderstandings and differences in expectations about what the money was intended for. Some local authority staff have assumed the money should be paid for personal care and anything else is unreasonable and a misuse of public money. This stems from the role local authorities have in implementing eligibility criteria to ration an inadequate financial resource:

"There has definitely been some abuse of Direct Payments, we have some people who have crazy packages like holidays to Goa and assistance to night clubs seven nights a week. There are some real horror stories." (Senior manager)^{cxiv}

"You shouldn't be able to use some of that money to have your gardening done or your decorating done, or whatever, if we don't do that within our substantial or critical remit." (Physical Disability Officer)^{cxv}

There is a logical fear amongst local authorities of being accused of profligacy and wasting money on some people's 'wants' rather than 'needs' when, due to financial restrictions, there are many people who need council arranged care and cannot qualify for it. In their State of Social Care report, CSCI have criticised

councils for tightening their eligibility criteria whilst acknowledging that the way that the system is funded needs to change.^{cxvi} Not only is there variation between councils as to who is eligible or ineligible for council-arranged social care, there is an increasingly sharp divide between those people who benefit from the formal system of social care and those who are outside it. People qualifying for services arranged by their council are seeing improvements and, in some areas, early steps towards a redesigned system offering personalised care. However, people who are not eligible for council-arranged services and cannot purchase their care privately often struggle with fragile informal support arrangements and a poor quality of life.^{cxvii}

Henwood and Hudson have argued that the personalisation agenda is incompatible with Fair Access to Care.^{cxviii} The ethos of self-directed support to give people greater choice, control and flexibility in their lives means that not all of the money in a personal budget or Direct Payment should necessarily be spent on personal care. Indeed, it can be spent on any services that are legal, contribute to meeting the goals of the person's support plan and keep them safe and well:

"Brenda in Oldham, for example, spends some of her budget on a holiday in Tenerife at a hotel that caters for disabled people with her personal assistant Jan – a market trader – to give her husband Derek a break. She preferred this to the local authority respite care. For about the same cost she achieved a far better outcome. Gavin spends part of his budget on a season ticket to watch Rochdale FC so he can socialise with his friends who take him to the match, thus giving his wife – his main carer – a break. In both cases the spending clearly contributes to the support plan's goals yet even so some people would question whether public money should be used to buy holidays and football season tickets. There is an unstated assumption in these debates that people in receipt of public money should be needy and the services they get a bit like eating greens." (Charles Leadbeater, Demos)^{cxix}

Henwood and Hudson have found that when people have the opportunity to specify and define their own needs they do not all demand services that others might consider frivolous. Rather they may define their needs differently to the standard services that they have been receiving:

"If you listen to what people actually tell you... our ordinary stock offer to them would have been day services... but one wanted to go for a walk... she was lonely. She didn't actually want to go to the day centre... that is what Self-Directed Support is- it's about listening to people. And it's about doing what you possibly can to deliver what it is that people actually want." (Manager, Adult Services)^{cxx}

Nonetheless, with limited resources available to local authorities, the need for rationing of money will apply just as much to personal budgets as it does with the current care system. There would be real financial risks for local authorities if budgets are not kept under control and as a result the level of choice achievable

through personal budgets may be severely curtailed. For example, if budget control is managed through a system where budget-holding staff are responsible for keeping an eye on the purse strings and deciding whether or not to authorise a package, there is the potential that the amounts the Resource Allocation System identifies as payable by the local authority for a run of agreed care packages may not be considered tenable by that member of staff holding the budget, resulting in the carefully agreed plans failing to obtain authorisation. There has also been some concern about how self-assessment fits in with eligibility and there is relatively little experience of implementation of systems to deal with these issues.^{cxxxi} Whichever way the system for allocating money is arranged, if inadequate funding is supplied to meet needs there is a danger that people who have personal budgets will be forced to act as rationers of their own resources, having to stretch reduced resources to meet their priority needs but restraining or reducing quality of life.^{cxxii} The difficulty that local authorities will have in reconciling the opportunity for choice with eligibility criteria could mean even the most reasonable and modest needs of people will continue to not be met.

CSCI are undertaking a review of Fair Access to Care Services eligibility criteria in the light of personalised services and Individual Budgets and by the autumn will make recommendations that will inform the Green Paper on the future funding of adult social care. A consultation document on proposed changes is expected later this year.^{cxxiii}

Conclusion

Now that the serious shortcomings of the funding and delivery systems for social care have been acknowledged, the personalisation agenda and the Green Paper on the funding of adult social care both provide opportunity for major reform. There are many options and scenarios that must be considered, and much detail to be finalised in terms of how the funding system and roles of the interested parties will look. A broad-based consensus will be needed to take things forward and deliver new affordable and sustainable systems.

Rachel Dittrich 24.04.08

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- ii Amongst Caring Choices participants, there were many calls for a wider range of care needs beyond those narrowly defined as 'personal care' (help with washing and dressing etc.) such as shopping or help with gardening, to be better supported. Caring Choices (2008) *The future of care funding: time for a change*, p.2. Retrieved 25 January 2008, from <http://www.caringchoices.org.uk/wp-content/uploads/the-future-of-care-funding-final-report-jan08.pdf>.
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